

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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8:44 a.m.

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1 P R O C E E D I N G S [8:44 a.m.]

2 MR. HACKBARTH: Okay. It is time to begin.

3 Welcome to our guests in the audience. We have got an
4 interesting mix of issues for the next couple days. Some,
5 including the first couple, are sort of more big-picture
6 strategic in focus, and then some of the later issues more
7 technical.

8 Our first topic today is synchronizing Medicare
9 policy across the options that Medicare beneficiaries will
10 face in the future. This is one of those strategic items
11 where we're trying to look down the road and make sure that
12 the work that Medicare is pursuing on various tracks in
13 traditional Medicare and payment reform, Medicare Advantage,
14 comes together in a way that is sensible, not just from the
15 perspective of the Medicare program but also from the
16 perspective of Medicare beneficiaries.

17 So Julie is going to lead the way on this topic.
18 Julie, it is all yours.

19 DR. LEE: Good morning. In recent months, the
20 Commission has been thinking about the relationship between
21 different delivery and payment systems under Medicare, such
22 as ACOs, Medicare Advantage plans, and traditional fee-for-

1 service. Specifically, is it an equal relationship? And if
2 not, should it be? Or should it favor some options over
3 others?

4 In the past, the Commission has expressed a
5 general desire to "move away from fee-for-service." In
6 today's presentation, we want to clarify what you mean by
7 "moving away" and by "synchronizing" Medicare policy across
8 delivery systems. And we also want to get your guidance on
9 the issues and questions the Commission wants to focus on
10 related to this topic.

11 Under the current program, there are three
12 delivery systems through which beneficiaries can get
13 Medicare services: traditional fee-for-service, Medicare
14 Advantage, and accountable care organizations, or ACOs. One
15 basic question to ask in that context is: How do these
16 options relate to one another? Are they equal in terms of
17 what beneficiaries get and what the program pays under each
18 option? If not, how are they different? And what do those
19 differences imply for beneficiaries and the program? And
20 how do we assess the value of each option to the program and
21 beneficiaries? Moreover, how should different delivery
22 systems relate to one another? Put it differently, how

1 should they be synchronized?

2 Throughout the year, we'll approach these two
3 questions in various ways, focusing on payment, quality,
4 risk adjustment, beneficiary choice of options, including
5 beneficiary education, plan choice, and point-of-service
6 incentives. But in this presentation, we'll focus on
7 payment and lay out the issues and questions for the
8 Commission to consider.

9 As we mentioned, there are three main delivery
10 options in Medicare under current law, and traditional fee-
11 for-service, ACOs, and MA represent different payment
12 methods and delivery system integration.

13 First, on the left, we have traditional fee-for-
14 service that pays for individual services, according to the
15 rates established by various payment systems. Although
16 there's some value-based purchasing that ties payment rates
17 to performance, providers overall bear no risk under fee-
18 for-service.

19 In the middle, we have ACOs whose payments have
20 two components: fee-for-service payment rates by service
21 and a shared savings bonus or penalty for the ACO for
22 meeting certain spending and quality targets. As a result,

1 ACOs bear limited risk for spending and quality under the
2 current payment model.

3 At the right, we have MA under which MA plans bear
4 full risk for their enrollees and get paid monthly
5 capitation payments by Medicare.

6 This slide summarizes the current program rules
7 for the three systems. Let's look at the Medicare program's
8 perspective first since it follows previous slide very
9 closely.

10 Traditional fee-for-service and ACOs are similar
11 in that the program pays both options based on the set
12 Medicare payment rates by service. The main difference
13 between the two is that ACOs can get bonus payments or
14 penalty based on spending and quality targets. By contrast,
15 Medicare pays MA plans risk-adjusted capitation payments
16 based on what MA plans bid to provide the Medicare benefit
17 and how their bids compare to MA benchmarks, which are tied
18 to local fee-for-service spending.

19 For the rest of the presentation, we'll focus on
20 the issues from the program's perspective. But we just want
21 to mention here that beneficiaries have an analogous set of
22 questions related to Medicare policy across delivery

1 systems.

2 From the beneficiary perspective, traditional fee-
3 for-service and ACOs look almost the same. Under both
4 systems, beneficiaries get the same Medicare benefit
5 package. Although ACO providers can informally encourage
6 beneficiaries to stay within the ACO, there's no rule that
7 prevents them from going to other providers outside the ACO,
8 as in traditional fee-for-service.

9 By contrast, beneficiaries' experience in MA is
10 noticeably different. First, they must enroll in an MA
11 plan. Second, benefits may vary across plans. For example,
12 MA plans may offer different cost-sharing requirements and
13 extra benefits, if the plan bid is less than the MA
14 benchmark. Finally, MA plans have a limited network of
15 providers or in-network incentives.

16 In this slide, we want to point out key
17 differences between ACOs and MA in how their spending
18 benchmarks are calculated. In general, the calculation can
19 be broken down to two parts: a base level of spending, and
20 an adjustment for trending forward the spending for the next
21 year. The sum of the two equals the spending benchmark.

22 Both ACOs' and MA's methodologies are conceptually

1 similar in having these two parts. However, they are
2 different in exactly what they use to calculate these two
3 parts. Here are a couple of top-line differences.

4 For ACOs, the level of spending is calculated
5 using the average spending of fee-for-service beneficiaries
6 attributed to the ACO; whereas for MA plans, it is
7 calculated using the average spending of all fee-for-service
8 beneficiaries in a county. In other words, the main
9 difference here is in whose fee-for-service spending is used
10 to calculate the average.

11 Now to the second part of the calculation. For
12 ACOs, the base level of spending is trended forward using
13 the national growth in average fee-for-service spending,
14 which comes in two different forms, depending on the type of
15 ACO; whereas for MA plans, it uses the projected national
16 growth rate in average fee-for-service spending. This has
17 been a gross oversimplification of the methodologies, and we
18 can go over the details on question.

19 As discussed, we currently have different program
20 rules across the three delivery systems. Let's look at some
21 payment issues arising from those differences.

22 There are two key questions we want to keep in

1 mind: one, how to set payment levels across different
2 delivery systems within a given area; and, two, how to set
3 payment levels across different areas.

4 To illustrate the issues, let's consider a simple
5 numerical example of payment across fee-for-service, ACOs,
6 and MA within a given area. And for simplicity, let's
7 assume a beneficiary of average risk, or 1.0 risk score.
8 This is an important simplifying assumption because we are
9 assuming away any potential differences in risk selection
10 across delivery systems in order to focus on those
11 differences in providers and payment rules across delivery
12 systems.

13 There are many different reasons why Medicare
14 payment for the same beneficiary can vary across delivery
15 systems. Under traditional fee-for-service, there are no
16 benchmarks or any budgetary controls on spending, and the
17 program simply pays for Medicare services used. As a
18 result, service use and payment can vary by geography,
19 providers, market conditions, and many other factors.

20 In general, Medicare payment under MA is a
21 function of three variables: the county-level benchmark,
22 plan bid amount, and rebate rate. By 2017, county-level

1 benchmarks will range from 95 to 115 percent of fee-for-
2 service spending (which can be adjusted upwards based on the
3 plan's star rating).

4 Rebate rates, which are applied to the difference
5 between the plan's benchmark and the bid amount that's
6 lower, also vary, ranging from 50 to 70 percent based on the
7 star rating.

8 Payment to ACOs depends on historical spending
9 incurred by the ACO's beneficiaries. Therefore, two ACOs
10 with different history of service use and practice patterns
11 can have different payments for the same 1.0 risk
12 beneficiary. In addition, payment to ACOs can also vary
13 depending on whether the ACO has shared savings or losses.

14 In the next two slides, we have two hypothetical
15 examples. The numbers are made up, and they don't come from
16 any specific areas, but they are roughly realistic.

17 Rather than going through the numbers one by one,
18 let me point out a few things that are conceptually
19 important in what's going on in each example.

20 So here's the first example. In Area 1, the
21 average fee-for-service spending is \$8,000 per year. That
22 makes it a low-spending area, so the MA benchmark would be

1 higher than fee-for-service, at 115 percent.

2 In addition to fee-for-service and MA, let's say
3 there are two 2 ACOs, each with a different history of
4 service use and practice patterns, resulting in ACO 1 with a
5 spending benchmark that is lower than the average fee-for-
6 service and ACO 2 that is higher than fee-for-service.

7 For example, you can think of the two ACOs having
8 different use of post-acute care services and diagnostic
9 testing, or ACO 1 having a more tightly managed practice
10 generally and ACO 2 doesn't.

11 So here is the Medicare payment across the four
12 delivery systems in Area 1. To drive these numbers, we made
13 two additional assumptions. We assumed a specific bid
14 amount for MA. We also assumed that both ACOs generated a 2
15 percent savings off their spending benchmarks, and they kept
16 70 percent of that in shared savings. All these numbers are
17 shown in the table, which we are happy to go through on
18 question.

19 To sum up, for the reasons we've discussed in
20 previous slides, different providers and payment rules
21 across deliveries system result in Medicare payment that
22 varies across different systems for the same beneficiary in

1 a given area.

2 Let's consider Area 2. As before, there are four
3 systems: fee-for-service, MA, and two ACOs. But in Area 2,
4 we have higher fee-for-service spending than Area 1, at
5 \$10,000 per year. That makes it a higher spending area, and
6 the MA benchmark is lower than fee-for-service, at 95
7 percent in this example.

8 We went through a similar calculation of Medicare
9 payment for the four systems, and the numbers are shown in
10 the table. For now, let me point out a couple of key
11 differences when you are comparing Area 2 with Area 1.

12 First, note that in Area 2 Medicare payment for
13 fee-for-service was the highest among the four systems;
14 whereas in Area 1, payment for MA was highest. However,
15 also note that for each system Medicare payment was higher
16 in Area 2 compared to Area 1 because Area 2 had a higher
17 Medicare spending overall across all systems. In general,
18 payment levels and relationships among delivery systems will
19 vary across areas.

20 The two hypothetical examples highlight several
21 issues for how to set the payment rate across different
22 systems under Medicare.

1 First, how to deal with spending variations within
2 an area for the same beneficiary?

3 Second, how to deal with spending variations
4 across areas when service use and practice patterns vary
5 geographically?

6 Third, how to set spending benchmarks across
7 different systems? For example, are benchmarks set to fee-
8 for-service spending? Are they at the area level, as in MA,
9 or at the beneficiary group level, as in ACOs?

10 Fourth, who gets the difference between Medicare
11 payment and actual spending incurred by the delivery system
12 when those spending variations exist?

13 In today's presentation, we discussed different
14 delivery systems available in Medicare and a couple of
15 hypothetical examples illustrating how Medicare payment
16 could vary across those systems. Now let's return to where
17 we started.

18 The title of this presentation says,
19 "Synchronizing Medicare policy across delivery systems," but
20 we haven't defined what we mean by "synchronizing." Does it
21 mean payment neutrality across delivery systems? In other
22 words, would Medicare pay the same amount for the same

1 beneficiary whether she gets her Medicare through fee-for-
2 service, ACO, or MA? Moreover, if it's payment neutrality,
3 how would we set that payment level, and how would we
4 address spending variations within and across areas?

5 Alternatively, if not neutrality, does
6 synchronizing mean moving toward one system over another?
7 For instance, would Medicare policy create incentives to
8 move away from traditional fee-for-service? If so, what
9 would that entail?

10 Additionally, given the direction and goals of
11 synchronizing Medicare policy, how would the program
12 transition to where we want to go and minimize disruptions
13 to the program as a whole?

14 Here are the three main questions from the
15 presentation. We look forward to your discussion and
16 guidance on our analytic questions and objectives for this
17 work.

18 MR. HACKBARTH: Okay. Thank you, Julie.

19 Let me just, for the benefit of the audience, talk
20 about the -- we're going to change the process by which
21 Commissioners participate in the discussion with the goal of
22 trying to make sure that we have a clear result at the end,

1 an opportunity for a more free-flowing exchange than we have
2 sometimes had in the past, while making sure that everybody
3 talks. And the piece of this that will be noticeable to
4 people in the audience and familiar to people who regularly
5 attend MedPAC meetings is that I am going to use the red
6 light here and Commissioners' comments are going to be
7 timed, much as the public comments are timed. And so when
8 you see me putting my red light on, that's what's going on.
9 I'm signaling to Commissioners that their budget has been
10 used.

11 So our first round, as always, is to ask whether
12 there are any clarifying questions for Julie.

13 DR. REDBERG: Thank you, Julie. That was
14 excellent.

15 My clarifying question is, on Slide 5, I'm just
16 trying to understand in the calculation of the benchmark,
17 it's average spending of fee-for-service beneficiaries in
18 what time period? In the last year or in the last five
19 years?

20 DR. LEE: So for MA it is the five-year moving
21 average that kind of moves forward. Under ACOs it is a
22 weighted average of three years, I think of the most recent

1 data available.

2 DR. REDBERG: And it's all Medicare beneficiaries,
3 so it includes the under-65 Medicare, the duals, and the
4 over-65's?

5 DR. LEE: No. For ACOs it's the spending of the
6 beneficiaries that are assigned to ACOs. So that's the
7 limiting criterion.

8 Now, for MA, I believe that actually there are
9 various categories that are subtracted, like it's non-ESRD,
10 it is non-hospice, so that there are various categories that
11 are subtracted from that calculation.

12 DR. REDBERG: Thank you.

13 MR. BUTLER: On Slide 8, help me, when you say
14 Medicare payment for same beneficiary within an area, what
15 would be definitions of what constitutes an area?

16 DR. LEE: We have not been precise about that, but
17 the smallest area could be a county. But I think for --
18 let's see. I think a way to -- the simplest way to think
19 about it will be like MSA. So that will allow for a couple
20 of ACOs to be feasible and also for a lot of MSA service
21 areas could correspond to that.

22 DR. NAYLOR: This builds on Rita's question.

1 Again, great report. On Slide 5, on the calculation, if an
2 ACO has 5,000 members this year, grows to 20 next year, it
3 has then this over-time weighted average. They're all
4 coming there from the same, generally speaking, local area.
5 So I'm trying to understand how adjustments are made quickly
6 enough to account for what might be a very different
7 population in year two and year three as the ACO grows.

8 DR. LEE: So my understanding is that that
9 baseline -- so the level of spending that is calculated,
10 that is calculated once at the beginning of the contract
11 year. But I don't know throughout during the three years if
12 there are new beneficiaries.

13 DR. MARK MILLER: David, could you go to the mic?

14 DR. LEE: I don't know how that gets incorporated.

15 MR. GLASS: Of course, it's kind of complicated.

16 [Laughter.]

17 MR. GLASS: So an MSSP -- and, Jeff, pay attention
18 to see if I got this right. They set the baseline, so the
19 three years prior to when the contract started for the
20 average for those beneficiaries that were aligned. And then
21 as you add people -- so that doesn't really change. It just
22 gets increased by the adjustment for change in spending.

1 And then as you add people and subtract people, their risk
2 score, if you will, is entered into the calculation to
3 either increase or decrease the original risk score. But
4 their historical spending is not for MSSP. So the baseline
5 actually stays the same.

6 And then Pioneer, it's different and more
7 complicated.

8 DR. NAYLOR: Thank you.

9 MR. ARMSTRONG: Can you go to Slide 8 again? So
10 when we make these comparisons -- correct me if I'm wrong --
11 the actual benefits to the beneficiaries are different? And
12 do we try to adjust for that at all? Or how does that play
13 into the comparison between these?

14 DR. LEE: You mean the actual benefit package,
15 Medicare --

16 MR. ARMSTRONG: The coverage, what is covered for
17 the MA cost is different than what's covered for fee-for-
18 service, and I actually don't know how different it would be
19 for ACOs. And --

20 MR. HACKBARTH: This would be for their Medicare
21 benefits, not for the supplemental benefits offered by an MA
22 plan.

1 MR. ARMSTRONG: Right, that's what I'm assuming.
2 And so I don't know how that would be a variable that would
3 have any influence on the relative cost to the Medicare
4 program or whether that needs to be adjusted for.

5 DR. LEE: So in this example for the MA where
6 there can be supplemental benefits, we only focused on the A
7 and B services for the basic Medicare benefit package, and
8 that's the only cost that we kind of took into that
9 calculation.

10 MR. ARMSTRONG: So that's how we do make sure
11 we're comparing apples to apples across this.

12 DR. LEE: Mm-hmm.

13 MR. ARMSTRONG: Great. Thank you.

14 MR. HACKBARTH: Other clarifying questions?
15 Seeing none, let's go to Round 2.

16 DR. CHERNEW: So, thanks, I thought this was
17 terrific. A few broad points.

18 The first one is, at least for me, when I think
19 about this synchronization, like harmonization, what at
20 least in my mind I think of, broadly speaking, is fiscal
21 neutrality across the programs, and at least in the examples
22 you gave, it was on total medical -- there are all sort of

1 total medical expense kind of notions. But other things,
2 like we talk about site neutral, it's a different thing, but
3 the basic principle of neutrality across sectors matters.

4 I think we'd like to have the same quality
5 standards, although if some organizational forum could
6 provide more benefits, better quality for the same fiscal
7 amount, I think we'd certainly let them do that, and try to
8 encourage them, in fact, to do that if they could.

9 If we have -- and you see it in a lot of places in
10 the program -- big gaps across the way, different types of
11 broad program areas are paid, you create arbitrage
12 opportunities that I think generates really unproductive
13 behaviors in a variety of ways.

14 I think it's possible we might want to deviate
15 from that basic notion of fiscal neutrality, but we should
16 really know why. So, for example, if one system was bearing
17 more risk, you could imagine if the program wanted to
18 offload that risk, we would pay a risk premium. The program
19 might not want to pay a risk premium, and I think that would
20 be a separate thing. But the point is really we should
21 know.

22 The key thing is cost differences across the

1 sectors in my mind are not an inherent justification for
2 higher payment. The program must value whatever it is that
3 you're getting in those different sectors. So simply
4 saying, "Oh, it's more expensive because..."

5 That said, the underlying rules across all these
6 sectors are inherently going to be different because the
7 sectors are different, and I think that's okay, but we
8 should try to the extent possible to minimize the
9 differences in the administrative burden associated with
10 different rules. But certain types of sectors are going to
11 inherently require different types of regulation, and that
12 might put them at a disadvantage. And I think if that's
13 true, that's actually a real disadvantage, you know, we
14 shouldn't try to compensate them for that in higher payment.

15 So that's at least what I think about this topic.

16 DR. COOMBS: So, my ideas center around the fact
17 that in the high-cost areas, if one could stratify a high-
18 cost area with wide variation, it might have a different
19 type of outlook in terms of what that looks like. In the
20 same vein as what Mike has said, that if a high-cost area
21 has some serious outliers and it's a bimodal distribution
22 where you have, say, two groups on either end of the

1 spectrum, you might have a different yield and incentivize a
2 high-cost area to have advantages that are different than
3 what would be seen in the low-cost area.

4 And I don't know if the model or the simulated
5 model could actually drill some numbers in to look at what a
6 bimodal distribution would look like in the high-cost area,
7 yielding the end product of what we see for Area 2 on page
8 eight. I don't know if you want to --

9 DR. LEE: Those examples are just -- they are not
10 -- they are roughly realistic, but they are not real. So we
11 were just trying to illustrate some of the issues that we
12 have to consider, so --

13 DR. MARK MILLER: Or, I would take her question.

14 DR. LEE: Okay.

15 DR. MARK MILLER: If we get guidance out of this
16 and some subsequent sessions where the Commissioners say, we
17 want to think about financial neutrality this way or that
18 way, then we can move to a process of where we would try and
19 simulate the impacts at the market level and try and get
20 some sense within a given market how much noise you see. At
21 this point, we would be very hard pressed to --

22 DR. COOMBS: So, that's interesting, because it

1 might be that you come back to it and you say, if you
2 simulated a model where there was an outlier of 21 percent,
3 say 20 percent, one-fifth of the ACOs that were in this area
4 were tremendous outliers to kind of drag that high-cost area
5 up, you might say that you might have a different kind of
6 policy that's implemented at that level.

7 DR. MARK MILLER: Well, I think that would be a
8 question for the Commissioners to discuss --

9 DR. COOMBS: Yes. Yes.

10 DR. MARK MILLER: -- and that's why simulating it
11 precisely would be hard without having some guidance from
12 you guys --

13 DR. COOMBS: Right.

14 DR. MARK MILLER: -- to say, in that case, I want
15 to do X.

16 DR. COOMBS: Yeah. So, I would actually recommend
17 that we actually look at what kind of different variation
18 exists that drags the high-cost area to where it is and look
19 at the percentage of ACOs in a market that would make it
20 look different.

21 MR. HACKBARTH: Craig.

22 DR. SAMITT: So, I'd like to focus my remarks

1 specifically on fee-for-service versus Medicare Advantage,
2 and the reason why I'd like to do that is, as I have
3 suggested before, I'm not sure we should be concentrating on
4 ACOs as sort of a permanent vehicle for value-based care
5 delivery. I see it as a means to encourage fee-for-service
6 groups to begin to experiment with alternative payment
7 methodologies and to shift from the traditional model to
8 alternative models. So, as I look at the example, it's hard
9 for me to really envision how to address ACOs.

10 So, I'd really like to concentrate on fee-for-
11 service versus MA. I'm a believer in the whole notion of
12 synchronizing the two models, in essence, and what I mean by
13 that is achieving alignment. We should be rewarding
14 Medicare Advantage plans that -- or groups that are bearing
15 risk -- to improve quality and reduce cost, and unless the
16 incentives really reward the groups to improve their
17 performance, I'm concerned that we won't see enough provider
18 incentives to move in that direction.

19 Likewise, I would say that we would want to
20 encourage beneficiaries to shift from fee-for-service to
21 alternative payment, as well, if we presume that the quality
22 is better and the savings accrue to Medicare.

1 So, I do believe that we need to achieve alignment
2 and synchronize those two models with the thought being that
3 if we continue to apply benchmarks for MA that are relative
4 to fee-for-service in a particular area and then apply
5 quality bonus, star bonuses to those MA plans, that in each
6 market, we will begin to see transition of fee-for-service
7 to Medicare Advantage. So, I believe in that
8 synchronization.

9 In terms of spending variation across areas, I
10 have a hard time understanding why we would set MA
11 benchmarks significantly higher than fee-for-service
12 averages in those markets. It seems to create just
13 distortion in that marketplace which seems to be
14 unwarranted. I'm not sure that's necessary. So, I think
15 the focus really needs to be, in essence, saying let's peg
16 benchmarks 95 percent to fee-for-service plus bonuses for
17 stars with the presumption that that will shift both members
18 who can share in the benefits of gaps to benchmarks and
19 providers who are rewarded for their good efforts for
20 quality and cost reduction in that direction.

21 MR. HACKBARTH: Thanks. Jack.

22 DR. HOADLEY: So, what I'm focusing on is the

1 geographic differences, and in some ways, it relates to both
2 what Alice and Craig said. When I look at Slide 8, a low-
3 spending area, we see here -- I think this illustrates
4 nicely the policy that we've set which says that in low-
5 spending areas, we're assuming to some extent that that low
6 spending level is at least a little bit wrong. And so in
7 the MA policy, you know, we used to do the 95 percent sort
8 of across the board and it was viewed as not working, and
9 particularly in low-spending areas, there was no ability for
10 managed care, Medicare Advantage to come in. So, we've got
11 a policy that says, well, we should set it higher because,
12 in some sense, that 8,000 is wrong and we're trying to
13 create a benchmark that says it goes up. Whereas on the ACO
14 side, we've not said that. We've said, well, that is kind
15 of right. Whatever history is is right and we'll try to
16 give some incentives within that.

17 When you go to the next slide and you look at the
18 high-spending area, we've said, okay, that 10,000 is wrong.
19 We're trying to get the MA down. We know there's room to
20 bring them down. And in a way, the ACO examples here, both
21 are lower, which might not empirically be what we'd expect.
22 On average, we might expect that they'd be closer to the

1 10,000. But, in any case, it's the same policy that says
2 we're kind of assuming history is the baseline.

3 So, we've really made two different decisions
4 historically on where to put baselines, and I think -- and I
5 don't know what the right answer is, but I think that's the
6 challenge. Is fee-for-service simply too low in the low-
7 spending areas and too high in the high-spending areas and
8 it should be closer to uniform, or are some of those
9 differences really legitimate that we need to reflect and
10 capture.

11 MR. HACKBARTH: Can I just quickly offer an
12 alternative perspective, and I don't -- I can't say that
13 this is right or wrong. Congress is not of one mind. It's
14 got a lot of different minds. But as Congress moved away
15 from paying 95 percent of local costs to paying above local
16 costs in some areas and below in other areas, the rationales
17 that I most frequently heard had to do with equity. It
18 wasn't that they thought that the spending was too low in
19 some areas. It was about equity.

20 The low-spending areas, like my home State of
21 Oregon, said, you know, we're so efficient, we need to be
22 rewarded for our efficiency and a way to do that, a vehicle

1 for doing that is through the Medicare Advantage program
2 giving us rates that are above fee-for-service costs. It
3 was not that, oh, we in Oregon think our quality is poor and
4 we need more money. It was, we need to be rewarded for
5 being so efficient.

6 The second equity argument was Medicaid
7 beneficiaries across the country should have a similar
8 access to the added benefits under Medicare Advantage. You
9 know, it was equity for Medicare beneficiaries. I don't
10 want my beneficiaries in Oregon not to have similar
11 supplemental benefits as they have in Florida.

12 And so it was not a judgment about quality being
13 poor or good, it was about different types of equity. Those
14 are the arguments that I heard.

15 DR. HOADLEY: I've certainly heard a lot of that,
16 you know, in those debates in those days, but I think part
17 of it takes us back, you know, whatever the actual
18 rationales in making the policies is, what is the correct
19 level of spending? I mean, we look at it in the Part D side
20 and see these vast differences. They're really hard to
21 explain. Should we be trying to get the lower-spending
22 areas a little bit higher, or we assume the lowest spending

1 in the country is right and bring them all down towards
2 that. But is it that there should be sort of a uniform
3 national price and the policy reflect that as opposed to, in
4 a sense, the ACOs accept whatever history is and says, well,
5 we're going to compare you to that, which may make sense in
6 the sort of narrow sense of an ACO policy, but maybe not.

7 MS. UCCELLO: So, Julie, thank you for this
8 chapter. I think it's really good, not only for this
9 discussion, but also kind of helped me frame my thoughts as
10 I read the subsequent chapters on how to think about some of
11 this stuff.

12 In terms of neutrality, I mean, Medicare should be
13 paying -- their payment should be closer across the
14 different delivery systems or organizations, and I think if
15 we -- I started thinking of this more as how we think about
16 the efficient providers, that we should be paying at
17 efficient provider levels. Well, we should also be thinking
18 about paying in terms of efficient systems. And in some
19 areas, those systems may be different than in others. In
20 some places where it may be more difficult for MA to be,
21 because of scale issues or other issues, it may be more
22 difficult for them to come below fee-for-service, I don't

1 know why we would have to pay them a lot more to do that.

2 I think there can be some differences, as Mike
3 said, with respect if there are quality differences or maybe
4 rewarding some additional risk bearing, but, in general,
5 thinking of things more equal across the different systems
6 and thinking about them more as kind of efficient systems
7 seemed to make sense to me.

8 DR. MARK MILLER: Can I say this one here, since
9 we're on the clock here --

10 MR. HACKBARTH: See, I didn't allocate you any
11 time.

12 DR. MARK MILLER: That's why I'm jumping in. And
13 I've got the clock here, so --

14 [Laughter.]

15 DR. MARK MILLER: So, I think I'm hearing you two
16 saying two different things. Ninety-five percent of the
17 market, Craig, what about a national, Jack, not asserting
18 it, but -- and then you said we should be working to the
19 efficient provider, but that does get tangled up in those
20 two definitions. In your comments, were you thinking within
21 the market or between the markets?

22 MS. UCCELLO: I was thinking that the most

1 efficient providers may vary across different areas based --
2 so within a market, yes.

3 DR. MARK MILLER: [Off microphone.] I'm with you.

4 DR. NAYLOR: So, others have addressed the
5 definition of synchronizing around fiscal neutrality and
6 alignment, and I think that that's what we are talking
7 about.

8 I, just in general, the comments about differences
9 in spending and how that's calculated between ACOs and MAs
10 raise questions for me. I don't know how you use average
11 spending for a select group of people today that could be
12 different tomorrow, and it seems to me there's a tremendous
13 opportunity for great variability, increasing or decreasing
14 risk in a population served in a very short period of time.
15 So, it would suggest a broader service area. A local
16 community is a better way to move.

17 I don't know that the only path we're moving is
18 from fee-for-service to Medicare Advantage, so I would think
19 that taking a very close look at how ACOs evolve as a path
20 toward alternative payments is very important, but I still
21 question whether or not spending -- the way we are currently
22 defining spending, based on beneficiaries attributed, makes

1 the most sense, since they do exist within an area and,
2 therefore, we have some comparability with MAs.

3 My last point, if any of that made sense, is that
4 I think beneficiaries are really important to think about as
5 a focal point for distributing shared savings. We
6 ultimately rely on the beneficiary to be managing a great
7 deal of their health and it seems to me that their
8 engagement and reinforcement of those behaviors is a really
9 important focal point for consideration.

10 MR. GEORGE MILLER: Just briefly, I would agree
11 with Mary that the beneficiaries should be part of the
12 equation as far as sharing some of that benefit, but I'm
13 struck by the other discussions we've had about a regional
14 variation, and so my concern is, as Jack very eloquently
15 went through the analysis on Slides 8 and 9, is how do we
16 determine the right price, whether it's nationally or
17 regionally, when we have variation, so much variation. So,
18 once we solve that problem, it would be better to decide
19 which is a better way to go. But, again, I just want to
20 emphasize that I think that having the beneficiary part of
21 the equation would be important, to reward them, as well.

22 DR. BAICKER: So, my thinking follows up on Cori's

1 and Mike's point. I, too, sort of think of the efficient
2 way to deliver care to a particular beneficiary and it seems
3 like we need to differentiate between variability in cost of
4 care that we think is fundamental and in some sense good
5 versus variability that is bad. If you're paying more to
6 deliver the same quality of care to the same beneficiary
7 under different modes, we don't want to support that. Some
8 beneficiaries are more expensive than others. You know, if
9 you have a more expensive health condition, you're going to
10 -- more than average should be spent on you. If it's a part
11 of the country where the costs of everything is higher, that
12 needs to be taken into account.

13 And so I would want to think about harmonizing in
14 a way that in no way discourages enrollment of particular
15 beneficiaries based on their attributes, because we want
16 that variability to be allowed to persist, but does not
17 reward inefficient use of resources to deliver the same
18 quality of care to the same beneficiary. So that plays into
19 the geographic variation, too. Some variability between
20 areas, I think, is not sensible -- a lot of it is probably
21 not sensible -- and some of it is unavoidable and due to
22 completely outside circumstances of the areas, and so we

1 have to differentiate between those, as well.

2 MR. BUTLER: So, I like using potentially guiding
3 principles to help direct these, so I'll suggest six, in two
4 minutes.

5 [Laughter.]

6 MR. BUTLER: One is, why not publish these things
7 more, whether -- look at Slide 8 versus 9 now, I'll work off
8 of. If it's MSA or if it's county -- could you flip to
9 Slide 8 -- is there a way that we can really kind of
10 understand these differences and make them publicly
11 available so we look at it?

12 The second is to make sure the methodology,
13 whatever it is, does not result in either benefit or
14 provider behavior towards a model that's more expensive to
15 Medicare. That's the negative way of saying.

16 The third would be, I don't know why you couldn't
17 synchronize at least the updates, the increases per year,
18 between the sectors to make sure you don't get further
19 distortions.

20 The fourth would be more of kind of behavior
21 incentive synchronization. Craig mentioned the MA plans and
22 the stars and so forth. I think in the fee-for-service,

1 particularly, you want to have the value-based purchasing
2 flex up to mimic and use the same kinds of successful tools
3 that are in either ACO or MA to kind of move that sector
4 along as best you can, and I know we're going to talk about
5 some of that in a later session.

6 The next one is in terms of do -- I like value-
7 based purchasing and that there's a reward for performing
8 against a benchmark and there's also a reward for
9 improvement. So I think there's some blend of encouraging
10 people to move to these models, even though they have a bad
11 starting point, so you do get some of those shared savings.
12 But if you blended that with a standard, maybe that's a
13 compromise way of kind of getting at it.

14 And, finally, as we do in all things, any kind of
15 these methodologies allow for some phasing.

16 So, those would be my thoughts.

17 DR. CHRISTIANSON: I'm beginning to hear some
18 consistency in terms of the Commissioners' thoughts about
19 this. Yeah, we're synchronizing our thoughts.

20 [Laughter.]

21 DR. CHRISTIANSON: So I won't ruin that. I guess
22 one of the things that I thought about as Michael was

1 talking, and maybe Kate, was to be cautious about equating
2 synchronization with equalization and how much can Medicare
3 tolerate in terms of differences in what we pay providers
4 based on value. I think are we willing to pay more for more
5 value? I think the answer has been yes, and the way that
6 we've structured different bonus arrangements and so forth.
7 But as we think about synchronization, let's keep in mind
8 that that's something that we've endorsed a policy in the
9 past that's resulted in, and I think reasonably so,
10 differences in payment rates across providers that reflect
11 differences in value. At least, we hope they do.

12 And then sort of related to that is another policy
13 that I think that MedPAC has endorsed in the past is the
14 idea that there's no reason to -- if you have beneficiaries
15 that have been risk adjusted and, as Kate was saying, if
16 you've somehow adjusted for variation of labor costs, there
17 isn't any particular reason that Medicare should gratify or
18 validate the decisions that are made by provider groups that
19 result in more expensive care.

20 And I know that in one of the previous MedPAC
21 reports, we've seen the argument that -- sort of trying to
22 rebut the argument that Medicare is a low payer with the

1 idea that, well, if you look across sites in highly
2 competitive private sector markets, hospital payments for
3 Medicare don't look so bad. But in less competitive private
4 sector markets where provider organizations make decisions
5 about their basic cost structure that results in a higher
6 cost structure, then in those markets, Medicare payment
7 doesn't look so good, and so you argue that Medicare
8 underpays.

9 Well, whatever we do in terms of synchronization,
10 I don't think we want to necessarily reward or validate
11 previous provider decisions in terms of their cost
12 structures, which may or may not be efficient.

13 DR. HALL: Well, in terms of the synchrony
14 dialogue, I guess I took a slightly different point of view
15 on what is the synchrony we're looking for. We're really
16 comparing three systems of care that have very different
17 historical backgrounds and experience. Obviously, Medicare
18 for 60 years, fee-for-service, MA for a couple of decades,
19 and now ACOs, relatively speaking, are just getting off the
20 ground and are still in the process of evolution.

21 So, consistent with a theme that's through almost
22 everything we're going to be talking about today, and that

1 is what is the value of any change or any perturbation of the
2 Medicare system, how does it benefit the patient in terms of
3 high-quality cost-effective care, and also, we're much more
4 cognizant of the experience of the beneficiary.

5 So, I would say that what we're looking for in
6 terms of synchrony is basically what is the unit of value
7 relative to the unit cost in the three systems, and I think
8 it's going to turn out to be a very heterogeneous argument.
9 We may become quite informed by ACOs as not only to what
10 works, but what clearly isn't going to work in many parts of
11 the country. Particularly as there's redistribution of an
12 older population, costs are going to vary from place to
13 place.

14 So, I would say we ought to be very cognizant of
15 the quality aspect of this as well as the cost and not let
16 that be in some separate silo, that someone else is going to
17 take care of that.

18 MR. GRADISON: I'm really going to be picking up
19 on comments by many of you, Craig and George and others,
20 about the beneficiary side in the context of this thought,
21 that I think it's very important to make the Medicare world
22 safe for diversity. And the reason I say that is that a

1 one-size-fits-all plan doesn't necessarily fit the
2 circumstances or the choices that might be made by 50
3 million-plus different folks.

4 That leads me to feel somewhat handicapped by not
5 having, at least in my mind or from the literature I'm
6 familiar with, any particularly clear idea about how choices
7 are made by the beneficiaries. I wish I knew more about it.
8 I think it would help to inform my thinking on this specific
9 subject and the one that's going to follow later in the
10 morning about quality.

11 I put the ACOs aside because that's not a choice
12 that's made by the beneficiary, not that -- I'm not trying
13 to say they shouldn't exist, but I'm interested in the
14 choices people make.

15 And, long-term, I'm extremely interested in the
16 possibility of offering additional choices way beyond the
17 ones, the two main ones that are available today. That's
18 for another discussion. That's one thought. What about the
19 beneficiary? What impact should that have on this
20 discussion?

21 The other thought I have has to do with the way in
22 which we think about fee-for-service and what it is. We've

1 recommended major changes in the reimbursement structure,
2 like the combined deductible is an example. I mean, these
3 are big deals. I'd kind of like to at least think, and
4 maybe with the help of the staff be led to try to analyze a
5 little bit more, let's assume that the fee-for-service
6 system itself changes the way we think it should be changed.
7 We've said this publicly. What impact, if any, might that
8 have on the way in which these different plans develop and
9 the comparison made between, in this case, at this point in
10 time, MA and fee-for-service, not just traditional fee-for-
11 service but maybe a future fee-for-service.

12 DR. NERENZ: Okay. The very first point I might
13 make would be a semantic one. Again, I don't think these
14 are delivery systems, as I understand the term. They are
15 payment models. They are vehicles to get to delivery
16 systems. But they are not delivery systems per se. Now, we
17 may just say, well, that's a pedantic point. Who cares?
18 But I think if we build on the theme of beneficiary choice,
19 we can find, certainly using MA currently as an example,
20 that there are choices of delivery system within MA plan or
21 across MA plans. You sometimes choose plans in order to get
22 to a particular delivery system.

1 Now, as I think about going forward on this, a
2 couple things that I think are very paramount in my mind in
3 terms of broad principles. One would be beneficiary choice.
4 The other would be administrative simplicity. I'll get to
5 the second one in just a second.

6 But, we can think about a system where
7 beneficiaries can have choices at two levels. They can
8 think about choosing a payment model, and they could
9 explicitly choose an ACO if that program evolved in that
10 direction. And then within the payment model they have
11 chosen, they could also choose delivery systems, and I tend
12 to favor that kind of multi-choice option.

13 It's not strictly necessary that CMS or MedPAC
14 favor one or the other. We can let beneficiaries choose
15 with the idea that the CMS contribution is essentially fixed
16 across these options, the way it is in many private sector
17 situations, and then beneficiaries can either pay more or
18 receive some sort of financial benefit, depending on the
19 choice they make relative to some base.

20 Since fee-for-service is the system that has the
21 longest history and is most commonly in place, it seems sort
22 of natural to think about that as the base. You have a

1 certain contribution from CMS if you choose that. That's
2 the way it is now.

3 Going forward, if you choose something more
4 expensive, there are ways, then, that you can pay more for
5 taking that choice. If you choose something less expensive,
6 there are ways to have some financial benefit of reduced
7 copay, reduced premium, for making that choice.

8 So, the general directions here would seem pretty
9 straightforward. But I'd start with the idea that let's not
10 talk about these as delivery systems. Let's talk about them
11 as pathways to get to a delivery system. I think that's the
12 way beneficiaries experience them.

13 DR. REDBERG: So, I try to think of this in terms
14 of, you know, from the program perspective, we want to be
15 efficient in that we want to spend money on things that are
16 actually improving outcomes. So when we're just looking at
17 payment, we're not really incorporating, well, how is this
18 actually helping beneficiaries, and also, what is it
19 covering, because as someone pointed out, these all cover
20 very different things.

21 For example, I recently went to the grocery store
22 and noted that my half-gallon of orange juice was no longer

1 64 ounces. So the price hadn't changed, but now I wasn't
2 getting a half-gallon. And that is sort of how we're
3 comparing it now. We could have the same price, but you're
4 getting a lot less in some certain areas and certain plans,
5 and so I think it's important.

6 And from a beneficiary point of view, I mean,
7 there really is no incentive in a fee-for-service plan to
8 have any kind of value because your premiums are the same
9 and the sky is the limit on how many providers you can get,
10 how many tests you can get, and that doesn't mean you're
11 getting good care, but you could --

12 And so I would favor going toward systems that
13 incorporated not just how much we spent, but what you got
14 for it, both in terms of services and in terms of outcomes,
15 because we want high-quality care and what we have now in a
16 fee-for-service system is a high-volume care. I don't
17 really think there's room for value in a fee-for-service
18 system because it doesn't incorporate -- there's no fixed
19 budget and there's no incentive to kind of look at value.
20 There's only incentive to increase volume, and that's what
21 we've seen, you know, is the trend has been much higher
22 volume. We'll talk about that in some other contexts.

1 And I also think, from a beneficiary point of
2 view, it's very confusing to have all of these choices. I
3 mean, we're in open enrollment now where I work and it's
4 very confusing for me to go through all of those systems and
5 I think it's much harder for beneficiaries because there's
6 so many different -- and so I think having -- focusing our
7 efforts on how to achieve efficiency in terms of more
8 services for less cost.

9 And when you think about what's the difference
10 between the high spending and low spending areas, I think
11 much less of it has to do with the beneficiaries and a lot
12 more has to do with providers and the delivery systems and
13 also with capital. We know that areas that have more PET
14 scanners probably spend a lot more money on PET scans, but
15 that doesn't translate to value. So I think we need to keep
16 that in mind when we're comparing areas and systems.

17 MR. ARMSTRONG: Well, first I would just start by
18 saying I felt like the questions for discussion are really
19 hard questions, and I'm not sure I have much more to offer
20 beyond what has been said. Just I would affirm that, like
21 many other Commissioners, generally I really value and want
22 to promote creating financial incentives to move down the

1 continuum toward, you know, value-based or outcome-based
2 payments. And I think MA is the best structure, and like
3 Craig, there are other alternatives, bundles and ACOs and so
4 forth, that kind of help get us accustomed to that and more
5 effective at that.

6 I also would agree that we do this through the
7 Medicare program in order either to get more for the same
8 amount or to pay less for the same services. And that
9 should be a principle that influences the way we pay for
10 these programs, the relative payments that we make for these
11 programs.

12 The last point I would make is that I felt it was
13 a little beyond the scope of this chapter, but this idea
14 that there's such spectacular variation from region to
15 region around our country in what we pay for, maybe really
16 just objectively, non-politically dealing with that may be
17 one of the biggest opportunities to impact future spend for
18 the Medicare program. And so if through this door we can
19 get ourselves into some more analysis around that, I would
20 encourage that.

21 MR. HACKBARTH: This is hard. There have been
22 lots of rich discussion and comments, and, you know, usually

1 my way of processing the discussion is to read the
2 transcript and sort of go through it and I have time to try
3 to piece together thoughts. Doing it real-time is really a
4 different proposition altogether and very hard.

5 So what I want to do is offer some themes that I
6 think I heard in this conversation, but also some previous
7 conversation, and see if we can sort of develop some
8 consensus on some really basic points. So I'll throw them
9 out, and they may resonate with you, they may not, but I
10 want to get your reactions.

11 Before I do that, though, I want to introduce two
12 other thoughts that are mine and maybe uniquely mine because
13 they are uniquely bad thoughts, but here they are.

14 One aspect of both Medicare Advantage and ACOs
15 that I think is not given sufficient emphasis is that
16 potentially they're frameworks for delegating decisions to
17 local organizations that now in traditional Medicare are too
18 often made in Washington. But in order to have effective
19 delegation, you also need to have accountability --
20 accountability for results on cost and quality -- and really
21 MA and ACO are potential frameworks for establishing that
22 accountability for defined populations on both cost and

1 quality.

2 But that is very important to me, is that it's, I
3 think, an affirmative argument for these initiatives that is
4 underplayed. Let's get responsibility out, but hold people
5 accountable for the results. So that's one thought that I
6 want to emphasize.

7 The second is that we at MedPAC often talk about
8 changing the incentives. We don't like the incentives in
9 fee-for-service, so we want new payment models, whether
10 offered by the Medicare program or Medicare Advantage plans
11 that get out of the volume-rewarding model. Of course, I
12 think that is very important.

13 But here, too, I think there is another point that
14 is sometimes not given enough emphasis. I think that
15 changing the incentives for providers and new payment models
16 are important, but an even more powerful way to change
17 provider behavior is shifting volume of patients, moving
18 volume from low performers to high performers. That is the
19 mechanism by which markets really drive efficiency.

20 Go outside of health care. In every market the
21 producers have an incentive to reduce costs because, you
22 know, they get a fixed price and they've got production

1 costs, and if they can reduce their costs, they get a larger
2 profit margin. But where you see dramatic improvements in
3 efficiency, it's because all of a sudden there's been some
4 event that has caused volume to shift, and that causes
5 people to fundamentally rethink what they do. And so we
6 want not just improved incentives -- of course, we want that
7 -- but mechanisms that potentially shift volume from low
8 performers to higher performers I think are very important.

9 Now, that gets me to some of the themes that I've
10 heard both in this conversation and previous meetings that I
11 want to lay out and get your reaction to.

12 Choices are important for both beneficiaries and
13 providers. A couple people picked up on the beneficiary
14 engagement and involvement in choices. Rita has mentioned
15 how challenging that is, and for sure it is challenging.
16 But the nature of the Medicare program, the diversity of
17 beneficiary needs, the diversity of the delivery system, the
18 diversity of the country -- and, oh, by the way, the
19 politics of all this -- means that forcing Medicare
20 beneficiaries to go into things that they don't like is not
21 likely to be effective or politically acceptable or
22 otherwise productive. So we need a system that offers

1 choices for beneficiaries.

2 In previous conversations I have also heard
3 Commissioners emphasize that we need choices for providers
4 as well, and, you know, in fact, that is a theme that I have
5 often mentioned. You know, we talk about moving to new
6 payment models, but we know -- in fact, some people have
7 mentioned this just today -- that the level of readiness,
8 the circumstances of providers to adopt new payment models,
9 is all over the map. And, you know, we couldn't require
10 everybody to be in ACOs today. That just wouldn't fit.

11 So we're talking about choices for both
12 beneficiaries and providers, and we need to think very
13 carefully about how to structure those choices and reward
14 people, beneficiaries, for going to high performers, low
15 cost, high quality, and reward providers for moving in that
16 direction.

17 So the vehicles that we're talking about here are
18 -- we have traditional fee-for-service, ACOs, and Medicare
19 Advantage as sort of our basic choice model. And Mike's
20 initial observation -- and he has written a fair amount
21 about this as well -- is that if we're going to have options
22 for beneficiaries and providers, we need to think very

1 carefully about the nature of that playing field. If we
2 don't, we can have some serious unintended consequences and
3 reward, for example, inefficiency when, in fact, we want to
4 do the opposite. And it was that observation that brought
5 us to this conversation.

6 And I think we've talked about the leveling at
7 both sort of the national level and regional variation and
8 intra-market variation. I think both are very important.
9 But if I had to give a priority between the two, it's the
10 intra-market that is most important to address thoughtfully.
11 They want to do the regional variation over time, but intra-
12 market, if you don't address that effectively, you get some
13 really untoward results that you don't want.

14 A last observation, and this pertains in
15 particular to -- actually I think this graph is a good
16 illustration of it. So we've got what seems to me some
17 inequity potentially between ACO 1 and 2. If you start with
18 a high cost base, if you are historically high cost, it's
19 easy for you to get rewarded under the current structure of
20 the program than if you were historically efficient. That
21 problem is compounded if, in fact, you move away from an
22 upside-only shared savings format to one where there's a

1 potential downside risk as well, and that's something we're
2 going to talk about a little bit later when we get to ACOs.
3 So I think this potential inequity between ACO 1 and 2 could
4 become a very pointed issue in the second round of
5 contracts.

6 Now, the point that I want to highlight here is
7 that as you think about dealing with the equity between ACO
8 1 and 2, what goes on in fee-for-service has a very
9 important effect on what your policy options are. If you
10 try to reduce the difference in targets between ACO 1 and 2
11 and leave fee-for-service open ended, what will happen,
12 especially as you move to two-sided risk, is that if you
13 have a high historical cost base, you'll say, "I just won't
14 play in ACOs. I'll just go back into fee-for-service, open-
15 ended fee-for-service, where I know I can make a lot of
16 money. It's open ended. I can generate volume. I'll just
17 go back to my old business model, and I won't play any
18 longer."

19 So, yeah, we want to offer choices for providers,
20 but if you have an open-ended fee-for-service program as one
21 of the options for providers, it's going to be very
22 difficult to deal with equity issues, intra-market equity

1 issues. And so we need to think about how if we offer free
2 choice of provider, open-ended fee-for-service as an option
3 for beneficiaries and providers -- and I said at the outset
4 I think we probably need to do that -- we need to think
5 about how to structure that option so that it isn't a refuge
6 from reform, it isn't a refuge from getting better whenever
7 pressure is applied.

8 So those are some thoughts. We have -- how much
9 time do we have left here, Mark?

10 DR. MARK MILLER: 35 minutes.

11 MR. HACKBARTH: We've got 35 minutes, and so we'll
12 now have some open discussion. Obviously I welcome reaction
13 to those thoughts, but if you want to go in other directions
14 as well.

15 What I will ask is -- I'm not going to just go by
16 order of hands, who's got their hands up. Jon is going to
17 go first. He got his hand up first. Then I'm going to ask
18 people to sort of pursue that thread and see if anybody
19 wants to go where Jon has started to lead us. If not, then
20 we'll ask for somebody to start a new thread. So I want to
21 have a little structure in this conversation. Jon, lead the
22 way.

1 DR. CHRISTIANSON: So I'll warn Mike that what I'm
2 going to do is ask Mike to do something. Scott's last
3 comments I think sort of raised the issue of variation in
4 payment of providers by geographic area, and I think, Mike,
5 you were on the IOM committee.

6 DR. CHERNEW: [off microphone].

7 DR. CHRISTIANSON: Okay. And I think that the IOM
8 committee raised some serious issues about the nature of,
9 you know, whether you should vary payment by geographic
10 area, and maybe you could summarize for the group a little
11 bit what their conclusions were in that regard.

12 DR. CHERNEW: I'm not sure -- I won't claim to
13 speak for them, but my understanding of their conclusions
14 was that they weren't in favor of changing payment by
15 geographic area, in large part because there's variation
16 within the geographic areas. And so this notion of creating
17 a level playing field mattered, but I think the summary I
18 would give is the unit of payment being the geographic area,
19 you know, to reward everyone there or not, didn't seem to
20 make sense to them.

21 DR. CHRISTIANSON: I would add to that that the
22 notion that you would actually be penalizing efficient

1 providers in some areas and rewarding inefficient providers
2 because of that.

3 DR. CHERNEW: That's exactly what they noted, is
4 that there's good providers in high-cost areas and there's
5 high-cost providers in low-cost areas. And so thinking in
6 the Nerenz delivery system sense is slightly different than
7 thinking in a geographic area sense.

8 MR. HACKBARTH: Okay. Anybody want to go further
9 down that path of talking about variation across geographic
10 areas?

11 MR. GRADISON: This will be real fast. I think
12 there's sort of a mythology, based in part on history and in
13 part on hope, that Medicare is a uniform national program.
14 It isn't. At least in many respects it isn't. And I don't
15 have any specific conclusion I want to draw from that except
16 just it might be an interesting thing at some point to just
17 give some thought to in what ways is it not a uniform
18 national program and why, because it may inform some of our
19 other discussions.

20 DR. CHERNEW: I just want to say there's
21 uniformity in terms of common rules and uniformity in terms
22 of outcomes, and it differs along those exact dimensions.

1 They try to be uniformity in terms of rules, but as we've
2 noted and as the IOM report noted, there's very differences
3 in terms of uniformity, in terms of a whole range of
4 different types of outcomes.

5 MR. GRADISON: I first came across this when I was
6 involved in the legislative side. It's a small example, but
7 I was looking into a constituent concern and found that,
8 depending on what region of the country you lived, you were
9 entitled to different numbers of changes of colostomy bags
10 in the course of a month or a year. A small example, but
11 there are a lot like that.

12 MR. HACKBARTH: There are a huge number like that.
13 So, Craig, you had your hand up. Did you want to go in a
14 different direction, a new thread? Anybody else on this
15 one?

16 DR. REDBERG: I do.

17 MR. GEORGE MILLER: Yes, just very briefly, to
18 Bill's point, my question is: How much of the regional
19 variation is just because of a higher price or demand for
20 services or more entrepreneurs or providers going in the
21 market because there's high demand? Do we know that
22 difference? And have we been able to analyze that and

1 determine if we're rewarding efficient providers or
2 rewarding just economic issues?

3 MR. HACKBARTH: This is a really important topic,
4 but I feel like we're sort of drifting away from the issue
5 that we're trying to raise in this presentation. We can
6 come back to geographic variation if people want to delve
7 into that in more detail. But I think we're sort of getting
8 away from how we create better incentives for both providers
9 and beneficiaries and deal with these issues.

10 Craig, do you want to take it in a new direction?

11 DR. SAMITT: Sure. I liked all of your --

12 DR. MARK MILLER: Rita.

13 MR. HACKBARTH: I'm sorry, Craig. Rita.

14 DR. REDBERG: Thanks. I was going to comment, and
15 it is on geographic variation, but I think it's related to
16 synchronizing, because my impression is like Mike's, that
17 the IOM report didn't want to go into areas because it's so
18 much individual provider variation that determines -- and
19 right now, again, the problem in fee-for-service is there is
20 no reward for the high-performing providers because in a
21 fee-for-service system it rewards high-volume providers, not
22 high-performing providers. And there is -- because most

1 Medicare coverage is determined by regional and local
2 decisions, there is tremendous variation in what's available
3 in different areas, you know, according to coverage and
4 then, of course, according to what is in your area, you
5 know, what services are available.

6 And then I just -- because I agree with you that
7 beneficiaries want choice, but it seems to me the choice
8 they want mostly -- and I'd be interested in what else you
9 were thinking of -- is in choosing their doctor. But
10 besides that, it seems beneficiaries consistently would want
11 to be able to choose their doctor and then get good medical
12 care, you know, when they needed it. Was there something
13 else you thought beneficiaries -- because, I mean, what I
14 was saying is I don't think they really want to go through a
15 long book of 100 pages and look at all these different
16 options on, you know, this one covers this much services,
17 and this one -- you know, I think people would like as much
18 services as they can for the least cost.

19 MR. HACKBARTH: Yeah, I agree with your comment
20 that for many Medicare beneficiaries, what choice means to
21 them is, oh, I have an unrestricted choice of providers.
22 And I think that's one reason that traditional Medicare,

1 which guarantees that free choice, has been and I think will
2 continue to be popular for many beneficiaries far into the
3 future.

4 There are other beneficiaries, though -- and I
5 think younger cohorts as they come into the program will
6 have a higher proportion of these people who are used to
7 saying, "I'm willing to trade off network size for premium
8 savings." And I think we've seen that in our own focus
9 groups. Joan's nodding her head. And I think there's other
10 research that suggests that there are some generational
11 changes that may occur there. But I agree with your initial
12 point that for a lot of beneficiaries, it is, "I want to be
13 able to go to my doctor without question."

14 DR. SAMITT: So I liked all of your points, but
15 the one that I really glommed onto the most that I'd like to
16 talk about is your concern about the ACO viability and
17 distortion. I commented earlier on the focus of fee-for-
18 service versus Medicare -- excuse me, versus MA, but I'm
19 admittedly worried about building upon, preserving, and
20 enhancing the viability of the ACO program, mostly because I
21 see it as a bridge from the old world to the new world. And
22 if the bridge is unstable, then we won't effectively make

1 the transition.

2 So the concern that I have about getting this
3 issue of synchronization right is we don't want to see
4 organizations step into the ACO program and step back to a
5 comfort zone of open-ended fee-for-service, because we're
6 not encouraging providers to move forward or we're not
7 encouraging beneficiaries to move forward. So if the
8 presumption is we want to move forward in the continuum, how
9 do we strengthen every step in the continuum to keep moving
10 people in a forward direction? And, in fact, and what we
11 haven't discussed much of is, Do we keep moving in a forward
12 direction by closing doors behind us? So can open-ended
13 fee-for-service really stay? Or very similar to the way we
14 will discuss later, does one-sided ACO stay or do we move
15 everyone to two-sided? The question is: Can the current
16 fee-for-service open-ended model still exist? Or does that
17 also need to move to some new plane where we can't go back
18 to the way things were?

19 MR. HACKBARTH: A couple quick observations, and I
20 would remind people that later on today we'll be focusing
21 specifically on ACOs and the rules of the gam and how they
22 might change. But I want to pick up on or add two things

1 about the weakness of the current model.

2 One is that the shared savings, the one-sided
3 model, I think is inherently a weak model in terms of
4 providing strong incentives to change. And Jeff some years
5 ago did some illustrations, you know, working through basic
6 math, of just how weak the one-sided model is, and we can
7 delve into that perhaps later on in more detail. The other
8 -- and a lot of people make that observation.

9 The other thing that doesn't get quite the same
10 attention is that, whether it's a one-sided or two-sided
11 model, ACO is built on a fee-for-service chassis. So all of
12 the dollars continue to flow, bills are submitted by the
13 individual participating providers, and people get rewarded
14 for volume. And if you're leading the ACO, your only lever
15 to really change the system is by distribution of bonus
16 dollars, or if it's a two-sided model, distribution of the
17 penalties incurred. But, you know, the current model
18 continues to reward volume, overpays specialty services,
19 underpays primary care. All of those things continue to
20 happen, and as we've discussed before, the fee-for-service
21 chassis means it limits the free flow of resources within
22 the system.

1 You know, part of what we want to do is get the
2 dollars to flow where clinicians think the highest value for
3 patients are, but under ACOs you only get paid if you meet
4 all of the fee-for-service rules about when the service was
5 provided, you know, all that stuff. There isn't the same
6 free flow of resources that you have under a capitated
7 system.

8 So those are just examples from me illustrating
9 your point about the weakness of that model, Mike.

10 DR. CHERNEW: My reaction to both of your comments
11 is essentially it's hard for us to always know which way
12 forward is, and I think the point of this notion of
13 synchronizing your level playing field is to allow
14 organizations to succeed or fail under a common set of
15 rules. So it might be that a one-sided model is weak, but
16 someone could make a legitimate argument so let it fail on
17 this common set of rules as opposed to predetermine that and
18 kick it out.

19 There's a concern that if we have too much stuff,
20 there's too much clutter in the environment, and so I do
21 think it behooves us to make each of the segments as
22 efficient as we can, including fee-for-service, in a variety

1 of ways.

2 My general sense, and I think the most complicated
3 part of this discussion, is the part of that exact point
4 which relates to paying for quality, because everyone says
5 that when we go around the table. My view is that we have
6 to start with fiscal neutrality, with a common set of
7 quality menus or payment, and we'll have a session in a
8 minute about what quality is. If an organization can do
9 better in terms of financial performance or in terms of
10 quality or in terms of broader network, I think those gains
11 -- if they do better than our level playing field, those
12 gains accrue to the organization and/or the beneficiary as
13 the playing field is set out. But my take would be we want
14 to have sort of a fiscally neutral platform with a common
15 set of what we will pay for better quality or better
16 benefits or better whatever and let organizations that can
17 do better succeed by pulling in patients the exact way Glenn
18 said about volume moving. And organizations could be a
19 plan, they could be a provider, and I think while you have a
20 view that ACOs are a bridge, I think other people believe
21 that inherently a provider-based system will do better than
22 a plan-based system in MA. And I don't want to take a

1 position on that point as much as make sure that the rules
2 allow both to succeed if they can.

3 MR. HACKBARTH: Others on this thread?

4 DR. COOMBS: So as we begin to look at benchmarks,
5 one of my concerns -- and I'm sitting here thinking that we
6 discuss this as though we're in a vacuum, and part of the
7 issues that I have with all four of the systems, if you will
8 -- ACO 1, 2, and a high-cost or low-cost area -- is there is
9 a segment of our population that we have reviewed in the
10 Medicare Advantage that we know is inadequate in terms of
11 minority and vulnerable populations may have a hard
12 transition there.

13 The other thing is the data on Pioneer ACOs and
14 where they're distributed in this country in terms of does
15 it get to, you know, minority communities or suburban areas?
16 What do ACOs look like in terms of demographics?

17 So, you know, we say leveling the playing field in
18 terms of payment. What about leveling the playing field in
19 terms of inclusivity of all groups? And we looked at this
20 in Medicare, specifically with the MA plans, and we actually
21 said that there's low minority participation. So if we
22 level playing fields, we should think about the

1 inclusiveness, not just quality for the people who are
2 there, but how inclusive is it? And you might find that
3 with the fee-for-service there's a disproportionate number
4 of minorities and vulnerable populations in the fee-for-
5 service, and if you set up an infrastructure that's really,
6 really rigid where you say let's build in some sticks in the
7 fee-for-service, then you've made some decisions that will
8 drive a different type of care for those people who are --
9 some people would call it "stuck in fee-for-service."
10 Others would say that fee-for-service is doing what it needs
11 to do for those beneficiaries that are there. So I think
12 that's the part that we can't be blindsided to.

13 MR. HACKBARTH: So, Scott or Carlos, I think the
14 national data -- and I don't know if you're referring to the
15 Boston market --

16 DR. COOMBS: One of our chapters [off microphone].

17 MR. HACKBARTH: The national data suggests that
18 minorities are, if anything, maybe slightly overrepresented
19 in MA plans. There are some complicated issues about how
20 you make those comparisons, but I don't think they show that
21 they're underrepresented.

22 DR. COOMBS: [off microphone] overrepresented.

1 MR. ZARABOZO: [off microphone].

2 MR. HACKBARTH: Would you come to a mic?

3 DR. MARK MILLER: I think the point is that
4 Hispanics are overrepresented -- represented African
5 Americans about the -- yeah.

6 MR. ZARABOZO: About the same [off microphone].

7 MR. HACKBARTH: At the national level, and it may
8 be --

9 DR. COOMBS: So I was speaking about the
10 maldistribution in terms of the crescent regions and
11 specifically with Pioneer ACOs and where they are, just
12 looking at the Pioneer ACOs in terms of two-sided --

13 MR. HACKBARTH: Pioneer ACOs would be a different
14 thing because they're much smaller in number, many fewer
15 participating organizations.

16 Okay. Who did I have next in line? Did I have
17 somebody?

18 DR. MARK MILLER: Mary.

19 DR. NAYLOR: I think it was me. I just wanted --
20 these last two comments, I think, are really where I think
21 this conversation needs to go. That we are thinking about a
22 framework that's not grounded in how existing payment

1 systems are today, because we have the capacity to improve
2 all of these options, but rather a framework upon which we
3 can think about measuring common ground, equalizing
4 payments, and transparency -- to Peter's point -- where
5 beneficiaries can see exacting who is served, what services
6 they are getting, what is the performance relative to that,
7 and they can have the capacity to move.

8 I also think, to your point about preparing
9 clinicians, the framework really does need to think about --
10 you know, if we want to get it different and we want to use
11 payment tools to get it different, we should think about how
12 we make different investments in the workforce to enable
13 them to move from an existing culture -- even if it's an
14 improved fee-for-service system -- to getting something
15 better out of it.

16 So I think what we're emerging with is a framework
17 that helps us to think about -- and all guided by these
18 great chapters to unfold. But I hope that we will continue
19 that part of the conversation.

20 MR. HACKBARTH: Others? Either a new direction
21 all together, or to add to this? Do you want to add to
22 this, Dave, or do you want to go new?

1 MR. GRADISON: A quick comment about incentives.
2 I would just like to observe that the incentives that we
3 talk about, or the penalties, with respect to both ACOs and
4 Mas are always directed to the provider, not to the
5 beneficiary. Just think about what might happen if some
6 portion of those savings were shared in cash with the
7 beneficiary, giving them a stake in making the decisions.

8 DR. NERENZ: I was just going to comment on a
9 couple of things, Glenn, that you said as you led into the
10 section. One is a comment and a question simultaneously on
11 the issue of volume shift as an incentive.

12 It strikes me -- and I would be interested in
13 thoughts of other organizational leaders around the table --
14 that those incentives are very asymmetrical. In a fixed-
15 cost environment, loss of volume is bad. And it seems like
16 pretty universally bad. Losing patients is bad.

17 I'm not so sure it works the other way. A busy
18 surgeon, for example, who already has a three-month lag time
19 to an appointment is not really rewarded by more volume.
20 And that's particularly true if the payment doesn't even
21 meet the average cost of that service.

22 So I guess I just wanted to make sure I was

1 thinking of that correctly, that if we're talking about
2 volume shift as part of the dynamic going on here, loss of
3 volume I think bites more in a negative sense than increased
4 volume adds. Is that fair?

5 MR. HACKBARTH: [off microphone].

6 DR. NERENZ: Okay. Then the other thing you
7 mentioned was that under certain scenarios, looking at that
8 chart up there, that organizations may decide they just
9 didn't want to work in the ACO environment, go ahead and we
10 are just going to run fee-for-service.

11 That would be true except -- just as Bill was
12 saying -- if there were tangible beneficiary incentives to
13 be in an ACO environment, if we make the assumption it's
14 truly better, an organization can't just unilaterally decide
15 to be in fee-for-service if beneficiaries want to go the
16 other way.

17 MR. HACKBARTH: Right on the asymmetry point. I
18 think, in particular, they are asymmetric in the short run.
19 In the long run, everything -- including fixed costs -- can
20 change. But in the short run, I think there is some
21 asymmetry.

22 Jon, did you have your hand up? No? Before I go

1 back to Craig, anybody else who hasn't been in?

2 DR. CHERNEW: Can I just say something related to
3 what Bill Gradison said?

4 MR. HACKBARTH: Okay.

5 DR. CHERNEW: Okay -- go ahead.

6 DR. SAMITT: I also wanted to echo Bill's comment
7 about aligning -- synchronizing and aligning, not just with
8 the providers but with the beneficiaries, as well. If we
9 presume to know the direction we do want to move, the
10 question is is have we achieved alignment with the
11 beneficiaries? Are there sufficient rewards to recognize
12 that if we're achieving higher quality outcomes, lower
13 costs, are we in some way rewarding the beneficiary not just
14 with improved health but also a desire to shift volume to
15 that type of setting.

16 MR. HACKBARTH: Let me just underline a point
17 here.

18 If you look across the models, in Medicare
19 Advantage, as currently structured, there are mechanisms by
20 which beneficiaries can share in the savings. They are
21 constrained by both legislation and regulation. The
22 principal vehicle has been expanded benefits and reduced

1 out-of-pocket costs at the point of service. But I don't
2 think there's anything to prevent plans from rebating Part B
3 premiums. They haven't done it. But in theory, if you had
4 a really low cost you could even say we're going to rebate
5 part of your Part B premiums; is that correct?

6 DR. HOADLEY: Some do do it.

7 MR. HACKBARTH: Some do do it.

8 DR. CHERNEW: A few.

9 MR. HACKBARTH: A few.

10 ACOs, in the current structure, there is no
11 mechanism for beneficiaries to share in the gains. That was
12 one of the things that we recommended, advocated for in the
13 initial round and CMS went a different route.

14 On the fee-for-service side, you know, the way the
15 system is structured, fee-for-service is sort of the given.
16 So if you stay in fee-for-service your premium never goes
17 up, even if fee-for-service is dramatically more expensive
18 than the alternatives in your community, MA, ACO, whatever.

19 So that means that the negative incentive, if you
20 will, for beneficiaries to stay in what could be a grossly
21 inefficient and even poor quality model in some markets
22 aren't there. They're basically insulated from pressure.

1 So we've got sort of this funny mixture under
2 current law of how beneficiaries see the alternatives and
3 feel rewards or penalties for their choices.

4 DR. CHERNEW: Picking up on that, there's this
5 subtlety which is important. We talk about it, there's fee-
6 for-service, ACOs, and MA. But of course, ACOs are part of
7 fee-for-service in the way that the whole thing is
8 structured. And so, that really is why you have this basic
9 problem.

10 I won't say more about it now, we have an ACO
11 section in a bit, but I think one of the questions that will
12 arise is is that the right conceptualization of where the
13 ACO program goes, in part because when you put it in that
14 broad framework of fee-for-service, you saddle it with a
15 bunch of other aspects of fee-for-service that might not
16 make sense given, in many ways, it has traits like an
17 organized system like MA or a bridge to MA, or whatever you
18 want to think about it.

19 And I think that's worthy of some discussion,
20 although we're going to have a session that will discuss
21 those things.

22 MR. HACKBARTH: Other comments, either on this or

1 in a completely different direction?

2 DR. CHERNEW: Can I ask if there is -- I've heard
3 sort of broad consensus around the basic notion of some type
4 of fiscal neutrality or payment neutrality, or whatever we
5 have heard. I think a lot of people have said that in a
6 variety of ways, with some consensus about finding common
7 ways to pay for quality or common ways to get savings to
8 beneficiaries.

9 I would be interested if people had strong or even
10 mild disagreements with at least that perception of where we
11 were if that's not characterizing what people think.

12 MR. HACKBARTH: Anybody feel -- have real problems
13 with that direction? Jack?

14 DR. HOADLEY: Not necessarily real problems with
15 it, but I think part of this goes back to the geographic --
16 the across markets and the within markets. I think you get
17 to very difficult implications of what that means.

18 So if we really are focused and you, I think, were
19 leaning towards the pay more attention within markets sort
20 of at least one cut at it, that would have implications say
21 on the MA payment policy that we've got right now to say
22 maybe that's the wrong policy if we really want to focus

1 within markets.

2 If we want to focus across markets, you take maybe
3 the MA policy is close to right and the ACO policies are
4 less good.

5 So I think the challenge of doing that is really
6 thinking about where we're within and where we're across
7 markets.

8 MR. HACKBARTH: So just to build on that, you're
9 right. You could say either you take the underlying fee-
10 for-service costs as sort of your starting point and say
11 what we want to do is have a level playing field within
12 markets wherever those fee-for-service costs might be in a
13 given case. Or you could say we think those are bad and we
14 want to adopt the MA structure or some other structure and
15 use that as the linchpin for leveling the intramarket
16 playing field.

17 A corollary of that, though, is that then you
18 would need to start charging differential fee-for-service
19 premiums based on where the markets stand relative to
20 national costs? There's a question mark at the end of
21 that.

22 DR. HOADLEY: I mean, that is a potential

1 corollary, I agree with that. I mean, I think that goes
2 back to what's the goal we ought to achieve? How much do we
3 think the geographic -- even granting that you look at some
4 of the price factors and can make adjustments for that,
5 there are clearly still differences that arise. And if we
6 really want to address that, I don't know whether I would
7 come down to staying that's a good policy solution. But
8 that's certainly a logical thing to consider on the table at
9 that point.

10 DR. CHERNEW: So I agree with that, and I think
11 Kate's original comment, though, I don't think got -- in
12 some ways -- enough attention, which is figuring out what
13 the things are we want, think are good or bad.

14 So in my list of that, I think we all agree that
15 we would want to adjust for health risk. We all agree we
16 would want to adjust for input costs. And I personally --
17 although I'm not sure we all would agree -- I personally
18 would adjust for aspects of SES, socioeconomic status, for a
19 variety of reasons.

20 I think there's some agreement that we should have
21 a common notion of paying for value or some version of that
22 that would be across the places.

1 Where it gets more complicated is I believe that
2 most of us think we conceptually wouldn't want to adjust for
3 different practice styles. We already have a quality
4 component. But if you're just doing more of something, we
5 wouldn't want to just pay you more for that. But the
6 transition to get there across geographies is very
7 complicated in a variety of ways, even within geographies.

8 There's other even more complicated things. I
9 personally, for example, would not be so keen on adjusting
10 for things going on in markets outside of Medicare. So
11 Medicaid programs -- we had this discussion -- Medicaid
12 programs in your area are horrible. Should Medicare pay
13 more? I'm not keen on adjusting for that, but there's some
14 discussion and I'm sure other people would have different
15 views on that.

16 There's also other aspects of the level playing
17 field. The Medicare Advantage plans have to pay higher
18 prices because they negotiate. The ACOs don't. So there's
19 market differences. How you feel about that in payments in
20 adjustments is worth of some discussion.

21 So I think if -- we won't do it now. But if we
22 begin to build, is I think what Kate was asking for, along

1 things that conceptually want to adjust for, get there. And
2 then this transition in equity issues that Glenn talked
3 about -- Peter even mentioned -- how we transition to them
4 is, in fact, a problem. There's political and other issues.
5 But I think knowing where we want to set it up is helpful
6 before we think about how we want to transition.

7 DR. MARK MILLER: [off microphone.] I was going to
8 try and summarize a set of things I heard, but you covered
9 -- [inaudible].

10 MR. HACKBARTH: Others?

11 DR. SAMITT: I just wanted to tag on to Michael's
12 comments. I agree with the recommended list, that you would
13 say would warrant adjustment. And I would be fully in
14 support of that.

15 The one comment that I would make about local
16 adjustments versus national adjustments, I would be
17 interested in knowing, does one lead to the other if we
18 developed the right synchronizing model on a local basis?
19 And so, in many respects, I would be interested in playing
20 this methodology out year after year after year. So if we
21 said we're going to fix this at the local level, which
22 really drives all organizations toward a more efficient

1 model, we have to realize that if we get the aligned
2 incentives correctly, we're going to shift patients from a
3 less coordinated fee-for-service model to a more coordinated
4 care model, lowering the fee-for-service benchmark over
5 time. Likely, more complex patients will also shift to a
6 more managed environment.

7 So if that happens market to market to market, do
8 we begin to see that the differences between markets narrow
9 if we get the methodology within markets correct?

10 DR. CHERNEW: If they got to ACOs, maybe. If they
11 go to MA plans, it's complicated because the benchmarks are
12 just the fee-for-service side. And so you could see where
13 it's not converging quite the way you say, depending on how
14 you do risk adjustment and such.

15 MR. HACKBARTH: Well, you're Mr. Spillover.

16 DR. CHERNEW: You could have spillover. That part
17 is true. Glenn's right. The answer is maybe. You could
18 have spillover, so it all would converge. But you could
19 also have a situation where the population left is just very
20 different. And so I'm not sure if it would converge. It
21 would certainly be nice if it would.

22 DR. MARK MILLER: And that could lead you to

1 conversations -- and this hooks up with your transitional
2 point, where if you do want to drive some of the change --
3 because I kind of think of fee-for-service ends up being the
4 benchmark, I'm with you, it starts to be fairly rigid for a
5 while.

6 I'm sorry, Peter, I'll be right there.

7 And then you can think about even how you update
8 over time, and try and drive some convergence across markets
9 -- as opposed to just letting them naturally get there.

10 I'm sorry, Peter.

11 MR. BUTLER: So I would encourage you, Glenn, as
12 you review the transcript or whatever to -- while gaining
13 some consensus about financial neutrality is what we're
14 shooting for, to right the three or four sentences in
15 English that defines what that is. Because I think each of
16 us, if we were challenged to do that right now, you would
17 get some very different definitions, despite the fact we've
18 talked about it for now -- that would be very helpful, to
19 say here's what we mean by financial neutrality.

20 MR. HACKBARTH: Any last comments? We're down to
21 our last couple of minutes?

22 [No response.]

1 MR. HACKBARTH: Seeing none, we'll move on. Thank
2 you, Julie. Good job.

3 Just in case there's any doubt, we haven't solved
4 that problem. We will come back to it.

5 So now we're going to turn to a theme that was
6 mentioned frequently, which is how we assess quality across
7 different arrangements offered by Medicare. John, are you
8 starting?

9 MR. RICHARDSON: All right. Good morning,
10 everyone.

11 Over 10 years ago, the Commission recommended that
12 Medicare should no longer pay providers of care solely on
13 the basis of the volume of services they rendered, but also
14 on the quality of the care that they delivered. In the
15 ensuing decade, the Congress and CMS have embraced quality
16 measurement across fee-for-service Medicare, Medicare
17 Advantage, and ACOs. As a matter of nomenclature, we will
18 refer to these three models here as "Medicare's delivery
19 systems."

20 Over the past few years, a number of Commissioners
21 and quality measurement experts, clinicians, and health
22 system executives have begun to ask whether the Medicare

1 quality measurement enterprise has become too fragmented,
2 unwieldy, and may be moving away from the goal of promoting
3 coordinated, patient-centered care. Given those concerns
4 and the Commission's interest now in thinking about policy
5 across Medicare's delivery systems, this is an opportune
6 time to step back and consider if a new approach to
7 measuring quality across the delivery systems is warranted.

8 In this presentation, staff will: review the
9 Commission's key positions on quality measurement over the
10 past 10 years; outline the concerns raised by Commissioners
11 and others in the past few years about Medicare's current
12 approach to quality measurement, particularly in fee-for-
13 service Medicare; present an example for your discussion of
14 one possible alternative approach that would use population-
15 based outcome measures to evaluate and compare quality at a
16 local area level across fee-for-service Medicare, Medicare
17 Advantage, and Medicare Accountable Care Organizations;
18 present the results of a preliminary analysis of one piece
19 of this alternative approach, which will illustrate the
20 interconnected policy and technical issues that would need
21 to be worked out in order to implement it; and, last,
22 present a list of those issues for your discussion and to

1 seek guidance for future staff work.

2 The Commission's past recommendations on quality
3 measurement have fallen into the three categories shown on
4 this slide.

5 First, the Commission recommended that Medicare
6 should measure and report quality of care for most types of
7 providers in fee-for-service Medicare and for Medicare
8 Advantage plans. The Commission urged the use of a small
9 set of clinical process, outcome, and patient experience
10 measures because this would minimize the burden of
11 measurement on providers and CMS and potentially make it
12 easier for Medicare and private payers to synchronize their
13 quality measurement programs.

14 Second, the Commission recommended that Medicare
15 should base a small portion of fee-for-service providers'
16 and MA plans' payments on their performance on those
17 selected quality measures.

18 Third, the Commission recommended in a
19 congressionally mandated report in 2010 how CMS could
20 compare quality between fee-for-service Medicare and MA, and
21 among MA plans, within a local area. This report included a
22 recommendation to the Congress to ensure that CMS had

1 sufficient resources to implement a quality measurement
2 system that could use population-level outcome measures,
3 such as admission rates for ambulatory care sensitive
4 conditions and mortality rates, to compare quality of care
5 between fee-for-service Medicare and MA in the local area.

6 The good news is that the Congress has enacted and
7 CMS has implemented quality measurement and in several cases
8 value-based purchasing for almost all fee-for-service
9 provider types, MA plans, and ACOs. However, stakeholders
10 from several perspectives have become increasingly concerned
11 over the past few years that Medicare's current policy
12 relies on too many clinical process measures that are, at
13 best, weakly correlated with health outcomes and, at worst,
14 may reinforce fee-for-service payment incentives to increase
15 the volume and fragmentation of care. Other concerns raised
16 are that the current approach is excessively complex and
17 burdensome and too unwieldy to coordinate with private
18 payers' quality measurement efforts; and that it diverts
19 providers' attention and resources toward improving the
20 quality of very specific care processes that Medicare has
21 chosen to measure within each silo of care rather than
22 encouraging efforts to solve more significant cross-cutting

1 quality problems, such as improving care coordination for
2 patients as they move across the continuum of care. In
3 short, Medicare's current quality measurement approach seems
4 to be losing its focus on promoting clinically appropriate,
5 coordinated, and patient-centered care.

6 In light of these concerns, we are presenting an
7 alternative direction for you to discuss. The starting
8 point for this alternative approach is the simple
9 observation that the providers in an MA plan and an ACO are
10 assessed as a group based on their aggregate performance for
11 the entire population of beneficiaries that are either
12 enrolled in the MA plan or attributed to the ACO. This
13 basic fact raises an intriguing question: Is it feasible to
14 compare quality across fee-for-service Medicare, ACOs, and
15 MA within a cohesive local area? If so, would moving
16 Medicare's quality measurement focus in that direction
17 better align with the Commission's goal of promoting care
18 that is coordinated and patient-centered and not fragmented
19 and silo-centered?

20 Perhaps instead of straining providers' and
21 Medicare's limited resources to implement and maintain
22 hundreds of provider-specific process measures, a more

1 effective strategy would be for Medicare to define the fee-
2 for-service, MA, and ACO populations in a local area and
3 then employ a small set of meaningful outcome measures that
4 rely on existing data sources, such as fee-for-service
5 claims and MA plan encounter data, plus existing patient
6 experience surveys to evaluate and compare quality across
7 these three delivery systems.

8 The table shown here presents one possible set of
9 measures for such a system. It includes rates of
10 potentially preventable hospital admissions and emergency
11 department visits; rates of mortality within 30 days of
12 hospital discharge; and a measure of "healthy days at home,"
13 the details of which staff are still developing, but
14 conceptually would be a measure of how well the delivery
15 system is doing at keeping beneficiaries healthy and not
16 using health care resources such as inpatient and ED
17 services when the use of such resources is potentially
18 preventable?

19 The other dimension of care captured in this
20 system would be patients' self-reported experience of care,
21 measured using existing CAHPS surveys. We are not asserting
22 that this is the definitive set of measures, but it is meant

1 to illustrate the parsimonious population-based and outcome
2 measure approach we are presenting for your discussion.

3 Next, to highlight several of the issues that the
4 Commission will have to grapple with in considering a
5 population-based measurement approach like this, Sara will
6 present the preliminary results of an analysis that she and
7 Nancy have been working on, using the first two population-
8 based measures shown in this table.

9 MS. SADOWNIK: I'm going to discuss our analysis
10 of potentially preventable events in the fee-for-service
11 Medicare population, as a means to compare differences in
12 fee-for-service ambulatory care at a regional level.

13 As an overview, potentially preventable hospital
14 admissions and potentially preventable emergency department
15 visits are acute-care events that might have been prevented
16 with appropriate monitoring, coordination, and follow-up by
17 ambulatory care providers. Although these potentially
18 preventable events are measured by their occurrence at
19 hospitals, the rates are not intended to be indicators of
20 hospital care. Rather, the indicators can be thought of as
21 coordination measures that move away from measuring quality
22 by provider and instead reflect the coordination of a

1 region's ambulatory care. Not all potentially preventable
2 events can be avoided in individual cases, and we would not
3 expect rates of zero. This fact reinforces our emphasis on
4 relative rates between regions, particularly when risk-
5 adjusted for differences in health status in the
6 populations.

7 We contracted with 3M Health Information Systems
8 and used the definitions for potentially preventable
9 admissions and ED visits that 3M had previously developed.
10 Other approaches exist to measure these events. We do not
11 endorse any one approach, but are simply exploring the use
12 of potentially avoidable events as a population-based
13 measure of ambulatory care.

14 We measured performance at the level of hospital
15 service areas, or HSAs, which are local health care markets
16 developed by the Dartmouth Atlas of Health Care. In this
17 presentation, we will review preliminary results of rates of
18 preventable events nationally and compare performance across
19 hospital service areas.

20 Now I'll run through our definitions of
21 potentially preventable events. For potentially preventable
22 hospital admissions, the patient required acute-level

1 services at the time they presented, but the need for the
2 admission might have been avoided with appropriate
3 ambulatory care and coordination activities. The use of
4 potentially preventable admissions as a population-based
5 measure of ambulatory care is well established. The Agency
6 for Healthcare Research and Quality has developed a set of
7 measures of potentially preventable admissions that is based
8 on ambulatory care sensitive conditions. 3M's method is
9 also based on ambulatory care sensitive conditions, but
10 differs because it excludes complications that would have
11 been preventable only in the long term, through years of
12 prior preventive care, such as lower extremity amputations
13 for diabetic patients. 3M's definition also includes
14 procedures whose appropriateness has been questioned by
15 clinical experts, such as spinal fusion.

16 This analysis excludes hospital readmissions
17 within 30 days of the index admission. We excluded
18 readmissions because we wanted to focus on accountability
19 for care among ambulatory care providers, and programs such
20 as the hospital readmissions reduction program already focus
21 on hospital accountability for readmissions. We wanted to
22 focus on events that more likely stem from a market's

1 ambulatory care infrastructure as opposed to those in which
2 the index admission may be implicated.

3 The design and use of potentially preventable ED
4 visits as a population-based measure is not as well
5 developed. In 3M's definition, potentially preventable ED
6 visits include visits for medical conditions that might have
7 been prevented through proper management and coordinated
8 care, such as an exacerbation of COPD, as well as conditions
9 that could have been addressed in lower-cost ambulatory care
10 settings instead, such as an upper respiratory tract
11 infection. 3M's measure excludes ED visits that resulted in
12 an inpatient admission; that is, we only include treat-and-
13 release ED visits. The measure excludes ED visits during
14 which a surgical procedure or therapy was performed. Both
15 the potentially preventable admissions and ED visit measures
16 also include nursing home sensitive conditions, which may
17 not necessarily be preventable in a community setting, but
18 could be preventable for beneficiaries coming from an
19 institutional setting, such as acute major eye infections.

20 Here is a high level summary of our methods. I'm
21 not going to detail our methodology in this presentation,
22 but we're happy to discuss it on question.

1 Turning to our results, we found that potentially
2 preventable events accounted for a substantial proportion of
3 all admissions and ED visits. In 2011, potentially
4 preventable admissions accounted for 23 percent of all
5 hospital admissions. The national rate averaged
6 approximately 78 events per 1,000 beneficiaries. Heart
7 failure was the most frequent cause for a potentially
8 preventable admission, followed by pneumonia and COPD. To
9 be clear, heart failure does not mean an AMI, which 3M lists
10 as a condition that is not considered potentially
11 preventable. Instead, while the need for a hospital
12 admission for heart failure might have been necessary at the
13 time, the need for the event might have been prevented
14 through better management of the condition in the community.

15 Potentially preventable ED visits accounted for
16 over half, 55 percent, of all ambulatory ED visits in 2011,
17 with a national rate of 227 events per 1,000 beneficiaries.
18 The most frequent reason was abdominal pain, which, to be
19 clear, does not mean a burst appendix. Here abdominal pain
20 as a cause for potentially preventable ED visit does not
21 imply that this condition could have been prevented but,
22 rather, that beneficiaries could have received care for this

1 in a lower-cost ambulatory setting.

2 We found that outcomes varied substantially across
3 HSAs. We also found extremes in the top and bottom
4 performing HSAs. These extremes were mostly found in
5 smaller HSAs, which may be more susceptible to the actions
6 of small numbers of patients or providers. We found
7 somewhat less variation in the rates among larger areas. We
8 are showing results here from relatively larger HSAs --
9 those with at least 5,000 beneficiaries, which represent 42
10 percent of all HSAs.

11 We have presented the ratios of actual to expected
12 events, which risk-adjust for differences in age and disease
13 severity among the population in different HSAs. A ratio
14 equal to 1 would mean that an HSA's actual rates of events
15 equal the rates that would be expected, given the age and
16 disease severity of its population. When the ratio is less
17 than 1, it means that the area is performing better than
18 expected. When the ratio is more than 1, it means that the
19 area is performing worse than would be expected based on its
20 population.

21 For potentially preventable admissions, we see
22 that HSAs range from, at the best, having ratios of 0.40,

1 meaning rates that are 40 percent of what would be expected,
2 to ratios of 1.76, meaning rates are almost 80 percent more
3 than what would be expected. For potentially preventable ED
4 visits, we see that HSAs range from, at the best, having
5 rates that are 16 percent of what would be expected, to
6 rates of preventable ED visits that are over twice what
7 would be expected. The mailing materials discuss other
8 findings, which we're happy to talk about on question.

9 In summary, we've presented early exploratory
10 results on the feasibility of using fee-for-service claims
11 data to evaluate potentially preventable admissions and ED
12 visits at the local level, in considering the use of these
13 potentially preventable events as population-based measures
14 of ambulatory care quality. We have a number of potential
15 areas for further research, such as continuing to analyze
16 factors that may be tied to rates of preventable events. We
17 may also look into the stability of rates, especially in
18 smaller HSAs.

19 MR. RICHARDSON: To wrap up, we'll pose several
20 interconnected policy and technical questions that would
21 have to be resolved if the Commission were to pursue a
22 population-based outcome measure approach as we've sketched

1 out here.

2 First, how should Medicare define the local area
3 within which outcomes are assessed? One option would be to
4 use a local inpatient hospital market area such as the
5 Dartmouth Hospital Service Areas that was in used in the
6 analysis Sara just described. Another option would be to
7 use the local MA payment areas that were recommended by the
8 Commission in its June 2005 report to the Congress, which
9 uses metropolitan statistical areas and Health Service Areas
10 that are defined by the National Center for Health
11 Statistics. This is also the definition the Commission
12 recommended in its 2010 report for comparing quality between
13 fee-for-service Medicare and MA at the local level.

14 The second question is, How should the population
15 be defined for each delivery system? The answer may be
16 relatively straightforward for MA plans, where the
17 population would be the plan's enrollees, and for ACOs,
18 where the population would be the organization's attributed
19 beneficiaries. Given those two definitions, one could
20 define the fee-for-service Medicare population as all the
21 beneficiaries in the defined local area who are not either
22 enrolled in an MA plan nor attributed to an ACO. Of course,

1 the real issue underlying how to define each system's
2 population is the question of defining the collective
3 responsibility and, therefore, accountability of the
4 providers in each system for the measured outcomes. How, if
5 at all, should Medicare approach this central question
6 differently when assessing providers' collective performance
7 under MA, ACOs, or fee-for-service Medicare?

8 Third, which quality measures should be used?
9 We've presented one possible set of population-based outcome
10 measures that could be calculated either from fee-for-
11 service claims data, MA plan encounter data, or existing
12 patient survey instruments. Are there other outcome
13 measures that you would like us to investigate? In thinking
14 about this question of which measures to use and whether and
15 how to risk-adjust them, you also must grapple with the
16 inevitable trade-offs between what would be feasible in an
17 ideal data- and resource-rich environment and what is
18 realistic to do in a world of limited resources and
19 imperfect data.

20 Fourth, should Medicare use any measures other
21 than the population-based outcome measures in fee-for-
22 service Medicare to address incentives inherent in that

1 system to increase service volume and intensity? For
2 example, should there be any ambulatory service overuse
3 measures, such as excessive or inappropriate use of certain
4 imaging services or prescription drugs; any hospital patient
5 safety measures such as avoiding central line-associated
6 bloodstream infections; or per-capita and per-episode
7 Medicare spending measures?

8 Fifth and last, should Medicare use any measures
9 designed to counter underuse incentives, such as those in
10 the current HEDIS measure set used for MA plans or the
11 similar types of measures currently used in accountable care
12 organizations? While these kinds of measures can monitor
13 for potential underuse of clinically appropriate care in
14 delivery systems that have incentives to limit service use,
15 they also would complicate the measurement system and may
16 require clinical data that are not easily obtainable today
17 or for the foreseeable future. Complexity and burden are,
18 of course, two of the primary aspects of the current system
19 you may decide Medicare has had more than enough of.

20 With that, we will conclude the presentation and
21 look forward to your questions, discussion, and guidance.

22 MR. HACKBARTH: Okay. Thank you very much. So

1 let's see hands of people with Round 1 clarifying questions.

2 MR. BUTLER: Slide 11. You mentioned that 30-day
3 readmissions are excluded. I think that's, I don't know, 15,
4 16, 17 percent -- right? -- of admissions. And then this
5 says they're 23 percent of potentially preventable
6 admissions. So if I look at that right and combine 23 with
7 roughly, say, a 17 percent readmission rate that it
8 excluded, is there a pool potentially of 40 percent of
9 admissions that are kind of -- might be thought of as
10 potentially reducible? They're mutually exclusive groups.
11 You've excluded from your definition of PPAs readmissions
12 within 30 days, right?

13 MS. SADOWNIK: That's right. The 23 percent is 23
14 percent of all initial hospital admissions, excluding
15 readmissions.

16 MR. BUTLER: Right.

17 MS. SADOWNIK: And I don't think we have
18 information on, of all readmissions, what percentage are
19 potentially preventable.

20 MR. BUTLER: Right. But I think the pool that we
21 ultimately are looking at as closer to 40 percent are things
22 that are being targeted overall? Not through this

1 methodology but collectively.

2 DR. MARK MILLER: I think that's [off microphone].

3 MR. BUTLER: Yeah. Okay.

4 MR. GRADISON: On number 12, page 12, the
5 variations are so extraordinary, I wonder what else may be
6 at work here. Question: Have you run these numbers against
7 data, socioeconomic data, that might be available on an HSA
8 basis?

9 MS. SADOWNIK: We looked at a few different
10 factors. We used two different -- we used two proxies for
11 socioeconomic status. We used a percentage of beneficiaries
12 in an HSA who are dual status as well as disability, and we
13 just looked at basic correlations, and we did find that both
14 of those factors were positively correlated with both
15 potentially preventable admissions and ED visits. So higher
16 shares, more events. But it's also worth noting that even
17 among areas that had high proportions of both of those
18 factors, duals and disability, there were some that had
19 rates that were better than expected and some that were
20 worse.

21 DR. REDBERG: Thank you. On Slide 11, so
22 sometimes heart failure certainly is preventable because you

1 could have adjusted medications in the office. But
2 sometimes there's just the inexorable progression of heart
3 failure. Is this just all heart failure admissions? Or was
4 there any attempt to have clinical distinguishing features?

5 MS. RAY: You know, I would want to go back and
6 double check that and get back to you on that.

7 DR. REDBERG: Okay.

8 MS. RAY: If you were to force me to answer, I
9 probably would say it's, you know, mostly all heart failure.
10 But, again, going back to Sara's point, we would not expect
11 rates to be zero in any case. We're looking at the relative
12 differences between areas.

13 DR. REDBERG: Right. Thank you.

14 DR. HOADLEY: I just wanted a little clarification
15 on the hospital service area definition. It seems clear in
16 a more rural area, but in an urban area, metropolitan area,
17 how tight is this HSA measurement level?

18 MS. SADOWNIK: The definition is -- or the way
19 that HSAs are defined are a group of zip codes where most of
20 the beneficiaries in that group of zip codes go to the
21 hospital or hospitals in that area for most of their
22 admissions. We found across all HSAs 83 percent only had

1 one hospital and 10 percent had two and only 8 percent had
2 more than three.

3 DR. HOADLEY: In a large area like the D.C. area,
4 there's a whole bunch of different HSAs across different
5 parts of the region?

6 MS. SADOWNIK: Actually, in Washington, D.C., just
7 Washington, D.C., itself is one HSA.

8 DR. HOADLEY: Okay.

9 MS. SADOWNIK: But Bethesda is one, Rockville,
10 Silver Spring.

11 DR. HOADLEY: That helps. Thanks.

12 MR. GEORGE MILLER: My question is similar to
13 Bill's on the socioeconomic issues and question. I think
14 you answered, but I just wanted to tease it out a little bit
15 more that if you have a minority population, like a large
16 Hispanic population in a Houston or an Austin or a Dallas,
17 were there notable differences or anything you were able to
18 learn? Anecdotally, I have been told why Hispanics use the
19 ED, as an example, versus going to primary care physicians.
20 I don't know if you were able to tease that out or not.

21 MS. RAY: That's something that as we continue
22 this analysis, we are going to look at the correlation in

1 the area. We are just beginning right now, and so we were
2 just focusing, as Sara had said, looking at the proportion
3 in a given HSA that were duals and disabled.

4 MR. GEORGE MILLER: And just a quick follow-up.
5 What other issues like transportation, how would they affect
6 this as well? Do people without any transportation, do they
7 use EMS to transport to them? Does that have a factor? Or
8 do we have any idea?

9 DR. MARK MILLER: I think it's going to be very
10 hard for --

11 MR. GEORGE MILLER: To tease that out?

12 DR. MARK MILLER: -- data that we're working with
13 here, to tease that out.

14 MR. GEORGE MILLER: Okay.

15 DR. MARK MILLER: Unless I'm unaware of something
16 that you guys have.

17 MS. SADOWNIK: No.

18 MR. GEORGE MILLER: Okay.

19 MS. SADOWNIK: No, we just took a very preliminary
20 approach looking at basically what's feasible with fee-for-
21 service claims. I think there's -- and sort of thinking of
22 this measure, you know, as coordination. In an ambulatory

1 care system, I think that issues like transportation or
2 other services that beneficiaries would need to impact those
3 events are not going to be looked at here, but would be
4 important to consider in next steps.

5 MR. RICHARDSON: And may I just pick up on one
6 thing? I think you said earlier, Sara, to the extent you
7 have looked at the variation when looking at HSAs that had a
8 higher than average number of duals, that you still saw very
9 -- even if you compared two HSAs that were both, you know,
10 duals majority or minority majority, you still saw variation
11 just looking across that subpopulation.

12 MS. SADOWNIK: Right.

13 MR. RICHARDSON: So even within that, there's
14 still variation.

15 MS. SADOWNIK: Right.

16 MR. GRADISON: On the point George and I were
17 talking about, I just would flag pages 16 and 17. None of
18 the high ones, the top of these two charts, is in the South.
19 Virtually every one of the lowly performing ones are in the
20 far South, plus the Rosebud Reservation in South Dakota. So
21 something else is going on here.

22 MR. HACKBARTH: Okay. Let's move on to Round 2,

1 and Bill Hall is going to go first.

2 DR. HALL: Thank you. I just wanted to compliment
3 you. This is such a great chapter. It really is. I think
4 it pinpoints this issue as well as anything that I've read.
5 I learned a great deal from it.

6 I had really just two points. One is to sort of
7 interject a sense of urgency about this whole process of
8 getting a different set of metrics that are somewhat less
9 complicated and more related to actual patient care.

10 There's no way to overemphasize the stress on
11 health systems, but also providers, in keeping up with the
12 multiplicity of criteria that we have to look at on a daily
13 basis.

14 My own community, where we think we're very
15 efficient in delivering care for Medicare patients -- in
16 fact, one of the lowest costs per beneficiary in the country
17 -- probably in our system about a third of all physician
18 time is spent keeping up with these regulations. This is a
19 huge expense and one, as you've commented on, isn't
20 necessarily correlated with real outcomes but are additional
21 process measures. So this is really a big deal, in terms of
22 straightening out the health care system.

1 Parenthetically to that, this whole process has
2 also changed a lot of physician thinking. For example,
3 there are now 16 medical speciality societies who have
4 joined a program nationally called Choose Wisely, which is
5 guidelines not so much about what to do but what not to do.
6 Almost all of these are quite relevant to the Medicare
7 population. Don't give people drugs that are going to alter
8 their sensorium so that they fall. Be careful with urinary
9 catheters. It goes on and on and on.

10 I think we should be informed about this process
11 because it also starts talking about a lot of outcome
12 measures that ultimately might have some value here.

13 At the same time, there's a lot going on in
14 hospital systems, a lot of competition going on. That can
15 also change results.

16 Kate had a recent piece in the New England Journal
17 talking about the difference between -- an interface between
18 competition and cooperation. So this is important.

19 The second point has to do with the use of the HSA
20 as kind of our population base for these comparisons. I
21 think there's a lot of difference in HSAs in terms of
22 availability of medical resources. So I followed your

1 computer links and pulled out actually from the Dartmouth
2 Atlas a map of the United States that showed all of the
3 3,00-plus HSAs. This is a map of the country. I don't
4 expect you to see the fine points.

5 But notice all of the red that's in here. The red
6 is what I want you to notice. These are all HSAs that have
7 at least four hospitals within the HSA. Some have a dozen
8 or so and oftentimes, like say in the Dallas-Fort Worth
9 area, they are all within walking distance of one another.

10 So this is not the same as Rosebud or a lot of the
11 other places. I don't know what we do about that, except to
12 say that I think we need to look very carefully at these
13 high intensity hospitalized HSAs which, I think in the
14 discussion you said comprise about 38 percent of all
15 Medicare recipients. I think that's worth looking at.

16 MR. HACKBARTH: Okay, thank you. Jon.

17 DR. CHRISTIANSON: It was very interesting data,
18 and as a research project, I think very timely.

19 I guess I wasn't on the Commission when the
20 discussion around the need to do this went forward. I
21 understand the problems with having multiple measures and
22 the burden on providers and so forth.

1 But I think there are also questions that can be
2 asked about measuring in the geographic area. These HSAs
3 are not health care delivery systems. They are geographic
4 areas. So what do you do? How are these measures
5 beneficial for beneficiaries?

6 As much as we might question, based on the
7 research, the use of the comparative data at the provider
8 level by beneficiaries in terms of choosing providers or the
9 degree to which it shames providers to becoming better,
10 clearly to me knowing that the fee-for-service providers as
11 a group do less well in one area versus another is not
12 necessarily going to motivate any fee-for-service provider
13 to do better or help any beneficiary to choose among fee-
14 for-service providers.

15 In fact, the free rider problem here is to wait
16 and hope that some other provider in your area is stupid
17 enough to invest resources in improving the geographic
18 average and you'll benefit from that.

19 And I think, depending on the number of ACOs you
20 can make a similar kind of argument there.

21 So how is this useful for Medicare policy? I
22 suppose it's useful for Congress to say as a whole, gee,

1 these ACOs or MA plans are, as groups, not doing worse than
2 fee-for-service. That's a pretty low bar in terms of
3 providing policy advice.

4 So one question for me is where does all of this
5 go? I mean, reporting -- as we've said before with respect
6 to costs, reporting on the aggregate geographic level can
7 hide very important geographic variation of providers within
8 that area and can create some sense that everybody is bad
9 within an area and I don't think we want to do that.

10 Not having been involved in the initial
11 discussions, I do kind of get that measuring at the provider
12 level, the ACO level, imposes burdens on providers. I'm not
13 sure that the response to that is to produce these measures,
14 although I find them very interesting as a researcher. We
15 are all fascinated with the geographic variation and we're
16 all impressed with the degree of variation and we all worry
17 about what you've controlled for or not controlled for when
18 you did the analysis.

19 MR. HACKBARTH: Since Jon has already focused in
20 on one of the topics that I wanted to examine in Round 3,
21 let me just build on his comment and then we can have the
22 benefit of everybody reacting if they so choose. I agree

1 with everything that Jon said. I would underline, though,
2 that the problem is that however desirable it might be to
3 assess at the level of the individual provider, what we're
4 finding is that there are real technical problems in being
5 able to accurately assess quality at the level of the
6 individual provider.

7 And so the policy question is what do we do in the
8 face of that limitation and what's been described here as
9 one potential path that you take when you can't do the best,
10 which is individual assessment.

11 The other thing I wanted to add is that one way of
12 thinking about this is that a message to providers that are
13 in the fee-for-service portion is I'm going to be assessed
14 for my quality alongside and calculated along with a lot of
15 people that I don't have any influence over, whose quality I
16 think may actually be poor. And so I can stay here and
17 accept that as the reality of population-based measurement
18 or I have an alternative. As opposed to the government
19 choosing my assignment for quality assessment, I can choose
20 my own and particulate through the ACO channel or
21 participate in a Medicare Advantage plan.

22 So the population level assessment is problematic

1 in various ways. Providers would not be without choices in
2 how they respond to it. At least let me offer that as a
3 hypothesis and I welcome reactions to it.

4 MR. BUTLER: So, I think we started this in the
5 summer retreat with the concept that first we had two many
6 measures. Second, they weren't outcome focused enough. And
7 third, they were not consistent across the different
8 segments. At least that's kind of how I think it was
9 initially framed, is my memory.

10 Now we've broadened the set of questions to maybe
11 they should be population based and a number of other
12 things. So you've got a lot of questions you're asking us
13 to respond to here. I'll do my best in a quick period of
14 time here.

15 So with respect to the definition of the
16 population, the HSAs -- yes, you mentioned 83 percent at one
17 hospital and so forth but I bet from a population standpoint
18 those that do have more than one are pretty densely
19 populated areas. I do have a struggle when I look at an
20 institution like ourselves, that kind of gets a little bit
21 from 85 different ZIP codes, where we would fit in something
22 like this.

1 The second is I like the PPV and PPAs and I
2 particularly like also including an HCAHP or CAHPS score as
3 part of the population base. I think go back to the 83
4 percent that are in -- if you really want -- those still, in
5 a sense, are process measures. If you really want to get
6 the outcome measures, if you really can define that
7 population, you have to look at the impact on obesity and
8 diabetes and really the health of the population itself as
9 opposed to these things. Because if you really could define
10 it, maybe you could see if you're making a difference over
11 time. That's consistent with our Community Health Needs
12 Assessment and what we're supposed to be doing.

13 As you flip to the next page, different kind of
14 topic but this hospital patient safety measures, in our rush
15 to have relatively few that are population-based, some of
16 these sit within the four walls of the hospital, are
17 absolutely their responsibility, need to be tied to payment
18 because we shouldn't be making some errors that are
19 increasing costs and so forth. So I wouldn't kind of
20 abandon that in our rush to kind of have a simple set that
21 could be applied to everybody.

22 And I do like the medical spending per beneficiary

1 measure as something that should be closely followed.

2 DR. BAICKER: I agree that the answers depend on
3 which question we're trying to answer, which problem we're
4 trying to solve. These surveillance type measures seem very
5 important to know to sort of map out the big picture
6 landscape of what's happening, but they don't seem so useful
7 for payments to individual systems, for patients or
8 enrollees to choose among options. Each of these, I think,
9 requires a different granularity of information that comes
10 with its own challenges.

11 That doesn't mean that there isn't still a lot of
12 potential upside simplifying and harmonizing those measures.
13 I think some of the complaints were about things like --
14 okay, we all know that infections are bad. But are
15 measuring them the same way across different delivery system
16 organizations such that people could actually use them to
17 compare, such that we could know how quality is varying
18 across these things.

19 I like these measures, too. I think they're very
20 informative but I don't feel as though they solve that
21 problem. And maybe that's just a topic for a different
22 chapter or they're not intended to solve those problems.

1 But I think the population-based measures in general are
2 going to have a hard time addressing those twin issues.

3 MR. GEORGE MILLER: Yeah, I would agree and not
4 repeat anything any of the other Commissioners said. One of
5 our challenges as a provider is to define what the measures
6 should be an appropriately and, while we have a great deal
7 of respect for what CMS and MedPAC would recommend along
8 those lines, but there are others out in the community. And
9 if you give us a defined set, that would be more
10 appropriate. So how we coordinate that and so we have the
11 measures.

12 Again, I agree with Pete. There are some things
13 that should be done for the payment. But again, condensing
14 them and having one set would be very appropriate across
15 everybody, NCQA, the Joint Commission, HEDIS, everything.
16 All insurance companies, everything.

17 DR. NAYLOR: So I can't wait until this chapter is
18 published. It will be required reading with all of the
19 doctor and post-docs. I think it's fantastic. I think the
20 evolution of the thinking and how often great intentions
21 don't always lead to great outcomes is a really important
22 message.

1 I also think that that key message around the 88
2 measures between inpatient and outpatient reporting that
3 don't get us to high value care is a critically important
4 measure and I think you've captured it beautifully.

5 I really like the overall direction for trying to
6 get to that parsimonious set of measures that can be useful
7 to a Medicare program in guiding how it pays for services,
8 which does not mean that the accountability won't still be
9 on individual providers and health system to figure out what
10 are the processes and relationships to outcomes that they
11 need to do to make sure that all of their providers are
12 delivering. I think that's exactly the kind of approach
13 that we're trying to inspire here.

14 So I really like the direction. I think the
15 measures that you're talking about, potentially preventable
16 hospitalizations and ED visits are important. Observation
17 days might need to fit in there some way, given what we're
18 learning there. And combining that with some beneficiary
19 expression of what it is like to be navigating all of these
20 care systems and care coordination communications so the
21 CAHPS measures makes a great deal of sense.

22 I worry about things like mortality when you're

1 talking about a 95-year-old -- I mean, so we'll have to
2 think about whether or not we're getting the right mix of
3 measures and whether ambulatory care sensitive for people
4 who are frail get us to the right things.

5 But that being said, I really think this is
6 exactly the direction that inspires payment and that
7 motivates delivery system change at the local level. And
8 then the systems are going to have to figure out what are
9 the right set of measures to make sure everyone on our team
10 is getting it right.

11 MS. UCCELLO: Well, notwithstanding the down
12 sides that people have mentioned, I really like the idea of
13 these population-based measures, in that I really think they
14 can provide incentives for providers and organizations to
15 really think about how to, in a sense, expand their sphere
16 of influence and trying to understand better the needs of
17 the community and not just when they're seeing them.

18 So I hear what other people are saying and I
19 understand but I really like that. Especially in
20 combination when a couple of years ago we were talking about
21 the quality improvement organizations and helping them kind
22 of think of things more on the community level. Also some

1 of the discussions we had about the readmissions policy
2 also, just trying to understand better how hospitals and
3 others can kind of incorporate the needs of the community as
4 a whole into what they're doing. I think it's important.

5 And kind of building off what Peter said, even
6 moving further into more population health assessments,
7 health measures would be great. But I guess maybe that just
8 doesn't, in reality, work.

9 In terms of some overuse and underuse measures, I
10 think we have to recognize that all these different systems
11 do have different underlying incentives and it does make
12 sense to incorporate quality measures that reflect those.

13 And just a question on the visits. So potentially
14 preventable visits can indicate either lack of access in
15 other settings or non-coordination in those settings. And I
16 think that those two causes can have different solutions.
17 I'm just wondering if we have any sense of more of the
18 distribution of what maybe the underlying causes are. I
19 don't know if that's even possible, looking at more access
20 issues that would be driving those.

21 MS. RAY: Yes, we do not have a sense of looking
22 at potentially preventable events. X percent were due to a

1 lack of coordination versus Y percent were due to lack of --
2 what I call effective care, after hours care, more open
3 scheduling, and so forth.

4 MS. UCCELLO: I just wonder if there's any way to
5 look at -- I know we don't like to measure access by
6 ambulatory providers per 1,000 or anything like that, but
7 maybe there's something we can do that just looks at visits.

8 DR. MARK MILLER: Yes, I mean, I think she is
9 correct that a visit measure could be driven by "your care
10 wasn't managed well in the community" and by "I have no
11 place to go at this particular hour in the evening" just as
12 an example. I think that's what you're trying to say.

13 I don't think it's straightforward but the two
14 things I think we could potentially think about is whether
15 areas sort themselves a bit by the underlying visit. Are
16 you there because you have a cough -- and these examples
17 will be wrong -- because you have a cough or because your
18 diabetes is out of control. And maybe that gives you some
19 indication.

20 And then on the other side, looking at the
21 utilization data and on visit rates. But that's going to be
22 highly imprecise because you don't know whether the person

1 visited the physician's office at 7:00 o'clock in the
2 evening or 2:00 o'clock in the afternoon.

3 But we understand your question, I think, if I'm
4 getting a nod out of you.

5 DR. BAICKER: Can I just say one factual thing on
6 that point? There are algorithms that you can use the same
7 discharge information to break things down into emergent
8 non-preventable, emergent treatable in another setting,
9 emergent non-emergent. So you can use a few simple
10 variables from the claims record to differentiate between
11 "you need care right now but it doesn't need to be in the
12 emergency department, if the doctor's office you could go
13 there" versus "if you had gotten better care before you
14 wouldn't have to be in the emergency department but now it's
15 progressed to something where you have to be in the
16 emergency department." You could do a more granular
17 decomposition without requiring any more data.

18 DR. MARK MILLER: I have just --

19 MR. HACKBARTH: Is that question or a statement?

20 MR. RICHARDSON: May I? Which is within an area
21 it will be interesting to see across the three models, the
22 three delivery systems, differences for a given condition.

1 And then you can start to look at -- it would be anecdotal
2 but are there MA plans there that have specific measures
3 that -- sorry, have they taken certain steps to allow people
4 to have access after hours, and those kinds of things.
5 Which maybe some of it not exactly causal but you could at
6 least make some inferences from that.

7 But I just want to emphasize, a bit piece of this
8 is looking within an area. As Glenn was emphasizing in the
9 previous session, a lot of this is going to be intra-area,
10 comparisons between the three models, not as much as the
11 analysis that we presented was looking across the areas just
12 for fee-for-service. But a huge component, of course, is
13 looking across the three models within an area, using
14 measures like this or however you decide to go.

15 DR. MARK MILLER: And I know we're over time, but
16 to Kate's question, the methodology we're working with is
17 going to kind of define whether we can respond to that. Do
18 we think we have the granularity? I haven't heard, in any
19 of our conversations, a granularity that would get you to
20 her point?

21 You know what, we'll take this offline, we'll
22 figure it out and we'll come back to you.

1 MS. SADOWNIK: With the data that we currently
2 have, we do not have the granularity to be able to do what
3 you're describing. That type of analysis is doable and it's
4 something that we could thing about. I think within --
5 those distinctions can be made and different events can be
6 put and have been put in different buckets like that. I
7 think that I would want to make sure that we take all of
8 that with a grain of salt and know that there can be
9 overlap.

10 MS. RAY: Just one point.

11 A couple of years ago I did present an analysis
12 that used the National Hospital Ambulatory Medical Care
13 Survey. That survey, you know, just pulling out those
14 visits for Medicare beneficiaries. But that does allow some
15 analysis of ED visits based on how the ED coded whether or
16 not the visit had to be treated right away versus could wait
17 however many hours. So we could come back to you with that,
18 as well.

19 MR. HACKBARTH: [off microphone.] We've got to
20 get back on track, continuing Round 2, Jack.

21 DR. HOADLEY: So like a lot of others, I think
22 this is really interesting analysis and I think definitely

1 worth pursuing. I think it's not as obvious how it fits in
2 -- I mean, Jon said some of this, others have. As a quality
3 measurement that you can sort of implement to do rewards and
4 things because of some of the issues. We are better off
5 moving to this HSA level from the referral regions that you
6 have brought us in a previous meeting. There are still
7 issues, as several have mentioned, about is the HSA still
8 capturing a community that's kind of a natural community
9 that these kinds of things we're talking about go on. I
10 mean, the D.C. example, the idea that all of D.C. is one HSA
11 and whether you're in Anacostia or in upper Northwest is all
12 being smushed together into one measure.

13 I would remind, because nobody sort of emphasized
14 this, what you're measuring here is all off of fee-for-
15 service claims. So in terms of our three levels, where it's
16 a combination of the ACO world and the fee-for-service world
17 but not the MA world. So just in terms of the data you're
18 looking at here, and obviously that could change at some
19 point with the right data availability.

20 As I started reading the paper, I said let's
21 correlate this with some things and see what's working. And
22 then you did the first thing I thought of, which is at least

1 some measure of wealth and some measure of the safety net
2 structure with community health center presence. So I think
3 that was really helpful.

4 I think there are some other things you could try
5 to throw up against these data, like the amount of primary
6 care physicians in a community and some other people mention
7 other things.

8 What's not clear is what you're capturing then. I
9 think you're understanding the variables better. In the
10 case of some kind of wealth measures, you may be saying
11 well, there's a confounding factor here. In others you are
12 actually measuring part of what you want to measure. Is the
13 system structured with the right amount of primary care and
14 safety net institutions and things to allow a good outcome.

15 So I think those are really good analytical things
16 to do. In a sense, it's more the research side of looking
17 at this but eventually may inform us towards thinking about
18 this as a quality measure.

19 MR. HACKBARTH: Okay, Craig.

20 DR. SAMITT: So I will take on -- I'm a big fan of
21 your work. I would go so far as to say coming from
22 organizations in my career that have invested heavily in

1 quality measurement and reporting, I think this is
2 absolutely critical for a lot of the same reasons that Glenn
3 describes. The experience that we have had is that
4 comparative reporting works and it results in improvements
5 and performance. Comparative reporting attracts talent. So
6 physicians want to be part of higher quality organizations.
7 And if this results in sort of a shift of providers to ACOs
8 or higher performing systems as a result of comparative
9 reporting, I think that's beneficial.

10 And the third rationale for why we've done this is
11 ultimately we believe that there will be pure data and
12 visibility comparing quality and cost performance between
13 various delivery system models. And that will lead to
14 volume growth for our organization, that we would care for
15 more patients.

16 So for a lot of reasons, I think this is
17 important.

18 I would like to answer all five questions, if I
19 may. So back to the first slide. I like the notion of
20 local MA payment areas as a measurement. We've talked about
21 synchronizing payment areas. Why would we not also tie to
22 it a value measurement, quality measurement? So that gives

1 us two pieces of information all within the same measurement
2 bucket. So I would say that would be my vote.

3 How to define the population? I like your
4 definition. I think it's the right way to go. The only
5 addition that I would make is I would measure MA down to a
6 deeper level because MA, from my point of view, is too
7 heterogenous. There are problems in measuring down to the
8 individual provider level on fee-for-service but you can
9 measure groups within MA plans that may have differential
10 quality performance. And we may see that capitated groups
11 via MA plans perform differently in quality than fee-for-
12 service paid groups in MA plans. So we may want to segment
13 and measure one level lower in the MA population.

14 Quality measures are great. I think you've picked
15 the right ones. I think the only thing I would add is are
16 there any post-acute care related measures that we could
17 consider to add to the list, that if these groups managed
18 post-acute care more effectively, that is also another
19 measure of better coordination. I don't know whether that's
20 feasible. To the point of whether it's feasible or
21 irrational to add that to the list, I would vote for that.

22 And then on the next slide, measuring to address

1 fee-for-service incentives, this is where I'm worried about
2 the complexity of measurement, that we could add so many
3 things to this list. I just wonder whether we can simplify
4 and create an elegant measurement in this space, like total
5 cost of care measures, which may encompass several of these
6 sub-measures. Is there something that we could bundle,
7 similar to the way we bundle quality, to bundle some of the
8 other fee-for-service related measures that we care about.

9 And the final thing that I would say is the
10 complexity for providers goes beyond just the complexity of
11 the Medicare portfolio alone. It's all payers. And so as
12 we look to evaluate simplification of quality measures, the
13 question is is there any harmonization that can be done with
14 both public and private to create a more simple environment
15 for quality measurement for the providers?

16 MR. HACKBARTH: Alice.

17 DR. COOMBS: Thank you. I think this is an
18 excellent chapter. Thank you very much. I will go straight
19 to the questions.

20 In terms of an area defined, I have a problem with
21 the HSA and I'd like -- I actually like Craig's idea of a
22 population payment area because it goes to what you really

1 want in terms of matching quality with what your payment
2 winds up.

3 But one of the other issues is the HSA is dated.
4 In terms of consolidation within health care delivery
5 systems, a lot has transpired since the origin of the HSA.

6 In terms of quality measures, I agree with the
7 population-based quality measures. One of the things, I
8 guess, you were grappling with was this whole notion of what
9 does the ED visits represent, and we actually did a study
10 for the Boston Health Commission -- you can actually go look
11 it up -- and we actually defined the different types of ED
12 visits that were avoidable, and the definition included
13 urgent -- one category was that the patient needed not to
14 come to the ED in the first place, and that was the routine
15 ED visit that should have been an office visit, and then the
16 truly, truly emergent visits. And it was interesting in
17 that the visits occurred during -- the bulk of the visits
18 occurred during the daytime when a doctor's office was open
19 or when you could have gone to another site for service
20 other than the emergency room.

21 That being said, sometimes the ED visit might
22 represent a proxy for workforce deficiency in terms of what

1 actually is available for patients to go to, and that is,
2 indeed, what we found in terms of wait times. And so a
3 proxy for why ED visits exist in terms of increased ED
4 visits might be related to the wait times of primary care
5 office visits, and that we found that if it was a two-week
6 wait, or you couldn't get in to see the doctor, it was a
7 proxy for why you would see these increased ED visits.

8 Just in terms of admissions, I think that you have
9 to be cognizant of the fact that where there is
10 consolidation, or where there is a high density of
11 hospitals, the threshold for admissions might be very driven
12 by other kinds of incentives, and although there may be
13 coordination of health care, it may be that patients are
14 actually cross-fertilized between health care delivery
15 systems and there may be a lot of leakage within a system
16 because of the proximity of other health care delivery
17 systems next to each other geographically.

18 In terms of other things to measure, I would -- I
19 thought about critical events. They represent system errors
20 and a lot of times can tell you a lot more. The frequency
21 is much less. The randomness of it is also a problem in
22 terms of you have an increase of critical events and smaller

1 numbers in terms of places where there are smaller
2 populations.

3 Thank you.

4 MR. HACKBARTH: Mike.

5 DR. CHERNEW: So, my main comment is I think we
6 need to frame this in terms of a quality measurement
7 strategy as opposed to just a list of quality measures, and
8 in doing so, as nice as it would be to have some sort of
9 common, just clear, this is quality, I think we have to
10 recognize some inherent problems -- the sample size,
11 differences in risk adjustment that came up in some of the
12 early round one questions, inherent unobservability of
13 certain important dimensions of quality, the fact that,
14 unfortunately, there is no single quality construct, that if
15 you have a lot of measures, they don't always load so well
16 on each other. So, to say there is quality, let's measure
17 it, I think isn't the right conceptual frame.

18 There's concerns -- actually, Bob Berenson has a
19 great piece Glenn actually told me about that I really would
20 make a pitch for. But, anyway, there's tendencies to teach
21 to the test in various ways, so there's a lot of
22 complexities besides what we want to do.

1 I tend to believe, and I could be wrong, that in
2 the grand scheme of where we're going, we have more measures
3 -- any one measure, you have to do sort of a cost-benefit
4 analysis, and I think where we are for the measures is we
5 have too many measures relative to the administrative costs
6 of collecting a lot of them. That's just my own personal
7 opinion.

8 I think that the merits of these population
9 approaches we're talking about depends on exactly how we're
10 going to use it in the sanctions, and I'm not completely
11 sure of that. Where I think about this is is that our
12 strategy might want to, at least as we move to these other
13 systems, make sure we don't have really bad performers, and
14 these population-based measures in fee-for-service might
15 give us a sense of what that means to be a really bad
16 performer. I obviously would like to get better in a whole
17 variety of ways, but I'm not completely sure exactly how we
18 do that, but I do want to make sure if we move to other
19 systems we don't have really bad performers that are
20 stinting on care and maybe the fee-for-service population
21 measures can help.

22 The last thing I'll say is that I think the

1 dollars per beneficiary type things or the resource things
2 are important measures in many ways, but they're not quality
3 measures. They're cost measures. And watching them is
4 important. But we shouldn't conflate them with quality.
5 There are other aspects of quality and I don't think we
6 should spend too much, but I don't think we should call
7 dollars quality.

8 MR. ARMSTRONG: So, just briefly, while I won't
9 reiterate a lot of the points that have been made by other
10 Commissioners, I think the one contribution I could make
11 here would be I think we need to deal with the complexity of
12 the measures and get a subset that works, but ultimately,
13 the real issue is, particularly in the fee-for-service
14 world, if you're measuring PPA or PPV, which, by the way, we
15 measure very closely and we pay very close attention to it
16 and I know our rates of admissions and visits will be
17 significantly lower than the fee-for-service around us, but
18 the issue is what do you do with the information? How does
19 it get organized so that it's actionable?

20 The comment I would just make is that there are a
21 lot of markets around the country that are reporting quality
22 information comparing medical groups at the medical group

1 level against a subset of HEDIS metrics, I think, some
2 process, some outcome measures. But it creates a great
3 dynamic for holding groups accountable that can actually
4 change their behavior and change the outcomes.

5 It just seems to me that, for us, in MA -- Craig
6 made this point -- in MA, we would convert our overall
7 results to some subsets that are at accountable groups to
8 manage that. How could you convert an individual provider
9 or a fee-for-service-based kind of metric in a similar way
10 to accountable groups that really can have an impact on the
11 overall outcomes?

12 So that's -- I think it's another variable. It's
13 another consideration for us in all this. And, I think,
14 frankly, one of the greatest challenges is that your
15 preventable admissions or visits could be very high or very
16 low. The real issue is, well, who's accountable? What do
17 you do with that?

18 DR. REDBERG: I thought this was a really
19 important chapter and you really summarized a lot of the
20 strengths and weaknesses of quality. And I think it builds
21 nice on -- we just talked about synchronizing payment,
22 because as I was saying, I think when we think about

1 payment, you want to think about what are you getting for
2 it, and I feel like quality is what we should be looking at,
3 and if we want to synchronize, we want to kind of
4 synchronize payment for quality.

5 Certainly, as a clinician, I think you're right.
6 We have way too many quality measures and it's really
7 undermining, first of all, physicians' happiness, because
8 you feel like all you're doing is checking off lists and
9 nobody is talking to the patient or taking care of patients,
10 and from a patient's point of view, you know, they're hardly
11 -- and they are very process oriented and intermediate
12 outcome oriented now, so I do think it's really important to
13 get away from those.

14 And I think on Slide 6, those are really patient-
15 centered measures, and I think that that incorporates all of
16 the things that we've been saying we want to achieve, is
17 looking at these -- potentially preventable hospital
18 admissions, I mean, and healthy days at home, because I
19 think that's what patients want and it really incorporates,
20 you know, are you going to go to ambulatory care? Are you
21 getting good -- it even incorporates the post-acute care.

22 And the only thing -- and you don't need an under-

1 use measure because, I mean, presumably, if there's under-
2 use, it's going to be reflected because then you won't have
3 these good outcomes. You'll have more higher mortality,
4 you'll have less healthy days at home, and you'll have more
5 preventable hospital admissions.

6 In terms of the patient experience, the quality
7 measure that I would suggest is really important and I think
8 we should add is we have communication, but specifically the
9 communication on risks, benefits, and alternatives before
10 any kind of procedure or test, because, I mean, that's
11 really what choosing wisely that Bill mentioned is kind of
12 centered on, is have that discussion. But it is discussion
13 to me how many patients have very invasive surgeries,
14 defibrillators, and they have no idea why they got it, what
15 the risks were, and were there alternatives.

16 And so I think, as a quality measure, did you
17 understand the risks, the benefits, and the alternatives?
18 Was there a choice? It would really change patient
19 experience and really improve quality of care and also
20 value, because we are right now spending a lot of money on
21 things that patients, if they had known risks and benefits,
22 would have definitely chosen not to have.

1 MR. HACKBARTH: Okay. Dave.

2 DR. NERENZ: Thanks again for teeing this up for
3 us. I do fully share Jon's concerns about this and I would
4 speak in support of the comments he made. I think there are
5 some real issues here. Let me just go a step or two
6 further, as devil's advocate on this.

7 If we can go to Slide 13, the second question
8 you're asking us. I would just assert for discussion and
9 debate that there is no collective responsibility at the
10 area level, at least in the American health care system, for
11 quality and cost. The concept simply does not exist. It's
12 not a technical issue. It's not about the measures. It's
13 just the nature of the social contract about medicine in
14 this country. It even goes into areas like the oaths that
15 physicians take. Their responsibility is to individual
16 patients. It is not to the community. It is not to the
17 collective.

18 And so I think you can do all this measurement in
19 a very meaningful way for a health plan, MA plans. You can
20 do it for ACOs. As Scott pointed out, you can do it for
21 medical groups. But in all those cases, you've got a
22 defined population. You've got an entity, a tangible legal

1 entity, and, I think most importantly, you've got an
2 agreement among the participants that some level of
3 responsibility exists. From that point forward, the
4 measures make sense.

5 But geographic areas, I think with few exceptions,
6 are not delivery systems. They don't perform. They don't
7 have accountability. It's like sort of measuring the
8 performance of all the people sitting here in this room
9 right now. The only thing we have in common is that we're
10 sitting here in this room. That's it.

11 So, the measures -- I like the measures. I like
12 the measures when they're applied in settings where you can
13 do something with them, but I do not think, at least until a
14 lot of things change, that a geographic area is how to do
15 it.

16 MR. HACKBARTH: Okay. I hear substantial,
17 although not unanimous, agreement that there are significant
18 problems in the current quality measurement regime, and Bill
19 led with this. A number of people repeated it. But just to
20 highlight a few of them, a proliferation of measures and
21 never growing administrative burden, including on practicing
22 clinicians as a result; a lack of coordination across payers

1 that further aggravates that problem; individual payers
2 developing their own unique requirements for information,
3 including information related to quality.

4 The measures are frequently focused on process,
5 not because there's a belief that the process measures are
6 really good, but they're easier to do, frankly, and as a
7 result, there are large gaps that we know to be very
8 important related to quality that are not assessed at all
9 and a lot of things of marginal importance that are heavily
10 assessed.

11 We've got problems -- if you try to move away from
12 process and look more at outcome, you've got problems with
13 risk adjustment and small numbers. These are points on
14 which I think there's broad, if not unanimous, agreement in
15 the comments that I heard.

16 Where there's way less agreement is with the
17 solution to that, and I want to just offer a few points and
18 then open it up for round three discussion.

19 One possible message that we might offer is stop
20 digging. We're in a hole. We've got this proliferating
21 burden of measurement, a lot of it low productivity, perhaps
22 even giving incorrect signals about quality, yet the

1 apparatus is geared up to keep adding, adding, adding,
2 adding, both legislative process and the regulatory process.
3 And just as an illustration of that, if you look at the
4 table in the chapter on value-based purchasing for hospitals
5 and the proliferation of measures with each successive
6 round, the vast majority of them requiring medical record
7 abstraction, which is very costly, right now, we're on the
8 track for making the problem that we've identified worse, I
9 think, year after year.

10 A second thing where we could have some
11 recommendation, and we said something about this in the
12 past, but we could be more forceful and pointed, is the
13 importance of moving to multipayer efforts. Here again, I
14 think, in some ways, we are not just off track but
15 accelerating the movement down the wrong way. There are
16 proposals, both regulatory and legislative, that would
17 require more measures, invite more people to get into the
18 measurement party, the festival of measurement, and none of
19 it would go through the NQF consensus process of saying
20 these are valid measures. It just bypasses that, which, as
21 I say, makes things worse.

22 The last point is more controversial, but I'll

1 offer it anyhow. Both Jon in his initial comments and Dave
2 said, you know, this notion that there's any community
3 responsibility for quality is a false one. I agree with
4 that. I'm not sure it should be that way, but I think that
5 is an accurate description of the reality. I think it would
6 be better if we could measure individual performance, but I
7 think, for all the reasons we've discussed here, that is
8 very difficult to do.

9 So, what is our message to Medicare beneficiaries
10 if, in fact, there's no collective responsibility and
11 there's no meaningful capability to measure individually?
12 Perhaps we should be saying to Medicare beneficiaries,
13 caveat emptor. Buyer beware. There is huge variation out
14 there and we can't -- Medicare can't vouch for it and no
15 providers are willing to vouch for it. You ought to really
16 take a look at systems that are prepared to vouch for their
17 quality, and fee-for-service isn't one of them.

18 So, those are some thoughts. I welcome reactions
19 to those thoughts. Stop digging. Emphasize multi-payer
20 efforts. And caveat emptor is the message to beneficiaries.
21 Or go someplace else.

22 DR. MARK MILLER: Stop saying that last thing.

1 DR. NERENZ: Just in response to the very last
2 thing you said, it wouldn't have to be strictly caveat
3 emptor in that, to follow on Scott's statement, there are
4 certainly mechanisms for providers, medical groups, and
5 other entities to offer up quality metrics either out of a
6 standard program or ones that they develop on their own in
7 the context of the fee-for-service system. And
8 beneficiaries could find that useful if that goes forward.
9 But I just would observe that an area measure does not
10 address the problem of variability and quality at the
11 provider level because there can be good and bad within the
12 same area.

13 MR. HACKBARTH: So let me just press on your first
14 point. If I heard you correctly, you're saying have more
15 people start producing measures --

16 DR. NERENZ: That view assumes that measures come
17 from people other than providers, and they do, in fact, but
18 we have very little, I think, currently of provider groups
19 individually or collectively offering voluntarily quality
20 measures for public dissemination, or cost measures for that
21 matter. My point was just that I think they could, and, in
22 fact, because of the diversity of provider types, it may be

1 that you inevitably need different quality measures. But
2 the difference is that the quality measures that a pediatric
3 neurosurgeon would choose to put forward are inevitably
4 different from those of a primary care practitioner. And I
5 think that's as it should be. And if you're choosing a
6 pediatric neurosurgeon, you want to know what that person
7 does. You can have that happen without having an enormously
8 large, cumbersome, infinitely huge measurement system at
9 some centrally designed level.

10 MR. HACKBARTH: Who wants to pick up?

11 DR. REDBERG: I actually think that's why this
12 measure proposed on Slide 6 is so beautiful, because it is
13 applicable to a pediatric neurosurgeon and the primary care
14 practitioner. If you're choosing a surgeon, you might want
15 to look at the specific outcomes for that procedure. But if
16 you're talking from a patient point of view, you know, no
17 matter what it is, you want to know are you going to survive
18 and are you going to go home and be healthy. That's why I
19 think the small measures that does incorporate a lot of
20 that.

21 You know, I think the challenge in the details for
22 us is that we don't really have a primary care provider

1 system, particularly not in fee-for-service Medicare. And
2 so it's almost impossible to do individual measures because
3 the same patients, you know, that see me sometimes see
4 several other cardiologists, not to mention five other
5 specialists and several other primary care doctors. So who
6 are you going to distribute this to? So unless we were
7 going to change that structure where we actually had a
8 primary care doctor that was responsible for each
9 beneficiary, it would be very hard to do individual
10 measures.

11 I think that we can't get too hung up in risk
12 adjustment because there was never a perfect risk
13 adjustment, you know, you can do age and sex and then -- but
14 if you have a large geographic area, sort of the other
15 things should wash out enough that the perfect can't be the
16 enemy of the good.

17 DR. CHRISTIANSON: So I think there are two issues
18 we're talking about here that we keep going back and forth
19 on. One I think Kate summarized very well, which is there
20 are a lot of measures out there and they're inconsistent and
21 we should be striving towards encouraging in the Medicare
22 program a smaller consistent level of measures. And I am

1 somewhat sympathetic to the notion that measuring all these
2 things are costly to providers, but I guess I would also
3 submit that the business model for providers is changing,
4 and measurement needs to be part of the cost structure. And
5 if we value measurement, we need to be willing to pay for
6 it.

7 Now, we don't want to impose unnecessary costs and
8 so forth, but, still, just basically the pushback on, "Oh,
9 it's costly, I don't want to measure it," doesn't get a lot
10 of sympathy from me.

11 The second part of the issue was, okay, if we're
12 going to harmonize the measures, do we need to measure at
13 the geographic level instead of the provider level. And I
14 think there's a lot of discussion around that, and I would
15 say to Rita's point, if these measures really are going to
16 be the way we're going to judge value, we're going to be
17 driven directly towards measuring cost at the geographic
18 level. I think that's the wrong way to go. I totally agree
19 with IOM's view on that, and I think the arguments they make
20 are similar for quality measures.

21 Now, I understand that the HSA level is sort of
22 smaller level in some of the analysis that the IOM did and

1 the geographic units that they used. But I think it does
2 drive us in an interesting direction, because if we're
3 really striving for value measures, do we want to measure
4 value measures at the geographic level and sort of treat all
5 providers within a given geographic area then as deserving
6 the same value-based payment? Or is that something to be
7 concerned about? And I'm kind of in the second camp.

8 DR. SAMITT: So I like your three premises. I
9 would modify two of them slightly, if I may. So in terms of
10 the no digging, I wonder if there is a methodology to
11 replace. So if we know that there are some quality measure
12 that currently exist that are process measures that are
13 really not driving any outcomes improvement, do we swap some
14 out as opposed to just creating more and more measures?

15 Harmonization absolutely I agree with.

16 And the last, I mean, I don't think we'd want to
17 convey the message of caveat emptor, but I do think
18 beneficiaries are entitled, even within geographic areas, to
19 be able to view differential quality performance from ACO A
20 to ACO B to ACO C to MA groups to global fee-for-service
21 with just the caveat being that we counsel beneficiaries
22 that there will be inevitable variability within each of

1 those buckets. So all we can show you is comparative
2 performance bucket to bucket, but there is going to be
3 variability within the buckets, so beware of that. Maybe
4 that's another way to twist it.

5 DR. CHERNEW: First let me pick up on something
6 that Jon said, which is I agree about measurement being part
7 of the business model, but I also think like clinical care,
8 measurement has to go through some sort of cost-
9 effectiveness or sort of tradeoff. And so the question
10 isn't should we not measure anything. It is are the costs
11 of doing the measurement worth it given the number of
12 measures, and that has to be viewed sort of collectively,
13 it's sort of at the margin. And I think in the end we would
14 agree.

15 As I said in my other comments, my personal sense
16 is we'd move to a point on the distribution where a range of
17 existing measures are probably not cost-effective and new
18 ones proposed don't add a lot. But I don't have a lot of
19 evidence for that. That's a general sense.

20 And then what I wanted to comment about David's
21 point about is nothing we're talking about here prevents
22 private organizations from saying anything about quality per

1 se, and so that people can do. My general sense is quality
2 measures are not that useful unless a lot of people are
3 reporting them. So having a given system say we're the best
4 at pediatric neurosurgery or whatever it is, according to a
5 measure that we have set up, is really not that useful
6 unless there's some sort of broad standardization. And the
7 concern and I think the reason why this becomes more of a
8 public good is the quality measurement/reporting system does
9 have a public good component to it.

10 And so while anyone can say what they want, I
11 think that's important, and I think our job is to try and
12 figure out, at least for the Medicare program, where the
13 public good aspect of that is, and doing that, recognizing
14 both the cost of the collection of the data and the inherent
15 limitations of that. And so that's my concern with allowing
16 private organizations to just on their own come up with
17 their own measures and then have a single one report it.

18 DR. NERENZ: Just a direct response, and certainly
19 no disagreement. In fact, I'm not sure we can do anything
20 in a First Amendment environment about what organizations
21 choose to say about themselves. So if we're just talking
22 about standard measure sets, I think all I would just

1 require is that the measure sets reflect the performance of
2 real entities who are really sort of granted or understood
3 to have the authority for a particular domain in which
4 measurement occurs, and that's my concern about the area. I
5 just don't think that --

6 DR. CHERNEW: And I wasn't responding to that [off
7 microphone].

8 DR. NAYLOR: This really builds -- so I'm not sure
9 that I want to -- it builds on the whole notion of the
10 Medicare program as a federal program that is responsible
11 for the whole of the Medicare beneficiary population, so on
12 to the public good framework. And I think we are
13 responsible for offering a framework that might be
14 complementary to what is -- to the public, to the
15 beneficiaries, that might be complementary to what
16 individual providers or systems, in fact, are doing but then
17 enable beneficiaries in a given community to understand how
18 well is my community doing in terms of performance in the
19 Medicare program.

20 So I don't see these as inconsistent at all. I
21 mean, I think that the whole notion is we know we are not
22 performing as well in multiple quality measures relative to

1 other countries. We know this. Care coordination is -- we
2 are ranked quite low on this, and that is a highly valued
3 good from the Medicare beneficiary's perspective. So how
4 might we change the quality measurement framework in order
5 to be able to add value to the beneficiaries' understanding
6 of what they're getting, and for us to understand how we're
7 using our resources.

8 MR. HACKBARTH: I just want to remind you [off
9 microphone] I'm trying to manage this in a way that we
10 actually have a conversation as opposed to a succession of
11 independent comments. So, Alice, do you want to respond to
12 something that --

13 DR. COOMBS: Yeah, it's a delayed response.

14 MR. HACKBARTH: Okay.

15 DR. COOMBS: But I was just sitting here
16 processing this whole notion of a pediatric surgeon and
17 looking at these indicators here. A pediatric surgeon who
18 gets to one of these indicators as -- you know, if you took
19 a group of pediatric surgeons in an area and they hit a
20 couple of these, that would be a serious concern. So the
21 level of specialty -- I think the specialties may have other
22 indicators that may be actually more applicable to their

1 specialties, and one thing I was thinking about that we
2 haven't gotten at, these things we're looking at mostly are
3 hospital centric, and the bulk of care occurs outside the
4 hospital.

5 And so one of the things that we should also
6 consider -- and I don't know how to get our arms around this
7 -- is the whole notion of escalation of care or services
8 that are required as a result of deviation from some type of
9 commonly accepted care, you know, within the confines of a
10 primary -- it may be within an ACO, and an ACO actually
11 could look at these things and see that there's deviation
12 from care that resulted in an escalation of care or some
13 kind of adverse event for a patient population.

14 But this whole notion of what we're looking at
15 here, mortality rates, is way down the line in terms of what
16 you want to get to in terms of a healthy population. And
17 some of these things are very, very gross in terms of what
18 we want, in terms of moving to a healthy people kind of
19 environment. And so I'm just thinking that, you know, at
20 some point escalation of care that actually resulted from
21 something that happened in the community, these things are
22 hospital centric.

1 DR. MARK MILLER: Can I just say one thing about
2 that? And it's not on your main point, but it is that
3 statement. If everybody at the table understands it, I want
4 to be sure that at least the public understands it.

5 These measures are -- although they're organized
6 by hospital service area -- and I'm going to make a comment
7 about that -- they're about trying to reflect the ambulatory
8 care in the community. It's sort of what's brought to the
9 doorstep of the hospital. So I don't want people to think -
10 - okay. So I'm getting the nods that I needed there.

11 And then the other thing is -- and I do understand
12 how you're using this term. I absolutely do. You know,
13 it's not a set geographic area, that hospital service area
14 is defined based on who touches which patients that go to a
15 given hospital, and each hospital service area can be
16 different.

17 Now, I understand that in a sense you could draw a
18 circle and say this is the geographic dirt that this
19 encompasses, but it does kind of vary from hospital to
20 hospital.

21 Now, the other notion of an MA service area has
22 some of that, but also, once again, gets turned into a

1 geographic area.

2 MR. HACKBARTH: So we're down to our last four
3 minutes here, and I have Jack, Peter, and Kate on my list.
4 And anybody else want to try to squeeze on? Mike. Okay,
5 and that will probably be more than enough.

6 DR. HOADLEY: My comment actually is very similar
7 to what Mark was talking about. I think there's a real
8 confusion -- not a confusion, there's a real complexity
9 about what we're talking about in these geographic kinds of
10 based measures, and, you know, it's why I asked way back at
11 the beginning sort of what is the HSA really defined as.
12 And in some cases it is kind of a boundary of dirt. It's
13 the District of Columbia or -- and that's a whole bunch of
14 hospitals because they are close to each other and overlap
15 in their kind of service. And it is why I think we're
16 having some trouble with thinking of it as a basis for some
17 kind of value-based payment because it does get outside the
18 hospital specific, even though it uses hospital-relevant
19 measures. And maybe part of the value here is that it's
20 useful as information to inform a broader community --
21 again, we can work on getting the community definition
22 right. But if we know that certain areas aren't doing so

1 well, they're on that below the median, well below the
2 median kind of location, does that, if not create
3 responsibility at the level of a doctor or a hospital, does
4 it create some kind of a community sense? And we have seen,
5 you know, with foundation-funded projects and things,
6 community-level efforts to try to step in. You know, how
7 successful they've been is harder to say.

8 And the only other thing I would add on one of the
9 other points on the sort of no more digging point is it
10 seems like -- and I'm not sure if this is true, but in Parts
11 C and D, there's been some effort to have a bit of a zero
12 sum measure set, so when they add new outcome measures,
13 they're trying to weed out some of the old process measures.
14 And part of that may be the transition from mostly counting
15 being able to measure process to mostly measuring outcomes.
16 But maybe that concept of sort of zero sum needs to get more
17 actively thought of, and so anytime you want to add a
18 measure, okay, what are you going to take out in exchange?

19 MR. BUTLER: One last comment on the population
20 base. I like the lens -- I like it a little bit -- I
21 compare it a little bit to episode of care. It's a great
22 tool to understand issues. It may not be translatable into

1 payment, but it's still an important one.

2 The second point is in our rush to diminish the
3 number of quality indicators, I would say we're doing just
4 the opposite in our own institutions and managing. If you
5 look to our University Health System Consortium, which is a
6 lot of the academic medical centers are a member, we've had
7 a ten-year journey of advancing a scorecard that has
8 quality, mortality, efficiency, equity, patient
9 satisfaction, all of these things that we learn tremendous
10 amounts from each other, and it's quite a robust list of --
11 and we spend more time on it than ever before, and it's not
12 just teaching to a test.

13 And the last comment is the HCAHPS I'm going to
14 plug again, or CAHPS, is not just a -- when we compare
15 ourselves to other organizations, we find a lot of
16 reliability in those numbers. And if you look at things
17 like likelihood to recommend or where do you rank 0 to 10,
18 the consumer is kind of right at judging our cultures more
19 than you think. And in a society that is increasingly
20 looking for the consumer's voice, they understand the
21 quality a little bit better than you think, even though I
22 recognize that we may have great outcomes versus some things

1 that weren't even needed and get high scores, but,
2 nevertheless, that voice I think is pretty darn important
3 in, you know, kind of assessing quality.

4 DR. BAICKER: So building on some of these points
5 about the number of measures, especially what Rita was
6 saying, each measure that you add has a cost to diminishing
7 the effectiveness of the other measures as well. It's not
8 only an extra burden on the provider hospital, whoever, to
9 do that recording, but the more unharmonized measures there
10 are, the more diffuse the signals to move towards higher
11 quality overall. There's a danger then if you're going to
12 have fewer measures, they have to be good measures, or
13 you're going to incentivize the wrong stuff. But Medicare
14 could do more to do its part to harmonize the measures to
15 make each one more powerful and hope that that proliferates
16 a bit more widely.

17 Now, again, I think a lot of those measures, if
18 they're going to go into payment or into patient
19 decisionmaking, you need to complement population-level
20 measures with more granular measures. But the harmonizing I
21 think has a real advantage to improving quality as well as
22 reducing provider burden.

1 MR. HACKBARTH: Kate, I'm not sure I understood.
2 So what I think I've read is that one of the problems with
3 the current measure set and growing measure set is a lack of
4 correlation. So the fact that Provider A performs well on
5 this measure doesn't really signal much about how they
6 perform on other measures. And I'm having difficulty
7 reconciling that notion, if I understand it correctly, with
8 your saying that more measures dampens the signal about
9 who's high quality.

10 DR. BAICKER: So I'm thinking of an example from
11 an experiment in the greater Mass. area of having different
12 insurers agree to harmonize their measures as implemented in
13 a common group of hospitals, so that if one insurer is
14 measuring, you know, 30-day this and another insurance is
15 defining the population differently and measuring it over 15
16 days and another insurer is -- now, this is an analogy. It
17 doesn't apply directly to Medicare. But the point is that
18 then each one -- you lose the ability to focus on actually
19 improving the outcomes because they're measured in so many
20 different ways that eventually it's all kind of blurred.
21 Greater Mass area

22 MR. HACKBARTH: Even if they're trying to measure

1 the same clinical process, they're measuring it differently.

2 DR. BAICKER: So that's analogous, not directly on
3 point, but I think the idea is that the more -- if there are
4 100 different things you're trying to do, you may actually
5 just give up on all of them, as opposed to a few measures
6 that actually capture the totality of the quality of care
7 you're delivering and then you don't get bogged down.

8 DR. CHERNEW: So there are several different
9 purposes for doing this, and I think they sometimes get
10 conflated, so I just want to list three in the priority, at
11 least in my mind.

12 So I think job one is to come up with a quality
13 measurement strategy that can allow us to make sure that
14 these organized systems of care we were talking about
15 earlier, whatever they are -- ACOs, MCO -- you know, isn't
16 substandard, not necessarily at the top end but we just need
17 to make sure that the quality is not substandard. And I
18 actually think the population-based measures that we've been
19 talking about might be useful in that process.

20 The second thing I think is important is to come
21 up with a quality strategy, if possible, that can improve
22 the incentives for providers to provide better care. That's

1 going to require somewhat more micro-measurement. It's
2 going to have a somewhat more difficult set of issues. I'm
3 not sure how well we can do that given the set of measures,
4 but I think that's a separate set of discussions and one
5 that's important that one needs to have.

6 The third thing that is important -- and I won't
7 say it's actually less important. It might be as important
8 as the second one. But the third thing is providing a
9 measurement strategy that can help beneficiaries support
10 them in their choices, either between plans, between
11 providers, whatever it is. That also is going to require
12 some level of micro-measurement, and there's issues of
13 reporting and stuff. And I think recognizing the quality
14 approach we take is going to have these three different
15 purposes that are going to each have different issues and
16 different priorities matter. And I would go on record as
17 saying the most important one for me is that as we transform
18 aspects of the system, we can guard against what we really
19 consider substandard care, however defined.

20 MR. ARMSTRONG: Just a brief response to this, and
21 it may be a statement of the obvious. But it just strikes
22 me that through the five-star rating of MA plans, we have a

1 system that's working incredibly well right now and that is
2 paying for quality, is giving members access to information
3 that informs their choices, that holds organizations
4 accountable. And I don't -- I mean, this comes back to the
5 point it's clear who's accountable in that system, and
6 that's what we're struggling with. But I just -- anyway, we
7 haven't acknowledged that actually we have a system that's
8 working really well, and we haven't asked is there a way of
9 distributing or applying some of the features of that more
10 broadly. Maybe it's just another way of imagining possible
11 solutions to this dilemma.

12 MR. HACKBARTH: Much more we can discuss on this
13 and will discuss in the future. Thank you all. Good job.

14 So now we have our public comment period before
15 lunch. We've got two people going to the microphone.
16 Anybody else who is going to want to make a comment during
17 the public comment period?

18 [No response.]

19 MR. HACKBARTH: Okay, so we have two -- oh, three.

20 So the ground rules are begin by identifying
21 yourself and your organization and when the red light comes
22 back on that signifies the end of your two minutes.

1 The floor is yours.

2 MS. LUPU: Thank you, hi.

3 Dale Lupu, L-u-p-u, on behalf of the American
4 Academy of Hospice and Palliative Medicine.

5 Thank you for this last discussion about moving
6 quality measurement forward. I want to comment that I heard
7 a lot of discussion about how can we get granular enough to
8 see about the accountability of various actors within the
9 system.

10 I want to speak from the patient point of view. I
11 think we also need to be granular enough so that patients
12 and families, when they're looking at the information about
13 potential providers can see whether the quality reflects on
14 their experience. I would say that not only are there
15 different buckets of providers but there are different
16 buckets of patient experiences. You've got the normal
17 healthy adult who might have a managed chronic condition.
18 You've got our really seriously ill frequent flyer kinds of
19 patients. And you could have a system who, when you're just
20 reporting a mean rate, they might actually be good at let's
21 say the healthy adult experience but terrible at our patient
22 population's serious illness experience, or vice versa.

1 So we need to be able to have some distinction. I
2 mean, at a very simple level would be just reporting
3 variability in addition to reporting means. But I think we
4 would argue that it would begin to be useful if we could
5 think of not a million buckets -- I like the stop digging
6 approach -- but some simple buckets on patient experience.
7 So patients can go and say what's this going to be like for
8 a patient like me, really really sick, who is going to die
9 probably. So I don't care about mortality rate. I care
10 about my experience in the very serious illness.

11 And my light isn't on so I will say the Academy,
12 along with colleagues in the Hospice and Palliative Nurses
13 Association, we are engaged now in a project called
14 Measuring What Matters, where we are going to try to come to
15 you guys in about six months with a small set of core
16 concepts and measures saying this is what really matters in
17 our community. It is getting missed. We are one of the
18 gaps that, for instance, CAHPS systematically misses really
19 seriously ill patients or patients who have died.

20 Thank you.

21 MR. DEMEHIN: Good afternoon. My name is Akin
22 Demehin on behalf of the American Hospital Association.

1 I just want to first thank you all for engaging in
2 this conversation about the number and type of quality
3 measures that we have in federal programs and really
4 nationwide.

5 We absolutely share the concern about the number
6 of measures, the resources needed to collect them and report
7 them. We definitely need that more focus and a more limited
8 set of measures is absolutely what is needed.

9 Just a couple of reflections on some of the
10 measures that you all discussed today. In terms of
11 measuring health outcomes, and in terms of measuring
12 population level outcomes, we certainly see a great deal of
13 value to doing so.

14 Just one word of caution. We also think that
15 using outcomes measures really requires a robust approach to
16 risk adjustment, some of which you all discussed this
17 morning. The measures that you discussed this morning are
18 based on claims data, and we have seen some examples of
19 claims-based measures whose risk adjustment doesn't really
20 allow for fair comparisons among organizations being
21 measured and may not actually be a true reflection of
22 quality of care.

1 The other thing that we would offer by way of
2 comment is we think it's really important that whatever you
3 measure, be it high level or more microlevel measurement
4 really be tied to national improvement priorities. The
5 National Quality Strategy provides one framework for doing
6 so. There are bodies such as the Measure Applications
7 Partnership, the National Priorities Partnership that can
8 help identify concrete priorities and a limited number of
9 measures that you can really implement and make progress.

10 And the last thing I would add is we have, at the
11 AHA, begun a process of engaging our leadership in trying to
12 identify areas of quality measures that we think should be
13 part of a much more limited national measurement set. Just
14 to give you some early impressions of what we're hearing,
15 issues around care coordination and patient safety are
16 really perceived as the biggest opportunities for
17 improvements. While these broader measures are useful, we
18 think there may also need to be a little more granularity,
19 as well.

20 Thank you.

21 MR. GORDON: Stuart Gordon from WellPoint.

22 I think I heard a consensus this morning on

1 continued use of the CAHPS measures as a tool. I think
2 WellPoint would be in agreement with that but we would
3 emphasize, as we have in the past and as I think we've heard
4 this Commission agree in the past, that the CAHPS measures -
5 - their utility varies depending on the population that's
6 being surveyed, that the duals population, that the folks
7 with lower socioeconomic status are less able to respond
8 ably in the CAHPS survey.

9 I think we saw an article last week on that. I
10 think we would urge the Commission to continue to keep that
11 in mind.

12 MR. HACKBARTH: Okay, thank you.

13 We will reconvene at 1:00 p.m.

14 [Whereupon, at 12:13 p.m., the meeting was
15 recessed, to resume at 1:00 p.m., this same day.]

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1 recommendations that the Commission would like to make would
2 need to be made in our next reports if we want them to
3 influence the next phase of ACOs.

4 Just as a reminder, the Pioneer program started
5 over a year ago. There were 32 ACOs in the program with
6 about 670,000 beneficiaries by the end of 2012. CMS reports
7 that 13 of the ACOs had enough savings to meet the minimum
8 savings threshold of one percent. One ACO shared in losses.
9 The other 18 had either savings or losses below the minimum
10 threshold or were in a payment arrangement that did not
11 share in losses in the first year.

12 We modeled how groups would perform relative to
13 the national trend from random variation alone and found
14 that more ACOs than we would have expected saved money.
15 This suggests that some of their strategies may have been
16 successful. We can discuss this in more detail on question.

17 Nine of the 32 ACOs withdrew from the
18 demonstration in July, such that 23 ACOs are staying in the
19 demo. Seven are reported to be applying to the MSSP, and
20 two likely will not be Medicare ACOs.

21 Our contractor interviewed 12 Pioneers, four who
22 left the demonstration and eight who chose to stay. We

1 wanted to get the perspective of ACOs themselves on
2 successes, challenges, and the overall experience with the
3 program. While ACOs were quick to point out the uniqueness
4 of the strategies and experience of each, there were some
5 common themes.

6 Most Pioneers chose to join the demonstration
7 because they saw it as an opportunity to expand their
8 existing care coordination efforts. Many also noted that
9 they did not expect fee-for-service to exist for much longer
10 in its current form and they saw ACOs as where things are
11 headed. Others mentioned that the choice of Pioneer over
12 MSSP came from being confident that they could control
13 costs.

14 The ACOs that chose to leave did not all lose
15 money, but most who chose to transition to MSSP did so
16 because of the reduced exposure to downside risk. Some ACOs
17 also highlighted concerns about the shared savings
18 methodology, including baselines, reference trends, and
19 rules for aligning physicians.

20 Most Pioneers stated that their focus, at least
21 for the first year, was on targeting and managing the care
22 of high-risk, high-cost beneficiaries. They used care

1 management and care planning tools, like nurse navigators
2 and medical homes, and also expanded the use of palliative
3 care for chronically ill beneficiaries. Especially after
4 seeing their first year data, ACOs are paying more attention
5 to post-acute care use rather than focusing on the acute
6 setting. Many ACOs encouraged physicians to improve
7 practice patterns by giving them more analytic tools to be
8 able to identify and track their high-risk patients and by
9 allowing them to share in any savings achieved by the ACO.

10 In general, Pioneers found that they were
11 attributed fewer beneficiaries than they expected. They
12 also reported that leakage of beneficiaries to providers
13 outside the ACO was an issue. One ACO was surprised to find
14 that this leakage occurred with primary care providers as
15 well as with specialists.

16 Expectations about shared savings were murkier.
17 Many ACOs reported that they did not know what to expect.
18 Several stressed that shared savings was not a primary
19 motivator, especially at the outset. They viewed the
20 Pioneer demonstration as a learning experience in
21 preparation for the future and a chance to invest in the
22 infrastructure that will lead to efficiencies down the line.

1 ACOs often noted that the baseline and reference
2 trends that CMS used were complex and not easily replicated.
3 David will discuss some of the pros and cons of different
4 ways to set baselines and trends in a moment and we can
5 discuss these technical issues in further detail on
6 question, as well.

7 Nearly all ACOs reported problems with the
8 timeliness of data sent by CMS, and some also discussed
9 difficulties with comparing CMS data to other sources, like
10 the clinical record.

11 As we mentioned in September, CMS reported program
12 savings of about 0.5 percent. Given that most of the ACOs
13 staying in the demo achieved savings, the program savings
14 from this group only would be higher. The ACOs we spoke
15 with confirmed that the cost of running the ACO was about
16 one to two percent. Some ACOs discussed significant front-
17 end investments in infrastructure and felt that their CMS
18 results did not reflect their true savings. This begs the
19 question: Will savings really grow over time? And, is
20 improvement over one's baseline sustainable, or will other
21 baselines need to be considered?

22 For example, in MA, the baseline is based on local

1 fee-for-service. In a system like that, the ACO would be
2 responsible for being more efficient than other providers in
3 the area rather than having to improve relative to its own
4 past performance.

5 Some of the Pioneers we spoke with were concerned
6 about the feasibility of continuous improvement over time.
7 David will describe somewhat different ways to construct
8 these baselines in a moment.

9 With that, I will turn it over to David, who will
10 discuss some other policy issues in more detail.

11 MR. GLASS: Thank you, Katelyn.

12 Now that we're up to date on the environment and
13 lessons learned so far, we can look at some issues on which
14 we will need your direction as we think about developing
15 guidance for the second phase of ACOs. The issues are one-
16 sided versus two-sided risk sharing, setting baselines and
17 benchmarks, and addressing issues of beneficiary assignment
18 and leakage.

19 The first issue is one-sided versus two-sided risk
20 sharing. Briefly, the two compare as follows. The
21 advantages of one-sided risk, that is, a model with no
22 shared losses, only shared gains, is that it could draw in

1 more ACOs to participate in the initial phase of the
2 program, even those that we are not sure of achieving any
3 savings.

4 The advantage of a two-sided risk model, where the
5 ACOs share in savings and losses, is that it gives a much
6 stronger incentive for efficiency. The incentive is greater
7 for two reasons. First, any improvement in efficiency will
8 pay off for the ACO, either in more shared savings or lower
9 shared losses. In the one-sided model, only if there are
10 shared savings will efficiency be rewarded. Second, the
11 savings threshold can be lower because random variation will
12 balance out over time in a two-sided model. The program
13 does not need the protection against random variation that
14 it does in the one-sided model. And, again, we can discuss
15 this more on question.

16 With that in mind, how should we think about the
17 issue of one-sided versus two-sided risk sharing? The
18 Commission commented on the MSSP proposed rule that the two-
19 sided risk should eventually be the only option. Pioneer
20 ACOs now all have two-sided risk, although they allowed some
21 ACOs to be one-sided in the first year. For the MSSP, two-
22 sided risk could be required for all existing ACOs as they

1 move into a second agreement period, and that's what's
2 implied in the current regulations.

3 But, should two-sided risk also be required for
4 new ACOs starting after some date, for example, any ACO
5 starting in 2015 or after? If new ACOs can be one-sided,
6 there could be a problem of some ACOs in a market being
7 under two-sided risks and others being under one-sided risk.
8 This could present issues of equity if, for example, ACOs
9 were able to recruit primary care physicians from other ACOs
10 based on having no share of losses.

11 Alternatively, should there be an option for one-
12 sided with a lower share of savings going forward? This
13 might be an option if you think there is a large pool of
14 potential ACOs that will not want to take on risk for losses
15 but should be brought into the program. This could be
16 allowed for the first year only of a three-year contract
17 period, as was done in Pioneer, or for the entire three-year
18 contract, as was done in the MSSP.

19 To start off considering the issue of setting
20 baselines and benchmarks, let us first review the way that
21 baselines and benchmarks are set currently in the Medicare
22 shared savings program. The ACO benchmark is the sum of the

1 historical baseline for the ACO's attributed beneficiaries
2 and an allowance for the actual national trend in fee-for-
3 service spending. So, let's look at an example of how this
4 works.

5 In this example, the historical baseline is the
6 weighted average of the previous three years of spending on
7 the beneficiaries attributed to the ACO, which in this case
8 is \$10,000. The reference trend for the ACO spending growth
9 is the absolute dollar amount of spending growth for
10 beneficiaries in fee-for-service, \$400 in the example. The
11 benchmark is the sum of the baseline in the reference trend
12 and is the target spending amount that the ACO must be below
13 in order to achieve savings. That is \$10,400. This means
14 if the ACO can keep the increase in spending for its
15 beneficiaries below four percent, they will have achieved
16 savings.

17 For the MSSP, the \$400 is the same for all ACOs,
18 regardless of the baseline. Thus, if our original ACO was
19 at the national average, the example as it was stated, if
20 the baseline were different, results would be different.
21 Here, we have a low-spending ACO in the first column. Its
22 baseline is \$7,000. It gets the same allowance for growth.

1 Thus, its benchmark is \$7,400, giving it a 5.7 percent
2 increase, which is higher than the national average.
3 Conversely, for a high-spending ACO in the last column, the
4 benchmark is higher, but the percent increase is less, 3.3
5 percent.

6 We like this approach because it gives a low-
7 spending ACO a little more room for growth because it may
8 already have been pretty efficient and recognizes that the
9 high-spending ACO may already have some room for increased
10 efficiency in its baseline amount.

11 With that example in mind, here are several
12 options you may want to consider for how to set the baseline
13 for phase two of ACOs. The first option for setting
14 baselines is the one that's currently used, the historical
15 spending for the ACO's attributed beneficiaries. Its
16 advantage is that it seems to be a reasonable starting
17 point, and if the change allowance is set to fee-for-
18 service, it would probably mean the program will likely not
19 spend more for those beneficiaries in the ACO than it
20 otherwise would have. The disadvantage is it may not be
21 sustainable in the long run for ACOs to continually improve
22 over their past performance, particularly if they were

1 already efficient.

2 Sticking with the historical baseline, one
3 improvement might be to express it in terms of use rather
4 than spending. This would avoid problems with differing
5 price levels. For example, for an efficient ACO in San
6 Francisco, an area with high prices, the \$400 increase in
7 the previous example is a much smaller increase than for an
8 ACO in an area with low prices.

9 The baseline, either spending or use, could also
10 be computed as a blend of the ACO's historical experience
11 and the national level, for example, 90 percent historical
12 and ten percent the national average. This would help areas
13 with low spending or use and recognize the opportunities for
14 efficiencies in areas with high spending or use in fee-for-
15 service, and that's the regional equity issue we were
16 talking about in the first session.

17 Finally, a totally different approach would be to
18 use local fee-for-service as the baseline, as in the MA
19 program. This approach would be a significant departure
20 from current rules, but may address the issue of
21 sustainability over time and would achieve equity among ACOs
22 in the same market. It could also help improve equity

1 between fee-for-service, MA plans, and ACOs, as you talked
2 about in the payment synchronization discussion.

3 After some option for setting the baseline is
4 chosen, decisions would need to be made on how to set the
5 trend in the benchmark. The trend could be set using the
6 absolute dollar amount, as is currently done in MSSP. This
7 gives an advantage to low-spending ACOs, as we discussed.
8 An alternative would be a percentage growth amount, which
9 could help overcome price differences. That approach is
10 used in MA, for example. Pioneer split the difference and
11 did half of each.

12 Finally, the benchmark could be set prospectively,
13 as is done in MA, or retrospectively, as is currently done
14 for ACOs. The advantage of prospective is that ACOs would
15 know their target ahead of time, but it's less accurate
16 because it's based on a projection rather than actual
17 growth. A retrospective target, which ACOs now use,
18 reflects actual trends, but ACOs do not know their target in
19 advance.

20 Another area for which you asked for more
21 information was the issue of passive assignment and opt out.
22 Under current rules, there can be limited awareness of the

1 ACO because the beneficiary does not sign up in any way for
2 the program. There is no enrollment. The beneficiary is
3 simply assigned. The ACO does send a letter telling the
4 beneficiary he or she is in an ACO and giving the
5 beneficiary the option to opt out of CMS sharing data with
6 the ACO. We hear about five percent of the beneficiaries,
7 on average, opt out. However, even if they do, their
8 spending is still counted for the ACO's performance. The
9 ACO just does not get any claims data from CMS to manage
10 their care.

11 The ACO is also allowed to provide some
12 information to the office about the ACO. However, there are
13 limitations on other forms of communications with the
14 beneficiary and some of the ACOs cited this as being an
15 issue so far. And we are looking into the guidelines and
16 seeing if there is room to broaden them.

17 The advantages to the current system are that the
18 ACO has little marketing cost and cannot select patients and
19 no action is required by the beneficiary to be in an ACO.
20 The disadvantages are that it is difficult to engage the
21 beneficiary, who may not know the ACO exists, much less that
22 he is in one, or what an ACO is supposed to do. The

1 beneficiary has no incentive to see ACO providers, which
2 could limit the effective care coordination, which is how
3 ACOs are supposed to succeed. The limitations of this
4 approach are reflected in the ACOs' experience.

5 ACOs reported issues with passive assignment and
6 with leakage from their networks. Several ACOs mentioned
7 that they were assigned fewer beneficiaries than they
8 expected and they wanted some way to bring in the patients
9 that weren't captured in the assignment algorithm, such as
10 patients who consider an ACO physician to be their primary
11 care provider. They would like to give these beneficiaries
12 an opportunity to join the ACO outside of the attribution
13 process.

14 One alternative to passive assignment is
15 enrollment. Beneficiaries would enroll in an ACO as they
16 now enroll in MA plans. This would require the ACOs to
17 market themselves and it would require the beneficiary to
18 make an active choice. It would represent a big change for
19 the program away from attribution.

20 A less abrupt change could be some form of
21 attestation in addition to passive assignment. For example,
22 the beneficiary could attest that a particular primary care

1 provider in the ACO is her primary care provider. While
2 this may better align beneficiaries with the ACO, it may
3 introduce selection issues or other problems.

4 Another issue raised by ACOs is that their
5 beneficiaries use providers outside the ACO, making it more
6 difficult to manage their care. One approach to address the
7 leakage problem would be to give beneficiaries an incentive
8 to use ACO providers. This raises two issues. Should ACOs
9 be allowed to offer lower cost sharing? Some would object
10 on anti-kickback grounds, but because the ACO does not want
11 to increase volume, that concern may not be valid.

12 The second issue is, should there be ACO-specific
13 supplemental plans. Because many beneficiaries already have
14 plans that cover their cost sharing, offering lower cost
15 sharing in an ACO may not be very effective. One approach
16 to make incentives more powerful would be an ACO-specific
17 supplemental plan, such as we discussed in September. We
18 developed this approach some more in your mailing materials
19 and we can discuss it more fully on question.

20 The point of all these steps is to try to give the
21 beneficiary more of a reason to want to be in an ACO and to
22 feel any gains that are made are not all going to others, an

1 issue that contributed to the managed care backlash in the
2 late 1990s.

3 So, I'll leave you with these issues for
4 discussion. Should two-sided risk models be required next
5 cycle or be the eventual goal? How should baselines and
6 benchmarks be set for the next phase of ACOs, and do those
7 decisions put us on a path towards synchronized payment
8 among ACOs, traditional fee-for-service, and MA plans?
9 Finally, how should we address attribution and leakage
10 issues? Should beneficiaries be allowed to make some type
11 of attestation, and should they be given a financial
12 incentive to stay within the ACO?

13 We'd be happy to try to answer any questions on
14 the presentation or paper you may have.

15 MR. HACKBARTH: Thank you very much. Good job.

16 So, round one clarifying questions for Katelyn and
17 David. Bill, and then Jack and George. Bill.

18 MR. GRADISON: I wondered whether your
19 recommendations, or are they options, among which we might
20 choose would depend on what kind of an ACO, really, it is.
21 So I have this question. Have you taken a look at academic
22 health centers' role as against non-academic health centers'

1 role in ACOs?

2 MR. GLASS: No, I don't think we have.

3 MR. GRADISON: Okay.

4 MR. GLASS: We could try. Are there?

5 MR. BUTLER: There are -- can I just comment on
6 that? The Pioneers, there are a significant number of
7 academic medical centers, actually, that are in the Pioneer
8 ACOs. I don't know, eight, nine, something like that, out
9 of 32.

10 MR. HACKBARTH: Reminder: We are in round one,
11 clarifying questions only. Jack.

12 DR. HOADLEY: My question is, the mechanics of the
13 two-sided risks, are plans paid the full amount and then
14 have to send money back? Is it withheld and then they get
15 the full amount? Which way does it work?

16 MR. GLASS: They have to pay it back.

17 DR. HOADLEY: Okay.

18 MR. GEORGE MILLER: Yes, a technical question on
19 Slide 10. Is it possible, based on our previous
20 conversation, is it possible for a low-spending ACO to be in
21 the same HSA as a high-spending ACO?

22 MR. GLASS: Yes.

1 MR. GEORGE MILLER: Okay. And then on Slide 13,
2 you mentioned the five percent opt out. Do we know why they
3 opt out? Has there been any analysis done, the reasons why
4 they're opting out?

5 MR. GLASS: I don't know. We don't know of any
6 reasons. We could --

7 MR. GEORGE MILLER: They just opt out?

8 MR. GLASS: Well, I mean, it could be anything.
9 It could be confusion. It could be they don't want their
10 data shared with the government, whereas, actually, it's the
11 other way around. It's the government sharing the data with
12 the ACO.

13 MR. GEORGE MILLER: Yes. Yes.

14 MR. GLASS: But we think there's probably quite a
15 bit of confusion on that.

16 MR. GEORGE MILLER: Okay. Thank you.

17 MR. HACKBARTH: Any other clarifying questions?

18 Scott, will you lead off round two.

19 MR. ARMSTRONG: Thank you. In a way, we have been
20 talking about this topic all morning, or all day long, and
21 now we get to really talk about it. And on the very last
22 slide are the three questions to organize the comments I'll

1 briefly make here. These are three seemingly simple
2 questions, but there's actually five or six questions inside
3 each one of them, and I won't get to all of that, but --

4 Generally speaking, I think it's worth just
5 reminding ourselves, and it came out, I thought, well this
6 morning that we're trying to create accountability for
7 outcomes in a care delivery system and ACOs are a vehicle
8 for trying to do that. But this analysis identifies all
9 sorts of ways in which it's flawed and that we are looking
10 to improve on that. Generally speaking, we do want to move
11 in this direction, but I think, as your paper showed, there
12 are a lot of things we can do better.

13 Also, generally speaking, I was just thinking
14 about how our policy is built on a principle that we've
15 wanted to make entry into ACOs relatively easy because we
16 think it's a good idea. But once groups are in, we want to
17 start making it harder and we want to start pushing more on
18 this idea of being accountable for outcomes for populations
19 of patients. And so I think that's really a mindset, if you
20 will, that I had as I went through your questions.

21 To them, specifically, yes, I think we should
22 reaffirm a position we've already taken that there should be

1 two-sided risk to the ACO payment structure. I think, here,
2 there are a lot of different ways you could create a
3 graduated approach to getting there. In a way, that's
4 really how the program has been designed. I would just say,
5 from a very practical perspective, is we are contracting
6 with large providers within our own network, moving toward
7 capitation. We always start and move incrementally to a
8 bigger and bigger risk and I think it just helps these
9 groups figure out how to do that.

10 The baseline -- a lot of, I think, here, excellent
11 questions -- again, I like the idea that you begin expecting
12 incremental improvement from your historical past as a way
13 to ease entry into this, but ultimately, these ACOs need to
14 be accountable for delivering on outcomes, including cost.
15 It's lower than just the fee-for-service. And so I think we
16 do need to find a way of getting back to a structure that is
17 based on local fee-for-service.

18 And then, finally, how in the world can a group be
19 accountable for care for a population of patients if they
20 don't have a relationship with them? The whole process of
21 identifying and attributing patients to the ACO has got to
22 be built, in my mind, and it's not just -- it's two ways.

1 It's so that the provider knows who they're accountable for
2 and so that the patient and beneficiary can play a role as
3 an active, engaged, and, I think in the end, ultimately much
4 healthier participant in pursuing their own better health.

5 The last point I would make would be this idea of,
6 whether it's through a supplemental plan or some other way
7 of tiering networks or tiering the out-of-pocket costs for
8 beneficiaries to create incentives works very well in the
9 rest of the world. Why don't we start applying it to
10 Medicare? I think it's an excellent idea and should be
11 pursued.

12 MR. HACKBARTH: Thanks, Scott.

13 Let me just offer a thought and give people an
14 opportunity to react. These are up here seemingly three
15 independent questions when, in fact, I think they are linked
16 to one another, and I think that your decision on the first
17 one has major implications for your decision about the next
18 two in the sense that if all ACOs must at some point move to
19 two-sided risk, they are going to be a lot more particular
20 about the benchmarks. And an organization that has a low
21 benchmark because of past efficiency isn't going to feel
22 very good about taking losses if their neighbor, which has a

1 high benchmark because of past inefficiency, is making
2 profits. So I think that issue will become even more
3 poignant.

4 And, similarly, I would suspect that to the extent
5 the organizations are asked to assume financial risk, the
6 issue of leakage and having mechanisms to steer patients
7 will take on added urgency for the ACOs.

8 So, that's just a thought about how they're not
9 independent questions but, in fact, linked questions.

10 Rita.

11 DR. REDBERG: So, just to build on that, I agree.
12 I think it's very important as we proceed with ACOs to sort
13 of strengthen the model, and leakage is clearly a big issue.
14 And the other thing besides the tiered supplemental, which
15 sounds like a good idea, is the other idea we talked about
16 earlier, and perhaps, I guess, the Commission suggested it
17 before I was on the Commission, but having patients share in
18 the savings, I think, also gives patients an incentive to
19 stay within the plan and share the same goals. I think it's
20 very difficult in the current model, if patients didn't
21 choose to be in an ACO, they probably don't even know what
22 an ACO is and are free to go anywhere else. But I think if

1 patients were able to share in the savings of an ACO, they
2 would be a lot more invested in the whole teamwork approach
3 and model of the ACO, so I would favor something like that.

4 And in terms of the baselines and the benchmarks,
5 certainly, what you just -- you know, it's always do you
6 reward improvement or do you reward absolute or relative. I
7 thought your suggestion in the mailing materials on page ten
8 of having a blend seemed to sort of address both of those
9 issues and would be worth exploring.

10 And I do think the two-sided risk model should be
11 required in the next cycle because that's kind of the best
12 way to ensure participation and commitment and to achieve
13 the goals of the ACO.

14 MR. HACKBARTH: One of the variations that was
15 mentioned in the presentation, the paper, is that you could
16 way that in the second cycle, everybody, including new ACOs,
17 had to have two-sided risk, or you could say that you're
18 entitled to one contract cycle where you have just upside
19 only. You get a training opportunity before you have to
20 accept two-sided risk.

21 DR. REDBERG: There was one, and I thought you
22 said for the first year of a three-year cycle, you would

1 have two-sided -- one-sided risk only --

2 MR. GLASS: The Pioneer had a variation of that,
3 yes.

4 MR. HACKBARTH: Yes, you could do it within
5 cycles, yes.

6 MR. GLASS: Yes.

7 MR. HACKBARTH: Right. But the basic idea is,
8 should everybody be entitled to a learning opportunity where
9 they do not have sided risk, so if people could react to
10 that, as well.

11 Rita, do you have a thought?

12 DR. REDBERG: Yes. I think that seems reasonable,
13 and it seemed -- I don't know if you had any other comments
14 based on your conversations with the ACOs, whether that
15 would seem -- it sounds reasonable to me.

16 MR. GLASS: Yes. The issue raises, you could then
17 have a one-sided and two-sided risk ACO in the same place
18 and the same time.

19 [Pause.]

20 DR. NERENZ: When I was reading the materials, it
21 was occurring to me temporarily that the term "one-sided
22 risk" was an oxymoron, because if all you can do is go up,

1 what's the risk? But if you go to Slide 6, there is indeed
2 risk. In fact, now my mental pendulum has swung the other
3 way. Look at the top two bullets. Savings have -- but it
4 costs you 1 to 2 percent to achieve that. And there's a
5 third bullet that's not up there. If you are a fully
6 integrated system that has hospital, specialty, ER
7 components, those savings are your fee-for-service revenues
8 that are now gone. So if you think about the whole picture,
9 you've got the infrastructure cost to set it up and run it;
10 you've got fee-for-service revenue lost. Both of those are
11 bad. And then you get a little bit of it back depending on
12 your quality production. It's really hard for me to see
13 across the board how this is an attractive program at all.

14 So rather than wondering about whether we should
15 be pushing people to a less attractive version of it, I
16 think if we start with the presumption this is a good idea,
17 I'd be thinking more about how do we make it attractive for
18 organizations that are not currently in it because they're
19 seeing it that way.

20 As it sits right now, the model's attractive to
21 two sort of concepts that relate to each other. It's
22 attractive to large primary care practices who do not

1 themselves incur the revenue losses. It's somebody else's
2 loss. It's also attractive to organizations that have high
3 historical spending patterns because you have some room to
4 move those down. And then you just switch to the other
5 side. It's unattractive to others.

6 So I think as we address the questions, we have to
7 think about who do we want in this program. Do we think the
8 current pattern of attraction is good? Is that what we
9 want? And, I'm sorry, could we flip to the question slide?
10 Because we could do some other things. You could go two-
11 sided risk, but then you'd have to add some features that
12 make it more attractive in general.

13 For example, if you want historically efficient
14 organizations in, you need to set the benchmark against
15 prevailing area rates or something else other than their own
16 historical performance. That would be an option. But then,
17 of course, in doing that now you disincen the currently
18 expensive organizations. So it's hard to get both.

19 Now, just in terms of the attribution, I think
20 there could also be concerns about the current attribution
21 model bringing too many people in, meaning people who have a
22 plurality of primary care visits but do not have actually a

1 meaningful continuity relationship with the system. So one
2 way to make it also more attractive might be to actually set
3 the bar higher in terms of the formulaic attribution, to
4 Scott's point, just make it so it's tighter, those people
5 with whom you actually have a relationship, but then allow
6 the bringing in of people who somehow may slip outside the
7 formula, but by some attestation or some other bit of
8 evidence do have a relationship.

9 MR. GRADISON: I've been so wrong about ACOs so
10 far that I'm not quite sure how to answer the question. It
11 has baffled me, frankly, in particular that hospitals would
12 want to join into an activity which would require a
13 commitment of high-level talent and their time, plus
14 exposure to risk and financial costs. To do what? To
15 reduce their income. I mean, you know, that's kind of an
16 interesting economic proposition. But maybe I misunderstand
17 it. I apparently do.

18 I prefer a phase-in to a two-sided model. I think
19 that we probably need to think through the alternative, and
20 I favor some type of monetary incentive for patients to stay
21 inside the network, or at least not go outside of it. And
22 it could be either way. I'd want to give some thought to

1 whether it would be a financial incentive to stay in or a
2 financial penalty to go out.

3 But, anyway, that's a current report on my state
4 of confusion.

5 DR. HALL: Thanks for clarifying that. So I think
6 we should do whatever is necessary to make consideration of
7 joining an ACO attractive to health systems. So I guess I
8 would favor at the very least the option of going one- or
9 two-sided risk, but probably most people will pick just the
10 upside just to start out with.

11 But I'm very puzzled by the lack of beneficiary
12 awareness of what they're doing. If we compare this to
13 successful Medicare Advantage programs around the country,
14 one of the hallmarks of a successful program is that they
15 very proudly advertise to their beneficiaries and others what
16 they offer and why their system is attractive. And the idea
17 of managing people without them knowing what organization
18 they were part of just kind of boggles me. I think that has
19 to be looked at carefully.

20 DR. CHRISTIANSON: Well, I also sort of favor
21 error on the side of encouraging as many organizations to
22 become ACOs in the near term as possible on the assumption

1 that there are benefits to be associated with organizations
2 thinking about managing care from a population health
3 standpoint and better coordinating care across sites of care
4 and across providers. So I favor the one-year contract
5 cycle where it can be just one-sided, and then moving from
6 there into a shared risk.

7 In terms of baselines --

8 MR. HACKBARTH: Can I just -- so one year --

9 DR. CHRISTIANSON: One contract cycle.

10 MR. HACKBARTH: One cycle, okay.

11 DR. CHRISTIANSON: That's right. I said that
12 wrong.

13 In terms of the baselines and benchmarks, I think
14 ultimately whether this program succeeds or fails in terms
15 of saving Medicare money depends on the trend and how we set
16 the trend rate. And I think that's the whole ball game,
17 frankly, and I think we need to spend a lot of time thinking
18 more about that. I don't have any particular suggestion,
19 but I'm just thinking about my experience evaluating
20 Medicaid contracts with HMOs, and over time what really made
21 a difference to the HMOs was the trend rate in terms of the
22 annual capitation payment much more than the initial

1 benchmark payment.

2 In terms of attribution, I think attribution is
3 what distinguishes ACOs in my mind primarily from more
4 managed care plan. And if we give up attribution, I would
5 say we need to do it in the context of you start out as an
6 ACO, you have attribution, you demonstrate that you can be
7 fairly effective at managing care, then people get to enroll
8 at some level with you. But that should be a beginning
9 point to transition to the MA program. I think that's
10 basically -- if you're going to have people enroll, you're
11 going to be accountable for an enrolled population, that's
12 the essential distinguishing feature. So then you become
13 some kind of MA plan. So we have to think about what that
14 transition is.

15 And then, finally, leakage. I'm always a little
16 bit perplexed by leakage. So when you first become an ACO,
17 your patients have always been going to providers that are
18 employed by, contracted with you, and other providers. And
19 so that cost of all of that is built into your initial
20 payment. So leakage is -- you're not penalized for leakage,
21 however defined, initially. So over time it seems to me you
22 ought to be -- if you think that your internal providers are

1 more efficient and better quality than the ones outside of
2 your system, you ought to be working hard with your patients
3 to get them to use those providers. And, by the way, in the
4 private sector, what providers are finding out is that their
5 internal providers are not always more efficient. In fact,
6 the leakage was to providers that were lower cost and better
7 quality. And managers of those systems are using that
8 information to try to improve quality within their own
9 system and reduce costs.

10 So this whole concept of leakage, it seems to me,
11 the responsibility for that should rest with the contracting
12 ACO, and ACOs don't in large part have networks. They have
13 providers that work for them or have contracts with them and
14 others. But it's not like a contracted network of providers
15 necessarily. So I really think that it's maybe not clear
16 how leakage is going to affect ACOs, but I think it's their
17 problem, and I think that's part of the efficiency incentive
18 they have.

19 MR. BUTLER: I think David did a nice job of
20 summarizing some of the issues, including the two parties
21 most likely to participate. And I'd point out the ones that
22 have the high spending baseline, if you both made it two-

1 sided and started phasing in national benchmarks, they'd
2 just say, "I'm out." You know, you're not going to get them
3 in.

4 I think more importantly maybe that's on my mind
5 is that we have the results from 32 Pioneer ACOs, and we
6 have some 200-plus other ACOs in motion. And I think in the
7 absence of -- or seeing the data from that, and if they're
8 making strides, you know, this is like alpha site is out
9 there, the Pioneer, we would be much better informed maybe
10 how far to push the next phase if we knew some of the
11 achievements of the next 200 in line.

12 So with that in mind, I would favor at a minimum a
13 year off the hook on two-sided risk, and maybe more until we
14 get some more data from the first year of the other 200
15 ACOs.

16 MR. HACKBARTH: Can we say anything about when CMS
17 is likely to have concrete information from the MSSP plans?

18 DR. STENSLAND: Probably not at least until the
19 beginning of the year. I think they're just internally
20 evaluating that data now.

21 MR. HACKBARTH: And at that point it would be the
22 year's worth of experience sort of on average?

1 DR. STENSLAND: Right. The first year data,
2 they're just looking at it now.

3 MR. HACKBARTH: Yeah. Okay.

4 DR. BAICKER: So I agree with a lot of the way Jon
5 characterized things. It makes a lot of sense to me to give
6 one contracting cycle's worth of one-year risk if it makes
7 people feel a little better. But then it seemed as though
8 the two-sided model has to be the long-run plan.

9 The leakage issue, clearly part of the goal is to
10 have the ACO feel responsibility for steering people towards
11 higher-value care. It does seem hard for them to do that
12 without a few more tools where those tools involve people
13 knowing which ACO they're in and how that's working, and
14 might also involve them having some more payment flexibility
15 to go towards protecting beneficiaries from cost sharing
16 when they're going to high-value providers and all of that.

17 So I feel as though the discussion of expanding
18 the suite of tools available to ACOs is probably important
19 for them being able to manage towards lower utilization and
20 also has some implication for attribution. I also don't
21 have a sense of whether as ACOs scale up and penetration
22 increases, if penetration increases, if that in any way

1 attribution easier in some way. I know mechanically it
2 would all look the same, but I can imagine at scale if a
3 greater share of the population is under this umbrella and
4 is being more actively steered by providers, there's going
5 to be a little less blurring. There might be a natural
6 separation where it's more clear who goes with which group.
7 It might not be. That's just an I don't think anybody an
8 answer with the data yet, but maybe this is a shorter-term
9 problem.

10 MR. GLASS: Boston will be a good test case of t
11 because there are I think five Pioneers there.

12 MR. HACKBARTH: Kate, in your comments on leakage,
13 what I thought I heard -- and I want to check this with you
14 -- is that your notion is to give ACOs tools that they might
15 use to encourage patients to stay within their system as
16 opposed to make it a standard feature of all ACO contracts
17 with CMS that they include, you know, a supplemental policy
18 that wraps around and provides incentives. So it's an
19 option as opposed to a standard feature. Am I hearing you
20 correctly?

21 DR. BAICKER: Yes, although I'm not sure that I
22 was very definitive on that point.

1 MR. HACKBARTH: Okay.

2 DR. BAICKER: But I would imagine that if it is a
3 useful set of tools for ACOs, they would try to -- I guess
4 then the question is whose decision is it. If it were a
5 standard wrap-around plan, that seems a little tricky given
6 that beneficiaries are sort of --

7 MR. HACKBARTH: It does.

8 DR. BAICKER: -- passively assigned to ACOs. So
9 it seemed more viable to me to have it be something that
10 ACOs could offer the people who were attributed to them.

11 MR. HACKBARTH: Yeah. The reason I ask is I can
12 imagine that some organizations might take Jon's
13 perspective, you know, leakage is overrated, we can control
14 that without any incentives, just based on how we relate to
15 our patients. Patients tend to go where, you know, their
16 primary care doctor urges them to go. And so getting
17 involved in this whole thing of, you know, financial
18 incentives, special wrap-arounds, I don't want to get --
19 that's just another overhead cost, another complication. I
20 just want to try to motivate our patients through our
21 interaction.

22 DR. BAICKER: But then --

1 MR. HACKBARTH: But others, depending on their
2 configuration, may say, you know, having some financial
3 tools is really important to me.

4 DR. BAICKER: And the advantage of it being an
5 option is that they could pick or choose that, and it could
6 also -- and this is, you know, again, getting further afield
7 from the way the world looks right now, but it could also
8 offer an opportunity to try to attract more people to your
9 practice model. And going back to your point about volume
10 mattering, if this turns into a valuable way to help manage
11 patients' care in a way that they appreciate and see as an
12 advantage, it could steer volume as well as hopefully keep
13 prices down.

14 MR. HACKBARTH: And some may see it as a defensive
15 mechanism, as was mentioned earlier. Some people, myself in
16 particular, have had the fear that the way this will play
17 with beneficiaries is: "Oh, this is managed care, I wasn't
18 given a choice. The savings are going to accrue to the
19 government and to the insurer, and I'm being cut out." And
20 so if you had some mechanism for saying to your patients,
21 "We're going to give you better care at a lower cost and
22 you're going to share in it," that may be a good defensive

1 mechanism.

2 DR. REDBERG: Right. Because, otherwise, we were
3 saying earlier that choice is really important to Medicare
4 beneficiaries, and the way the ACO is set up now, it seems
5 like they're losing their choice because they're assigned to
6 an ACO and now we're encouraging them not to exercise their
7 current free choice of any specialist. So I do think they
8 have to have some buy-in.

9 MR. GEORGE MILLER: Yeah, on the first question, I
10 agree with most of the Commissioners that moving to a two-
11 sided risk model makes sense, but to give a cycle, not just
12 one year but a cycle.

13 And I agree with the second point with everybody
14 else.

15 But on the third issue, I agree with Kate. I
16 would just make it a little more prescriptive in that one of
17 the tools would specifically be shared savings with the
18 beneficiary, and that somehow be part of the education
19 package that that particular ACO would have as a tool and
20 strengthen that to keep them in. You're still going to have
21 choice, as Rita said, but part of that choice is the fact
22 that you could share in the savings. If you choose to opt

1 out, you may not share in the savings, but if you stay in,
2 you could share in the savings.

3 DR. MARK MILLER: So, Jon and Kate and George, you
4 were saying three years.

5 MR. GEORGE MILLER: Right [off microphone].

6 DR. MARK MILLER: Right. Everybody gets one
7 three-year period, so those who have had their three years
8 would be moving to two -- got it.

9 DR. NAYLOR: So I absolutely think we should be
10 trying to promote accountable care, and ACOs represent a
11 path to do that. I think two-sided risk should become our
12 future, and I think whatever we can learn from the Pioneers,
13 13 out of 32 had shared savings, which is pretty good in
14 terms of early return, and now we have the others, from a
15 learning health system that helps the next generation of
16 ACOs to really strengthen the model, I think we should
17 really try to promote.

18 I do also agree that patients should have some
19 capacity to share in the savings achieved by this model, and
20 that becomes at least one of the tools in a toolbox to
21 promote their engagement.

22 I do lean toward -- I think that a primary goal is

1 for the systems themselves to figure out how to maximally
2 engage patients as part of it.

3 You know, on this issue which was raised the last
4 time, I do think in the short term we should really try to
5 think about ways in which we can promote a higher level of
6 access of Medicare beneficiaries to ACOs, and certainly the
7 convoluted path right now to other than physicians really
8 warrants, I think, important and immediate attention.

9 MS. UCCELLO: So I really like the way that you
10 frame things, Scott. I really agree that as we think about
11 this, think about, you know, bringing in these
12 organizations, having them transfer to greater risk over
13 time, and then putting more pressure in terms of the payment
14 benchmarks and changes in those benchmarks, kind of along
15 the lines of what we were talking about in the first
16 session, makes a lot of sense.

17 In terms of the one-sided versus two-sided,
18 correct me if I'm wrong, but it seems like the two-sided
19 risk is actually more of a psychic barrier than an actual
20 something that makes more economic sense in that -- Jeff, I
21 seem to recall your presentation a few years ago that made
22 it seem like, well, everybody should prefer the two-sided.

1 DR. STENSLAND: I have an example here, but just
2 not to slow it too far down, the incentives are bigger in
3 the two-sided model, so there's the psychic reason why
4 people might have more of an incentive in a two-sided model
5 just because they fear downside more than they like upside;
6 but also because there's so much random variation.
7 Basically when you have a two-sided model, you know that
8 either -- if you can actually reduce utilization, you're
9 going to get some benefit out of that, either through a
10 reduced penalty or a bonus. It's a sure thing that if you
11 actually change practice patterns, you would benefit to some
12 degree, maybe not enough to overcome your cost of doing it,
13 but you will benefit to some degree.

14 In a one-sided model, there is no guarantee that
15 you will actually have any sort of benefit from your actions
16 and actually reduce utilization because random variation
17 might just happen that year and you might not get a reward
18 even though you did some good things.

19 So the incentive to actually do stuff and actually
20 try to reduce utilization, reduce capacity expansion, is
21 much bigger in the two-sided model.

22 MS. UCCELLO: So because of that, I would actually

1 be okay with requiring two-sided from the get-go. However,
2 you know, if we really think that that's going to cause
3 organizations to really not want to pursue this, then I'm
4 also comfortable with having the first cycle being the one-
5 sided.

6 In terms of the attribution and linkage, for
7 exactly the reasons you mentioned, Glenn, I am very for
8 having differences in cost sharing or whatever, just so that
9 beneficiaries can share in these savings. They're not
10 getting lower premiums, but if there's something we can do
11 in terms of the cost sharing, I think that would be good.

12 And I would also mention -- and to do that, I
13 think you need to have some kind of acknowledgment by --
14 whether it's attestation or something, that the
15 beneficiaries know that they're in there.

16 And I would just also mention that, you know, part
17 of the reason that doing this is so complex is just the way
18 the supplemental plans go, and we made recommendations in
19 terms of the fee-for-service plan design and how
20 supplemental policies are treated that would, I think,
21 reduce that complexity somewhat. So I think it's just
22 something to keep in mind.

1 And then just finally, when we think about what
2 kinds of organizations we want coming in, I think we care
3 most about those that are the higher cost, because that's
4 where the opportunities are in terms of lowering spending,
5 better treatments for beneficiaries, and more generally, so
6 that when we're trying to decide when there are things that
7 affect -- policies that affect the higher-cost ACOs
8 differently from the lower-cost ACOs, we want to think about
9 how to kind of keep those higher-cost ones coming in and
10 giving them the incentives to lower their costs.

11 DR. HOADLEY: So I think I'm convinced because of
12 some of the things that Jeff was just talking about that,
13 you know, the move towards full two-sided risk does make
14 sense, although I would probably still want to transition.
15 Whether it should be a year or a cycle I guess I am neutral
16 on at the moment.

17 I am concerned about sort of the financial
18 consequences, and it's hard to think about the variety of
19 kinds of organizations that are acting as ACOs. And I think
20 about the debates a decade or two ago about provider-
21 sponsored organizations moving into the MA program, and the
22 concerns about their ability to take on risk, and sort of --

1 I don't think I have enough numbers in my head to kind of
2 think that through in this case, but I do think that's
3 something we should worry about. Are we getting either some
4 organizations involved who, because they're going to
5 actually have to pay money back, there is some question of
6 sort of the financials of it? Is there some advantage doing
7 more of a withhold followed by a full payment? Or because
8 if we go with the kind of thing we're thinking about with
9 two-sided risk, does that then limit the kinds of
10 organizations that would choose to do this? And is that a
11 bad thing? I mean, do we want some of the less fully
12 capitalized kinds of organizations? Right now are we
13 getting mostly sort of larger academic health centers, large
14 hospitals who clearly do have, you know, some ability to
15 absorb some cash flow from time to time? But do we also
16 want the smaller organizations?

17 And then on the second question of the baseline, I
18 guess one of the things I wondered about -- and I was
19 looking back at Slide 10 and trying to think about, you
20 know, if we have organizations in this example -- I don't
21 know if these were just hypothetical numbers, I assume, but,
22 you know, if in one market you had the sort of 7,000 to

1 12,000 kind of range, that's a very different story and
2 actually raises questions. How in one's market where you
3 should have some general similarities in some of the
4 geographic things we thought about before, would you be
5 getting that big a difference? Empirically within a market
6 are we seeing more like, you know, a 9,500 to 10,500, in
7 which case, you know, having a market-level benchmark isn't
8 as big a shock as it would be with that.

9 So I think if we understood a little bit more of,
10 you know, what the dollars might look like, how is it that
11 one organization in the same market, how much different
12 could it possibly be? We're not talking about, you know,
13 Scott's kind of organization that's a real integrated
14 system. We're talking about, you know, people still in the
15 fee-for-service world. So before I would want to think
16 about the answer to the baseline and benchmark question, I'd
17 want to know a little more how those numbers played out.

18 And then on the last question, you know, John
19 started, and some others have picked up, on the notion of
20 coming up with some ways to do shared savings and engagement
21 that doesn't sort of go to the Medicare Select, Medigap-kind
22 of thing. I'm pretty skeptical about that as an approach.

1 I would need to be convinced that that could work. And even
2 the straight attestation, I think the ability to sort of --
3 I mean, I try to think about what would you say to somebody,
4 "Why should I join, attest to, or whatever this
5 organization?" You're either going to get to that sort of
6 managed care backlash kind of thing, or people are going to
7 say, "I don't know what this is." I think even a lot of
8 smart people would have trouble explaining to somebody,
9 their own parent, you know, what this was.

10 So I think if there's some room for creativity on
11 the ACOs' part and maybe there's some regulatory or
12 legislative barriers that need to be lowered to allow some
13 creativity given Medigap and all the other things, to allow
14 them to find ways -- I mean, obviously now they can work
15 with the providers to get there, but I think that's a good
16 way to think about it, try to come up with creative kinds of
17 things that don't --

18 MR. HACKBARTH: Back on the issue of risk, we've
19 sort of implicitly talked about risk as though it were a
20 dichotomous variable -- you're either bearing downside risk
21 or you're not -- when, of course, it's a continuous
22 variable. You can do risk sharing, caps on risk, and I

1 think it's just important to keep that in mind. So even if
2 we say conceptually that there ought to be some downside
3 risk borne by the ACO, that doesn't really say anything
4 about the level that we're contemplating. That would be
5 sort of a subsequent decision.

6 DR. HOADLEY: I think that's a really good point.
7 Part D plans have full downside risk, but it's very tempered
8 by reinsurance and risk sharing.

9 MR. HACKBARTH: In fact, your speaking and your
10 connection to Part D is what made me make that point.

11 DR. SAMITT: So I wanted to put my comments in a
12 context. You know, my sense is that our hope for ACOs is it
13 was one means of overcoming fee-for-service inertia and
14 moving in a positive direction. And I would imagine that
15 what we're hoping for is we want to achieve better outcomes
16 through the formation of ACOs. We want to encourage
17 providers to pursue a bridge between volume and value, and
18 we want beneficiaries to see the value of ACOs versus fee-
19 for-service.

20 And so I guess my question is: How much progress
21 are we making overcoming that inertia? And do we need to
22 make some changes so that we keep moving forward as opposed

1 to slipping back? And that's the context of my answers to
2 these questions. I absolutely believe we should require
3 current one-sided to move to two-sided. In fact, my
4 perspective is that they've already made their 1 to 2
5 percent investment. Why would they now not pursue greater
6 potential movement upside to move forward?

7 I would offer new ACOs a full new cycle. I would
8 be concerned about jumping right into two-sided. We already
9 know how many people chose two-sided right out of the bat
10 when they were offer one-sided or two-sided. So I'd be
11 afraid just offering two-sided wouldn't get so many takers
12 from folks who are just in traditional fee-for-service. And
13 I don't think one year is enough for people, one year of
14 non-risk is enough for people to feel comforted if it's a
15 foreign world for them.

16 So I do think it needs to be a full cycle. I
17 would go so much further to say, Have we already garnered
18 the groups that are more amenable to ACOs? And does the
19 one-sided need to be even more attractive the next time to
20 bring another tranche along? Or will people just stay in
21 the comfort zone of fee-for-service? So we either need to
22 make one-sided more attractive to bring more or make fee-

1 for-service less attractive so that we keep moving forward.

2 And then in terms of really all the questions, I
3 agree with Glenn that they're all interrelated. My sense is
4 that the one-sided and two-sided has been really more fee-
5 for-service-like in all of these elements, and if we're
6 afraid that people will slip backward, maybe we need to make
7 all of these other elements more MA-like, that it is local
8 fee-for-service or a blend to encourage performance relative
9 to others as well as performance relative to self, as well
10 as making enrollment attractive and benefit and gain-sharing
11 with beneficiaries and other MA-like functions as a way to
12 really move the pendulum in the direction of value-based
13 care delivery.

14 DR. COOMBS: So for the first question, I think
15 that two-sided risk models are somewhere in the future, and
16 I want to call your attention to Table 2 that speaks about
17 random variation. And my concern is the different types of
18 ACOs that exist, and just the notion of random variation and
19 how the benchmarks would be established in the small ACOs as
20 compared to ACOs that have greater than 10,000
21 beneficiaries, and the range there you can see is quite
22 different for 5,000 versus 10,000 beneficiaries.

1 One concern that I have is the wisdom of the crowd
2 speaks to the fact that nine out of the 32 Pioneer two-sided
3 risks withdrew for a reason, and that the uptake for the
4 two-sided risk involves I think a number of issues, and part
5 of it is that the fear of loss is greater than the want for
6 the gain, and that a lot of providers may see a threat in
7 terms of the infrastructure necessary to get over the hurdle
8 of the 1 or 2 percent. And I actually think it's probably -
9 - in some situations it may be much more than the 1 to 2
10 percent to get to the place where you have a Cadillac
11 version of an ACO. And so I think that's an issue for me.
12 I think I agree with Craig in terms of where in the future,
13 I think it's going to take longer because there's a
14 timeline, because what you want is you want to make the two-
15 sided risk attractive enough that people want to do it.
16 When I was reading the chapter, I said, "Now, who would want
17 this?" And that's the question that came up first. Who
18 would want this? Would I buy this pair of shoes in the
19 store? It would be difficult for me if I didn't have all of
20 the necessary ingredients to kind of carry it off.

21 And then in terms of the baseline and benchmarks
22 to be set, I agree with -- I think someone said it. It's in

1 the chapter on the blended combination. I think that helps
2 to correct for some of the issues we talk about in terms of
3 historical controls versus national benchmarks, maybe doing
4 some kind of blend.

5 In terms of attribution and leakage issues, I
6 think there's some other issues outside of the primary care
7 in the ACO, and that has to do with the specialists and the
8 exclusivity clauses in terms of local dynamics within
9 accountable care organizations. And we have seen that when
10 you have a specialty in which there is some local forces in
11 terms of stress of the numbers that that might be an issue
12 for the ACOs and going forward.

13 And then the leakage in terms of being in close
14 proximity to some of the larger medical centers, and the
15 whole notion of consolidation, because a lot of small
16 providers are saying, "Who do I get on the train with? I
17 need to be in an ACO. Who do I join?"

18 So I think that we want to be able to encourage a
19 transition, but you can't do it in big leaps. You can't
20 jump from a fee-for-service and go all of a sudden into an
21 ACO that's willing to bear two-sided risk. So I think the
22 transition would be enhanced by considering the environment

1 that the providers are practicing in.

2 DR. CHERNEW: So I want to start picking up with
3 something that Craig said, which is there's this question
4 about how to get providers to join, and as much as we talk
5 about the design of the ACO program, one of the key things
6 is the attractiveness of the other part of the program. And
7 I think focusing, at least to some extent, on what's going
8 on there will begin to answer why you would join -- not
9 because you love it, because you hate what the alternative
10 is.

11 MR. HACKBARTH: Fee-for-service.

12 DR. CHERNEW: Fee-for-service. The alternative
13 portion of fee-for-service, right? And the key to these
14 ACOs, all of them, is that it allows the provider to capture
15 efficiency, so if you can manage post-acute better, if you
16 can reduce readmissions, if you can do, you know, all these
17 other types of visits by e-mail, we think there's a lot of
18 inefficiency. This allows the providers to capture that
19 efficiency on their bottom line in a way that fee-for-
20 service fundamentally doesn't in a world where fee-for-
21 service payments are fundamentally under a lot of pressure.
22 So you can convert those efficiencies into profits if you

1 can convert those efficiencies into profits, which is easier
2 said than done, which is why I'm an academic.

3 [Laughter.]

4 DR. CHERNEW: But in any case, I think that's the
5 theory of why people would join these things, and that leads
6 me to the point that the benchmark, as Jon said in the
7 beginning, I think the benchmark becomes crucially
8 implement, and the trending of it. And I think it's
9 probably fundamentally not a good idea to have organizations
10 compete against themselves. The way they set it up, it
11 adjusts for risks, but it adjusts for inefficiencies in a
12 bunch of ways. It's not only a bit unfair cross-
13 sectionally, but over time, as you become more efficient,
14 your target rolls and it becomes problematic. And so I
15 really think we need to think through that. And as we begin
16 to think through that, there's this question of one-sided
17 versus two-sided or how long. Ideally, per our earlier
18 discussion today I'd want the two-sided one, which people
19 seem to prefer, to win in the marketplace, but we don't
20 really have the mechanisms to allow that to happen the way
21 people are choosing or not choosing or the way the system is
22 set up. So in the context of this discussion, I prefer

1 giving them some time on cycle and then moving to two-sided
2 risk would be my preference. But my real preference would
3 be a sort of level playing field and organizations could
4 decide what they wanted to get into.

5 My last point would be why ACOs are not -- and
6 maybe there's a bunch of reasons, but one really important
7 one is there's insurance regs for MA plans, not for ACOs,
8 and there's a bunch of other sort of differences, so don't
9 think of these as just another MA plan run differently.
10 There's really fundamental institutional differences.

11 MR. HACKBARTH: So I think one of the themes here
12 in at least some of the comments is that if you have
13 voluntary payment reform, that is, providers have a choice
14 whether to participate or not, that really has ramifications
15 for program design. So to just pick up where Mike was, if
16 it's voluntary whether a provider becomes an ACO, then
17 presumably they'll look at the benefits of the ACO and the
18 risks, but also the attractiveness of the alternative, which
19 is to say in traditional Medicare and not be involved in
20 ACOs.

21 If the model we're offering is, well, old
22 traditional Medicare will continue as it has been and you

1 will be able to take advantage of it the way you have in the
2 past, have a volume-focused business and use it to maximize
3 revenue, boy, a voluntary ACO you're going to have to make
4 the terms really delicious to get people to move out. And
5 I'm afraid that's sort of the trap that we're in, and that's
6 one of the reasons why, if you say, now, it's not just
7 upside only gains, downside risk, it could have a dramatic
8 impact on participation. I think Dave did a nice outline of
9 some of the reasons that a provider would say, "Not for me,"
10 especially if you go to two-sided risk.

11 But where that leads me is to the question of what
12 is the success of this program. Is it how many
13 organizations we can entice into being ACOs? If it is, you
14 know, I think that means that two-sided risk is going to be
15 difficult to impose. I think you're going to have to make
16 it really attractive for people to come in; or,
17 alternatively, make traditional Medicare increasingly really
18 unattractive. Or another way to think about it is, you
19 know, we're not looking to maximize the number of ACOs.
20 What we're trying to do is give an opportunity to
21 organizations that really are pretty well set up to do this,
22 another way for them to participate in a program.

1 So to take Dave's description, if all the academic
2 medical centers are out, if there are no hospital-based
3 ACOs, if they're all sponsored by physician organizations,
4 is that necessarily a bad thing? I can imagine that, in
5 fact, that may be ultimately the most sustainable model of
6 an ACO and trying to jimmy the rules so it's attractive to
7 academic medical centers may compromise your design and not
8 enhance it.

9 So I've gone on too long already. There are some
10 thoughts in there for people to react to. You know, I
11 think, what is success? What do we mean by success? How do
12 we judge success of this program I think is a really
13 fundamental question that we've sort of -- not just here,
14 but all of us collectively -- the big "we" -- have sort of
15 jumped over in our eagerness to have more ACOs.

16 [off microphone] So we're now onto Round 3.
17 Questions? Ultimately, what I want to do is get to these,
18 but I think we needed to sort of broaden the discussion in
19 order to be able to think carefully, systematically about
20 these questions.

21 DR. NERENZ: Just in response and agreement to
22 what you just said, I would find it successful from a

1 program design perspective if ACOs became a successful,
2 sustainable niche thing that sat alongside MA as opposed to
3 being a pathway to MA. It might sit alongside even some
4 remnants of traditional fee-for-service in environments
5 where that also seemed to be working well. So I'd just --
6 to echo that point, I don't think I would judge success by
7 some just vast volume growth. A niche thing would make
8 sense to me, with that understanding that certain
9 organizations may be well suited for this model but not
10 everybody, and you wouldn't seek to have everybody in it.

11 If I could ask a question to Katelyn and David and
12 Jeff, back to this issue of the two bullets on line 6, did
13 any of the organizations that you talked to actually
14 describe themselves as having net savings, meaning savings
15 net of program costs?

16 MS. SMALLEY: I believe a few of them did.

17 DR. NERENZ: The average numbers would suggest
18 not, but some did?

19 MS. SMALLEY: Yeah, there was kind of a large
20 variation in how well certain organizations did versus
21 others.

22 DR. NERENZ: Okay.

1 MR. GEORGE MILLER: Those who did, could you kind
2 of describe what they look like and do you understand what
3 drove their success?

4 DR. STENSLAND: I think I would caution on that,
5 and there is a couple of them that said we had net gains,
6 but I think it cautions going back to the random variation I
7 talked about. There was a whole lot of random variation
8 going on here.

9 MR. GEORGE MILLER: Well, that's --

10 DR. STENSLAND: And we would expect a couple to
11 look really good almost if everybody just did random stuff.
12 And so when we only have three or four examples of people
13 who actually had net-net savings, as David talks about, I
14 think it's maybe too early to jump on those and say exactly
15 what they're doing because we're still not so sure if those
16 net-net savings, how much of it's due to them being better
17 operators than other folks and them just being luckier.

18 DR. CHERNEW: I've also heard from places around
19 that they think they actually did better than the scoring
20 showed up at CMS. So I don't know if you've heard that as
21 well, but there's been some dispute, at least where I've
22 been, about the way the scoring is all going. So I think

1 this is still pretty fluid in terms of what's really
2 happening.

3 MR. GLASS: Yeah, we mentioned how the baselines
4 were set and how the benchmarks were set and how all that
5 worked out. There were some questions raised. So we're
6 trying to figure out how that's working out.

7 MR. ARMSTRONG: So just a couple of points, one
8 following up on this. You know, let's not forget that there
9 is incredible waste in our system, and it could be luck --
10 and while this isn't for the faint of heart, it's not easy,
11 with upside and downside risk it could be worth a lot of
12 money for these organizations. And so it's like we haven't
13 really said that, but there is -- I mean, I think that's a
14 real drive for well-run, well-organized group practices, and
15 we want that.

16 Second, and not unrelated, is, Glenn, to your
17 question, how do you measure success? Well, this is just
18 another tool in the toolkit to lower costs and improve
19 health outcomes for the beneficiaries. I think, you know, a
20 concern I would have just from a very on-the-ground
21 practical point of view is that the word ACO is what
22 everybody is talking about. I mean, our care delivery

1 systems have changed so much through consolidation and
2 mergers and alignments in the last few years, driven by this
3 idea. And yet there's very little evidence, at least in my
4 anecdotal experience, that they've done anything to achieve
5 the goal of lower cost or better outcomes. And it just
6 seems to me that part of our issue is continuing to drive
7 payment reform that allows us to convert what has been a big
8 transition in the care delivery systems into a transition
9 that actually creates value instead of one that just
10 maximizes margins on a fee-for-service-based payment
11 structure.

12 MR. HACKBARTH: Go back to these questions for a
13 second. One of the paradoxes here is that the organizations
14 that are best positioned to do the work that Scott has
15 described, many of them have done a lot of it already, and
16 under the way the program works, they're punished with a low
17 baseline. And so we're sort of trying to make the program
18 inviting for the people who haven't done the work of the
19 past, who for the reasons that Dave outlined may be
20 reluctant to do it because they're going to lose hospital
21 admissions and, you know, have revenue hits, and designing
22 it against the people who have the most potential to drive

1 high value. You know, we're sort of at war with ourselves
2 in the design here.

3 DR. MARK MILLER: And this is where I feel like
4 I'm trying to figure out what to carry out of these
5 conversations here and this morning. You know, this morning
6 we were talking about something of a financially neutral
7 posture towards the three delivery -- or payment systems.
8 Then we're saying here, well, we have to make it attractive
9 to -- maybe make it more attractive to get people in. But
10 if you don't put any pressure on fee-for-service and you
11 make it attractive to go into a one-sided risk thing, you
12 haven't necessarily, at least on the spending side, achieved
13 anything.

14 MR. HACKBARTH: Right.

15 DR. MARK MILLER: And if anything, you've probably
16 spent more money. And maybe you get the quality payoff.
17 There does seem to be some evidence there. And I don't mean
18 to dismiss that, but I have a hard time reconciling we're
19 driving people to something when it's sort of we're not --
20 if we're neutral on fee-for-service -- and you may have some
21 views on that. If we're neutral on fee-for-service and then
22 enticing on the ACOs, I'm not sure we're driving -- other

1 than the people who already know how to do it, you know, how
2 much we're driving. And that's what I hear, sometimes
3 driving, sometimes we're not, and I'm a little --

4 DR. COOMBS: But I want to speak to the notion of
5 some forms of creativity in that, you know, Glenn said
6 something about the type of risk and better defining that.
7 If you were to develop risk corridors that were specific to
8 different concerns of different groups, you might create a
9 paradigm where people were more likely to say, okay, I'll
10 accept this two-sided risk, and that you can mitigate some
11 of the risk and some of the concerns and maybe that might be
12 a situation where, you know, ACOs in certain regions would
13 say I'm going to go ahead and undertake this.

14 The other thing is the attribution in terms of
15 changing the whole notion of one or two encounters as a
16 defining assignment and how you do it prospectively versus
17 retrospectively. There's a way in this -- I guess in the
18 U.K. there's like a 5 percent mullet. You get a certain
19 aliquot of patients where you're not responsible for, and
20 maybe a possibility that something like that. On the
21 creative side, you might be able to redefine the
22 relationship that exists in a way in which it subtracts some

1 of the patients that you may have had a minimal encounter,
2 i.e., what settings are they seen in and how you can better
3 define what a relationship is with a provider.

4 DR. HOADLEY: I'm intrigued by your bringing up
5 this notion of this may be more of a niche -- could be more
6 of a niche thing, and it sort of goes to the same point Mark
7 was making and a couple of others have made. And I think
8 what's not obvious a priori to me is who's in that niche or
9 who should be in that niche. And so is it that we should be
10 looking for the really weak performers and trying to figure
11 out some way to get them to finally engage something? Is it
12 actually get the good ones to keep doing better and
13 reinforce what they're doing? And I don't know if there's a
14 way out of the many organizations that are doing this that
15 we can look at differences between, you know, hospital-
16 based, academic health center-based, group practice-based
17 kinds of examples out there, or whether we even have enough
18 information yet to do that, but to try to get a sense of not
19 just the big numbers but what are they doing. You know,
20 where has it really changed some ways that they're operating
21 in order to say maybe that's the niche that's actually
22 creating some success?

1 MR. HACKBARTH: So if you're content to have this
2 be a niche, i.e., the goal is not to convert everybody in
3 the health care delivery system into ACOs, that has certain
4 policy ramifications, like one is I think it really changes
5 your thinking about how you set benchmarks. You want to
6 quickly move to a system where payment is not based on past
7 performance, but based on some market level.

8 If your ultimate goal is to try to move everybody
9 or a high percentage of care delivery into this new model,
10 then I think one of the implications of that is that you've
11 got to have a clear, explicit strategy for how you're going
12 to make fee-for-service increasingly uncomfortable. And
13 there's going to be push as well as pull. You won't be able
14 to make a pull attractive and positive incentives rich
15 enough without blowing the budget. You're going to have to
16 push them out the door.

17 DR. CHERNEW: Very much in that spirit, I believe
18 now we have in current law a set of update rules that are
19 going to make fee-for-service increasingly difficult for a
20 series of groups, and I personally would be comfortable
21 allowing the efficient providers that joined the ACO
22 programs to make more money than they would if you gave them

1 their past performance baseline. In other words, you may
2 spend some money in the front end, but you would get them in
3 and that would be attractive to them, would have to work
4 through that. What you would then find is that people left
5 not in the ACO program would be the less efficient groups in
6 the fee-for-service side, and I have to say personally I
7 would be much more comfortable being much tougher on fee-
8 for-service if I had a bunch of groups that were in ACOs or
9 other places that were providing good quality care at low
10 cost, and that would be the way that my strategy would play
11 out.

12 Another way to think about that is I hear a lot of
13 people say things. I never hear people compliment the fee-
14 for-service system in general. Now, maybe they just don't
15 talk to me about that. And I think there's a lot of things
16 about the fee-for-service system that makes it hard to
17 manage and run. As that system becomes more and more
18 problematic with the other various current law things, we
19 need to have a system that groups that can't become MA plans
20 for a whole variety of reasons, we need to have a place
21 where they can go, where they can succeed financially and
22 provide high-quality care and, you know, not go bankrupt.

1 Building this type of system, whatever that is, I view as
2 that place. And hopefully we can do it in a way where they
3 can live there.

4 DR. CHRISTIANSON: I think what I'm going to say
5 has some relevance to what the discussion points have been
6 here. I want to make a couple of observations based on work
7 that I'm doing with people in the private sector.

8 One is this focus on shared risk models. The
9 health plans that I've talked to that have multiple total
10 cost of care contracts and they've had them in place for a
11 while find that more and more of their more sophisticated
12 systems are saying they don't care about shared risk -- one-
13 side, upside, downside risk. They want what they used to
14 not want under health plans, which is full risk capitation
15 contracts, we will go buy reinsurance. And then the whole
16 deal in terms of as the payer, whether you save money or
17 not, is the benchmark and trend and what you can negotiate.

18 And I would hypothesize that the more successful
19 ACOs in Medicare are going to eventually say this is what
20 we're getting in the private sector, why can't we get
21 similar contracts from Medicare. And are we willing to
22 consider that? And if we do consider that, do we want to

1 have as a condition enrollment? And then notwithstanding
2 what Mike said about all the different regulations and so
3 forth, at some point when you have a full risk contract and
4 you're enrolling people, do you have to shift over and
5 becomes an MA plan? And so we do have to think about
6 transition I think a little more than we have.

7 And then Slide No. 6 where the folks talk about is
8 improvement from your own baseline sustainable over time,
9 I'm probably influenced too much by some time I spent with a
10 health plan on Tuesday that has multiple total cost of care
11 contracts and has had them for four or five years, and the
12 first thing that came out of their mouth was, "This is not
13 sustainable. This is not a sustainable model. It's not
14 sustainable over time, and cost savings are not sustainable
15 over time." That's from their perspective in the private
16 sector.

17 So the reason for that was nothing change din the
18 market structure when you went this kind of payment. So
19 when they're negotiating global budgets with care systems,
20 it's no different than negotiating fee-for-service in terms
21 of the relative leverage between the provider systems, the
22 consolidated provider systems, versus the health plan. In

1 fact, the provider systems, by virtue of what they've done
2 under their total cost of care contracts, have become more
3 consolidated, and so if anything, the leverage has shifted
4 the other way. So, well, so what?

5 So what do you do about that? Well, what they've
6 done about that is they're already kind of past total cost
7 of care contracts, and they run private health exchanges,
8 and they offer what used to be their total cost of care
9 contract as narrow network options in their private health
10 exchanges. So the higher costs that the providers are able
11 to negotiate are now revealed to consumers as the cost of
12 choosing that option in a private health exchange. And
13 these integrated delivery systems that have ACO contracts
14 are now being offered. This is just the starting of what
15 may be a trend. Who knows? It has options within Medicare
16 Advantage contractors. So the Medicare Advantage contractor
17 will have a limited network alternative for people to
18 choose, which will be the ACO contractor. So the ACO
19 contractor is an ACO contract, and it accesses Medicare
20 beneficiaries through the Medicare Advantage contracts.

21 So these are all, you know, things I'll put out on
22 the table to show that this is going to be a morphing,

1 quickly developing kind of area, transitional area, and
2 we're spending a lot of time worrying about whether it
3 should be 1 or 2 percent shared savings contracts, and I
4 think in the private sector it's moved in a lot of different
5 directions from that, and it's going to continue to move,
6 and we need to be thinking, you know, further ahead -- not
7 that we're not worrying about important stuff, but the
8 market is moving along, and we need to be aware of that, I
9 think.

10 DR. MARK MILLER: But implicitly that means that
11 it's a baseline that's not historical. And I think it's
12 widely understood that that doesn't last for very much
13 longer or doesn't -- and they are at two-sided risk.

14 DR. CHRISTIANSON: [off microphone.] Right.

15 DR. MARK MILLER: Right. Okay.

16 DR. CHRISTIANSON: [off microphone] ... funny,
17 it's the classic thing that health plans had trouble
18 negotiating capitated contracts in the past, but these
19 organizations have developed -- they have built the
20 continuum of care, they are serving larger portions of
21 patients in the community, their risk is more predictable.
22 And now they're saying the insurance market is pretty good,

1 I can buy reinsurance fairly cheap, and I can make some
2 money because I can negotiate really favorable markets
3 because I have a lot of leverage in the market.

4 MR. HACKBARTH: The third question, about
5 attribution leakage, these private contracts, what are they
6 doing on that? When they negotiate total cost of care with
7 delivery system A, what are the terms about leakage?

8 DR. CHRISTIANSON: Well, attribution happens
9 pretty much the way it is now except where they are offered
10 as alternatives in a private health exchange in which people
11 have to actually sign up.

12 MR. HACKBARTH: Yes.

13 DR. CHRISTIANSON: They manage the leakage.

14 DR. MARK MILLER: Can I ask one -- I know we're
15 behind but can I just ask him one more thing?

16 MR. HACKBARTH: Okay.

17 DR. MARK MILLER: So then wouldn't -- where did he
18 go?

19 MR. HACKBARTH: He's there. He's hiding.

20 DR. MARK MILLER: Man, he's good. Man, he just
21 like disappeared.

22 [Laughter.]

1 DR. MARK MILLER: When you see him, ask him this:
2 So then wouldn't that lead you to say some of the discussion
3 about making it more attractive, I could take your comments
4 as look, there are people who have moved down this road,
5 they know how to do it.

6 So would you end up making it more attractive to
7 draw more people? Or would you say look, there's people
8 here who know how to do this, so move and other people will
9 just have to catch up?

10 DR. CHRISTIANSON: So I think it's not an
11 either/or. It's more of an argument for flexibility in
12 terms of -- in how we treat different ACO contractors moving
13 forward.

14 MR. HACKBARTH: Peter.

15 MR. BUTLER: So the fact is, we squeeze fee-for-
16 service system now and it's actually delivering pretty good
17 results on a per capita increase basis, ironically.

18 I still think that a three year cycle is a good
19 way to go. The people that are in the Medicare ACO world
20 are the ones that have -- they haven't had the competencies.
21 You need three years, at least, to get the cultural
22 competencies, much less the investments, made. And you're

1 getting it for free, in a sense, because the one to two
2 percent, they are funding themselves.

3 So what is the downside? The ones that compared
4 well to the benchmarks can flip right to MA now if they
5 think that the shared risk isn't strong enough. So why
6 wouldn't they -- that's what I hear from my ACO colleagues,
7 that say hey, I'm going to go right to MA. I get the whole
8 savings there.

9 So needing to have that two-sided risk set at
10 benchmark levels for the ACOs may be not that important if
11 they've got the MA option and they can keep all of the
12 savings if they go that direction.

13 MR. ARMSTRONG: I just briefly wanted to
14 acknowledge -- and I can't remember where it was, but in
15 some of our previous discussions on this topic we have
16 imagined what this transition looks like and the different
17 levers we have to encourage at.

18 I think we've always referred fairly loosely to
19 the prospect that the transition itself is going to cost
20 money and that there will be an increase in our costs before
21 you are able to decrease costs.

22 I think that question sort of indirectly got

1 begged a few times in this discussion here and we ought to
2 explore that a little bit more. What do we really mean by
3 that? what are the investment costs? Is it luring people
4 into ACOs and then cranking down on the reimbursement? What
5 do we mean by that?

6 I just was reminded that we've acknowledged that
7 there's a transition plan that won't be free, that the whole
8 system is going to need to build and then execute.

9 MR. HACKBARTH: [off microphone.] Any other
10 concluding comments?

11 [No response.]

12 MR. HACKBARTH: Okay. Next up is post-acute care.
13 So this represents a significant change in direction from
14 most of what we've been talking about this morning and we're
15 sort of back in more traditional MedPAC mode here, focusing
16 on at least a group of silos, if not one particular silo.
17 So, who's leading the way? Evan.

18 MR. CHRISTMAN: Good afternoon. Carol, Sara, and
19 I will walk you through some approaches to rationalizing
20 Medicare's payment for post-acute care.

21 For many years, the Commission and others have
22 been concerned about the multiple PAC payment silos in

1 Medicare. The BBA established separate PPSs for the four
2 PAC providers and there has been concern that these separate
3 systems have discouraged coordination across silos and led
4 to inefficient payment. These separate silos exist even
5 though these providers often overlap in the services they
6 provide and the patients they serve. Medicare payments for
7 similar patients can vary significantly between settings
8 because each setting has its own approach to setting base
9 rates and measuring patient case mix. Efforts to understand
10 the overlap have been hindered by a lack of robust
11 comparative patient data. Currently, the PAC silos collect
12 data using formats unique to each setting. Consequently, it
13 is difficult to assess how often the silos provide similar
14 services to similar patients.

15 A new tool designed by CMS to measure care across
16 silos addresses these concerns and presents an opportunity
17 for a more patient-centric PAC system. Ideally, some or all
18 of the current silos could be consolidated into a new
19 payment system where Medicare's payment is based more on a
20 patient's needs and not the site of care selected.

21 There are several directions for the Commission to
22 explore that would facilitate this goal. The more sweeping

1 approaches would eliminate some or all of the separate PPSs
2 and replace them with a consolidated post-acute care payment
3 system. More incremental approaches would retain the
4 current silos but synchronize prices for select conditions
5 within each silo, when possible, to ensure that similar
6 patients are paid at similar rates under the separate
7 systems.

8 I am going to talk first about efforts to
9 establish a common payment system for the existing silos and
10 then Carol will discuss the second approach.

11 Establishing a common payment system would require
12 that Medicare have data that permitted it to assess patients
13 across the various PAC silos on a comparable basis. Such
14 information is necessary for establishing case mix indexes
15 for payment and for assessing outcomes. Medicare's current
16 approach to collecting patient assessment data is siloed.
17 It mandates unique assessment tools for three silos and does
18 not collect patient assessment information from LTCHs. Each
19 silo's use of dissimilar data makes it difficult to compare
20 patient severity and quality.

21 For example, the tools use different approaches to
22 defining patient characteristics, like functional status,

1 have different requirements for when they are to be
2 administered during a stay, and use different scales for
3 measuring the severity of a patient attribute. Medicare
4 also has no required tool for screening patients for PAC
5 needs at discharge from the acute care hospital. As a
6 result, there is no standardized assessment information for
7 evaluating patient PAC needs at discharge.

8 The difficulty of using the current tools to
9 compare patients across silos led MedPAC to suggest that a
10 new tool designed for cross-sector measurement be developed.
11 In 2006, Congress mandated that CMS develop and test a
12 common assessment instrument for post-acute care, one that
13 could explore the feasibility of establishing a common
14 payment system for the PAC silos.

15 In response to this requirement, CMS developed the
16 Continuity Assessment Record and Evaluation, or CARE, tool.
17 The tool assesses a patient on a range of factors, including
18 clinical diagnosis, functional status, and other measures of
19 clinical severity. CMS fielded the tool to test its
20 viability. Providers in each of the four PAC silos use the
21 tool, as well as a sample of acute-care hospitals that
22 evaluated patients at hospital discharge. The test included

1 140 providers in 11 different markets and over 54,000
2 assessments were collected.

3 A contractor for CMS used the data to test the
4 feasibility of building a case mix index for a common post-
5 acute care payment system. The contractor tested whether a
6 single set of patient characteristics could predict the
7 direct costs of nursing and therapy for a patient,
8 regardless of the setting used. The analysis found that a
9 model could predict a significant amount of the services
10 provided, suggesting that the care data could be used to
11 establish a common consolidated PAC payment system. The
12 analysis suggested that a case mix index that combined the
13 three inpatient PAC settings, IRF, SNF, and LTCH, together
14 would work best. Home health would be paid separately.

15 The analysis also examined quality across the
16 silos and found generally similar outcomes for risk-adjusted
17 quality indicators across the settings, suggesting that the
18 PAC sites achieved similar results when they serve similar
19 patients.

20 A reformed PAC PPS would have many parts and there
21 are many decisions about which settings should be included
22 and how to set the payment levels. This slide gives an

1 illustrative example of how it could work in practice. In
2 this example, there is a combined payment system for
3 inpatient PAC settings, the IRF, the LTCH, and the SNF.
4 Patients referred to an inpatient PAC setting would be
5 assessed at hospital discharge. This assessment would be
6 used to help determine the appropriate site of care. The
7 assessment would be the same for all patients, regardless of
8 the PAC services they ultimately received. Because a
9 patient's condition can change, they would also be assessed
10 when they are admitted to the post-acute care site.

11 A new PPS would replace the current separate PAC
12 systems for IRF, SNF, and LTCH. The new payment system
13 would cover all inpatient PAC care under a single system,
14 with a single rate and case mix system that applied to all
15 three settings. The case mix adjustor would use the data
16 reported on the patient assessment instrument to set the
17 payment at a level that would cover their expected costs in
18 the inpatient PAC setting. In this approach, the new PPS
19 would generally cover the PAC services included in the SNF,
20 IRF, and LTCH PPSs. It differs from bundling in that it
21 would generally not include things that are paid separately,
22 such as physician fees or hospital readmissions.

1 CMS has released a report to Congress on the CARE
2 demo and satisfied the Congressional mandate, but it plans
3 further work in several areas to explore possible reforms to
4 the PAC payment systems. First, it plans to develop quality
5 measures based on the functional assessment items included
6 in the CARE tool. CMS is also setting the feasibility of
7 using the CARE data in the current PPSs for each silo.
8 Under this approach, CMS would retain the siloed pay systems
9 but use CARE assessment data in place of each silo's unique
10 tool.

11 Despite the promising results of CARE, current law
12 requires separate payment systems that have separate payment
13 levels, effectively reinforcing the status quo. Though the
14 demonstration suggested a more patient-centric system is
15 possible, CMS currently does not have a plan for pursuing a
16 consolidation of the PAC silos.

17 The CARE data suggests several additional steps.
18 First, the Commission may want to consider making a
19 recommendation mandating a common assessment approach so
20 that comparing patients across silos is easier. The
21 Commission encouraged CMS to develop a reliable cross-sector
22 approach to assessment, and though this does not address the

1 current silos directly, it would be an enabling policy that
2 makes more sweeping changes easier to implement.

3 Second, establishing cross-sector quality measures
4 would be helpful for better understanding the value of the
5 PAC services Medicare buys. Cross-sector measures would
6 enable the program and beneficiaries to better understand
7 the value of each provider, possibly leading to better
8 decisions about the appropriate site of care.

9 Finally, the CARE demonstration indicated that a
10 common payment system was possible. Establishing such a
11 system would be consistent with the desire to move Medicare
12 to a more patient-centric system of payment, and so the
13 Commission could consider urging CMS to begin focus efforts
14 to establish a more unified system of PAC payment.

15 The Commissioners should discuss these policy
16 options and highlight issues or concerns they would like us
17 to address in future analysis.

18 DR. CARTER: Evan talked about one approach for
19 PAC reform, using a uniform assessment to develop a single
20 patient-centered payment system across PAC settings.
21 Because this large-scale reform will take time to implement,
22 we are pursuing another track that can be accomplished in

1 the shorter term and would be a stepping stone to broader
2 reform. This other approach is to narrow prices Medicare
3 pays for similar PAC services in patients.

4 This would pursue two of the Commission's goals.
5 First, it applies the idea of site-neutral payments to PAC,
6 and second, because fee-for-service is likely to remain in
7 place for many years, Medicare's payments should reflect
8 low-cost care.

9 We considered narrower prices between IRFs and
10 SNFs because we know from the demonstration that comparable
11 patients are treated in both settings and the outcomes are
12 the same or similar. Yet, Medicare pays very different
13 prices. Site-neutral payments would move Medicare towards
14 basing its payments on patient characteristics, not the
15 setting where they were treated.

16 Let's first look at data on whether the patients
17 admitted to SNFs are similar. These data come from the PAC
18 demonstration and they show the overlap in the functional
19 status of patients admitted to SNFs and IRFs. Going up the
20 slide is the functional ability of patients at admission,
21 with a high score indicating more independence and a low
22 score indicating dependence. The last pair of bars compares

1 the ability of patients to conduct self-care activities,
2 such as dressing and eating, at admission, with IRF data on
3 the left and SNF data on the right. The right-hand pair
4 shows patient mobility at admission. Each bar represents a
5 percentile, so you can see the distribution of the abilities
6 across the patients treated in each setting. The top bar is
7 the tenth percentile, then the 25th, and the 50th, and so
8 on, and the red dots represent the mean functional
9 abilities.

10 You can see that the means and the distributions
11 of these measures are very similar, meaning that the
12 patients admitted to IRFs and SNFs are similar in terms of
13 their functional status.

14 Now, let's turn to outcomes. The PAC
15 demonstration and evaluation is probably the best comparison
16 to date of the outcomes of patients treated in SNFs and IRFs
17 because of the risk adjustment and the common assessment
18 tool that was used to compare patients. Here, we show two
19 risk-adjusted outcome measures, changes in self-care and
20 mobility, and these are risk adjusted. You can see from
21 these that the mean and the distribution of outcomes are
22 pretty similar. SNF patients, on average, achieved slightly

1 less improvement in self-care, though the differences were
2 small, and the changes in mobility were not statistically
3 different.

4 As Evan mentioned before, the demonstration also
5 looked at rehospitalization and found that the risk-adjusted
6 rates were not statistically different between the two
7 settings.

8 Even though SNFs and IRFs admit similar patients
9 and achieve similar outcomes, Medicare's payments to the two
10 settings are quite different. Here, we list several
11 conditions frequently treated in IRFs and SNFs. Medicare
12 payments to IRFs range from ten percent higher to 90 percent
13 higher than those made to SNFs. For example, on the first
14 line, we see stroke with major comorbidities and
15 complications, MS-DRG 64. Payments to SNFs are about
16 \$11,000, while payments to IRFs were 90 percent higher, or
17 about \$21,000. In another example, major joint replacement
18 -- that's MS-DRG 470 -- payments to SNFs averaged \$8,800 and
19 payments to IRFs averaged \$13,500, or about 70 percent
20 higher.

21 Given the overlap of the settings yet the
22 differences in Medicare payments, we are undertaking a

1 project to evaluate setting narrower prices between the two
2 settings. We plan to focus on select conditions, and I'll
3 describe in a minute how we selected those. We will develop
4 a common payment metric, since SNFs are paid on a per day
5 basis while IRFs are paid on a per discharge. We will put
6 our price comparisons on a discharge basis.

7 We will also compare the patients and make sure
8 that they are comparable, looking at their comorbidities,
9 risk scores, and age. Because the CARE tool is not in use,
10 we will use a simplified crosswalk between the assessment
11 tools that will allow us in a limited way to compare the
12 functional status of patients in both settings.

13 We will model IRF payments under the current SNF
14 policy, and using the alternative SNF design that we
15 recommended back in 2008. We are working with research from
16 the Urban Institute to update this alternative design to
17 reflect more recent practice patterns. And we are working
18 out how to estimate payments for patients treated in IRFs,
19 given that the patient assessment data is different between
20 the two settings.

21 In selecting the conditions to explore, we
22 considered three factors. We wanted conditions that are

1 often treated in SNFs, even in markets where beneficiaries
2 have the option to go to an IRF, as a way to ensure that the
3 setting is safe for these conditions. We also wanted to
4 select conditions that make up a sizeable share of the
5 business, of Medicare's business in IRFs. And, finally, we
6 looked at studies that compare IRFs and SNFs in terms of
7 their costs and outcomes. Based on these considerations, we
8 decided to focus on beneficiaries recovering from three
9 conditions, major joint replacement, hip fracture, and
10 stroke.

11 In closing, we'd like the Commission to discuss
12 the next steps that we are taking for advancing PAC reform.
13 The first is to consider narrower prices between SNFs and
14 IRFs for select conditions. This short-term strategy can be
15 seen as a stepping stone to broader reforms that move fee-
16 for-service away from basing payments on site of service.

17 The Commission could consider making a
18 recommendation to require a common assessment approach so
19 that comparing patients across silos is easier.

20 The Commission could also consider requiring
21 Medicare to establish cross-sector quality measures so the
22 program and beneficiaries can more easily compare the value

1 of the care furnished.

2 And, finally, the Commission could consider
3 whether Medicare should develop a common payment system for
4 two or more of the existing PAC silos.

5 The Commission should discuss these steps and if
6 there is additional information you would like to see or
7 concerns we will need to address as we move forward with
8 this work.

9 MR. HACKBARTH: Okay. Thank you very much.

10 I think this should be easier in the sense that
11 this is, as I said at the outset, a little bit more
12 traditional topic, sort of constrained and focused, and I
13 think the presentation and the materials are excellent. So,
14 we will begin with our round one clarifying questions. I
15 have Bill, Craig. Bill, go ahead.

16 MR. GRADISON: My main question is whether you've
17 come across anything in the private sector that might shed
18 light on this situation and the choices that have been made
19 here, and in particular, I'm sorry, I don't recall the name
20 of the company, but there's a relatively new company that
21 Tom Scully with private money has set up which is going, as
22 I understand it, at risk in this field. I took a look at

1 their website once and I don't know much more about it, but
2 I am curious whether there's anything that you would like to
3 share with us from private sector experience in general or
4 about this particular enterprise, if you don't mind.

5 MR. CHRISTMAN: I mean, the short answer to your
6 question is, yes, Bill, we are looking at it. There is --
7 Tom Scully's NaviHealth company was recently in the news.
8 But there are a range of actors who are moving in this area
9 and it's coming out of a couple of different areas. It's
10 companies who are trying to help people set up ACOs or
11 participate in the bundled payment for care initiative that
12 CMS has, who are trying to build sort of a post-acute care
13 management infrastructure.

14 And we've started a project where we're going to
15 talk with some of these individuals that are doing different
16 models of payment. We're looking at across all payers, not
17 just what people are doing for Medicare, but for the private
18 sector, so we hope to pull some of that in as we collect
19 that data.

20 MR. HACKBARTH: So, the basic concept, though, is
21 insert another party in the system that will collect fees,
22 share in risks and benefits, and they will take on the

1 assignment of overseeing post-acute care, proper placement,
2 all that stuff. So it's a new actor, a new box on the grid.
3 Is that accurate?

4 MR. CHRISTMAN: Yeah. I mean, I guess -- we're
5 just getting into this. I would say that some of them do
6 look like that. NaviHealth puts itself at financial risk.
7 So, in a sense, instead of -- you can think of it as a new
8 box being inserted, or you can think of it as one box
9 replacing ten from the health insurers' perspective.

10 MR. HACKBARTH: Yes, but they are a new type of
11 entity. They sell their services to an insurer.

12 MR. CHRISTMAN: Yes. Yes.

13 MR. HACKBARTH: This is some other risk-bearing
14 entity.

15 MR. CHRISTMAN: Exactly.

16 MR. HACKBARTH: Yes.

17 MR. ARMSTRONG: Glenn, I just would add, there are
18 Medicare Advantage plans that have been doing this for a
19 long time, too.

20 MR. HACKBARTH: Yes. And that's what I mean by
21 this is a new actor as opposed to it being an in-house
22 function. This is a new enterprise that says, oh, we have a

1 product. We'll offer it to Group Health of Puget Sound.

2 Okay. Let's see. Somebody over here had their
3 hand up. Craig.

4 DR. SAMITT: My question is about the care
5 assessment tool. What is the vision on who would complete
6 this assessment tool? Is it pre-post-acute care providers
7 or is it the post-acute care providers themselves?

8 MR. CHRISTMAN: You know, this is a question we're
9 still thinking about, but there have been two places that
10 two people are focusing on, and one is could CARE or a tool
11 like it play a role in helping hospitals with the discharge
12 process so that we could get a little bit more systematic
13 about how -- where people are referred, you know, come up
14 with a standardized way of measuring their status at
15 discharge, and trying to use that to inform the discharge
16 decision. You know, that's driven by the variability we see
17 in where people with the same conditions are referred to.

18 The second piece of this is in the CARE
19 demonstration, they also assess people at admission to their
20 PAC site, and that could be used -- that information could
21 be used to feed into a standardized post-acute care payment
22 system. All patients, regardless of where they were

1 referred to, would get assessed on the same system and the
2 payments would be the same and not driven by the site of
3 service.

4 And the one thing I guess I should just clarify is
5 CARE did both. They -- most of the assessments were
6 collected at post-acute care sites, but they did have a
7 small sample where they had hospitals -- had a small sample
8 of hospitals who did it at discharge, as well.

9 DR. MARK MILLER: [Off microphone.] And I think
10 the key thing is to do it up front and do it all in the same
11 place and time, so it's not like I can assess 14 days after
12 they've arrived in PAC and you are doing it somewhere else.

13 MR. CHRISTMAN: Right.

14 MR. HACKBARTH: So, Mary is going to lead off
15 round two.

16 DR. NAYLOR: With the high bar that I'll be more
17 rational.

18 [Laughter.]

19 DR. NAYLOR: First of all, just another great
20 chapter in this journey that we're on to achieve some kind
21 of rationalization, so let me comment on your proposed next
22 steps, and I might not do it in exactly the order.

1 I really think that the CARE tool is a very robust
2 measure, as evidenced by your wonderful analysis, and
3 represents an important opportunity, even if we only focus
4 on selected elements of it, to encourage use by CMS for
5 hospitals and post-acute care settings. So I really think
6 it represents a great opportunity to rationalize what is a
7 journey for many people. It's not usually just hospital and
8 one site. It's often hospital plus one post-acute plus
9 another post-acute on the way someplace.

10 I also think the great opportunity to focus on
11 quality measures derived from the CARE tool in the two
12 areas, self-care and mobility, represent gargantuan -- I'm
13 in self-care. I saw the data where there were some small,
14 meaningful change in IRFs relative to SNFs, but these two
15 areas are really very critical knowledge -- understanding of
16 how to get meaningful change in the sector.

17 On the issue of uniform prices, I think the data
18 are very compelling about the overlap in functional severity
19 and represent, therefore, a great rationale to pursue this.
20 And I love the methods that you are proposing in terms of
21 why you selected the conditions and how you're going to do
22 that.

1 It does -- you know, so here's the question. The
2 data are not compelling about the long-term impact of IRFs
3 versus SNFs and so the one question as you're going through
4 that analysis that we may or may not be able to understand
5 is how one option of 3.5 hours, or three hours and two
6 modalities, five times a day, gets us to a better longer-
7 term -- does it get us to a better longer-term outcome than
8 two modalities, 2.4 hours, three times a day, and whether or
9 not we look at impacts of these services just in the short
10 term or whether we have a longer-term view is very
11 important.

12 All that said, I think we should be working toward
13 a common payment system where it is rational that
14 substituting lower-cost high-quality services for higher-
15 cost same quality services is a path we should pursue.

16 MR. HACKBARTH: Mary, do you agree -- so, as I
17 read the presentation, there were two paths offered. We
18 could sort of try to do broad reform of post-acute care or
19 we could identify a particular target, like the IRF-SNF
20 substitution. Do you like the focused --

21 DR. NAYLOR: I saw this as part of the path toward
22 rationalization. I don't see it as the only, and we've been

1 talking about others. So, I see, because of -- you have
2 such rich data about saying the people with the same
3 functional severity are in two different sites getting
4 services, it's a really important path to say, can we look
5 at post-acute more broadly.

6 MR. HACKBARTH: Yes.

7 DR. NAYLOR: And certainly the three sites, long-
8 term care hospitals, IRFs, and SNFs, together represent an
9 opportunity to do this, although it seemed like your data,
10 or the data, said home health is a separate ball that we may
11 need to look at a little differently. Did that answer your
12 question? No.

13 MR. HACKBARTH: I think so. If not, I'll come
14 back.

15 Cori.

16 MS. UCCELLO: Actually, I really like the way that
17 the presentation and mailing materials were framed, and I
18 think this might get at Glenn's question of I don't think
19 this was an either/or. It seems like, okay, we have set out
20 where we want to go in the long term and then, well, what
21 can we do in the short term that can help move us in that
22 direction. So, I would say yes to all of these points.

1 In terms of Craig's question on when this CARE
2 assessment is used, it seems to make the most sense to do it
3 at hospital discharge so you're discharging the person to
4 the best place. That's it.

5 DR. HOADLEY: So, I have one sort of question in
6 the weeds. On Slide 13, you look at the cost ratios, and I
7 know at some point in the, I think it's Table 5 in the
8 longer paper, you do something where you split out the
9 communities that have both kinds of facilities in the same
10 community. I assume this is across the board?

11 DR. CARTER: It's across the board.

12 DR. HOADLEY: And have you looked at whether this
13 changes if you only look at the communities that have both
14 types of facilities?

15 DR. CARTER: I haven't looked at that, but that
16 would be easy to do.

17 DR. HOADLEY: It seems like it might be
18 interesting --

19 DR. CARTER: Yes.

20 DR. HOADLEY: -- to see whether these ratios are
21 similar, get smaller, get bigger --

22 DR. CARTER: Right. Right.

1 DR. HOADLEY: -- or something like that. So that
2 just seemed like it might be a useful thing.

3 Beyond that, I mean, in terms of the questions, I
4 can mostly ditto what's been said, I think. I really agree
5 that you did a nice job of laying out the sort of logic and
6 the methodology for the IRF and SNF, sort of the short-term
7 fix, and it is really compelling that the settings are
8 adequately comparable to go ahead and do something to try to
9 create more uniform prices. And I think the rest of the
10 track that's in the additional steps makes a lot of sense to
11 me.

12 DR. SAMITT: So, I am fully supportive. I think
13 this is a great short-term solution. I call it a short-term
14 solution because, similar to all of our prior discussions
15 today, I think, longer term, we want to really have
16 accountability shift upstream so that clinicians are making
17 wise choices about the appropriate post-acute care setting.
18 So, ultimately, I feel that that would be more optimal.

19 I do have concerns about the assessment timing. I
20 would want to make sure that whoever's completing the
21 assessment is doing so objectively so that if we're using
22 this as a mechanism for payment, so that there aren't any

1 inappropriate behaviors there in terms of the assessment.

2 And then, finally, I want to go where Scott is. I
3 checked within our own group at Health Care Partners how we
4 do this and the answer I got was we observed this conclusion
5 may years ago and shifted the referring methodology for
6 specific diagnoses to specific settings. And so I do
7 believe there is a great deal to learn from Medicare
8 Advantage groups that are already beginning to try to
9 innovate. And we may find, as we look at those groups, more
10 information about how to structure some of these assessments
11 in terms of timing and what other diagnoses beyond the ones
12 that you've recommended we could consider next for this
13 rebalancing.

14 DR. COOMBS: Thank you very much. This chapter
15 was excellent. I agree with everything that was said
16 already, especially the care assessment tool.

17 The one question that I had was regarding the
18 three-day rule for the SNFs and what kind of accommodations
19 we need to take in consideration. I was even thinking that
20 bundled care with a certain number of days that extend
21 beyond some period, you know, 21, 30 days, for both IRFs and
22 SNFs in this area would be maybe a good thing in terms of

1 looking at overall costs and quality.

2 So, just about this three-day rule, recently,
3 there's been some question about observation admissions and
4 SNF admissions and who's on the hook for actually the
5 coverage of the SNF if it's just an observation, acute care
6 hospitalization.

7 DR. CARTER: So, in the paper, we talk a little
8 bit about if you were to go down this road, what kinds of
9 the regulations would you want to consider waiving, and the
10 three-day rule is a little different because here we're
11 thinking about, well, would you waive it for SNFs or apply
12 it to IRFs, and so you see there's quite a bit of discussion
13 in the paper about that.

14 The three-day requirement for SNFs was always
15 intended to distinguish SNF Medicare-covered post-acute care
16 from long-term care. That's a little different than IRF
17 care because you don't have the same problem in trying to
18 distinguish care within the same facility, services that are
19 covered from services that aren't.

20 So, my personal opinion, and this would be
21 something for you to discuss either now or, I think when we
22 come back, we will talk more carefully -- lay out sort of

1 what are the regulatory things you would want to waive. The
2 three-day requirement for me -- if you impose it on IRFs, it
3 would make it actually harder for beneficiaries to get
4 access, so I don't think that's a good idea. And I do think
5 that the three-day requirement, putting aside whether you
6 think observation time should count towards that, I think is
7 very important for ensuring that Medicare pays for post-
8 acute care, that patients are hospitalized for a condition
9 that is truly acute, and tries to minimize whatever might --
10 there could be some incentives to cost shift. I think for
11 facilities, for nursing facilities to rehospitalize folks
12 for a very short period of time in order to requalify for
13 Part A coverage.

14 And so I think that the three-day rule -- my own
15 opinion is I think the three-day rule is important for
16 Medicare and I just don't see it as relevant for SNFs --

17 DR. COOMBS: Right.

18 DR. CARTER: -- and I don't see it as relevant for
19 IRFs.

20 DR. COOMBS: And, lastly, I wanted to say that the
21 DRGs, you hit it right on. Those are the most important
22 DRGs to undertake.

1 DR. CHERNEW: I have a somewhat embarrassing
2 question to ask because of my ignorance, but -- so I agree
3 with what everybody said, and I won't repeat, but the
4 question I have is can you remind me briefly about how the
5 payment systems are working for -- is this a conversion
6 factor issue? Is it the way in which the particular bundles
7 are set up for the different settings? In other words, I
8 don't know if we're talking about changing weights on things
9 or if we're changing conversion factors across and some of
10 the nitty-gritty.

11 DR. CARTER: We're thinking about something much
12 simpler than that, which is for these conditions to simply
13 apply a SNF payment. So, sort of pulling them out of the
14 IRF PPS and paying them what a payment to a SNF --

15 DR. CHERNEW: So, this is loosely what
16 was asking. So, when you do that and you pull
17 people out of the IRF PPS, are there going to be residual
18 patients in the IRF buckets that you pulled some of them out
19 of and -- I just was curious, maybe this is for a longer
20 discussion, but I was -- I'm trying to understand, beyond my
21 general enthusiasm for everything that's up here, issues
22 related to the mechanics of how this would work, given that

1 I believe the two settings are in different payment systems
2 with different conversion factors and different groupings.

3 MS. SADOWNIK: I think you're raising a good
4 question for -- that is something that we should include in
5 our analysis as we move forward to the phase where we're
6 actually looking at payments, because, for example, looking
7 at stroke, we're talking about taking one of the -- just one
8 of the DRGs that feeds into -- one of the DRGs coming from
9 the hospital that feeds into all of the stroke patients in
10 the IRF population, and currently, relative values are
11 compared across all IRF patients to all other diagnoses.
12 So, once you take one subset of that out, I think that is
13 something that we should look at.

14 MR. HACKBARTH: [Off microphone.] There has to be
15 some recalibration of your payment system to reflect the
16 move of some patients out of IRF and into SNF payment, so --

17 MS. SADOWNIK: I think it's a good point to
18 consider, what would be the residual effect on the IRF -- on
19 the payments for the other IRF patients who are not --

20 DR. CHERNEW: You've picked people based on their
21 discharge DRG, which is how the hospitals were paid. But
22 when they move to another setting, SNF or IRF, they're not

1 paid a DRG payment. They're moved into the payment system
2 that's appropriate for that setting, and that has a whole
3 different set of categorizations of the patients. I
4 understand that.

5 DR. MARK MILLER: Yes, and I think we understand
6 you, that once there is -- if there were a policy position
7 that the Commission took here, we'd also have to think about
8 the downstream implementation issues, and it does raise this
9 question. Are we engaged in some recalibration after the
10 fact in order to bring everything back into true?

11 DR. CHERNEW: And, really, I was just trying --
12 so, I'm very supportive of all of this and all the
13 discussions, I think, were. I'm just trying to figure out
14 how big a lift it's going to be to get there in particular
15 areas.

16 DR. MARK MILLER: We can put some thought into
17 that.

18 MR. HACKBARTH: Scott.

19 MR. ARMSTRONG: So, briefly, I just would agree
20 and reinforce the point of view that's been represented,
21 that I'd encourage us to apply this site-neutral payment for
22 the same service kind of policy that we've applied in a lot

1 of other areas, and if we can move more quickly on the IRF-
2 SNF payment changes, then I support doing that.

3 And secondly, then, advancing a prospective
4 payment for post-acute care is great. I think it's smart.
5 I think just the one comment I would make would be as we're
6 thinking about that, we should remember that there's
7 tremendous value that comes from a prospective payment for
8 post-acute where you have these currently disjointed payment
9 structures, just because we would stop overpaying for
10 things. But that's a key moment in the overall course of
11 care for patients and the implications for doing post-acute
12 really well could be enormous for costs and care elsewhere
13 in the care system. Readmission rates, for example, or -- I
14 mean, there are just a multitude of different ways in which
15 we might want to think about additional quality payment or
16 additional variables in that pre-prospective payment rate
17 that would create value that may not show up right there in
18 the post-acute experience.

19 A last thought on this is that, particularly
20 looking at the slide, I'm just thinking that -- how do we
21 create incentives -- no, let me put it differently. An
22 enormous impact on the cost of post-acute care would be to

1 cut in half the number of joint replacements we do to begin
2 with, and you don't need to do that many. So, how do you
3 bring shared decision making into a system where patients
4 are engaged in real discussions about data-driven choices
5 and that we stop needing to use so many services to begin
6 with.

7 DR. SAMITT: Yeah, it's too late when they're in
8 the SNF.

9 MR. HACKBARTH: Rita.

10 DR. REDBERG: Well, I certainly agree, this was a
11 very clear chapter and a little simpler because I think we
12 all endorse integrated payment and delivery systems, and I
13 agree that those are the right conditions to look at. Maybe
14 if we have a quality measure of discussing risks and
15 benefits of procedures, that would get us towards fewer
16 joint replacements. So, I think we should go forward with
17 the common payment system for all post-acute care.

18 And the only other thing I wanted to mention was
19 that Judy Feder had an article -- a perspective in the New
20 England Journal a few months ago on rethinking Medicare
21 incentives for post-acute care services and she referred to
22 a CMI large-scale demonstration of bundled payment for

1 hospital and post-acute care services. So, I assume we'll
2 get some more data from that demonstration. It sounds like
3 it was just starting at this time, or just announced.

4 DR. CARTER: Yes, that just started.

5 DR. NERENZ: Yes, thank you. A lot of interesting
6 things here.

7 I was also very interested in Table 5 on page 21
8 of the binder materials, but for a little different reasons
9 than what Jack brought up. When we look at the figures that
10 you showed, and these are the ones on pages 12 and 13 --
11 when you look at the figures, you're impressed by the
12 comparability of patients in the two settings, and that
13 certainly is the take-home message, and then you think from
14 there to the payment choices.

15 But if you look at Table 5, if I'm interpreting
16 correctly, that takes me the other way. That says that in
17 places where people theoretically could go to one or the
18 other, these are not 50-50 splits. These are really extreme
19 splits. Virtually all of the patients in some of these
20 categories go to IRFs. Why?

21 MR. GEORGE MILLER: [Off microphone.] Location.

22 DR. NERENZ: Well, and I've just been hearing a

1 couple things. Location, okay, or that the payment is
2 greater, okay.

3 DR. REDBERG: [Off microphone.] The ratio was
4 two-to-one for IRFs to --

5 DR. NERENZ: No, I understand, but is that
6 actually -- I mean, it could be the explanation. Is it
7 really the explanation, or do IRFs do something that these
8 people really need that is not captured in the mobility and
9 the independence metrics?

10 MS. SADOWNIK: I don't think we have a clear
11 answer in most of these cases. So, the IRF population, it's
12 worth noting, is a group that you have to be, or you need to
13 be in an inpatient setting or want to be, so you need to be,
14 you know, sort of impaired enough. But at the same time,
15 you have to be able to tolerate three hours of rehab therapy
16 a day. So, for some of these -- you know, for some
17 conditions, there is likely some sorting going on by
18 severity or by specialization or, you know, spinal cord or
19 traumatic brain injury. But for some of these other
20 breakdowns in patients, you know, why is one DRG for stroke
21 split one way versus another DRG, we don't have a clear
22 answer that I think we have. There may be some clinical

1 nuances. It's just one idea of, you know, maybe patients
2 with some major comorbidities may be more appropriate in a
3 facility like an IRF that has to meet all the conditions of
4 participation for a hospital or some other sort of clinical
5 nuances in that way.

6 MR. HACKBARTH: Dave's question leads me to ask
7 this one. So, in the past, we've sometimes observed that
8 SNF is a malleable category and the capabilities of SNFs are
9 sometimes influenced by what other alternatives exist within
10 their community. So, the SNFs that exist in communities
11 where there are IRF alternatives may look different in terms
12 of their capabilities to handle patients than SNFs that
13 exist in communities without IRFs.

14 So, if we now go to a site-neutral payment system
15 and we're paying SNFs in IRF communities who have not
16 developed these capabilities because the norm in that
17 community is that they go to IRFs, are we raising issues
18 about the capability of the SNFs to provide, in fact, the
19 same level of care?

20 DR. REDBERG: Perhaps on Slide 12, where you have
21 the changes in function between IRFs and SNFs, because
22 they're so similar, even though the IRFs have more intensive

1 rehab, the three hours, so I wonder if you separated it out
2 by -- if you separated out the SNFs that were in the
3 vicinity of IRFs from the SNFs that were on their own,
4 whether that would separate out more, like perhaps are those
5 SNFs doing more.

6 DR. CARTER: This is not data that we have, so
7 these were results that came out of the demonstration --

8 DR. REDBERG: Academy --

9 DR. CARTER: -- and so that doesn't allow us to
10 look at SNFs co-located in the same market, if you will.
11 These are risk adjusted, and so in that sense, they are seen
12 as being comparable.

13 DR. REDBERG: How many facilities were represented
14 in this table, do you know?

15 DR. CARTER: That, I'd have -- do you remember how
16 many IRFs --

17 MR. CHRISTMAN: I don't remember. You know, there
18 were a total of -- of all types, there were a total of 140
19 facilities in the entire CARE demonstration. I mean, off
20 the top of my head, in each column for IRF and SNF, there's
21 probably in the low thousands of patient cases in there.
22 There's probably, maybe, somewhere two or three thousand

1 assessments for each setting.

2 DR. MARK MILLER: Where I think this conversation
3 goes and where David's question goes is, so, we have Table 5
4 and you see in some of these conditions there is a real
5 disproportionate in one setting versus another, and then in
6 some of the others it's much more distributed between the
7 two settings. It may be through the work and developing the
8 crosswalk to try and get a look at the risk we find
9 conditions in which we say, look, the risk here suggests
10 they need to be in an IRF. So then for policy purposes, we
11 wouldn't argue that that payment should be the same. And it
12 may be that David has pointed out a couple of categories
13 here of, like, they absolutely need to be here. That should
14 come through in the risk. And then they would be off the
15 table.

16 But we can walk through and explore these things.
17 But a couple of these, there's a mix of where the patients
18 are going, and I would suggest that that may be a fertile
19 place to be looking at how different are these patients and
20 whether we should be paying different --

21 DR. CARTER: Right. So, when we --

22 DR. MARK MILLER: That's what I hear in your

1 question.

2 DR. CARTER: Right. When we talked about looking
3 at strokes, we're talking about one of the three DRGs for
4 exactly that reason.

5 DR. MARK MILLER: [Off microphone.] Exactly. I
6 think --

7 DR. CARTER: Right.

8 DR. MARK MILLER: [Off microphone.]

9 DR. CARTER: Right. And, actually, this work
10 might -- and Sara can speak to this if she wants to chime in
11 -- but some of this work may actually lead us to think that
12 CMS's criteria for IRF conditions that qualify as IRFs need
13 to have a certain share of their patients in 13 conditions,
14 but the category of stroke is very general and this may lead
15 us to think about more specific criteria of the types of
16 strokes that are appropriately placed in IRFs, in the same
17 way that all joint replacements don't count towards IRFs,
18 but it's the bilaterals and the obese and the over-85s. So,
19 we're thinking this work may also bleed into some
20 examination of the criteria that IRFs meet in terms of the
21 conditions that count towards being paid as IRFs.

22 MS. SADOWNIK: Right. Very well said there. Some

1 of the 13 conditions that have a number of sort of patient-
2 centered specific criteria, like Carol said, you have to be
3 over 85 or a certain BMI, and then other conditions are just
4 much more broadly defined.

5 MR. GRADISON: I fully support what you were
6 doing. It seems very important, very exciting, and looking
7 forward to the next step.

8 DR. HALL: Well, I've joined the chorus. I think
9 we're on the right track here.

10 But I would interject a note of caution at this
11 point. I don't know how many of you have been in an IRF or
12 an SNF. An IRF looks a lot like a hospital, not only that
13 it's in the same building, but the intensity of professional
14 staff, the sophistication of the equipment, specialists
15 running all over. It's a very different animal than a
16 typical SNF unit, which, frankly, looks like a nursing home
17 but it does have the accoutrements to do physical therapy.

18 In my area, we almost never send an older Medicare
19 patient to an IRF. One is they would absolutely not be able
20 to participate in the required three hours a day. It just
21 isn't going to happen in a thousand years. And their length
22 of stay will be sharply limited because it doesn't really

1 fit the -- that type of patient doesn't really fit well with
2 what a lot of IRFs feel they should be doing. So, the vast
3 majority of our people with stroke would go into an SNF
4 directly.

5 If a patient does go to an IRF, paradoxically,
6 they often have better function than the person who goes to
7 the nursing home. They have to, by definition, have better
8 function or they wouldn't qualify. So, in some senses,
9 that's a self-fulfilling prophesy.

10 I had trouble understanding why there was so much
11 parity between the functional state, and I think we should
12 entertain some consultation from rehabilitation groups who
13 have looked at this to really see if this observation here
14 obtains in their experience. The last thing I would like to
15 see is that we disenfranchise Medicare recipients from
16 getting IRF services in those unusual cases where they get
17 them. The typical group of patients in an IRF, to be sure,
18 includes some Medicare patients, but there will also be a
19 lot of spinal cord injury of young people, athletic
20 accidents, brain trauma.

21 So, I think the next phase of this, looking at
22 what might be called gero-specific diagnoses, specifically

1 stroke and hip fracture, would be very informative. And
2 there, I think, for the most part, we'll find that people
3 will do well in SNF.

4 Now, the NIH has designated a number of stroke
5 centers around the country, academic medical centers who are
6 set up to facilitate the care of people with stroke, giving
7 proper drugs, particularly clot-busting drugs, early on in
8 the course, et cetera. They use IRFs. And so some of this
9 may be an artifact of people who are incentivized in a very
10 different way in terms of stroke.

11 So, anyway, the whole point is, I think we're on
12 the right track. We ought to keep going on that. But let's
13 keep in mind that we're talking about medical facilities
14 that do very, very different things for people and I think
15 we could get confused if we don't continue to study that.

16 DR. CHRISTIANSON: Well, I would endorse the first
17 three bullet points and I'm probably not ready to endorse
18 the first without seeing some more data on other non-IRF,
19 non-SNF, what you call existing PAC silos. I would call
20 them PAC alternatives, I guess. But there are others
21 besides IRFs and SNFs and I would want to see a little bit
22 more information before I would say, yes, we should create a

1 common payment system.

2 MR. BUTLER: So, I think the middle two bullets
3 are the key that unlocks the door. If those are well done
4 and we feel good about them, which you're hearing some
5 support for, then I think the rest can follow. And I think
6 as much as we're encouraged, not only statistically but
7 visually, the similarities, don't rest easy yet that you've
8 got it exactly now.

9 I had the same reaction as David and was going to
10 ask on -- the numbers are just kind of shocking to me, the
11 percent of, for example, joint replacements that were going
12 -- some DRGs of joint replacements are going to IRFs. I was
13 kind of stunned by that. I thought that that had long ago
14 kind of moved away more from IRFs. I think you would find in
15 the bundled payment models, pilots that are out there,
16 wouldn't be surprised if home care is being swapped out a
17 lot for some of those, and it's not an IRF versus SNF trade-
18 off. So that area, particularly;, seems to be ripe for
19 focus.

20 The last thing I would say is that we've talked a
21 lot about the three-hours requirement and so forth, and you
22 mentioned this in the text, but I would mention it here.

1 If, in fact, you are going to get SNF rates in an IRF, then
2 you're going to have to relax that requirement in the IRF so
3 that they're on a level playing field and you're matching
4 the service with the payment and not subjecting to the IRF
5 to the standards that are more expensive that are being
6 applied to their other patients.

7 DR. BAICKER: I'm definitely supportive of this
8 down payment towards the larger effort, and I thought the
9 billing exercise was really interesting and suggested that
10 there will be even further to go, and hopefully you get more
11 information from this first down payment on harmonization to
12 how many silos you would be able to go across.

13 MR. GEORGE MILLER: I agree with all the
14 colleagues, so I won't restate that, but I would like to
15 bring up the notion that Scott mentioned and Rita, and I
16 would think this is a good opportunity to -- and especially
17 if you look at the slides of the types of studies that are
18 done, while I certainly appreciate the quality of care that
19 is given in these settings, but the question should be,
20 should we introduce palliative care as an alternative to
21 some of these methodologies, particularly giving patients
22 the education and choice. Instead of choosing these, they

1 have the education and choice with the proper consultation
2 by their physicians and truly encourage shared decision
3 making. So, they may choose not to take these types of
4 procedures. We know we've heard anecdotal stories about a
5 90-year-old getting total joints and folks that may not live
6 longer still going through an exercise. So, I at least want
7 to put the discussion on the table about palliative care and
8 how we can incentivize the discussion along those lines and
9 then maybe use that as a lever to reduce some of the total
10 number of procedures that are being done.

11 MR. HACKBARTH: [Off microphone.] So, what I hear
12 is a pretty strong, near unanimous affirmation of the
13 direction that you've described, not just working across
14 silos, but using the IRF-SNF for selected conditions as a
15 starting point of that effort.

16 Are there questions, Evan, Sara, and Carol, that
17 you have? What I'm trying to do is figure out an efficient
18 path for us to get to a conclusion on this. We've affirmed
19 the general direction that you've presented. Are there
20 questions that you have about what information Commissioners
21 need to sort of get to the next step down the journey.
22 Mark, I invite you on that, as well.

1 DR. REDBERG: [Off microphone.]

2 MR. HACKBARTH: Pardon me. I'm sorry. Did --

3 DR. REDBERG: [Off microphone.] I have another
4 question.

5 MR. HACKBARTH: You have another question? Sure.

6 DR. REDBERG: Can you remind me why you didn't
7 include home health in this model, because it seems to me
8 that some of these patients, at least, could be cared for
9 and be happier and get better recovery and less cost to
10 Medicare at home with home health, you know, PT/OT.

11 DR. CARTER: I think we just wanted to start with
12 two institution-based settings because home health, even
13 because there isn't a facility, the cost of that care is
14 very different, not just in terms of bricks and mortar but
15 sort of who's employed by a home health agency. So, just in
16 terms of kind of trying to care institutionally-provided
17 rehab, we started here.

18 DR. REDBERG: I can understand that, but I think
19 we should --

20 DR. CARTER: But, I agree with you. There are
21 definitely patients who can go home.

22 MR. CHRISTMAN: I think what we run into, part of

1 it is if the alternative to a site of care is home health
2 and you want to build sort of a common single rate, if you
3 set that rate averaging the home health and the
4 institutional rate, you will get a rate that will
5 demonstrably overpay the home health agency and leave the
6 institutional setting underwater. And maybe that's what you
7 want to do. But it would, obviously, create some secondary
8 issues.

9 Another piece of this to go at it, as you guys
10 have talked about earlier, is engaging the beneficiary in
11 savings and some way to do that. You know, another way to
12 go at this is cost sharing, and you could use that as a
13 signal to indicate that, for your condition, this lower-cost
14 setting will be just as successful. If you opt for the
15 higher-cost setting, you may do that, but this is the
16 consequence.

17 MR. HACKBARTH: I think that's an important point,
18 Evan, and Nancy Kane, who used to be a Commissioner, used to
19 observe that we're never going to get to the right
20 utilization pattern by titrating the payments per unit of
21 service for different locations. If you really want to get
22 to appropriate use of facilities, you need to move to

1 bundled payment and other things that we've talked about.

2 This, as I conceive of it, is a more narrow effort
3 to not try to accomplish the whole task of proper placement,
4 but within a very narrow category where we think there's
5 real similarity in patient, engage in payment equity, ensure
6 that Medicare is paying the rate of the most efficient
7 provider of that service. It's a related activity but it's
8 not quite the same thing as trying to assure proper
9 placement for all patients. Pricing tools will never be
10 good enough, strong enough, robust enough to assure proper
11 placement. They can interfere with the process and
12 encourage improper placement, but they're never going to get
13 the whole job done.

14 And so I would worry, for the reasons that Evan
15 describes, including a very heterogeneous group of providers
16 into it would compromise the limited goal of this pricing
17 activity in the name of trying to accomplish a task that's
18 really beyond pricing alone. That would be my fear.

19 Does that make sense, Rita? It doesn't look like
20 it does.

21 [Laughter.]

22 DR. REDBERG: I see what you're saying. I just

1 think, from a patient in a clinical point of view, if
2 someone can recover at home, we should be -- you know, I
3 think a lot of times, it doesn't happen now because we don't
4 -- it's not reimbursed, we don't cover it, it's a lot easier
5 to discharge people to a post-acute care IRF than it is --

6 MR. HACKBARTH: ...does that make sense for you?
7 It doesn't look like it does.

8 DR. REDBERG: I see what you're saying. I just
9 think, from a patient and a clinical point of view, if
10 someone can recover at home we should be -- I think a lot of
11 times it doesn't happen now because it's not reimbursed, we
12 don't cover it, it's a lot easier to discharge people to a
13 post-acute care IRF than it is --

14 MR. HACKBARTH: And I absolutely agree with that,
15 both for quality reasons and financial reasons. That's one
16 of the reasons why I'm so enthusiastic about payment reform.
17 I think it's difficult to accomplish that goal by
18 manipulating relative prices for PAC services.

19 DR. CHERNEW: I'm going to make an assertion that
20 might be wrong, but I think one of the challenges for this
21 whole area is that observing case-mix well -- I don't know
22 enough about the CARE tool, but there's a lot of unobserved

1 things about individuals, their social support, their
2 ability and willingness to undertake rehab, and a whole
3 bunch of things that we don't observe very well that the
4 actual clinicians actually do observe.

5 And my own personal view is the solution is not to
6 try to figure out how we can observe everything because that
7 strikes me as just a disastrous way to go, but set up
8 structures to give enough flexibility to providers to do the
9 right thing and have at least a sensitive enough measurement
10 tool -- and it might be the CARE tools getting us there, I
11 don't know enough about it but I hear good things from you -
12 - but nevertheless about it, to make sure that we can
13 monitor at least if quality is getting a lot worse.

14 So we need to be able to have a system as we do
15 any of this stuff to make sure that when we do it quality is
16 not deteriorating a lot. I am reasonably comfortable that
17 we can get there, but I do realize that unlike a lot of
18 things -- maybe everything has this -- but in this area in
19 particular there's a ton of unobserved things about patients
20 that we can't hope to observe or to pay on or to manage or
21 to direct.

22 DR. MARK MILLER: Well, some of them may have been

1 overtaken. In trying to answer the question that you framed
2 a minute ago, I think you can think about this a couple of
3 different -- that a few things are going on here.

4 One is, and we may have said this already -- this
5 is why I can't remember whether it's overtaken -- is whether
6 you come back in the short-term and the Commission says
7 well, many years ago the Commission said we need to have a
8 common assessment instrument. CMS did it. Then they did
9 this analysis and now the thing exists. And we're sort of
10 at a point where well, now what do you want to do?

11 The Commission could give the policy process a
12 push and say this is what we have to work with and so let's
13 begin to think about how to integrate it.

14 Now that's actually kind of a question, too. Do
15 you just attach it? Do you integrate it into the existing
16 tools? There is some complexity there that has to be
17 thought through. But that's a step we could take and maybe
18 even in the short term come back to you and say are you on
19 board? Do you want to make a recommendation? That's one
20 thought.

21 The second thought is -- well, I'll go to the
22 bigger one where I think in the end does bring you guys back

1 into saying the same types of things. Ideally, if you have
2 a common assessment instrument, you can potentially move to
3 a patient-oriented assessment and say here's the payment and
4 become much more agnostic about the mix of the actual
5 settings. I'm going to do a little IRF, then I'm going to
6 go home. Or I'm going to go home and whatever the case may
7 be.

8 I think that's a long run out. The instrument is
9 just been created, we're only now perhaps getting it plugged
10 in. That's a long run. And I see that the price comparison
11 is an exercise in sort of thinking through some of the risk
12 issues that rise, some of the issues that Mike and David and
13 others have raised, this realistic "could we get patients
14 that kind of look like each other and pay them kind of the
15 same" and have a short-term strategy of trying to get some
16 more rationality in the prices if that analysis supports it.
17 And then before we get to the bigger solution of a unified
18 system.

19 So the short term thing would be do you want to
20 make a recommendation on a CARE instrument? And then beyond
21 that -- and this is not immediate -- do you want to make a
22 recommendation on a more unified price? But that won't be

1 in the next couple of months, if you see the layout.

2 And then the grand unified system maybe, and
3 that's even longer yet.

4 So that's kind of I see what our work plan from
5 this conversation. That's my attempt to answer your....

6 MR. HACKBARTH: So reactions to that?

7 So step one would be to say we think CMS should
8 begin changing the assessment tools to implement the CARE
9 elements.

10 DR. NAYLOR: I also think a hybrid of that might
11 be to say if not the whole tool, which does very much draw
12 on this notion that there are lots of things we need to pay
13 attention to, social support, et cetera, cognition which we
14 pay no attention to in anything, but anyway.....

15 If not the whole look, what are the key domains
16 that we could think about. So I think that that might be --
17 and especially the areas that they have paid close attention
18 to as contributing to variation in use of services in the
19 post-acute environment.

20 MR. GRADISON: Another advantage of a limited step
21 in this direction within the broader context of thought is
22 that it might encourage the private sector to move more in

1 this direction and reinforce back and forth a movement that
2 might be faster than if it were just for our population.

3 MR. HACKBARTH: Mark, in your characterization,
4 you said the pricing step is down the road, or some similar
5 language. How long is the road that we're talking about?

6 DR. MARK MILLER: And the pricing thing is --
7 okay, so the three steps are common assessment instrument,
8 are there for a selected set of conditions a more unified
9 price, and then there's the big giant change.

10 MR. HACKBARTH: That's what I'm talking about,
11 step two.

12 DR. MARK MILLER: Step two, that's what I thought.
13 I'm going to say -- and I'm getting a look from
14 everybody, you better watch it.....

15 MR. CHRISTMAN: We're interested to hear what you
16 say.

17 DR. MARK MILLER: I'm interested in hearing what
18 we can pull off here.

19 My sense of this is we're hoping to come forward
20 to these guys in the spring with some results on the work
21 that we're doing there.

22 DR. CARTER: Right.

1 DR. MARK MILLER: And I wouldn't say a
2 recommendation necessarily. That will really depend on what
3 we find. This is one of those things where the research has
4 to settle out to have a pretty clear idea where we're going.
5 And since we don't know what it's going to tell us --

6 DR. CARTER: Right.

7 DR. MARK MILLER: I wouldn't assert a
8 recommendation in the spring but I'm hoping for analysis
9 that informs this issue in a decent way come spring. And by
10 that, I mean the March and April meetings.

11 DR. CARTER: Right. And even with results, in the
12 same way that you thought about ambulatory services
13 differently, depending on the services; right? You had
14 these five criteria and when they met all five you thought
15 about equal prices but if they only met three you were going
16 to narrow the prices.

17 Well here, this is a much more complicated
18 service. And so, even given the results that we see, one of
19 the issues we will need to come back to you about is okay,
20 so are we talking about leveling the playing field or making
21 the playing field more level? And by that I mean prices,
22 but I also -- and Mark's right, and I think Glenn mentioned

1 this, too -- we will need to have a conversation about what
2 are we going to do on the regulatory requirement side.

3 So I think we will have information for you in the
4 spring, but I don't think we'll be ready for a
5 recommendation.

6 MR. HACKBARTH: And using Mark's framework, what's
7 the timing on step one, a recommendation to CMS to
8 incorporate elements of the CARE tool in patient assessment?

9 MR. CHRISTMAN: I think we could give people a
10 good sense of what we would say could be in a
11 recommendation, thinking about some of the issues that Mary
12 is talking about, that Mark has brought up. It's pretty
13 established I think that the CARE tool performs as well or
14 comparably to the existing tools. It's sort of ready.

15 It's thinking through the -- we haven't really
16 thought through the particulars of what we would want to say
17 about a transition in terms of how long and what exactly to
18 include.

19 MR. HACKBARTH: Okay.

20 DR. CARTER: One of the complicating things is the
21 PPSs currently run on their own patient assessments. And so
22 you need to -- and CMS has this work underway to think

1 about. If you plug in CARE tool elements, how well do the
2 PPSs perform. That work is just underway so we haven't seen
3 those results.

4 That kind of analysis we couldn't do, certainly
5 not for a March recommendation and we don't have the staff
6 time to do that even for June.

7 So I think a broad recommendation about using the
8 CARE tool is one thing. But thinking about -- like Evan
9 said, how do you transition it for using it for payment. In
10 the short term, for each of the individual silo PPSs, I
11 think we'd need to give more thought to that.

12 MR. HACKBARTH: I think we are the point where we
13 can move on to the next item. But what I have heard is
14 broad affirmation of the concepts that you laid out. It
15 sounds like you have what you need from us in terms of
16 support and ideas and so we look forward to your coming
17 back.

18 Thank you.

19 And so, our last session -- I had to do a double-
20 take. It actually is the last one. There is an end to the
21 winding road -- is payment for chronically critically ill
22 patients in hospital settings.

1 [Pause.]

2 MS. KELLEY: Good afternoon. Julian and I are
3 here to continue our discussion of improving payments for
4 the medically complex patients we've been calling the
5 "chronically critically ill," or CCI. As you know,
6 Medicare's payment rates for CCI patients in LTCHs are
7 higher than payments for similar patients in acute-care
8 hospitals. This results in inequities across providers and
9 also creates incentives to move patients into LTCHs -- a
10 problem because not all patients are good candidates for
11 that level of care.

12 In April, Julian and I reported on the history of
13 how we can to have different payments for these similar
14 patients, depending on the type of hospital they receive
15 care in and the consequences this has had for both the
16 Medicare program and for patient care delivery in some areas
17 of the country.

18 We also presented results from an analysis that
19 attempted to define and describe CCI patients and where they
20 receive care, and we described some approaches we've been
21 working on to make payments for CCI cases site-neutral and
22 more patient-centered.

1 Since then, CMS published a proposed rule on the
2 LTCH PPS in which the agency discussed a possible framework
3 for LTCH payment reform. Today I'm going to quickly review
4 our concerns about LTCHs and our work on identifying the CCI
5 patients who appear to be most appropriate for admission to
6 LTCHs. And I'll also remind you of the reform approaches
7 that MedPAC staff has been working on. Then I'll bring you
8 up to date on the CMS framework that was discussed in the
9 proposed rule.

10 It's important to emphasize that CMS' framework is
11 not a proposal. No structural changes to the LTCH PPS have
12 been proposed by the Secretary. However, it's fair to say
13 that the framework that was discussed in the proposed rule
14 provides insight into the types of changes the Secretary
15 might consider in the future.

16 Let me begin by reviewing the Commission's
17 concerns about LTCHs. First, when the LTCH PPS was
18 implemented in 2003, its rates were based on inflated costs,
19 resulting in overly generous payments that provided few
20 incentives for efficiency. In addition, the LTCH payment
21 system includes policies such as the 25-day average length
22 of stay requirement and the short stay outlier policy that

1 likely distort the delivery of care and the use of resources
2 in these facilities.

3 Second, there are almost no established criteria
4 for admission to an LTCH. That means acute-care hospitals
5 in areas with LTCHs can unbundle care by transferring costly
6 patients, and LTCHs can admit any patient needing hospital-
7 level care as long as they maintain that greater than 25-day
8 average length of stay. Without criteria for admission,
9 it's not clear whether or which patients treated in LTCHs
10 require that level of care.

11 Third, some parts of the country have many LTCHs
12 while others have none. The oversupply of LTCH beds in some
13 markets may result in the admission of less complex cases
14 that could be cared for with comparable outcomes in other
15 less costly settings. This, of course, is not difficult to
16 do because, as I mentioned, there are almost no criteria for
17 admission to an LTCH. In fact, in areas of the country with
18 very few or no LTCHs, many Medicare beneficiaries do receive
19 similar services in other settings.

20 The key issue in reforming payment is determining
21 how to define the chronically critically ill. In 2004, the
22 Commission recommended that the Congress and the Secretary

1 of Health and Human Services develop facility and patient
2 criteria to ensure that LTCHs serve only the most medically
3 complex patients. But identifying those patients has proven
4 to be difficult. Researchers have described CCI patients as
5 exhibiting metabolic, endocrine, physiologic, and
6 immunologic abnormalities that result in profound
7 debilitation. However, such abnormalities and debilities in
8 hospital patients are not readily identifiable in claims
9 data. As you know, Medicare does not collect assessment
10 data for these or any patients in acute-care hospitals or
11 LTCHs.

12 Research suggests that one of the best available
13 measures of high acuity in hospital settings may be the
14 number of days a patient spends in an ICU. As we presented
15 in April, staff has used this metric to define CCI patients.
16 In an analysis of 2011 Medicare claims for IPPS and LTCH
17 services, we identified CCI cases as those discharges with
18 eight or more days in an intensive care unit or critical
19 care unit. You'll recall that we found that about 6 percent
20 of all IPPS cases are CCI -- that is, they have eight or
21 more days in an ICU -- and of the CCI cases in acute-care
22 hospitals, about half go on to use at least one

1 institutional post-acute-care provider: a SNF, an IRF, or
2 an LTCH. Only 9 percent of these CCI cases in IPPS
3 hospitals go on to use an LTCH.

4 We also found that, by our definition, most LTCH
5 cases are not CCI. About 60 percent did not spend eight or
6 more days in an ICU during an immediately preceding acute-
7 care hospital stay.

8 The payment reform approaches we presented in
9 April are based on the premise that the most medically
10 complex patients have always been a small share of the total
11 population of hospital inpatients. Both of the approaches
12 we're exploring would be site-neutral. They would pay the
13 same for cases in acute-care hospitals and LTCHs, and both
14 approaches would incorporate special treatment of CCI cases
15 in both settings in order to better align payments with the
16 costs of case.

17 The first approach would change the outlier policy
18 to reduce facilities' losses on CCI cases. Medicare would
19 apply the same IPPS base payment rates and weights to
20 hospital patients in acute-care hospitals and LTCHs. More
21 generous outlier payments would be available for CCI cases
22 in either setting. A lower fixed-loss amount would be

1 applied to CCI cases, and Medicare would pay 90 percent of
2 hospitals' costs above the CCI outlier threshold. The
3 outlier policy for non-CCI cases in IPPS hospitals and LTCHs
4 would remain unchanged, with Medicare paying 80 percent of
5 hospitals' costs above the non-CCI outlier threshold.

6 The second approach would create new MS-DRGs and
7 weights for CCI patients in both acute-care hospitals and
8 LTCHs. This can be thought of as adding a new level of
9 severity to the base DRGs that have a high prevalence of CCI
10 cases. Weights for the CCI MS-DRGs would reflect the
11 average relative costliness of patients in the groups
12 compared with that for the average IPPS case. Because these
13 relatively costly cases will have been extracted from the
14 current MS-DRGs, new weights would also need to be
15 calculated for existing MS-DRGs as well, reflecting the new
16 lower average cost per case. Non-CCI cases, whether in
17 acute-care hospitals or LTCHs, would be paid using these
18 non-CCI MS-DRGs and weights. All outlier cases, whether CCI
19 or non-CCI, would be subject to the same fixed-loss amount
20 and would continue to receive 80 percent of costs above the
21 threshold.

22 Both approaches would significantly reduce the

1 payments LTCHs receive for non-CCI cases, thereby reducing
2 incentives for LTCHs to admit patients who are not
3 appropriate candidates for LTCH services.

4 Both approaches would also create an incentive for
5 providers to lengthen ICU stays.

6 The first approach, in which a new outlier policy
7 is applied to CCI cases, has some friction built into it
8 because providers would have to absorb some losses before
9 the CCI outlier policy would kick in.

10 The second approach would create much stronger
11 incentives for providers to classify patients into CCI DRGs,
12 so additional policies would need to be considered to
13 counter this incentive. Both approaches would improve
14 equity among providers of hospital care. Medicare would pay
15 a comparable amount for services furnished to CCI patients,
16 whether that care was furnished by an acute-care hospital or
17 an LTCH. In addition, acute-care hospitals in areas without
18 LTCHs would no longer be disadvantaged relative to acute-
19 care hospitals with available LTCHs to which they can
20 discharge CCI patients sooner.

21 These approaches would also change the level and
22 distribution of payments to hospitals. We'll present the

1 financial impacts of these approaches at an upcoming
2 meeting.

3 Now let's turn to the CMS framework for reform
4 that was discussed in the May 10 proposed rule. The
5 framework CMS discussed would be consistent with current
6 law, maintaining the separate LTCH payment system as well as
7 the requirement that LTCHs have an average length of stay of
8 more than 25 days for all Medicare patients, whether CCI or
9 not.

10 CMS suggested a more restrictive definition of CCI
11 cases in LTCHs than the one MedPAC has been exploring.
12 Appropriate LTCH cases would have specific clinical
13 characteristics that can be identified in claims data and
14 that are identified on this slide, and eight or more ICU
15 days during an immediately preceding acute-care hospital
16 stay. Let me say that again, that we need to have both
17 those: the specific clinical characteristics and eight-plus
18 ICU days.

19 Full LTCH payment rates would be limited to these
20 CCI cases. Payments for all other LTCH patients would be at
21 IPPS comparable rates. No changes would be made to the
22 IPPS.

1 In terms of the expected effects, we see some
2 similarities and differences between the CMS framework and
3 the approaches MedPAC has been exploring. Similar to
4 MedPAC, under CMS' framework LTCHs could continue to admit
5 any patient they thought could clinically benefit from LTCH
6 services. But because payment for non-CCI cases would be
7 sharply reduced, LTCHs likely would focus primarily on
8 admitting CCI cases.

9 Unlike under MedPAC's approaches, under CMS'
10 framework the separate LTCH payment system would remain, as
11 would higher payments for LTCH cases, so long as they had
12 long ICU stays in an immediately preceding acute-care
13 hospital stay. Acute-care hospitals, however, would see no
14 direct financial gain from increasing the number of days a
15 patient spent in an ICU, so gaming incentives would likely
16 be reduced.

17 Like MedPAC's approaches, CMS' framework would
18 improve payment equity across hospital settings by paying a
19 comparable amount for services furnished to non-CCI
20 patients. However, unlike MedPAC approaches, CMS' framework
21 does not address inaccuracies of Medicare's payments for CCI
22 cases in acute-care hospitals. CMS' framework would be

1 expected to produce savings by reducing payments for non-CCI
2 cases.

3 Our next steps are to continue our work on
4 estimating the impacts of MedPAC's two approaches, and we'll
5 develop a payment model based on CMS' framework so we can
6 estimate the impacts of that framework. We'll report these
7 results at an upcoming meeting.

8 That concludes my presentation, and Julian and I
9 are happy to answer any questions.

10 MR. HACKBARTH: Okay. Thank you, Dana and Julian.
11 Round 1 clarifying questions?

12 DR. MARK MILLER: Can I make one clarifying
13 comment? Just for any of the public or anybody writing
14 about this, we will not be estimating the impacts for CMS'
15 proposal. We will be doing a framework like CMS' framework,
16 because there's not enough detail to estimate it
17 specifically. Just in case there's any lack of clarity on
18 that.

19 DR. COOMBS: I was going to ask about the
20 extrapolation from what we know now in terms of the
21 percentage of non-CCI, if it were to go to a CMS in terms of
22 the 60 percent/40 percent ratio of non-CCI versus CCI and

1 what that would look like, especially in the face of the
2 fact that the CCI compensation is not going to be the 80
3 percent above the benchmark as in the other two options, the
4 other two approaches.

5 MS. KELLEY: I'm sorry. I'm not sure I got your
6 question. What the CCI cases would be under CMS' framework?
7 Go ahead.

8 MR. PETTENGILL: I think what you're asking is how
9 would the CCI cases under the CMS definition compare with
10 the CCI cases in ours in terms of numbers and percentage of
11 cases and so on? Is that right?

12 DR. COOMBS: Theoretically, this shouldn't change.
13 It's just the reimbursement for them is changing. Is that
14 correct?

15 DR. MARK MILLER: Both of your statements can be
16 correct. It is true that whatever the definition is, the
17 reimbursement for some set of cases that are currently in
18 LTCHs would go down to more of a PPS rate. I, like Julian,
19 thought the first part of your question was, well, how many
20 cases does that affect in the general MedPAC ideas and how
21 many cases does that affect in the general CMS ideas. And
22 we can say with some certainty that more cases would be

1 affected under the CMS framework. We have to fill in some
2 gaps in, you know, what has been written to simulate
3 something like that, so giving you an exact number I think
4 would be hard for us to do.

5 DR. COOMBS: Can I ask one more --

6 DR. MARK MILLER: And I'm getting blank stares.

7 MR. HACKBARTH: The important part [off
8 microphone].

9 DR. COOMBS: One more clarifying question. In the
10 area SA, if you were to take Approach 2 -- I think you
11 alluded to this -- there were little or no LTCHs in a
12 hospital setting, what would that look like in terms of a
13 hospital that would have the capacity to take care of a CCI
14 for an extended period? Would that change or would it
15 impact on a regular DRG in a hospital with acute respiratory
16 failure, there's no place for the patient to go after
17 they've gotten to a meta stable state?

18 MS. KELLEY: So in an area where there aren't
19 LTCHs?

20 DR. COOMBS: Yes [off microphone].

21 MS. KELLEY: An acute-care hospital under the
22 second approach that we're talking about, under that

1 approach we would have new CCI DRGs, so that case, if that
2 case had spent eight or more days in the acute-care
3 hospital, that would bump that case up to a higher-paying
4 DRG for the acute-care hospital, and the acute-care hospital
5 would receive that payment.

6 MS. UCCELLO: I just want to clarify what CMS
7 framework means. It's in the proposed rule, but it's not a
8 proposal. Is it just like a request for information or
9 comments on something that they're not planning immediately
10 to do?

11 DR. MARK MILLER: You have described it well.

12 [Off microphone discussion and laughter.]

13 MS. KELLEY: I think -- it was a discussion in the
14 rule. They were very clear that they were not proposing
15 anything. This was a discussion -- as you know, they've
16 sponsored a great deal of research over the last few years,
17 so there was a long summary of the findings of that research
18 and some conclusions that one might draw from that research,
19 and where those conclusions, if you did draw them, might
20 drive you in terms of developing future payment policy, and
21 they requested comments on these ideas.

22 MR. HACKBARTH: So they're sort of where we are,

1 in other words, right?

2 DR. MARK MILLER: That's exactly right [off
3 microphone].

4 DR. CHRISTIANSON: So on page 6 you've got some
5 bullet points, Slide 6, and one of them, you could have said
6 9 percent, but you started out with only 9 percent, which
7 expresses, I guess, either concern or surprise. So my
8 question is: You also said that there were many communities
9 where there were no LTCHs. So does this 9 percent average
10 in those communities too? Or does this look -- is what
11 percentage of patients in communities where there were
12 significant LTCH opportunities were...

13 MS. KELLEY: So it's an average, and that's a
14 national average, so it does include the areas where there
15 was almost no LTCH use. There are occasionally patients
16 that do travel long distances to use an LTCH.

17 DR. CHRISTIANSON: You would get a higher number
18 if you --

19 MS. KELLEY: This would be much higher --

20 DR. CHRISTIANSON: -- limited the analysis to
21 places where --

22 MS. KELLEY: Much higher in certain communities.

1 DR. CHRISTIANSON: -- they had opportunities to
2 use LTCHs.

3 MS. KELLEY: Yes, absolutely.

4 DR. CHRISTIANSON: So I find that a little bit --
5 I'm not sure what the concern then -- until you see the
6 other number.

7 MS. KELLEY: And that's work we're doing as well.

8 MR. GRADISON: I want to make sure I understand
9 your relationship between what we're talking about and the
10 outlier pools under PPS. First of all, just order of
11 magnitude, do you have any idea how large a proportion of
12 the total outliers in acute-care hospitals are represented
13 by the populations we're talking about here, CCI and non-
14 CCI? Is it a major part of the 5 percent or whatever?

15 Let me explain why I ask. I'm aware from past
16 experience of some major issues about the outlier pool.
17 There was a period of years when it was claimed that the
18 Secretary had overestimated the amount of money needed in
19 the pool, and the amount set aside was not used, which at
20 least in the short run reduced the payments to the
21 hospitals. The department responded, well, it averages out
22 over a period of time. But we're in an environment where a

1 percentage or two here and there can make a difference. I
2 just kind of wondered how this fits into that type of an
3 issue.

4 MR. PETTENGILL: I'm not sure that it does, but I
5 couldn't give you an exact percentage of outliers that turn
6 out to be CCI cases at this point, but that's work that
7 we're also doing. We'll come back to you.

8 MR. GRADISON: Thank you.

9 DR. REDBERG: You had in the mailing materials on
10 page 21 the data that I think you had presented last time we
11 talked that the mortality wasn't very different between
12 LTCHs and acute-care hospitals. But what is the mortality,
13 like 30-day or one-year?

14 MS. KELLEY: In an LTCH? The mortality rate in a
15 LTCH? I knew you were going to ask this, and I looked it
16 up, and, of course, it has gone straight out of my head.

17 Okay. So the mortality rate in an LTCH averages,
18 I believe, about 15 percent, and that's patients that die in
19 the LTCH. It varies quite dramatically across patient
20 types, so, for instance, a patient with septicemia who's
21 also on prolonged mechanical ventilation, I believe the
22 mortality rate in the LTCH for those patients is about 40

1 percent, and an additional 15 percent or so die within 30
2 days after discharge. Other DRGs, patients that, for
3 example, are admitted for after-care or pressure sores have
4 much lower mortality rates. So it really does depend on the
5 DRG in question.

6 MR. HACKBARTH: Peter's going to lead off on Round
7 2.

8 MR. BUTLER: If you could go to the last slide? I
9 think Glenn is asking me to lead off because maybe he
10 figures I can handle -- these questions aren't too tough.
11 "Don't model, don't model, whatever you do." Just kidding.

12 This is obviously a sensitive topic in the sense
13 that these are very vulnerable populations, and I would just
14 remind you that, as I've said before, I was involved about
15 20 years ago in three large organizations that came together
16 and said, you know, we have five or six of our ICU beds
17 filled with ventilator patients. They're kind of clogging
18 the thing up. And, in addition, they're kind of --
19 certainly our DRG payments, even with outliers, weren't
20 covering the costs. And if we had our best pulmonary people
21 put together a hospital to kind of do these things, we'd all
22 be better off. So it really wasn't -- you know, so it was a

1 voluntary effort to kind of make this happen, which I think
2 I said also is easier to do in an urban market. I think
3 when you have some fairly large ICUs and you can depend on
4 not just one hospital but some large hospitals to help make
5 this work.

6 So with respect to -- so I've always thought of
7 this as a narrow definition, a fairly narrow definition of
8 CCI as being the ones to really make sure we do and do right
9 in the right setting, and, again, don't overpay for the non-
10 CCI. So of the options, obviously I'm saying I support
11 these even if Mark says I'm not sure how we can do some
12 shadow kind of modeling of CMS.

13 But the first one, which is the outlier, my bias
14 would be that that is probably a better mechanism, depending
15 on the data, than new DRGs, which always creates a rapid
16 movement to try to document how you can fit into those DRGs.
17 So I think my bias would be one versus two, but I think it's
18 great to model both of them.

19 I actually am intrigued by the CMS because I think
20 it does several things. First of all, it is a narrow
21 definition. The second is the point that Mike brought up in
22 the previous discussion, and that is, you leave the -- you

1 don't intermingle the payment mechanism in the hospital with
2 a payment mechanism in another provider setting. All you're
3 doing is fooling with the LTCH payment system and making
4 adjustments there. And the third part of it is not exactly
5 self-serving because, you know, as somebody who has
6 hospitals, I always like more payment, not less, but I don't
7 know that you need to -- I don't know that you need to, in
8 effect, put additional money on the hospital side. There
9 already is an incentive, I think, to move out to another
10 setting, where appropriate. And if you say, well, you know,
11 hospitals don't have LTCHs in certain markets, well, they're
12 existing without them now, so I think we would be adding on
13 payments either through new DRGs or outliers, in effect,
14 when you don't even have the LTCH option there. So I'm not
15 sure what we would be doing to advance the model
16 necessarily, and we certainly wouldn't be saving money if it
17 were applied there.

18 I hope that makes sense, my arguments, but -- so I
19 actually kind of am more leaning a little to potentially the
20 CMS model as one that could work.

21 DR. HALL: Peter's point about being sensitive to
22 the patient population is very real. These are desperate

1 people, and where there is an LTCH in a community, I think
2 it serves the community very, very well. So I think
3 whatever options that we come up with, we ought to
4 acknowledge that there's considerable value to the health
5 care system for Medicare recipients to have an LTCH system
6 available.

7 MR. ARMSTRONG: I'll donate my two minutes to
8 Mike.

9 DR. CHERNEW: I can take a lot of time if I --

10 MR. HACKBARTH: We've got 10, 12 minutes.

11 DR. CHERNEW: I do have a question. In the
12 mailing materials in the end, there's a text box where you
13 talk a little bit about hospitals within hospitals and free-
14 standing LTCHs. I'm curious about the joint ownership
15 between acute-care hospitals and LTCHs and how in places
16 where there aren't LTCHs essentially parts of the acute-care
17 hospital like Peter described begin to look like LTCHs in
18 certain ways.

19 MS. KELLEY: In order to qualify as an LTCH for
20 payment under the LTCH PPS, the facility has to have a
21 completely separate financial structure, even if they're
22 located within an acute-care hospital. So they have to have

1 a separate board; the financial structures must be and
2 ownership must be distinct. So that was put into place in
3 order to safeguard against some financial irregularities
4 there.

5 There used to be a lot of hospitals within
6 hospitals, so a wing of an acute-care hospital would be
7 owned and operated by an LTCH company. After CMS made some
8 changes and required that no more than 25 percent of an
9 LTCH's patients come from one acute-care hospital, the
10 benefits of having a hospital within a hospital in your
11 acute-care facility really declined. And so now we see
12 fewer hospitals within hospitals and more free-standing
13 LTCHs located across the street from acute-care hospitals.

14 So, you know, there is some maneuvering around
15 that goes on like that, but they do technically have to be
16 distinct financial structures.

17 DR. CHERNEW: I want to just to say or ask, as we
18 move towards bigger integrated systems, like, for example,
19 ACOs, which we've talked a lot about today, are therefore
20 not allowed to own both an acute-care hospital and an LTCH
21 because of the rules that you just said? I care in part
22 because of the -- I'm interested in the inpatient ICU stays

1 and the joint incentives around that. And then, of course,
2 one way to solve part of this problem is to integrate within
3 the same organization and try and get the overall population
4 right. So I'm interested in the possibilities of doing
5 that.

6 MS. KELLEY: I don't know the answer to that
7 question, so we'll have to look into that. But Mark --

8 DR. MARK MILLER: [Off microphone.] -- just to
9 make sure that I understand what your question is, and to
10 pick up where Peter was. If someone were to approach this
11 CMS framework, your concern is that the way I'd want to work
12 this is if I had a relationship with the LTCH, then the
13 arithmetic between the number of days in the ICU versus
14 putting the person in the LTCH, I could start to try and
15 arbitrage.

16 DR. CHERNEW: [Off microphone.] That was my first
17 concern.

18 DR. MARK MILLER: That was the concern I
19 understood.

20 DR. CHERNEW: Yes, right.

21 DR. MARK MILLER: And I think there's two things
22 that potentially -- I'm not sure that end that, but militate

1 against it, which is the separate financial structure and if
2 you keep the 25 percent rule in place.

3 MS. KELLEY: Right. And one of the things CMS had
4 asked for in the proposed rule was comments on whether or
5 not if you were to redesign the LTCH payment system in this
6 sort of a -- in the model of this kind of framework, would a
7 25 percent rule still be something you would want to have.

8 DR. CHERNEW: And just my second question, spurred
9 by Dana -- [off microphone] -- but I didn't have it until
10 Dana answered the first one, is there's other times we have
11 discussions about post-acute bundling and a whole series of
12 other things. If I thought about that way of thinking about
13 the world or an ACO way of thinking about the world, then
14 all of a sudden the answers to these questions, I view them
15 as sort of completely different. And so some of those rules
16 that were put in place to deal with the frictions between
17 acute care and LTCHs, what I would want to do to do that
18 might be an impediment to moving to another type of payment
19 model to solve a similar problem in post-acute -- [off
20 microphone] -- and trying to sort out in the grand bigger
21 picture.

22 DR. MARK MILLER: [Off microphone.] -- bigger

1 picture. You have said and others have said, and I think
2 some different sets of staff have said, when you think about
3 moving to an ACO framework, for example, and somebody says,
4 okay, I'll take risk, we have often said, in that
5 environment, you want to start to strip away some of these -
6 - and you have made this point many --

7 DR. CHERNEW: [Off microphone.] Things are hard
8 to strip away.

9 DR. COOMBS: So, I think one of the things that
10 struck me was just the criteria used for defining the CCI
11 patient outside of even the eight-day rule of requiring an
12 ICU, because you could get around that, theoretically, in
13 some systems, and then combining that with, as you've
14 mentioned, approach two, and even if there was an area where
15 there were LTCHs available, a hospital could conceivably
16 kind of add on or mushroom a patient who could stay in their
17 system extended time, theoretically, and there would be some
18 incentives to do that directly, right? And so that would be
19 an issue with that piece.

20 And then the approach one, actually looking at
21 having a uniform IPPS system within LTCHs and hospitals, a
22 similar thing might exist, as well, potentially.

1 MS. KELLEY: So, under approach one, a patient
2 would be eligible for the higher CCI outlier payment in an
3 LTCH if they'd had a previous -- an immediately preceding
4 acute-care hospital stay with that long ICU number of days.
5 So, yes, there -- theoretically, there would be incentives
6 for hospitals to lengthen ICU stays in order to qualify
7 patients both in their own facilities and LTCHs for CCI
8 outlier status, but, of course, for a case to be an outlier,
9 you have to run a loss. So that builds in some friction
10 into the -- it's not quite the financial incentive --

11 DR. COOMBS: Right.

12 MS. KELLEY: -- because you have to run that loss
13 before the outlier payments kick in.

14 DR. COOMBS: But there is still an incentive in
15 both the approaches to extend the ICU stay.

16 MS. KELLEY: Yes.

17 DR. COOMBS: Okay. And, as I mentioned before, I
18 think LTCHs are very important, especially myself being an
19 ICU doctor and dealing with patients who have so many
20 comorbid conditions in terms of needing ventilators and
21 dialysis and things of that nature, and in some areas, there
22 are very few institutions that can actually accommodate

1 those type of patients. And I do believe that that impacts
2 access for beneficiaries indirectly because of availability
3 of ICU beds, which are very limited in hospitals.

4 So, you know, looking at the CMS model, it almost
5 appears like that is a more favorable arrangement in terms
6 of doing what you want to do. We're concerned about the
7 proliferation of LTCHs and the incentives for LTCH's
8 development, but this would actually control costs, and I
9 would wait to see what kind of more information will be
10 yielded from models in terms of anticipating what that
11 actually looks like going forward.

12 But, you know, I would be concerned about a
13 possible gaming the system in both approach one and two for
14 acute-care hospitals, more so in this situation. And
15 approaches one and two actually does what you want it to do
16 in terms of the non-CCI cases.

17 MR. PETTENGILL: Just to be clear, I don't want
18 anybody to walk away with the idea that there really is an
19 incentive to increase the ICU length of stay under option
20 one because while the cost of adding a day or two of ICU
21 care might not be all that large, the gap in payment between
22 the payment rate for a CCI case and the outlier threshold is

1 still there, and the outlier payment is -- even though it's
2 90 percent of the costs above the limit, above the
3 threshold, it's not going to make up for that loss, okay.
4 So there's really no incentive to extend the stay.

5 Under option two, when you extend the stay to get
6 CCI status, it might be the case that the payment bump you
7 get from going into a CCI category would be large enough to
8 offset that cost.

9 DR. COOMBS: In some situations, though, in the
10 ICU, patients are actually waiting for a bed. And in the
11 cases where they're actually waiting for a bed, you're not
12 going to have any advantage while you're waiting for the bed
13 under the current system. So this would be even better than
14 what happens for a patient who's actually waiting to be
15 placed.

16 MR. PETTENGILL: Yeah. There might be an
17 incentive for hospitals to expand their ICU capacity.

18 DR. SAMITT: I just have two quick things. I'm
19 also intrigued by the CMS framework. When I kind of looked
20 at the puts and takes of the pros and cons of the various
21 proposals, the only con that seemed to emerge in the CMS
22 framework was the impact on communities that didn't have an

1 LTCH, that those hospitals would, in essence, be
2 disadvantaged because they wouldn't have an alternative
3 other than to maintain the patient's care within the
4 hospital.

5 So, if there's a comment period, the question is,
6 is just the comment that there could be an exception awarded
7 to hospitals with CCI patients in an environment where there
8 isn't an LTCH and would that help resolve that remaining
9 gap.

10 The second comment that I would make is we talked
11 -- many of us talked about the vulnerability of the
12 population. We also can't forget the importance of informed
13 decision making with these patients about advanced care
14 planning and palliative care, and somewhat similar to
15 discussions we had earlier, this is not the time to do so.
16 There really should be an imperative with families and
17 patients sooner to have these types of discussions because
18 it will influence this total population.

19 DR. HOADLEY: I was going to raise questions about
20 the incentives on the ICU use, but I think you've well
21 discussed that. I don't really have anything to add on
22 that.

1 The only real alternative to using that as the
2 criterion would be if you had an assessment, which you don't
3 have. I mean, is that pretty much right?

4 MR. PETTENGILL: [Off microphone.] Right.

5 DR. HOADLEY: Okay.

6 MS. UCCELLO: So, I am a little flummoxed on how
7 to decide kind of between these different kinds of options.
8 One question I had was that what are the incentives, given
9 there are -- I mean, what's the ability to increase time in
10 the ICU, given the differing incentives across the options?
11 We talked about that already a little bit.

12 Also, what's been mentioned, too, is what happens
13 to the hospitals without LTCHs and are they disadvantaged,
14 and Peter is almost suggesting that they might not be. So
15 understanding kind of what's going on with them and how they
16 relate, I think, could help me, at least, think through
17 these issues.

18 But I think the bottom line is that any of these
19 approaches seem to be better than what we have now, and so
20 we don't want to be kind of paralyzed by a wealth of
21 imperfect choices, but just something would be better.

22 DR. NAYLOR: Pass.

1 MR. GEORGE MILLER: I want to just add my comment
2 from the last time about this, I think, would be under
3 discussion. Very good chapter. Very rich discussion.

4 But as I was reading this, it raised the issue
5 about palliative care. I don't have the statistics, but it
6 seems to me that this is just absolutely perfect for the
7 discussion of shared decision making, engaging the patient,
8 and maybe we should consider in some ways incentivizing the
9 provider to have that conversation and in some way document
10 that the patient clearly understands that these alternatives
11 have additional risks for maybe never recovering or spending
12 a long time in a state that the family maybe never intended
13 for their loved one or them themselves predicted in having.
14 I think it's the notion of saving a life versus prolonging
15 dying.

16 And in the reading, in the chapter, it had a
17 couple articles about that. Even after an 84-year-old woman
18 decided not to have valve replacement, several other
19 physicians tried to convince her to change her mind and they
20 even talked to her son about changing her mind. I think we
21 could tremendously impact the types and numbers of
22 procedures if we somehow -- not somehow, but incentivize

1 that discussion about shared decision making involving the
2 patient clearly understanding and that there are additional
3 risks. While I think Bill and others are right that these
4 providers have valuable services where needed, but I
5 somewhat suspect we do way too many in the community, way
6 too many of these procedures.

7 DR. BAICKER: I think I've lost track of a key
8 piece of the rationale for the development of our proposals
9 that I'm sure you've outlined for us in the past, but I know
10 I would benefit from thinking about again, which is when I
11 look at the CMS proposal, one thing that's very different is
12 maintaining a separate LTCH structure. And the other thing
13 that's different is how they're defining the appropriate
14 patients for -- that includes the conditions as well as the
15 ICU stay.

16 One of the challenges with the CCI definitions
17 that we've been using is that they're neither sensitive nor
18 specific in some sense. Now, you don't want them to be
19 perfectly sensitive and specific in that you think there's
20 variation in LTCH use that's inappropriate and the goal is
21 not to replicate that in some other definition.

22 But is there an evolution of our definition of

1 which patients might be subject to the special CCI outlier
2 payments, or whichever option we choose if we go away from
3 the LTCH version, that would be more optimally sensitive and
4 specific, by which I mean flagging patients who ought to go
5 to a different kind of care, whether it's an LTCH or a
6 different -- that kind of care, and flagging only patients
7 who are in that kind of care, not more broadly. I'm
8 wondering if there's anything to learn from the CMS approach
9 about how we define the patients for the extra payment arms,
10 regardless of which of our two approaches one were to
11 pursue. Does that make sense?

12 [Off microphone discussion.]

13 [Laughter.]

14 MS. KELLEY: I do think -- all right. I'll turn
15 on my microphone. So, I do think that there is something to
16 be learned from their approach. I think we -- Julian and I
17 felt that we suffer from a lack of, perhaps, the medical
18 expertise that would be required to help us kind of narrow
19 down the definition, and RTI -- I'm sorry, CMS worked with
20 RTI to help sort of broaden that out. They also, I think,
21 have used the CARE data and the assessment tool information
22 to also help give a, you know, a more robust definition of

1 what these patients look like, and that's the kind of
2 information that we're lacking. We don't have an assessment
3 tool that's used in the hospital setting, but certainly if
4 there were one, one would hope that it could not just help
5 us pick out the patients that are right for this particular
6 kind of care, but also who's not right and maybe what a
7 better path would be for those patients.

8 DR. BAICKER: Just to follow up, that would have
9 the advantage of allying, potentially, whatever -- some of
10 the remaining concerns about incentives to change behavior
11 and treatment if they were based on things that were
12 sufficiently backward looking, that they had even less
13 incentive for that, because I really like the approach that
14 you've outlined of not having separate LTCH payments. But
15 to maximize the value of that approach, it seems like the
16 fine-tuning would then happen on the "who gets the outlier
17 payments" or whatever mechanism we choose.

18 MS. KELLEY: Yeah.

19 DR. MARK MILLER: [Off microphone.] Can I ask an
20 actual question, too, that's triggered by that?

21 DR. BAICKER: Was that it?

22 DR. MARK MILLER: That was it.

1 [Laughter.]

2 DR. MARK MILLER: So, I think from this morning
3 we're even now. Can we leave it? All right. So the game
4 is still on. All right.

5 [Laughter.]

6 DR. MARK MILLER: The other way I could hear
7 something that -- in her question, and you can not agree --
8 is, in a sense, you have three payment policies: An outlier
9 one, a DRG one, and then a continued split model, for lack
10 of a better word. And inside each of those, you could try a
11 definition that is ICU eight days, or ICU eight days plus
12 the conditions that CMS is asking, and you could almost, in
13 a sense, have that variation cut across the three payment
14 models. That's what your comment made me think of.

15 DR. BAICKER: Yes, or any other --

16 [Discussion off microphone.]

17 DR. MARK MILLER: [Off microphone.] Or any other
18 --

19 DR. BAICKER: Right.

20 DR. MARK MILLER: [Off microphone.] -- that we
21 were able to --

22 DR. BAICKER: And the definition of the

1 potentially appropriate payment is patient for the extra
2 payment is necessary for our approaches because we've
3 eliminated the separate silo. It's not necessary for the
4 separate payment approach under CMS because you could just
5 say, anybody who is in that facility is the appropriate
6 patient. That's not the option they're outlining. So you
7 could have it in all three. You must have it in the first
8 two.

9 MR. HACKBARTH: [Off microphone.] So, we're still
10 very much at a developmental stage on this. To the extent
11 that people have voiced opinions about options, there's
12 actually been some division of opinion about that.

13 I guess my question is, did you folks get what you
14 wanted out of this presentation, or is there -- are there
15 some questions that you have for us? And that applies to
16 you, too, Mark. Are you good?

17 MS. KELLEY: I think we're okay.

18 DR. MARK MILLER: [Off microphone.] We're good.

19 MR. HACKBARTH: Okay. Any concluding comments
20 from Commissioners? Mike?

21 DR. CHERNEW: One of the issues per the Kate-Mark
22 exchanges, when you have two separate systems, like an LTCH

1 payment system and another payment system, you have two
2 separate conversion factors floating around and a bunch of
3 other things and that has some ramifications of complexity,
4 because whenever there's heterogeneity, we have a problem.
5 So, I think there's a bigger picture about what you want to
6 do through weights off a single conversion factor and then
7 outliers versus when you want to have multiple conversion
8 factors floating around which then pull other things in.

9 I don't know the answer to that in this case, but
10 that's how I interpret Kate's comment and your exchange, and
11 I think that is actually conceptually a very important point
12 in post-acute, because we have a lot of separate conversion
13 factor payment systems walking around and all of them have
14 their own separate weighting systems and all of them have
15 their own separate data that they use to categorize people
16 into what actually gets weighted.

17 MR. PETTENGILL: One thing to note about the CMS
18 framework is that it does keep a separate system. You're
19 not -- if you were to collapse to a single set of weights
20 and a single conversion factor, as you call it, then what
21 that would imply is that you would be making higher payments
22 for CCI cases in acute-care hospitals, as well, that met the

1 criteria, and that's not where we're going. We do that in
2 option two, the second approach, but not in the CMS --

3 DR. CHERNEW: And I wasn't advocating one way or
4 the other. I was just trying to point out there's trade-
5 offs, because you pull other people in in different ways --

6 MR. PETTENGILL: Right.

7 DR. CHERNEW: -- across all these systems as you
8 deal with that, and that's where the just conceptual
9 framework of sorting through, I think, ultimately happens.

10 MR. PETTENGILL: Right. And maybe someday, if we
11 had the assessment data, you could define clinical
12 categories that would cross both environments, and then you
13 could do that.

14 MR. HACKBARTH: Okay. With that, we are done.
15 Thank you, Dana and Julian. Good work.

16 We will now have our public comment period. We
17 have two at the microphone? Anybody else on the way there?
18 So three.

19 The ground rules are please introduce yourself and
20 your organization. When the red light comes back on, that
21 signifies the end of your two minute time period.

22 I just would like to emphasize, as I usually do,

1 that this is not only -- or even your best -- opportunity to
2 comment on the Commission's work. The best opportunity is
3 through the staff, but you can also use our website where
4 there is an opportunity to make comments on each meeting.

5 With that, your two minutes has started.

6 MS. ARCHULETA: Great. Thank you.

7 I am Rochelle Archuleta with the American Hospital
8 Association. I have brief comments on the LTCH session and
9 also the site neutral session.

10 First, on LTCHs, we understand the overriding
11 concerns of the Commission in terms of preserving the LTCH
12 space for just the sickest patients, and we certainly share
13 those concerns. However, the approaches shared in April and
14 reviewed again today, we think have an over reliance on a
15 single metric. We really do believe that the number of ICU
16 days serving as the sole test, the sole gatekeeper, is an
17 reliable way to determine who should be eligible for LTCH
18 coverage and LTCH payment.

19 We've closely studied this metric and it's clear
20 that ICU days, on their own, are not a reliable indicator of
21 severity of illness. What we see is that as the number of
22 ICU days goes up -- four, six or eight, wherever you would

1 set the threshold, you're going to have patients with high
2 severity of illness both above the threshold and below. And
3 you're going to have patient with lower severity of illness
4 above and below.

5 What we'd like to see as an alternative, is see
6 the ICU metric combined and used as part of a two-pronged
7 test rather than a single-printed test. That's the
8 direction that we're heading in in our work, and that we
9 would encourage you to consider.

10 On the second session, site neutral payment for
11 SNFs and IRFs, we would note that in 2010 the admission
12 criteria for IRFs were meaningfully raised by CMS. This set
13 IRFs apart from SNFs even more. It required that IRFs could
14 only admit hospital-level patients.

15 As a result, we feel that from that point forward
16 the IRF product and the IRF patient population became even
17 more distinct from SNFs. And we would encourage you
18 therefore, in your comparative work moving forward, to only
19 use data from 2010 and later. You can even see in the CARE
20 tool report to Congress that older data is used and we would
21 encourage you to move away from that approach.

22 In summary, we feel strongly that if Medicare

1 rules, which they do, they limit IRF to hospital-level
2 patients and very specifically lay out the scope of services
3 that IRFs have to deliver. As noted today in the
4 discussion, if it's not a SNF product -- we are talking
5 really apples and oranges here -- then the payment should
6 really correspond to the product that's being delivered.

7 And then on quality, both the Commission and CMS
8 have noted that acuity and function levels are much higher
9 in IRFs to start with. So again, repeating myself, it is
10 different populations being treated. But the quality
11 outcomes are different as well. It is especially important
12 to note that IRFs have far superior readmission rates. They
13 have a lower readmission rate.

14 So we just think that moving forward the quality
15 ramifications of site neutral payment should be very closely
16 considered as we move forward down this track.

17 Thank you very much.

18 MS. WHEATLEY: Hi, I'm Mary Wheatley from the
19 Association of American Medical Colleges.

20 I just want to have a comment or two going back to
21 the ACO discussion and the role of academic medical centers
22 in ACOs.

1 First of all, the AAMC represents teaching
2 hospitals and the close to 100,000 clinical faculty that
3 work at the associated faculty practices. We have actually
4 been engaged -- a lot of academic medical centers have been
5 engaged in both the Pioneer and the Medicare Shared Savings
6 Program ACO. So they are actively involved either as their
7 own entities or often with the broader community
8 environment.

9 Second, we are actively being the environment
10 where we are educating the next generation of doctors and
11 other professionals. This is the kind of environment where
12 you want to make sure that the alternative payment models
13 are being implemented in so that they have exposure in how
14 to deliver new kinds of care and bring it to their own
15 practice.

16 Given those two things, given who we are and what
17 role we play in the community network and the services that
18 we provide, we just want to make it abundantly clear that a)
19 we have been actively participating and we think that
20 encouraging academic medical centers to be part of an ACO
21 program would actually be a measure of success in any kind
22 of ACO policy.

1 Thank you.

2 MS. LUPU: Hi, Dale Lupu, L-U-P-U.

3 Now I want to switch hats and I'm speaking on
4 behalf of myself. I'm faculty at George Washington
5 University Center for Aging Health and Humanities in the
6 School of Public Health.

7 I just wanted to sort of do a shout-out to Dr.
8 Samitt and Dr. Miller for raising the issue of shared
9 decisionmaking and palliative care during the discussions on
10 post-acute care and LTCHs.

11 I wanted to point out that I was watching
12 something that is an exercise that I give to my public
13 health students. It's an exercise I call the blind spot. I
14 ask them to go look at public policy and look for the places
15 where we -- once you look at it -- conspicuously fail to
16 really consider the policy issues around hospice and
17 palliative care.

18 I watched that for your last two discussions. Not
19 to criticize, but I watched it. So in post-acute care there
20 was no discussion -- no policy analysis of where palliative
21 care or hospice or shared decisionmaking fits in the post-
22 acute care environment. The same thing happened with LTCHs.

1 I remember that last spring when you talked about
2 LTCHs you did say aren't some of these patients appropriate
3 for palliative care? You guys, Commissioners, said that.
4 But there's no analysis.

5 And I want to suggest that what's happening is you
6 are unintentionally falling prey to what we often criticize.
7 There is no payment mechanism for palliative care. And the
8 hospice payment mechanism is very walled off at the moment.
9 So when you analyze by -- when you look policy-wise and
10 analyze by provider payment mechanism, palliative care is
11 invisible. It falls into a blind spot.

12 So what do we do about that? One is we could have
13 a payment mechanism for it. I'm not sure that's the right
14 thing.

15 I think the real thing to do is we need cross-
16 cutting quality measures and we need what in the field we're
17 calling the denominator question. And we don't have it yet.
18 We need a reliable way to identify that patient population
19 that is a palliative care patient population. Maybe it's
20 CCI but we don't really know yet.

21 I think that would help. And again, it would help
22 us shift towards a person-centered, patient-centered

1 approach, not just a payment model approach.

2 Thank you.

3 MR. HACKBARTH: Okay, we are adjourned until 8:00
4 a.m. tomorrow.

5 [Whereupon, at 4:44 p.m., the meeting was
6 recessed, to reconvene at 8:00 a.m. on Friday, November 8,
7 2013.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 8, 2013
8:00 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
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [8:01 a.m.]

2 MR. HACKBARTH: Okay. Good morning. We have
3 three items this morning: first, Medicare managed care; and
4 then two sessions related to our upcoming discussions about
5 payment updates -- one on physicians and the other on
6 hospitals. So beginning with managed care, Scott?

7 DR. HARRISON: Good morning. Next month we're
8 going to present the status of the MA program information
9 that generally goes into the March report, but today we're
10 going to present some material on two specific topics that
11 you may want us to develop further for next month.

12 The first topic is the treatment of employer group
13 plans under the program. We are concerned that the employer
14 group plan bids that are a determinant of Medicare payment
15 do not reflect the plan's costs as accurately as do the bids
16 of the non-employer plans, and thus Medicare may be paying
17 employer plans relatively more than the non-employer plans.

18 The second topic addresses the fact that MA plans
19 do not include hospice benefits. If an MA enrollee chooses
20 hospice, the enrollee must get those benefits through the
21 Medicare fee-for-service program, and the resulting benefit
22 package becomes fragmented. Kim will present the material

1 for the hospice issue after I finish with the employer
2 plans.

3 To orient you, let me remind you about the MA
4 program and payment system.

5 The MA program allows beneficiaries to receive
6 their Medicare Parts A and B benefits, other than hospice,
7 through a private plan rather than through the traditional
8 fee-for-service Medicare program. Medicare pays the MA plan
9 a capitated amount, adjusted for the health risk of the
10 individual beneficiary. As of September, 28 percent of all
11 Medicare beneficiaries were enrolled in MA plans.

12 Plans submit bids each year for the amount they
13 think it will cost them to provide Parts A and B benefits.
14 Each plan's bid is compared to a "benchmark," which is a
15 dollar amount set for each county. A plan's benchmark is
16 based on the benchmarks of the counties it serves and on the
17 plan's quality rating. I'll go into more detail next month
18 on how the benchmarks are set, but I can provide more detail
19 today on question.

20 If a plan bids above the benchmark, Medicare pays
21 the benchmark, and the beneficiaries make up the difference
22 with a premium.

1 If a plan bids below the benchmark, Medicare pays
2 the bid plus a rebate, calculated as a percentage of the
3 difference between the bid and the benchmark. Plans with
4 higher quality ratings are awarded higher rebate
5 percentages. The rebate must be used by the plan to provide
6 extra benefits to the beneficiaries. The benefits could
7 take the form of reduced cost sharing for Medicare services
8 or could also take the form of additional non-Medicare
9 benefits.

10 What I've just described applies to all MA plans.
11 While most MA plans are available to any Medicare
12 beneficiary, certain types of plans can limit their
13 enrollment to a subset of Medicare beneficiaries. Today I
14 am focusing on MA plans that are available only to retirees
15 whose Medicare coverage is supplemented by their former
16 employer or union.

17 For this presentation, I will refer to these
18 plans as employer group plans. Such plans are usually
19 offered through insurers and are marketed to groups formed
20 by employers or unions. One plan can serve the retirees of
21 thousands of employers; 2.6 million, or 18 percent, of all
22 MA members are enrolled in employer group plans.

1 The dynamic of the bidding process for employer
2 group plans is more complicated than for other MA plans
3 because the employer group plans can negotiate benefit and
4 premium particulars with employers after the Medicare
5 bidding process is complete. The bids CMS sees may not
6 reflect the actual benefits and costs in the plans which the
7 employers actually buy. Conceptually, the closer the bid is
8 to the benchmark -- which is, the maximum Medicare payment -
9 - the better it is for the plan and the employers, because a
10 higher bid brings in more revenue from Medicare, potentially
11 offsetting expenses that would have required a larger
12 contribution from employers.

13 On the other hand, non-employer plans have an
14 incentive to bid below the benchmark to obtain rebates they
15 can use to finance extra benefits that, in turn, are used to
16 attract increased enrollment.

17 So let's look at this slide that illustrates
18 competition among two non-employer plans and shows how the
19 calculus may be different for the employer plan. Assume we
20 have three plans in a county where the benchmark is \$1,000
21 per month and assume all the beneficiaries are of equal risk
22 and the plans are of equal quality.

1 The two non-employer plans bid \$820 and \$900,
2 respectively. Plan No. 1 would receive a total of \$918 from
3 Medicare per member per month, and Plan No. 2 would receive
4 \$970. However, when the plans build their benefit packages,
5 Plan No. 1 will have \$98 to spend on extra benefits to
6 attract plan enrollment, and Plan No. 2 will have only \$70
7 to spend. This is the nature of the competition. If a plan
8 can underbid its competitors, it will look more attractive
9 to beneficiaries.

10 Now look at the employer plan on the right. It
11 bids \$990 and would receive \$997. It would only have \$7 in
12 extra benefits to offer to beneficiaries, but the plan has
13 already assured itself enrollment through negotiations with
14 employer groups, so its bids serves more to maximize
15 revenue.

16 So the bids here are theoretical, but
17 conveniently, they are reflected in reality. In fact, as we
18 reported in our March report, the median employer plan bid
19 was 99 percent of its benchmark, while the median non-
20 employer plan bid 86 percent of its benchmark.

21 As a result of the bidding behavior, for 2013, the
22 employer group plans bid an average of 106 percent of fee-

1 for-service spending and are paid about 108 percent of fee-
2 for-service, while non-employer plans bid an average of 94
3 percent of fee-for-service and were paid about 103 percent
4 of fee-for-service.

5 So if we are not comfortable with the reliability
6 of the employer plan bids, how else could we determine
7 payment rates for those plans?

8 One option would limit payments to employer plans
9 to the average plan payment in the county. There may be
10 some counties that do not have non-employer plan bids, and
11 in such cases, the benchmarks would be used as the limits.
12 An option like this was included in the President's 2013
13 budget. It was scored by CBO as saving approximately one-
14 half billion dollars in its first year.

15 Employer plans, however, tend not to think of
16 themselves as county-based. Many of the plans submit
17 nationwide bids, and the average enrollment per county in
18 their service areas is under three beneficiaries. So
19 another option for setting employer plan payments would be
20 to use the national average bid to benchmark ratio for non-
21 employer plan bids and apply that to employer plans. In
22 2013, the average bid of non-employer plans was 86 percent

1 of their benchmarks. Under this option, employer plans
2 would have their bids set at 86 percent of their benchmarks.
3 If this policy option had been in effect for 2013, MA
4 employer plan payments might have been one-half billion to a
5 billion dollars lower.

6 Under both options we would want to maintain the
7 incentives for employer group plans to improve their
8 quality. It would be possible under either of these two
9 options to adjust the resulting payments for the plan
10 quality level.

11 Now Kim will discuss the hospice in Medicare
12 Advantage.

13 MS. NEUMAN: So the next topic is hospice and
14 Medicare Advantage, and I'm going to start with a little
15 budget on hospice.

16 Hospice provides palliative and supportive
17 services for beneficiaries with a life expectancy of six
18 months or less who choose to enroll. When a beneficiary
19 elects hospice, the beneficiary agrees to forgo curative
20 care for their terminal condition. Beneficiaries can
21 disenroll from hospice at any time and can re-enroll later
22 as long as they meet the eligibility criteria.

1 Medicare fee-for-service pays hospice providers a
2 per diem rate to cover services associated with the terminal
3 condition and related conditions. In 2011, about 49 percent
4 of Medicare Advantage decedents and about 44 percent of fee-
5 for-service decedents used hospice.

6 Hospice is carved out of the Medicare Advantage
7 Benefits package. Here's how that works:

8 An MA enrollee who elects hospice typically stays
9 in the plan but gets hospice services paid by Medicare fee-
10 for-service. Fee-for-service becomes responsible for
11 hospice and any other Part A or B services. Medicare
12 Advantage is responsible for supplemental benefits and
13 certain Part D drugs.

14 To reflect the Medicare Advantage plans' reduced
15 responsibility, the government's payment to the Medicare
16 Advantage plan is reduced to just include the Part D payment
17 and the rebate dollars, and the beneficiary's premium is
18 unchanged.

19 The rationale for the hospice carve-out from
20 Medicare Advantage is not fully known. According to a HCFA
21 review article by CMS staff, hospice was first excluded from
22 the Medicare risk plans' capitated rates in the mid-1980s

1 because there was a small number of hospice providers at
2 that time and cost data were limited. The Balanced Budget
3 Act of 1997 made clear in statute that hospice was carved
4 out of Medicare managed care, and it remains carved out
5 today even though it is common for private plans to include
6 hospice in their benefits package.

7 Yesterday you discussed the idea of synchronizing
8 Medicare policy across systems. Hospice is example of an
9 area where policy differs across fee-for-service, Medicare
10 Advantage, and ACOs.

11 Fee-for-service pays for hospice care. The ACO
12 benchmarks include hospice in the shared savings targets.
13 But the MA benchmarks and the capitation payments MA plans
14 receive exclude hospice.

15 In addition to differences in financial
16 accountability across systems, there are also differences
17 within MA plans in terms of the extent to which the plans
18 have financial liability for end-of-life care for their
19 members.

20 Plans have full financial responsibility for end-
21 of-life care for those beneficiaries who do not elect
22 hospice; in contrast, a plan's financial responsibility is

1 limited for those beneficiaries who do choose hospice. This
2 raises the question: Does it make sense for MA plans to
3 have full financial responsibility for end-of-life care for
4 some of their members but not all of them?

5 This next chart shows how the hospice carve-out
6 results in a complex and fragmented set of coverage rules.
7 So if you look at that first line in the chart, that shows
8 you the situation for an MA-PD enrollee before hospice
9 enrollment. Responsibility for all services is under the
10 umbrella of the MA plan.

11 That second line shows how coverage rules change
12 when the MA-PD enrollee elects hospice. Fee-for-service
13 pays for hospice care on a per diem basis, and that per diem
14 payment covers all services and drugs associated with the
15 terminal condition and related conditions. And for about
16 half of all hospice enrollees, that's all they get while
17 they're in hospice. For the other half of hospice
18 enrollees, they receive additional services for conditions
19 unrelated to their terminal illness. And when that happens,
20 financial responsibility is split. Fee-for-service is
21 responsible Part A and Part B services unrelated to the
22 terminal condition, while the MA-PD plan would be

1 responsible for Part D drugs unrelated to the terminal
2 condition and any supplemental benefits. For example, they
3 may be responsible for reduced cost sharing for Part A and
4 Part B services unrelated to the terminal condition under
5 certain circumstances.

6 In the chart, we have a third bank of information
7 at the bottom which shows sort of another anomaly that
8 affects a smaller group of beneficiaries, and that's the 17
9 percent of hospice enrollees who disenroll from hospice.
10 When a hospice live discharge occurs, financial
11 responsibility for care for the MA enrollee who is no longer
12 in hospice remains split between fee-for-service and
13 Medicare Advantage from the day of disenrollment until the
14 beginning of the next calendar month.

15 Given how the hospice carve-out leads to
16 fragmentation at several levels, a policy option that could
17 be explored is including hospice within Medicare Advantage.
18 One key question would be how would this affect the MA
19 payment rates. As a starting point, we could think about
20 what would happen if hospice was treated like other Medicare
21 services in calculating MA plan payments.

22 If you rolled hospice costs into the MA capitation

1 rate calculation, it would increase the government's monthly
2 base payment rate to MA plans since hospice expenditures
3 would be spread across the payment rates for the entire MA
4 population. And what this would mean is that the payment
5 rate that a plan receives for an individual beneficiary
6 would not depend on whether the beneficiary elected hospice.

7 So what would be the implications of doing
8 something like this? Broadening the package of services
9 that MA plans are responsible for to include the full
10 continuum of end-of-life care may promote care coordination
11 and incentivize plans to focus more on efforts to improve
12 quality, efficiency, and satisfaction with care for patients
13 with advanced illnesses.

14 It's also possible that some plans may choose to
15 experiment with covering concurrent hospice and curative
16 care, as a few are currently doing in the commercial
17 working-age population. Since the Medicare population and
18 the working-age population are different, it's hard to know
19 to what extent MA plans would pursue concurrent care
20 approaches, but including hospice within MA would give them
21 that option. If hospice were included within Medicare
22 Advantage, MA enrollees may be required to obtain hospice

1 care from providers in the plan's network, so they may have
2 fewer providers to choose from than in fee-for-service.
3 There would also be additional administrative costs
4 associated with contracting for both plans and providers,
5 like there are with other Medicare services.

6 From a Medicare program-wide perspective,
7 including hospice within Medicare Advantage could be a
8 potential step toward synchronizing policy across fee-for-
9 service, Medicare Advantage, and ACOs.

10 Finally, while the rationale for considering this
11 type of policy would be coordinated integrated care, not
12 savings, a clear question is: What would be the effect on
13 Medicare program spending?

14 Right now, Medicare Advantage is paid more than
15 100 percent of fee-for-service on average, so today this
16 policy option might be a cost. If you were to consider this
17 for 2017, when Medicare Advantage and fee-for-service are
18 expected to be at parity, our sense is that the effect on
19 Medicare program spending would be minimal.

20 So, to conclude, we've talked about two issues
21 today: Medicare Advantage payments to employer plans and
22 the hospice carve-out for Medicare Advantage. As far as

1 next steps, we would find it very helpful to get your
2 feedback on whether you would like us to more fully develop
3 these two issues and bring them back for your consideration
4 in December and January.

5 MR. HACKBARTH: Okay. Thank you. Good job.
6 Isn't it nice to have something real concrete, not abstract
7 and ethereal?

8 Okay. So we've got 60 minutes for this session in
9 total. We spent about 15, so that means we've got 45 to go
10 here. What I propose to do is have a quick Round 1 and then
11 go to Round 2, two-minute allocations, as yesterday. I
12 don't envision any Round 3. That's how we'll get within the
13 60-minute budget.

14 During your Round 2 comments, I would ask you to
15 address the questions here on each of the two issues, and
16 it's okay to say, "I'm not sure at this point." But if you
17 have an inclination about what to do on the employer issue
18 and hospice, Round 2 would be a good time to reveal it.

19 MR. GRADISON: Have you taken a look at the option
20 of making it possible for the MA plans to have a choice year
21 by year as to whether to include this or not to include
22 this? I mean, this is sort of an either/or option. I just

1 wondered if you had taken a look at something along those
2 lines.

3 MS. NEUMAN: We hadn't at this point. Are you
4 thinking of something more along the lines of an optional
5 benefit?

6 MR. GRADISON: Well, the benefit from the
7 beneficiary's point of view, they'd still get the benefit.
8 But the question in my mind is whether an MA plan, if this
9 change were taking place, would have to include hospice, or
10 whether they could say, well, we'd just rather stick with
11 the arrangement that we've had before and have the hospice
12 benefit be paid by traditional Medicare. I'm not trying to
13 complicate it. I'm just wondering if you had taken a look
14 at that. I can see some practical problems, but you're
15 focused on it much more than I am.

16 MR. HACKBARTH: It's okay to say, no, you haven't
17 taken a look at that and we'll think about that.

18 Round 1 clarifying questions?

19 DR. HALL: Just quickly, what do we know about the
20 durability of employer-based MA plans? Are these
21 increasing? Decreasing?

22 DR. HARRISON: Enrollment has been increasing.

1 DR. HALL: By?

2 DR. HARRISON: Kind of about at the same level as
3 general MA plans, maybe slightly higher the last few years.

4 DR. CHERNEW: Can you go to Slide 5? So you said
5 when you did this slide that non-employer plan 1 had \$98 to
6 go to extra benefits and non-employer plan 2 had \$70 to go
7 to extra benefits. Who decides how much the extra benefits
8 actually cost? In other words, if you do vision or dental
9 or whatever it is, who determines what's in that plan?

10 DR. HARRISON: So CMS reviews bids as they come
11 in, and they put a particular emphasis on the cost of the
12 supplemental benefits. They don't want shifting between
13 those two because you could tell that the bidding behavior
14 would change.

15 DR. CHERNEW: But is it possible that the first
16 plan gave vision and they said it cost \$50 and another plan
17 gave vision and they said it cost \$40?

18 DR. HARRISON: It is possible, but CMS is supposed
19 to review looking for that.

20 DR. CHERNEW: And when you get to the employer
21 plan 1 and they do vision, who knows what goes into 7?

22 DR. HARRISON: Employer plans wouldn't put vision

1 in their bid generally. Generally what they're putting in
2 is just A/B benefits.

3 DR. CHERNEW: So they're bidding higher, but then
4 after -- this is my question. So then they might actually
5 offer vision.

6 DR. HARRISON: Right.

7 DR. CHERNEW: So the basic problem seems to be --
8 and I'm sorry for -- this is really clarifying.

9 [Laughter.]

10 DR. CHERNEW: No, honestly.

11 MR. HACKBARTH: Probably for somebody.

12 DR. CHERNEW: One of the asymmetries is the
13 employers don't have to say how they're spending the money,
14 but the other ones do.

15 DR. HARRISON: Right.

16 DR. CHERNEW: Okay. I understand.

17 DR. MARK MILLER: It's like you maximize the
18 revenue, you work out the benefit later.

19 DR. CHERNEW: But that's because the law is
20 different between...

21 MR. HACKBARTH: Clarifying questions?

22 DR. COOMBS: Table 2, they both have the same

1 discharge rates from hospice, and I'm wondering if the
2 disease processes for which they were admitted to hospice
3 are known in terms of whether or not there's concordance
4 with the two discharge rates for the type of diseases in
5 which they're discharged.

6 MS. NEUMAN: That's exactly right, that the live
7 discharge rates do vary by disease, and we do not at this
8 moment have the MA fee-for-service data cut by disease, but
9 we will have it very soon. So we should be able to give you
10 information on that.

11 DR. COOMBS: Thank you.

12 DR. REDBERG: When you're discharged from hospice
13 because it's more than six months, does that happen on the
14 first day, or is there any flexibility in that?

15 MS. NEUMAN: That could happen at any time during
16 the month.

17 DR. REDBERG: But it's always --

18 MS. NEUMAN: Yeah, and it may not happen exactly
19 at the 180th day as well. I mean, they make an assessment
20 at a certain point about whether you're eligible for an
21 additional benefits package. And so at that point, that
22 could happen at any time.

1 DR. REDBERG: And has it generally stayed around
2 17 percent? This data was 2010?

3 MS. NEUMAN: It has been in that neighborhood.
4 There has been a slight trend downward, but it's very
5 slight.

6 MR. HACKBARTH: Any other Round 1 clarifying
7 questions?

8 MR. ARMSTRONG: So on Slide 5, this I think is
9 just a variation on the question Mike was raising. So the
10 employers -- given the process that you described, the
11 employer plans, they can bid right up to the limit there.
12 But is part of the explanation for the difference that the
13 benefits themselves are just more generous?

14 DR. HARRISON: Certainly an argument would be that
15 -- by the way, the risk scores for the employer plans tend
16 to be lower than average. But what they claim is that these
17 are higher utilizers given their illnesses, and probably one
18 of the reasons is they do have a richer benefit package,
19 smaller co-pays, and so they probably do use more services.

20 MR. ARMSTRONG: Okay.

21 MR. GEORGE MILLER: On Slide 8, have you been able
22 to determine the spend rate for those beneficiaries who had

1 hospice versus those beneficiaries who did not have hospice?
2 Is there any comparative data?

3 MS. NEUMAN: So there's been literature on that
4 topic. Sort of the question you're asking is: Does hospice
5 save money? Is it budget neutral? Does it cost?

6 MR. GEORGE MILLER: Right, right.

7 MS. NEUMAN: And the answer to that question is
8 varied. It hinges a lot on the patient's length of stay. A
9 big chunk of hospice's potential to save money comes in the
10 last month or two of life when the most expenditures occur.

11 MR. GEORGE MILLER: Right.

12 MS. NEUMAN: So when lengths of stay go beyond
13 that point, there continues to be savings, but at a certain
14 point the costs overtake the savings. And so it will depend
15 on the length-of-stay profile of the patients.

16 MR. GEORGE MILLER: Thank you.

17 MR. HACKBARTH: Okay. Let's go to Round 2.

18 MS. UCCELLO: Okay. I think this was a great
19 chapter, and I'm supportive of moving forward on both of
20 these issues. And I think as you noted, this ties back to
21 our first session yesterday when we noted our desire to have
22 more synchronicity between systems, so I think we'd

1 certainly want it within a system in terms of the MA -- how
2 we treat the MA plans, as well as the hospice. I don't
3 think it's desirable or appropriate to be giving these
4 employer-based MA plans incentives to maximize their
5 payments, and that's really going on in the way this is
6 structured.

7 I had been concerned when I thought about this
8 about what might happen to employer decisions to even offer
9 retiree coverage. So I reached out to a few actuaries who
10 are employee benefit consultants, and they said that it's
11 almost too late to be worried about that because it's
12 already happening. Employers are already moving their
13 retirees to private exchanges where they have options of the
14 individual MA plans. So my concern about that is lessened.

15 I think using the bid to the benchmark ratio seems
16 like a reasonable approach, and I think the points that Mike
17 and Scott were talking about I think are really important
18 here.

19 On that slide with the charts, those bids are
20 still only for the A/B. They don't reflect more generous
21 plans, but what could be going on here is if they have more
22 generous plans, utilization is going up, driving up the A/B

1 cost, similar to our concerns about the very generous
2 Medigap plans. So I think that's what's going on here, and
3 I think that's something that we're not comfortable having
4 as incentives in how things work.

5 And just more generally, with respect to MA plans,
6 it's my sense that many plans -- not all but many plans --
7 really focus their strategy on maximizing revenues as
8 opposed to managing costs. And so we need to kind of keep
9 putting the pressure on to encourage plans to look at the
10 cost side rather than just the revenue side.

11 In terms of hospice, again, I just think it makes
12 sense to include hospice within the MA, not carve it out,
13 and I think that the advantages of coordination exceed some
14 of those administrative issues that you brought up.

15 MR. HACKBARTH: Cori, could you just go back to
16 MA? Which of the two options did you favor for --

17 MS. UCCELLO: The bid to benchmark ratio.

18 MR. HACKBARTH: Okay. So the second one.

19 DR. NAYLOR: So thank you. This was a terrific
20 chapter. I intuitively think these are both important
21 directions. On the first, the employer setting the bid to
22 benchmark equal to nationwide seems to be the direction

1 given the data that you had shared. I would probably like
2 to know even more the impact on beneficiaries and what this
3 might mean in terms of both access -- availability of the
4 benefit package, but also their co-pay, so how adjustments
5 might impact directly the beneficiaries.

6 On the hospice benefit, I think that this makes
7 great sense to integrate this all into a comprehensive plan.
8 I'd love to know how the MA plans themselves would respond -
9 - are responding to this. Many are moving in the direction
10 of trying to create palliative and other kinds of services,
11 and so I think it could be very well received, but I'd be
12 interested in knowing a little bit more about how leadership
13 of the plans would think about this option.

14 From a beneficiary's perspective, I think this is
15 exactly what we need to be moving toward, a seamless
16 journey.

17 MR. GEORGE MILLER: Yeah, I would just simply add
18 that I would support the bid-to-benchmark ratio.

19 DR. BAICKER: I definitely agree on the
20 integration of the hospice benefit.

21 As for the employer versus non-employer MA plans,
22 I have to admit that I didn't really appreciate that

1 difference until I read this chapter, and I'm still thinking
2 through some of the different ways of adjusting the
3 benchmarks. I'd be interested to see the limited
4 information we have on what the enrollees look like in the
5 two different types of plans. You mentioned that they have,
6 on average, a lower risk score. You know, if only we had
7 detailed encounter data.

8 [Laughter.]

9 DR. BAICKER: We would have a better sense of how
10 much the utilization patterns differ, but that's obviously a
11 product of what the benefits look like. And I would also
12 imagine that whatever we do, the risk adjusters would still
13 play in. If they were differentially selecting or not
14 selecting risk, that would adjust the payments. But we know
15 the risk adjusters aren't perfect, although they're much
16 better than they used to be, so it would be great to just
17 see a profile of what the pools, the two different pools
18 look like to have a sense of how much we think selection may
19 be playing into what the pools look like and what the
20 implications would be for different ways of benchmarking.
21 But clearly from what you've outlined, some adjustment to
22 the payment is definitely in order, and I'm still just not

1 quite sure about how the different mechanisms would play
2 out.

3 MR. BUTLER: So I do support the direction on the
4 employer group plans. I guess I'm leaning to bid-to-
5 benchmark, but that's not with great conviction or
6 knowledge. It seems like it's the better way to go.

7 On the hospice, I averted Round 1 because I was
8 worried it wasn't a clarifying question, but on private
9 insurance that you say typically includes hospice, is there
10 anything that is different typically about the benefits or
11 how they pay hospices in the private sector versus in
12 Medicare?

13 MS. NEUMAN: So there's not a lot of data on the
14 benefits package that they offer and specifically the
15 payment rates. Anecdotally we hear that they often model
16 their benefits package on Medicare, but that's not 100
17 percent. And as I said, the payment rate information is not
18 available.

19 MR. BUTLER: It does make, though, perfect sense
20 to integrate it, so I would support that direction.

21 DR. CHRISTIANSON: I would support going forward
22 in both these areas to develop specific proposals. On the

1 managed care plans, a second alternative seems to me to be
2 the best, so I guess we're pretty consistent so far on that.

3 But I would like you to spend some time trying to
4 work up and explore whether there are other alternatives
5 besides the two that you proposed.

6 And then I was wondering if you could summarize
7 for us what the arguments might be in favor of the status
8 quo in terms of treating employer plans, the base plans, the
9 way they are. Could you comment on that right now? What
10 would people say who would support doing that?

11 DR. HARRISON: I imagine since it removes some
12 money from those plans, the employers would feel like
13 they're getting a better deal now and more likely to offer.

14 DR. CHRISTIANSON: So Cori sort of raised the
15 issue of her concern, which was alleviated by talking to
16 people about whether employers would be less likely to offer
17 retiree plans. So those are the only two things that you
18 come up with in your research that would support keeping the
19 status quo?

20 DR. HARRISON: I mean, I think there has been a
21 long trend of the employers trying to -- instead of offer
22 specific products, to sort of cash out so that they have a

1 more predictable stream going forward. And so they're
2 putting money into the exchanges, and I assume that is going
3 to -- I would think that's going to continue. That's sort
4 of a hot new thing out there for the benefit consultants to
5 offer these exchanges.

6 DR. CHRISTIANSON: That's an argument in favor of
7 the status quo, leave things alone now?

8 DR. HARRISON: Well, I think you might just see
9 lower enrollment in the employer plans and instead having
10 employers subsidize the individual products, and that's
11 probably going to happen anyway.

12 DR. CHRISTIANSON: Yeah, so without putting words
13 in your mouth, which I clearly am trying to do, if we ignore
14 this, will it go away on its own?

15 DR. HARRISON: Don't know how long, but could.

16 DR. HALL: I had the same thoughts about Jon in
17 terms of what's going to be the long-term trend of employer-
18 sponsored MA plans. But if we were going to stay with it, I
19 guess I would favor the bid-to-benchmark ratio.

20 Just a comment about the hospice benefit. I think
21 there's some key differences between the typical hospice
22 patient in the Medicare-eligible age range and people who

1 are younger. People who are younger, once they reach
2 hospice, it's generally because of a single catastrophic
3 illness -- a devastating cancer, an unanticipated stroke, an
4 accident. So that the predictability of that six-month rule
5 is pretty good.

6 Conversely, in the Medicare population, as it gets
7 older, the hospice benefit generally comes in at a time when
8 municipality comorbidities are expressing themselves
9 simultaneously. It makes prognostication much more
10 difficult so that that 17 percent of people who move in and
11 out of the hospice benefit, it creates enormous trauma to
12 families and patients because, remember, when you sign up
13 for hospice, you say, "I will agree to forgo my Medicare
14 benefits for such things as hospitalization, antibiotics,
15 fluids, maybe even nutritional support." And it's a whipsaw
16 back and forth.

17 So I think more integration of that into an MA
18 plan, a good hospice plan, would alleviate a lot of these
19 difficulties that seem to be present very often.

20 MR. GRADISON: This paper is the first I was --
21 brought me for the first time to understand the difference
22 with the employer plans, and I'd certainly like to give more

1 thought to it. But initially the bid-to-benchmark proposal
2 makes a lot of sense to me, but I'd like to kind of
3 understand it better than I really do.

4 As for the hospice benefit, I think it definitely
5 should be included.

6 DR. NERENZ: Also, to me it seems an easy yes on
7 the hospice benefit. I won't repeat what others have said.

8 I'm having much more trouble understanding the
9 other issue here. If we go to Slide 5, you don't show
10 uninsured PMPM costs here. Usually on a slide of this type,
11 if we're trying to understand people's bidding behavior,
12 that's an element that would be in there.

13 DR. HARRISON: So the bid is supposed to be the
14 cost of the A/B benefits.

15 DR. NERENZ: And is that empirically true, as far
16 as we know? Because you were telling us that they're the
17 incentives, like for non-employer plan 1 to bid as low as
18 possible, but clearly it can't be \$10. So I was just
19 curious as you were walking us through that. And then
20 likewise for the employer plan, as high as possible, what
21 the ratio was between the bids and the cost. Now, I at
22 least can think about it a little more clearly if the bids

1 and the cost were part of the same number. But is that true
2 in fact?

3 DR. HARRISON: Okay. So for non-employer plans,
4 the bids are built up through actuarial methods using past
5 experience and then actuarial factors that maybe Cori could
6 tell us more about, or maybe not.

7 [Laughter.]

8 DR. HARRISON: And so they look at what the -- I
9 mean, the cost is supposed to be in the bid, and the bid
10 reviewers look for that.

11 DR. MARK MILLER: As well as their overhead and
12 their profit. So when you're saying the word "cost" --

13 DR. NERENZ: Yeah, yeah, I understand. Okay. I'm
14 just trying to understand because --

15 DR. HARRISON: The problem is with employer bids,
16 we don't really think that is their cost. They're plugging
17 in a number that doesn't mean very much. I mean, you can
18 tell because the convergence around the benchmark is a
19 little --

20 DR. NERENZ: Okay.

21 DR. HARRISON: -- too great for coincidence.

22 DR. NERENZ: Understood. Okay, okay. That to me

1 was an important point, because I just was trying to find
2 out where the constraints were or where the requirements
3 were.

4 All right. And if that illustration is sort of an
5 actual representation, is there a reason we should
6 understand about why costs in the non-employer side should
7 be distinctly lower than on the employer side, if they are
8 indeed lower?

9 DR. HARRISON: Why they should be lower?

10 DR. NERENZ: Why they should -- what's that mean?

11 DR. HARRISON: We don't necessarily think they
12 should be lower. We think the employer plans are bidding a
13 number higher than their cost.

14 DR. NERENZ: And is that reflected in any publicly
15 available profit margin data? Because at least on the
16 illustration, there's a significant profit margin then in
17 the employer plan, if the costs are not different across the
18 two --

19 DR. HARRISON: See, the problem is we don't know
20 what the actual cost is in the employer plans.

21 DR. NERENZ: Okay. Well, I guess that sort of was
22 going back --

1 DR. HARRISON: Yeah, right. Right.

2 DR. NERENZ: -- to my first question. Part of the
3 answer was, well, the bid is the cost. Okay, fine. And
4 then it leads me to --

5 MR. HACKBARTH: [off microphone].

6 DR. NERENZ: Okay. I'm trying to -- maybe these
7 were all clarifying questions. Okay. So for the non-
8 employer plans, bid and cost have some close relationship to
9 each other. Employer plan we're not sure.

10 DR. HARRISON: Right.

11 DR. NERENZ: Thank you. Okay. I still don't know
12 quite where to go with that, but okay, fine.

13 Then the only other thing -- and my time is up --
14 to Slide 7, I just also want to understand. The second
15 option, Slide 7. Is the word in the second bullet, bid-to-
16 benchmark ratio, does the word "bid" have any meaningful
17 meaning? It's not actually

18 DR. HARRISON: For the non-employer plans, we
19 think it does.

20 DR. NERENZ: Well, but it's not a voluntary bid,
21 if I -- it's just a set price, right? Well, if it's set at
22 a ratio that's calculated from one number relative to non-

1 employer plans, how is it voluntary? I just am missing that
2 point, how it's voluntary, or how it's --

3 DR. MARK MILLER: You're right. The policy would
4 say for employer plans we're no longer taking a bid; we're
5 assuming a bid-to-benchmark ratio from the non-employer
6 plans, which we think reflects a competitive or more
7 competitive market.

8 DR. NERENZ: Okay. That's what I wanted to
9 clarify. It's not really a bid in the sense we usually
10 think about it. It is a set price.

11 DR. MARK MILLER: For the employer [off
12 microphone].

13 DR. NERENZ: For the employer. Understood.

14 DR. MARK MILLER: After the -- in the context of
15 the policy.

16 DR. NERENZ: Thank you.

17 DR. REDBERG: So thank you. I also wasn't aware.
18 The disparity in the employer group -- employee group plan
19 costs and bids, and it doesn't make sense, and I would
20 support the bid-to-benchmark ratio suggestion. And, in
21 general, it doesn't -- they are lower-risk groups. In
22 general, people that are healthy -- that are working are

1 slightly healthier, and it would make sense to be lower
2 risk. So for the plans to be spending more and costing more
3 makes me wonder what they are spending the extra -- what the
4 extra services are and, you know, what the sort of quality
5 and outcome measures are in those groups as compared -- is
6 that really all care that is leading to better outcomes or
7 higher patient satisfactory? And certainly I support
8 putting -- adding hospice to the MA plans.

9 And, you know, just on that note, I think we also
10 need to perhaps at some time think about how we could also
11 encourage more use of hospice and have the concept
12 introduced, because certainly a lot of patients and doctors,
13 we just don't think of hospice until way later in the course
14 of disease, and often, you know, quite when it would have
15 been, because there's a lot of very positive things about
16 hospice. Even at end of life, there's a lot more support
17 and comfort measures that patients and their families really
18 appreciate, and I think a lot more could benefit from
19 hospice and palliative care.

20 So certainly in cardiology, you know, there are a
21 lot of heart failure patients that we just don't think early
22 enough in the course of hospice care, and that's actually

1 why I was asking that seemingly random clarifying question
2 about how many go out, because I wonder, kind of following
3 from what Bill said, you know, it's very hard to predict
4 when it's six months left of life, and I just wonder how
5 important it is to have it be so exact that it's six months
6 and could there be -- you know, why can't it have some more
7 flexibility? Because it is upsetting to go in and out or
8 have to figure -- it could discourage some people from
9 electing or using hospice because they might think it's not
10 six months left but it is, or maybe it's more than six
11 months, but why does it have to be that rigid six months?

12 DR. MARK MILLER: Can we -- and I just want to
13 make sure in case this isn't clear, if you are put in -- if
14 you are diagnosed and choose -- and the prognosis is six
15 months, and you come to the end of the six months, you're
16 not required to leave. You can be recertified and get an
17 additional, you know, benefit period. And sometimes people
18 stay in hospice for very long periods of time.

19 So the six months, you're right that that's the
20 prognosis that qualifies you for the benefit, but when it
21 comes to the end of six months, it's not like, okay, you
22 have to leave hospice. That is not a requirement. There is

1 no hard back end. Kim, I'm right -- I'm not --

2 MS. NEUMAN: Yeah, that's exactly it.

3 MR. GEORGE MILLER: And in addition, if you have
4 an event that's not related to the diagnosis, you still have
5 the Medicare benefits for those other services if you're
6 hospitalized.

7 DR. MARK MILLER: That's also --

8 DR. REDBERG: So how many patients --

9 MR. GRADISON: I had a hand in writing the hospice
10 legislation. The six months was taken directly from what
11 was happening in the private sector at the time. There was
12 really no analysis one way or the other. That's just the
13 way it was.

14 DR. REDBERG: How many beneficiaries elect to stay
15 on more than six months?

16 MS. NEUMAN: So I would say that of those that are
17 in hospice in a year, about 20 percent of them are beyond
18 180 days. Now, you know, it's -- I think the default is
19 they continue in hospice unless the hospice says that they
20 do not view them to meet the eligibility criteria any longer
21 or unless they have a change of heart as far as what their
22 goals are. So I think that's kind of how it operates most

1 of the time. And, you know, the live discharge rate that
2 you see, a chunk of that is people who have either gotten
3 better or stabilized. And then there's others who have live
4 discharges very early in their stay, you know, after a
5 couple days in hospice. So it's a real mix in that 17
6 percent number that you were looking at.

7 MR. ARMSTRONG: Briefly, I just will agree, affirm
8 the same point of view as my colleagues that these are two
9 issues we should move forward with and evaluate. I thought
10 David laid out a series of questions that are very similar
11 to the ones that I would have on the first topic.

12 The only other question I would ask would be for
13 me to -- this is a surprise that it was an issue, and I
14 really appreciated learning more about it. The only issue
15 or question I would have would be somewhere I'm sure we have
16 an inventory of all the issues, payment policy issues with
17 the Medicare Advantage program, and why this would rise to
18 the top for us now would just be a question that I would ask
19 relative to the other things that we could be looking at. I
20 just don't know the answer to that question. There may be a
21 good one. But as we go forward with this, I think, you
22 know, to put this particular topic in that context would be

1 useful.

2 On the hospice, again, for all the reasons around
3 synchronizing programs and so forth, this is the right
4 direction to head in. The issues of risk adjustment are
5 going to have to be paid close attention to, and I think
6 it's a great opportunity also for us to talk about hospice
7 is a program that we want our Medicare Advantage patients to
8 be in. And so what might be some complementary quality
9 metrics that we could be examining?

10 For example, in our paper there's a 49 percent
11 national rate of MA deaths in hospice. I know from my
12 organization, our rate is in the high 50s. And so does this
13 payment change give us an opportunity to also make some
14 statements and establish some targets around improving some
15 of those quality metrics at the same time?

16 MR. HACKBARTH: So on your first point about why
17 this MA policy change as opposed to others and whether
18 there's an inventory of other things we're looking at, as
19 you very well know, a large number of changes were made in
20 the Affordable Care Act in MA policy. At least broadly
21 speaking those changes, many of those changes were in
22 directions, general directions that MedPAC had long

1 advocated.

2 That said, it is not exactly what we have
3 advocated in the past, but there was a huge amount of effort
4 put into this reform of Medicare Advantage payment policy.
5 Because of that, my sense has been, well, it doesn't make
6 sense for us to go back again and again and say, well, we
7 would do this differently, we would do that differently.
8 It's sort of time to let it rest for a while.

9 However, this particular issue is one that sort of
10 was left unaddressed by the Affordable Care Act, and while
11 it's not a really big fish, in my view at least, the current
12 policy does not make a lot of sense.

13 And so I -- and help me out here, Mark and Scott.
14 I don't plan to bring lots of other Medicare Advantage
15 payment issues here that this could be coupled with. There
16 is an Medicare Advantage train being loaded up, and so we
17 either do it in isolation or not do it at all.

18 MR. ARMSTRONG: Even those comments were helpful.
19 Just being involved in an MA plan, I've got a lot of big
20 blips on my radar screen. Well, this employer plan was not
21 even on it, and so that was the reason why I asked that
22 question. But, you know, to affirm that we've actually

1 thought that through and just exactly the points you made
2 were actually for me quite helpful.

3 DR. MARK MILLER: And the only thing I would add -
4 - and some of this goes to the exchange between Jon and
5 Scott as well. We're in an environment where people are
6 dealing with sequesters and debt ceilings and everything
7 else, and there's half a billion dollars here that's sitting
8 on the table, and I think that warrants coming back and
9 asking why we did leave it behind. And you're right, we
10 dealt with big issues, and some of the small fish, if you
11 will, were left behind.

12 I would also say offline, if some of those blips
13 you feel we should be dealing with and we're missing them,
14 you should definitely tell us that.

15 DR. CHERNEW: Two things. The first one is I
16 agree with the hospice stuff. Regarding the -- the second
17 thing had to do with the MA plans, so my first instinct is
18 the easiest solution would be to equalize the rules in how
19 you deal with the accounting so you could simply say that
20 the employer plans have to do their accounting of benefits
21 if they want to offer supplemental benefits the same way
22 that the non-employer plans do so that they can't bid at the

1 benchmark and then offer much more generous plans so that
2 the playing field's level.

3 I do agree that this needs more work. My concern
4 with what seems to be the preferred option around, which is
5 Option 2 -- which I don't have a problem with particularly
6 if there was some reason why we couldn't do the other -- is
7 that if there's a plan that's only in the South and the
8 South has a different bid-to-benchmark ratio, they would
9 complain about it; or there's a lot of other aspects that go
10 into making that work for specific employers. I would
11 support that incidentally, although my preference would be
12 to equalize the underlying rules that led to this
13 discrepancy in my belief based on the other question, is
14 that the asymmetry in the rules, is that the employer plans
15 don't have to justify the costs of their added benefits, so
16 they can bid high, avoid the Medicare portion that comes
17 out, and then offer whatever it is they want, which appears
18 to be more generous than actually what the other folks are.

19 MR. HACKBARTH: So, Mike, on your first point, is
20 it that the accounting rules are different for the employer
21 plans? Or is it the absence of competition that results in
22 this different bidding behavior?

1 DR. HARRISON: So we certainly think the absence
2 of competition makes this possible. The other thing is
3 there are differences in the accounting rules, and I would
4 need to look into them a lot more to figure out exactly how
5 they do it. I know that there's -- the employer plans have
6 a waiver for some of this stuff so that the bids are not
7 reviewed as closely.

8 So these plans are offered, let's say Blue Cross
9 offers plans, right? And they may cover thousands of
10 employers. It would probably be pretty hard for them to go
11 through and list every benefit package and what the premiums
12 ended up being, and I would imagine that would be kind of a
13 mess for them.

14 DR. CHERNEW: All right. So I don't actually
15 think it's just competition. I think it's because they
16 don't have to -- maybe because it's administratively too
17 complex. But I think the problem isn't so much lack of
18 competition. It's that they can offer whatever benefits
19 they actually want without having to justify them with a
20 lower bid.

21 DR. HARRISON: Right. That's right.

22 DR. CHERNEW: In fact, I would have argued if the

1 other plans could offer whatever benefits they want but
2 didn't have to justify them with a lower bid, they also
3 would have bid up at the benchmark and then just competed on
4 the benefits underneath to avoid the portion going to
5 Medicare.

6 But, anyway, that aside, the only other thing I
7 would say that I think relates to this is two things:
8 There's a lot of evidence that the competition -- the bids
9 in the non-employer section aren't related to costs either
10 for a bunch of reasons that I won't go into now, or at least
11 particularly closely. And the second thing is I think in
12 many cases it's the same plans. So you could have Aetna
13 bidding in the employer and Aetna bidding in the non-
14 employer. So these aren't different plans in --

15 DR. HARRISON: So that could be another option
16 where you say that Aetna's bid-to-benchmark ratio has to be
17 the same in the two sectors. That might be something we
18 could look at.

19 DR. CHERNEW: So my bottom line is I'm not sure
20 why you can't just equalize -- making them justify it, but
21 maybe it's administratively prohibitive. So thinking
22 through the exact form of the solution is important. I

1 don't have a particular problem with 2, but I see some
2 issues with it.

3 DR. NERENZ: I just want to clarify, for those who
4 really know this, what the nature of the competition is on
5 the employer side. Let's say we're talking about the AT&T
6 retirees, just to pick an example. Every year, do several
7 plans bid for that group of people? And then if so, do the
8 individual retirees --

9 DR. CHERNEW: [off microphone].

10 DR. NERENZ: Okay. Well, how does it work? I
11 just was seeing the shake of the head.

12 DR. HARRISON: Every once in a while, you'll see,
13 you know, a major employer group switch insurers, but I'm
14 not tied into all that literature. But it happens from time
15 to time.

16 DR. NERENZ: And is the competition for individual
17 retiree enrollment in this model? Or do all the AT&T
18 retirees by contract go into whatever plan or plans AT&T
19 selects?

20 DR. HARRISON: Yes, that's what they do.

21 DR. NERENZ: And it's plan singular generally or
22 multiple?

1 DR. HARRISON: I would think they probably have a
2 couple choices, but probably with one insurer.

3 DR. CHERNEW: [off microphone].

4 DR. NERENZ: Within MAs, that's what I'm
5 interested in.

6 DR. HARRISON: Right. And they're going to -- you
7 know, AT&T has got retirees all over the country, so they've
8 got to make sure that they have a plan that bids over the
9 whole country.

10 DR. NERENZ: Okay. And I just want to understand
11 what the nature of the competition is when we say -- and at
12 what level, how often, for whom, who decides. Okay.

13 DR. MARK MILLER: I think that would still drive a
14 high bid, because you're trying to show up at the employer
15 and say these are the many dollars that I have to work with
16 you to build a benefit. So even if I'm trying to steal away
17 the employer, we're both showing up and saying I have 700
18 whatever dollars and this is what I'll do for you, and then
19 the --

20 DR. HARRISON: And the other thing is what the
21 employers are trying to do a lot of times is trying to
22 mirror their under-65 coverage so that the plans look the

1 same. And so that can be pretty hard with the MA package to
2 get it to match. There's probably not one on the shelf
3 that's going to match yours, that you've got to customize
4 it.

5 MR. HACKBARTH: Okay. We're down to our last 5
6 minutes or so.

7 DR. COOMBS: So I support the bid-to-benchmark. I
8 would like a little bit more information about that 17
9 percent. The fact that -- Scott, you brought up the point
10 about the Medicare Advantage versus the fee-for-service in
11 terms of the percentage is 50 percent decedent rate. You
12 can't tell much from that because it might be that if you
13 entrain the right type of patients or people in this group,
14 that the percentage might be even higher, which meant that
15 you did appropriate care for the patients that deserved it.

16 I think it's important to know what the patients
17 look like in both subsets. My problem is really the whole
18 notion of the carve-out, and I know it's the BBA of '97.
19 But the carve-out is part of the problem in terms of not
20 allowing the MA plans to be innovative. If you had to
21 assume 100 percent agency for all the people under your
22 umbrella, you might invoke different policies under your

1 umbrella of patients to say that we want to really make sure
2 we look at palliative care because we're responsible for 100
3 percent; we don't have an opt, we don't have a window out.
4 And I think that going forward, the higher the percentage of
5 Medicare Advantage -- you know, it's 2.6 million versus 11.
6 As you increase the percentage, you would want the MA plans
7 to take more responsibility in the sense that they would
8 have greater control and you would have better vertical
9 integration. Conceivably that's why we're promoting this.
10 So why the carve-out? I think we need to address the carve-
11 out.

12 DR. SAMITT: So in terms of the employer plans,
13 I'm ending up where Michael is. I don't have a clear sense
14 of whether either of these scenarios levels the playing
15 field. I think what we should try to seek out is whichever
16 option levels the playing field. And if what Michael
17 suggests, which is that the employer plan rules need to
18 match exactly MA plan rules to level the playing field, I'd
19 be in favor of that.

20 If employers want to offer supplemental retirement
21 benefits to their retirees, there are other ways to do so
22 other than to fold in additional health benefits.

1 On the hospice side, intuitively it sounds
2 absolutely right. What was most important to me was the
3 notion that including hospice benefits allows plans to
4 really appeal to the patient with concurrent hospice and
5 curative care. I'm where Scott is. I think we need to be
6 talking in a shared decisionmaking fashion with patients.
7 And if patients are less inclined to think about hospice
8 because they're afraid they'd like periodic curative care,
9 then it would make sense to actually bundle the benefits.

10 DR. HOADLEY: So I support the hospice discussion
11 for many of the reasons that have already been said.

12 My only additional question on that is I know you
13 said that one impact on the beneficiary would be if a plan
14 has a more limited network for hospice providers. And
15 obviously, in that case, if they want to use the non-network
16 provider their costs would be higher, and whether there's
17 any other situation that would affect beneficiary costs with
18 such a change. So we should make sure we know about
19 anything that is on the table in that regard.

20 On the employer plan, again I'm supportive of
21 moving in this direction. I had questions about sort of the
22 issue of shifting employers out of this, and that's been

1 discussed. You had brought up in a little bit of your pros
2 and cons some things where the different options might tilt
3 a little more or a little less in that direction. I think
4 it's important that we make sure that we have thought that
5 through, and you have already started to do that.

6 On the options, one of the things that occurred to
7 me was one of the same things that Mike mentioned, which is
8 what about the situation where an employer is pretty
9 regionally based. Now obviously, when we're talking about
10 retirees, they do scatter. But it's different for a large
11 national employer whose employees start out all over the
12 country than if you have a very regional employer whose
13 retirees are likely to stay somewhat in that region. It
14 does strike me that with the national benchmark there could
15 be some odd effects there.

16 And so I think it's useful to think through that
17 and whether that makes that option less attractive. So I
18 would say I'm not sure on which option. I'd like to at
19 least hear some thought about the impact and whether we have
20 any empirical data on the geographic distribution of
21 retirees.

22 The only other thought I wanted to throw in was in

1 thinking about this -- and I should know more about this --
2 but whether there's any parallel on the Part D side with the
3 employer-based benefits. We obviously don't have the same
4 benchmark structure to start from, but we do have a fast
5 increasing number of employers that are putting their
6 retirees into Part D -- I mean, employer-only Part D plans
7 because of the change in the ACA on the tax treatment of the
8 retiree drug subsidy. So that's actually -- the number of
9 employer-only Part D plans has actually tripled in the last
10 couple of years.

11 DR. HARRISON: Right.

12 DR. HOADLEY: And I don't know if there's any kind
13 of bidding issues there.

14 DR. HARRISON: So for D, employer plans bids are
15 not looked at.

16 DR. HOADLEY: That's what I thought.

17 DR. HARRISON: They're excluded from the
18 calculations of the national benchmark. They're excluded
19 from low-income subsidy, I believe.

20 DR. HOADLEY: That's right, I think.

21 DR. HARRISON: So they are excluded.

22 DR. HOADLEY: So, I don't know if, on the bids

1 that are coming in on the Part D side, for their employer-
2 only Part D plans, whether there are some issues -- and I'm
3 going to go back and think about that a little bit -- but
4 that might be something that we should at least be aware of,
5 if there's any kind of parallel issue there.

6 MR. HACKBARTH: Thanks Jack. Good job, Kim and
7 Scott.

8 We now need to move ahead to physician payment.
9 This is a prelude to our December discussion on updates.

10 DR. SOMERS: Good morning. At this session, Kevin
11 and I will review recommendations that the Commission has
12 made previously and could choose to rerun for the March
13 report chapter on physicians and other health professionals.
14 Then we would like to discuss and seek the Commission's
15 guidance on longer-term issues for future work.

16 Specifically, we will review the Commission's
17 standing recommendations on repeal of the sustainable growth
18 rate, or SGR. For the past two years, the Commission has
19 reiterated its position in its March reports. Assuming that
20 our annual assessment of payment adequacy continues to show
21 no significant change in beneficiary access to care, the
22 Commission could reaffirm its position in the March 2014

1 report. We will also review additional recommendations that
2 the Commission could choose to rerun regarding establishing
3 an HHS panel on misvalued services, improving payment
4 accuracy and appropriate use of ancillary services, and
5 reforming graduate medical education. Finally, we will
6 discuss longer-term issues for future work.

7 Yesterday, the Commission discussed in great depth
8 quality measurement across Medicare's delivery systems. For
9 future meetings, the Commission may also want to discuss
10 quality measurement as it relates specifically to payment
11 for physicians and other health professionals.

12 Today, we would like to discuss and hear the
13 Commission's views on another longer-term issue, payment for
14 primary care. We will begin with our review of the
15 Commission's recommendations on repeal of the SGR.

16 The Commission has long held that the SGR as an
17 update formula is fundamentally flawed. The SGR is a
18 formula that was intended to control spending on services
19 furnished by physicians and other health professionals by
20 setting a limit on aggregate expenditures. If actual
21 spending in a year exceeds the limit, then the annual
22 payment rate update for the next year is to be reduced to

1 bring spending in line with the limit.

2 However, tying annual payment rate updates to
3 aggregate expenditures does not incentivize providers to
4 restrain volume growth since those who restrain volume
5 growth receive the same update as those who do not.

6 As illustrated in the chart on this slide, the SGR
7 has not restrained volume growth. Spending per beneficiary,
8 indicated by the red line, is the product of the payment
9 rate and volume per beneficiary. Updates to the payment
10 rate have been modest from 2000 to 2012, as indicated by the
11 green line. But because of the robust volume growth,
12 spending per beneficiary has increased by 75 percent over
13 the same time period. The rapid rise in spending per
14 beneficiary has caused actual spending to exceed the SGR
15 limits every year since 2002, resulting in negative payment
16 rate updates specified by the formula. In response, the
17 Congress has implemented short-term overrides of the payment
18 rate cuts every year after 2002.

19 In recent years, the payment rate cuts called for
20 by the SGR have been particularly draconian. For example,
21 for 2013, the SGR would have resulted in a 27 percent
22 payment rate cut, but the Congress overrode the cut with a

1 payment rate freeze. The Commission has become increasingly
2 concerned that those legislated overrides of the formula's
3 deep cuts are creating instability in the Medicare program
4 for providers and beneficiaries.

5 Moreover, changing budget estimates make it clear
6 that the time to repeal the SGR is now. In October 2011,
7 CBO's estimate of the cost of a ten-year freeze in payment
8 rates was about \$300 billion. Due to slower volume growth
9 in recent years, their current estimate of a ten-year freeze
10 is \$138 billion.

11 The Commission has urged the Congress to act and
12 take advantage of this lower estimate. If history is any
13 guide, volume will reaccelerate and the cost of repeal will
14 increase again. In addition, further delay encumbers more
15 rational reforms and would expose beneficiaries to an
16 increasing risk in the long run of impaired access,
17 especially access to primary care.

18 In developing its recommendations on repeal of the
19 SGR, the Commission adhered to a set of principles. Repeal
20 of the SGR is urgent. Beneficiary access must be preserved.
21 The Physician Fee Schedule must be rebalanced to achieve
22 equity of payments between primary care and other

1 specialties. Pressure on fee-for-service must encourage
2 movement toward new payment models and delivery systems.

3 Working from those principles, the Commission made
4 four distinct recommendations in an October 2011 letter to
5 the Congress and reiterated those recommendations in its
6 March 2012 and March 2013 reports.

7 First, in place of the SGR, the Commission
8 outlined a ten-year path of legislated updates, including
9 updates for primary care services that are higher than
10 updates for other services. The higher updates for primary
11 care services will help bolster primary care for the
12 important role it will play in a reformed delivery system.

13 Second, CMS should collect data to improve the
14 relative valuation of services. As part of the process of
15 determining payment amounts for the 7,000-plus services on
16 the Physician Fee Schedule, CMS assigns relative values to
17 the services based on data, often outdated, from physician
18 specialty societies that have a financial stake in the
19 process. The Commission maintains that CMS needs current
20 reliable and objective data. To meet those needs, the
21 Commission recommended that CMS collect data on a recurring
22 basis from a cohort of practitioner offices and other

1 settings where practitioners work to establish a more
2 accurate relative valuation of services.

3 This leads us to the Commission's third
4 recommendation. With the improved evaluation of services,
5 CMS should identify overpriced services and underpriced
6 services and rebalance the fee schedule accordingly. The
7 Congress should direct CMS to achieve an annual numeric goal
8 equivalent to a percentage of fee schedule spending.

9 And, finally, the four recommendation. The
10 Medicare program should encourage physician movement from
11 fee-for-service into risk-bearing Accountable Care
12 Organizations by creating greater opportunities for shared
13 savings.

14 Now, I turn it over to Kevin to discuss additional
15 recommendations that the Commission could rerun and to
16 discuss payment for primary care as a longer-term issue for
17 future work.

18 DR. HAYES: There are a number of recommendations
19 that the Commission made previously that complement the
20 recommendations that Julie just reviewed. Those
21 recommendations could be restated for the March 2014 report.

22 For example, on the issue of misvalued services,

1 the Commission recommended that the Secretary establish a
2 standing panel of experts to help CMS identify overvalued
3 services. The Commission also made a series of
4 recommendations for improving the accuracy of payments for
5 ancillary services -- these are services such as imaging and
6 tests -- and a recommendation on appropriate use of those
7 services. The recommendations were to, one, bundle payments
8 using comprehensive billing codes; two, reduce payments when
9 multiple imaging studies are furnished during the same
10 session or when imaging or other tests are ordered and
11 performed by the same practitioner; and three, a prior
12 authorization program for advanced imaging.

13 Another set of recommendations to consider would
14 be those on reform of payment for graduate medical
15 education. The Commission recommended a new performance-
16 based GME program in which payments to institutions are
17 contingent on reaching desired educational outcomes and
18 standards, including providing education and training in
19 evidence-based medicine, team-based care, care coordination,
20 and shared decision making.

21 Now, with that, we have concluded the portion of
22 the presentation on possible recommendations for the March

1 report. Let's shift gears now and take a few minutes to
2 talk about a longer-term issue for possible discussion at
3 future meetings.

4 It concerns primary care. In particular, it is
5 the question of whether there is adequate support for
6 primary care under fee-for-service and whether there should
7 be a change in the method of payment for these services.

8 Medicare beneficiaries generally have good access
9 to the services furnished by physicians and other health
10 professionals. However, in both patient surveys and
11 physician surveys, access to primary care practitioners
12 raises concerns more so than access to specialists.

13 One issue with fee-for-service payments for these
14 services is that they can be passively devalued. Primary
15 care services are passively devalued when other services in
16 the fee schedule are overpriced. Unless there is a
17 reduction in fees for the overpriced services, there is no
18 budget neutrality adjustment that would raise the fees for
19 services that are not overpriced, including primary care.

20 Another issue is the concern that fee-for-service
21 does not adequately support care coordination. Fee-for-
22 service payment is payment for uniquely defined discrete

1 procedures that can be billed one by one. By contrast, the
2 cognitive activities that characterize care coordination are
3 focused more on comprehensive team-based care for a panel of
4 patients with diverse needs, one of whom might need
5 management of multiple medications, another who requires
6 counseling on dietary habits, another who needs guidance on
7 use of social supports in the community, and so on.

8 The rationale for supporting primary care is that
9 this care can improve the overall efficiency and quality of
10 care. Research on regional variation and the mix of primary
11 care versus specialty care has shown that a higher share of
12 primary care physicians in a region's workforce is
13 associated with higher quality and lower cost. Further
14 evidence comes from the early experience with medical homes.
15 For example, during a medical home pilot in Rhode Island,
16 cost savings were achieved in the first two years, due in
17 part to reductions in emergency department visits for
18 ambulatory care sensitive conditions.

19 However, there is a caveat on these findings.
20 While acknowledging that a higher share of primary care
21 practitioners is associated with lower spending at a point
22 in time, other researchers have found that the share of

1 primary care practitioners may not have an effect on
2 spending growth. This research suggests that changes in
3 just the composition of the physician workforce may not be
4 sufficient to reduce spending growth.

5 Inadequate support for primary care would also
6 pose risks for the future. Those about to obtain health
7 insurance coverage are likely to increase the demand for
8 health care, including primary care, starting in 2014. In
9 addition, the retirement of the baby boomers will have two
10 effects, one, more Medicare beneficiaries; and two, with
11 retirement of baby boom physicians and other health
12 professionals, there is a loss of those professionals
13 available to provide care. An implication is that new
14 physicians must see primary care as an attractive specialty
15 choice.

16 Steps have been taken to improve payment for
17 primary care consistent with Commission recommendations.
18 PPACA included provision for a Primary Care Incentive
19 Payment Program. The program consists of a ten percent
20 bonus on payments for services billable under the feed
21 schedule and defined as primary care. There are eligibility
22 requirements for the practitioners receiving the bonus in

1 terms of specialty designation and having a practice focused
2 on primary care. The bonus program expires at the end of
3 2015.

4 There are also a number of medical home
5 demonstrations underway. As you heard at the September
6 meeting, they are multi-payer, meaning that Medicare is
7 participating, but also private payers and Medicaid
8 programs. A difficulty with multi-payer demonstrations is
9 that it is difficult to use the results to estimate spending
10 effects specific to Medicare.

11 Separately, CMS is proposing to add billing codes
12 to the fee schedule for complex chronic care management. We
13 can provide further information about this proposal on
14 question.

15 One question Commissioners may wish to consider is
16 whether it's time for almost a change in strategy to
17 overcome the limitations of fee-for-service payment for
18 primary care. One element would be rebalancing the fee
19 schedule. Julie went over the Commission's recommendations
20 on repeal of the SGR. Those recommendations include
21 legislated updates for primary care that are distinct from
22 updates for other services. There is also reduced payments

1 for overpriced services. Also on the topic of overpriced
2 services, recall the point I made a moment ago about the
3 Commission's previous recommendation concerning an HHS panel
4 on misvalued services.

5 So, there are several ideas on rebalancing the fee
6 schedule, but there's another policy option you may wish to
7 consider and that is making payments for primary care a
8 blend of fee-for-service and, say, a monthly or quarterly
9 per beneficiary payment. Reasons to consider this would be,
10 one, it's a way to pay for activities other than face-to-
11 face office visits, activities not adequately accounted for
12 under the fee schedule. Two, it may dampen the fee-for-
13 service incentive to increase volume. And, three, it could
14 build infrastructure for medical homes. The method of
15 payment for medical homes is a per member, per month
16 payment.

17 To actually implement a per beneficiary payment
18 for primary care, it would be necessary to make some design
19 decisions. Which practitioners would be eligible for the
20 payment? If the current ten percent primary care incentive
21 bonus is a model, eligibility could be based on specialty
22 designation or the share of allowed charges derived from

1 services defined as primary care.

2 Another criterion for establishing eligibility
3 might be delivery of prerequisite services, such as the
4 plurality of evaluation and management services. And some
5 or all of the capabilities of a medical home could be
6 considered, capabilities such as providing responses to
7 patient inquiries after normal office hours.

8 The next design decision listed here is linking
9 beneficiaries to practices. If the process for ACOs is a
10 guide, there could be an initial linkage performed
11 prospectively and then a retrospective correction for
12 inaccuracies.

13 Another design decision if implementing a per
14 beneficiary payment for primary care involves deriving the
15 amount of the payment. One approach could be to estimate
16 the cost of resources required for care coordination. This
17 would be staff, equipment, supplies, practitioner time, and
18 price that out in terms of cost per beneficiary, say, per
19 month. This is the approach taken as CMS prepared for a
20 medical home demonstration called for under the Tax Relief
21 Act passed in 2006.

22 Another approach is to aim for a per beneficiary

1 payment that, when totaled, would represent a desired share
2 of practitioners' total payments. For example, the goal
3 might be that, on average, practitioners derive 20 percent
4 of their payments from Medicare via per beneficiary payments
5 and another 80 percent from fee-for-service. The amount of
6 each per beneficiary payment would be set to achieve that
7 goal.

8 One last design decision to mention here would be
9 to identify a funding source. Making per beneficiary
10 payments budget-neutral would be a way to redistribute
11 payments from overpriced services to primary care.

12 To sum up everything Julie and I covered, the
13 Commission has a number of options for making
14 recommendations in the March report on payments to
15 physicians and other health professionals. In addition to
16 reiterating the recommendations on repeal of the SGR, you
17 could have a goal of addressing a broader set of policies
18 and could restate recommendations made previously,
19 establishing an HHS panel on misvalued services, improving
20 payment accuracy and appropriate use of ancillary services,
21 and reform of GME.

22 And then there are longer-term issues for

1 discussion at subsequent meetings: Quality measurement and
2 payment for primary care.

3 That concludes our presentation. We look forward
4 to your discussion.

5 MR. HACKBARTH: Okay. Thank you, Julie and Kevin.

6 Before we do round one clarifying questions, I
7 just want to make a couple additional comments. As I said
8 at the outset, what we're trying to do here is set up the
9 discussion next month on updates for physicians as part of
10 our March report. As everybody knows, the Congress is
11 working on SGR repeal and some associated changes in
12 physician payment.

13 Broadly speaking, the work underway is consistent
14 with past MedPAC recommendations. Could you put up Slide 5
15 for a second. So, those have been sort of the core
16 principles that we have advocated and the legislation now
17 pending, which includes the bill reported out of the Energy
18 and Commerce Committee in the House and then the statement
19 of principles agreed to by the Senate Finance Committee and
20 the House Ways and Means Committee are broadly consistent
21 with these principles that we've been advocating.

22 The idea that I'm offering for your consideration

1 is that what we do in our March report is focus on
2 reiterating our principles summarized here on Slide 5, not
3 vote on any new recommendations or even re-vote on past
4 recommendations. The detail of our recommendations, for
5 example, could be included in an appendix or it could be
6 summarized in the text of the chapter. I don't have a
7 strong feeling about those options at this point. But the
8 key thing would be no new votes, stick with reiterating,
9 emphasizing broad statements of principles.

10 The reason that I prefer that approach is that
11 there is momentum on this issue and the last thing that I
12 want to do is anything that might disrupt the progress now
13 underway.

14 Now, at the end of the presentation, we raise a
15 couple new issues, for example, changes in payment for
16 primary care, and what I want to emphasize there is that's
17 longer-term work. I do not envision that we're going to try
18 to reach a quick conclusion on that or recommendations in
19 the March report. I'm raising those for careful
20 consideration and deliberation.

21 So, that's the context for that and I invite your
22 reactions to that as our basic approach on physician

1 payment.

2 With that preface, round one clarifying questions.

3 Clarifying question, Bill?

4 MR. GRADISON: I'm not sure. It's a very short
5 question and I'd understand if you'd rule it out of order,
6 but my understanding is the AMA has made some announcements
7 recently which, as I understand it, suggest some changes in
8 the way that the relative value, time spend, and so forth
9 will be determined, and that was all since you put your
10 material together. I think it's relevant, but if it's not
11 the right time to ask it or for another day, I would
12 understand that.

13 MR. HACKBARTH: Yeah, let's defer that. I do
14 think it is relevant for something that I want to get into
15 in round two and was alluded to in the presentation. One of
16 our past recommendations has been to change how the RUC
17 process, broadly defined, works, and Kevin indicated that
18 one thing we could do is reiterate past recommendations
19 there. But let's save that discussion for when we get to
20 round two.

21 Round one clarifying question, Peter?

22 MR. BUTLER: Absolutely clarifying. The reiterate

1 SGR recommendation, just so I can be sure I'm crystal clear,
2 the principles are one thing, and I believe we voted on
3 those. Of course, then we had our famous letter that had
4 not only the principles, but if you really want to look for
5 places that may pay for this, here are some things that
6 we've processed. We haven't voted on all of them, et
7 cetera, et cetera. I don't think you mean that as part of
8 what would be submitted. You're just talking about the
9 principles.

10 MR. HACKBARTH: Correct. So, put up Slide 5
11 again. So, you'll notice nothing in here about how to
12 offset, and that is by design --

13 MR. BUTLER: It's clarifying --

14 MR. HACKBARTH: Yes, but I appreciate your asking
15 that because I think it's important to be really clear about
16 this. And so these would be the principles emphasized in
17 the chapter. As I said, one approach might be to say that
18 the text of our October 2011 letter, which is the one Peter
19 is referring to, that had potential offsets, et cetera,
20 could be in the appendix, just as referred to it in the text
21 and the detail is there. But we would not be voting on any
22 particular strategy for offsets. What we are doing is

1 focusing on these four principles.

2 DR. COOMBS: Question. So, would that letter with
3 the offsets, you said, would be in the appendix as it was
4 sent last year? The letter that was sent last year --

5 MR. HACKBARTH: That's one approach, would be to
6 put it in the appendix. You know, it is what we've said and
7 that's the history of it.

8 I would also add that there was a letter in the
9 spring of --

10 DR. HAYES: April of this year.

11 MR. HACKBARTH: -- April of this year, which was
12 much shorter and just sort of updated the October 2011
13 letter, recognizing that now the CBO score for repealing SGR
14 was dramatically lower and that would alter the array of
15 options that Congress has for offsets.

16 DR. CHERNEW: The offsets weren't, you should do
17 these things. They were things to --

18 MR. HACKBARTH: They were options, a list of
19 options for Congress to consider. In fact, let me just
20 pound on this point to make it really clear. So, in October
21 2011, what we said is it's Congress's decision whether or
22 not to offset the repeal of SGR. MedPAC takes no position

1 on that. Further, it is Congress's decision, if it decides
2 to fully offset, whether to fully offset from within the
3 Medicare program or to use increased taxes, reduce spending
4 on defense, whatever. Those issues are Congress's
5 prerogative. We take no view.

6 However, we noted that one of the reasons for not
7 repealing SGR for the last decade has been it cost too much,
8 and so we tried to nudge the process forward by saying that
9 if Congress decides to offset and do it from within
10 Medicare, there are places it might reasonably look for
11 potential savings. So that's the structure of the October
12 2000 [sic] letter in summary.

13 DR. COOMBS: So, my only point was that if they're
14 in the midst of some kind of negotiations, that adding a
15 suggestion like that might be something that might enter
16 into decision making or kind of --

17 MR. HACKBARTH: It isn't adding a suggestion.
18 It's that it's already there. That is our historical
19 position, which is very well known in the Congress. So I'm
20 just trying to envision what the chapter might look like so
21 that somebody who isn't enmeshed in this process can pick up
22 the chapter and read it and understand, oh, this is what

1 MedPAC has recommended in the past, and putting it in the
2 appendix is one way to do that without -- with minimizing
3 the risks of disruption.

4 DR. REDBERG: I have a clarifying question. I
5 think it's a clarifying question. On Slide 9, on the
6 primary care may not reduce spending growth, it stated that
7 in our mailing materials, but I wasn't clear on why that
8 would be true, because all of the data show that primary
9 care is much less expensive, and most of our high-value and
10 very expensive care is in specialist care. Is that because
11 we just would have more primary care practitioners but the
12 same amount of specialty care and that's why the spending
13 growth isn't restrained, or I wasn't sure of the reason for
14 that.

15 DR. HAYES: The distinction here has to do with a
16 one-time change in spending versus a change in the rate of
17 growth in spending. And so the research on a one-time
18 change in spending, you know, comparing one region, one
19 State, let's say, to another, is that there is a -- there
20 can be, potentially, a downward shift in spending with a
21 higher share of primary care physicians and other
22 professionals relative to specialty care.

1 But then there's a separate question of whether
2 that change in mix is sufficient to change the slope of the
3 curve, in other words, the rate of growth in spending, and
4 there, the research has shown that the change in mix would
5 have an effect of a one-time change, but not necessarily a
6 change in the growth rate.

7 DR. REDBERG: [Off microphone.]

8 DR. CHERNEW: I'm sorry. The efficiency of
9 primary care seems to be constant over time. So if primary
10 care, say, always reduces spending by 20 percent or 20
11 percent cheaper, exactly for all the reasons you say, that
12 20 percent seems to be constant over time. So then the rate
13 of growth ends up being constant over time because you're
14 constantly 20 percent less expensive. So the --

15 DR. REDBERG: But it would be a lower growth rate.
16 I mean, you could have -- you've shifted the whole curve
17 over. I mean, you --

18 DR. BAICKER: Which is a lower level, not a lower
19 growth rate.

20 DR. REDBERG: -- the absolute amount would be less
21 over time, but just the rate --

22 DR. CHERNEW: [Off microphone.] This will

1 probably be semantic, and we can discuss it when everyone
2 else is asleep.

3 MR. HACKBARTH: And this has sort of a round two-
4 ish feel to me.

5 [Laughter.]

6 MR. HACKBARTH: So, round one clarifying
7 questions. Any others?

8 [No response.]

9 MR. HACKBARTH: Okay. So, let's begin round two,
10 and Craig is going to lead off.

11 DR. SAMITT: So, can we go back to Slide 5. I'd
12 start by saying I wholeheartedly endorse your
13 recommendation, Glenn, that we restate the prior
14 recommendations for repeal of the SGR. It's of critical
15 importance and we must underscore it yet again.

16 The only supplemental concern I would offer is
17 about the fourth bullet, that I want to be sure that we
18 underscore the imperative to move toward alternative
19 delivery systems. You know, while we want to stabilize fee-
20 for-service rates and we want to ensure access for
21 beneficiaries, I believe we also want to allow physicians
22 who participate in ACOs or MA to fare better than fee-for-

1 service, and so I think that point needs to be underscored
2 so we don't drift back to security with fee-for-service. We
3 want to continue to overcome inertia and move forward. So
4 that would be my only concern about these recommendations
5 and wondering if there's any other way to underscore that
6 fourth bullet.

7 The other thing that I very much would echo your
8 sentiments is all of the other supplemental recommendations,
9 I endorse nearly all of them, and they all need to be very
10 thoroughly vetted and evaluated and explored separately
11 because I think they stand alone on their own merits, that
12 these are many additional supplemental opportunities that we
13 should consider. First and foremost, strengthening the
14 payment to primary care, considering a modification of the
15 payment methodology to primary care, and focusing on the
16 valuation of RVUs to make sure that overvalued services are
17 redone.

18 The only personal experience that I would
19 underscore is about the primary care methodology shift. I
20 would thoroughly endorse a blend focusing on a per
21 beneficiary payment for all the reasons that you described,
22 and I may have missed whether you underscored -- for me, one

1 of the most critical points is that if we ultimately want to
2 tie quality bonus payments for fee-for-service
3 beneficiaries, we now have a vehicle to apply bonus payments
4 on a population chassis, not a fee-for-service chassis. So
5 one of the elements of compensation redesign that we've
6 always done in my organizations is we want quality bonuses
7 to be applied per population unit, not per RVU, or not per
8 fee-for-service unit, because it doesn't further enable or
9 endorse a fee-for-service-based approach.

10 So, I think I'll leave it at that.

11 MR. HACKBARTH: Thanks. While we have Slide 5 up,
12 I meant to mention something about the third bullet,
13 rebalance payments for primary care and other specialties.
14 There's two distinct -- they're related but still distinct --
15 ideas here. One is increase payment for primary care.
16 Another is to rebalance between evaluation and management
17 versus procedures, imaging, et cetera. And in the past,
18 MedPAC has endorsed both of those.

19 So, you know, within a specialty -- you know, take
20 cardiology -- we would like to see a rebalance between, you
21 know, interventional cardiology and the procedures done
22 there versus evaluation and management services done by

1 cardiologists. We think there are some errors in how those
2 relative values are set. So isn't all just primary care
3 versus specialties. There's some within-specialty
4 rebalancing that needs to be done as well.

5 So I'm going to come to you in a second, Alice. I
6 want to do Jack next so he doesn't end up being last two
7 rounds in a row.

8 DR. COOMBS: [off microphone] me next time.

9 MR. HACKBARTH: Yeah.

10 DR. HOADLEY: So on the general issue of repeating
11 the recommendations, I'm very supportive of that. I was not
12 on the Commission when various of these recommendations were
13 done, but had I been, I would have been supportive of them,
14 and I think our repeating them is a way -- if that's true
15 for most of the Commissioners who have come since those were
16 done, it's a way to sort of at least implicitly acknowledge
17 ongoing support.

18 On the primary care issues, I think there's some
19 really interesting stuff in what was put in the
20 presentation, and I really encourage going forward. There
21 are some questions that I have that I think are -- I'd like
22 to hear more of as this goes forward. One is the 10 percent

1 bonus. You know, do we have any sense of its impact? Do we
2 have any sense of how much physicians are really even aware
3 that it's out there and then whether there's been any kind
4 of behavioral impact? So partly, you know, that says
5 whether just a straight increase is something that makes a
6 difference.

7 Second, on the medical home demonstrations, you've
8 pointed out some of the difficulties, but to the extent that
9 we have any evidence of whether some of the approaches with
10 that have helped in some of the ways we're interested in, I
11 think that would be great. Maybe that's just not possible
12 given some of the design issues.

13 On some of the other issues you raised, I think
14 one of the things I find difficult is to think about on this
15 notion of a per beneficiary payment, sort of how do you link
16 -- it's the same issue we talked about yesterday with ACOs
17 and some other stuff. You know, how do you link the payment
18 to a particular beneficiary? You know, is this going to end
19 up requiring some kind of attestation or attribution or
20 something, and sort of how do we think that true in this
21 particular context, and whether that's just a necessary
22 complication?

1 Some of the criteria you put on for thinking about
2 something like the 24-hour access, which makes a lot of
3 logical sense, what's the administrative feasibility of
4 doing something like that? Do we need to collect -- is the
5 government going to have to collect office hours for
6 everybody? And that might not sound like a good route to go
7 down. So how do we get that concept without creating some
8 kind of an administrative issue.

9 And then you mentioned the CMS care management
10 code. Obviously it would be helpful to see how that
11 compares with some of the other ideas that we have on the
12 table.

13 So those are just the kinds of things that I think
14 would be helpful as we think this through.

15 DR. COOMBS: One of the things -- of course, I
16 support the repeal of the SGR and preserving beneficiary
17 access. But one of the things I wanted to talk about was
18 the non-face-to-face time, which is really huge in primary
19 care offices in terms of being able to do what you need to
20 do to keep patients out of the emergency room, actually
21 intervene at a level where you don't necessarily have to
22 have the patient come to the office, but you might tweak a

1 diuretic or something to keep the patient from going into
2 congestive heart failure. So I like the per member per
3 month specifically because it incentivizes care that doesn't
4 have to happen in the office.

5 And medical homes, we all talk about medical
6 homes, and some of us believe that medical homes have always
7 existed in medicine. But indeed it's being able to do a
8 continuum of care and having a system readily available for
9 patients. So I know that that would impact just the
10 throughput for the beneficiary.

11 This whole piece about getting it right with
12 payments for primary care is huge. I was an internist at
13 one time, and I can tell you that the decisionmaking for the
14 provider is what do I do to get to the next level of being
15 able to cover just the cost of doing business. That varies
16 from urban areas to rural areas, and something has to
17 happen. And I agree with you, Glenn, that the primary care
18 workforce is a very fragile workforce, and it's fragile from
19 a number of perspectives in terms of the absolute number,
20 the quality of the experience, the turnover, and many
21 believe that because of the percentage of doctors who are 55
22 or older, if the stock market does very well, maybe we'll

1 have an efflux of doctors who will retire, and then we'll
2 really be in trouble, because some communities might lose
3 one or two primary care doctors that may have been covering
4 3,000 patients or so, and then that community suffers
5 tremendously.

6 So I support all four of these, but I wanted to
7 say something about the GME and what we do to grow the
8 primary care workforce. There is a workforce commission
9 that is unfunded, and I know there is a recommendation for a
10 panel for HHS looking at this. But there's a workforce with
11 people who have already been assigned. It's unfunded, it
12 has not met. But it's fully equipped to actually deal with
13 some of the issues around primary care workforce, and I
14 think the primary care workforce is a conundrum that will
15 affect beneficiaries going forward. And if we can get this
16 piece right, it would be huge. But I think it's going to be
17 us looking at the resources that are out there already,
18 that's all positioned to actually deal with those issue of
19 primary care workforce.

20 MR. HACKBARTH: Let me just build on Alice's
21 comment for a second. As I think about the potential of
22 changing the payment method for primary care from solely

1 fee-for-service to at least a blend of per patient and fee-
2 for-service, what interests me is not so much the notion
3 that if we had stronger primary care it will reduce total
4 costs or that it will improve quality. I'd love for that to
5 happen. I personally believe that that would happen. But
6 as Kevin reported, the evidence is uncertain on that.

7 For me, the most compelling reason to change the
8 payment method for primary care is to facilitate a change in
9 the production function, if you will, for primary care.
10 Fee-for-service payment is a straitjacket. You only get
11 paid for certain types of activities, heavy emphasis on
12 face-to-face activities. If dollars flow on a per patient
13 basis, it allows freedom to build primary care practice that
14 will make a lot more sense, potentially can see more
15 patients, by bringing in non-physician people into producing
16 primary care as efficiently as possible. In fact, by
17 happenstance, I read a series of articles in Health Affairs
18 in November related to this issue, and I borrowed the term
19 "changing the production function" from one of those
20 articles.

21 And so we're not going to resolve this issue
22 today, but as we talk through it, that is as much my

1 orientation as, oh, robust primary care is going to reduce
2 total costs or improve quality, even though I believe that
3 to be the case.

4 DR. CHERNEW: So I support the rerunning of the
5 other recommendations. Half of my comments were going to
6 say what you just said, so I won't say them.

7 I want to pick up on something Jack said, which is
8 I'm intrigued by the notion of blending payment, in part
9 because it helps us push to accountability, and precisely
10 because we might have to work through issues of attestation
11 or whatever it is, making sure that you have a place to go,
12 I actually like that feature of it, although it needs to be
13 thought through some.

14 The last two quick points. I like the idea of
15 funding some of this payment for primary care by reducing
16 the prices of overpriced services. But I don't particularly
17 like the idea of mechanically always saying that things are
18 budget neutral. I think that thinking pushes us to get
19 prices wrong, and it has been part of the way we have gotten
20 into this problem. If we think the price for something is
21 right, I don't see why it should change when the price for
22 something else changes. And sometimes that works in our

1 favor, and then we seem to like it. But other times it
2 works against us, and then we're stuck in this conundrum.
3 So I don't like the principle of things being budget
4 neutral, but I do like the notion of paying for more primary
5 care by reducing the price of overpriced services.

6 MR. ARMSTRONG: I would also just say you guys
7 said most of what I wanted to say, but first I want to
8 affirm the principles around SGR. I think it was a really
9 excellent product from this Commission's work, and I'm proud
10 of it, and I think we should remind people that we did that
11 work however we can.

12 And then I'm very excited about these issues going
13 forward. I just would add that the two points in particular
14 I wanted to make. We're shifting dramatically our primary
15 care workforce from physicians to nurse practitioners, and
16 we're finding that the pharmacists and other staff that are
17 part of that team are as important as the primary care
18 doctor. And so the way we set up the payment structure
19 really needs to reinforce the value of that team and the way
20 that they work.

21 And then, second, we have -- many of our primary
22 care practices now, 60, 70 percent of the visits are

1 virtual. And everyone benefits from this and loves this.
2 But outside of MA, we don't have any mechanism for paying
3 for that.

4 And so if those are the kinds of issues that we're
5 going to deal with, I think that's a very exciting prospect.

6 DR. REDBERG: And I will also just build on, for
7 example, what Scott just said about -- and Alice did as well
8 -- rebalancing primary care, because I think that is a great
9 strategy, particularly to include the non-face-to-face time,
10 because it strikes me it also ties into what we were talking
11 about yesterday and the potentially preventable emergency
12 room visits, because certainly in my specialty of
13 cardiology, so many of the admissions that I see for very
14 atypical chest pain, which I think if it had been seen in
15 the office, would have never gone to the emergency room,
16 tell me they tried to reach their primary care doctor, there
17 was as covering doctor, there was a covering nurse, there
18 was someone who didn't know them, who didn't feel
19 comfortable, even if they heard atypical chest pain,
20 nothing, go to the emergency room, but it was clearly a
21 preventable visit if someone -- if their doctor had been
22 able to talk to them. And so I think there's a lot of

1 potential, but right now a lot of people don't, you know,
2 there's no reimbursement for phone and e-mail. Most of now
3 with electronic health records can message, and I get lots
4 of messages, which is really efficient, but no
5 reimbursement.

6 And then on the SGR, I certainly agree with just
7 reiterating what we had already stated and not adding
8 anything new at this time, because it's just time to move.

9 I would just point out on Slide 2, it's quite
10 striking, but I'll just say it. You know, the problem isn't
11 so much with the payment updates. It's that the volume has
12 increased incredibly, and Congress overrode the formula. I
13 mean, that's the urgent part, is that volume is 80 percent
14 up since 2000. And what have we gotten for that increase in
15 volume. I mean, to me, that's what we urgently need to
16 address, is what's driving that increase in volume. Are our
17 beneficiaries better off? We know that estimates are 30
18 percent of what we're spending now is waste and
19 inappropriate care or care that's making beneficiaries
20 worse, and that to me is the urgent problem. So, yeah, we
21 should get rid of SGR, but we also need to look at -- we
22 know a lot of that is in imaging, and, you know, we know

1 that physicians that have financial ties to imaging centers
2 have a much higher use of imaging and that we need to
3 address that. The self-referral is still an issue.

4 Proton beam was mentioned recently because I think
5 one of the societies -- and they're choosing wisely, which
6 we mentioned yesterday -- named proton -- I think it was the
7 Radiology Society said we should be --

8 MR. HACKBARTH: Oncology [off microphone].

9 DR. REDBERG: Oncology. Because proton beam
10 scanners, which I believe too are being acquired by centers
11 locally and certainly around the country, are very
12 expensive, and a lot of what they're used for is prostate
13 cancer. Medicare pays very generously for this treatment,
14 although there is absolutely no evidence that it's any
15 better than much less expensive treatments, and actually
16 most of prostate cancer that's being treated probably should
17 not be treated. And so I think if we really want to get at
18 the problem in SGR, the problem is in that high-volume and
19 high-cost services that not only have no benefit but are
20 probably more risky for our beneficiaries.

21 And just the last thing, in that regard, you know,
22 with addressing the new technologies, which is some of what

1 drives it, CMS is using in some new technologies, as you
2 know, coverage with evidence development, and I just think
3 we should encourage because that allows new technologies to
4 be covered but also to collect data, and CMS needs to go
5 back, look at that data, have it publicly available, and
6 decide if the coverage is appropriate or not.

7 MR. HACKBARTH: Thank you.

8 DR. NERENZ: I certainly like the general
9 direction here, and I just would echo and support things
10 other folks have said about flexibility in payment to
11 support things like virtual visits, messaging, teams that
12 include non-physician providers -- all good.

13 I just want to point out that there's an
14 opportunity here to weave a few things that we have talked
15 about under other topics, including, for example, the issue
16 of attestation that came up yesterday in the ACO discussion
17 in this discussion; that is, if there's going to be a PMPM
18 payment or perhaps a billing code-based payment for care
19 coordination the way that we're currently seeing coming,
20 that depends on the existence of a defined relationship, and
21 I think we should really look here for the opportunity to
22 use the payment system to establish that relationship, A, to

1 build on it but also to establish it, including things as
2 basic as some sort of billing code through with a physician
3 would claim care coordination responsibility for a patient.

4 Now, maybe that can be attested, you can match,
5 different ways, but at least there are opportunities to do
6 that. I would just suggest as a little side branch to that
7 thought that there may be special circumstances under which
8 a specialty physician would actually be carrying, and
9 appropriately carrying, care coordination responsibilities
10 for a patient across the whole spectrum. So whatever we
11 design should allow that when appropriate.

12 But my key bottom line point is that I think we
13 have an opportunity here to build systems in which the
14 relationship of longitudinal care coordination is clarified,
15 and then from that point, quality measures can be built,
16 like, you know, again, who's responsible for something like
17 per capita costs? Well, now there's a clearer way to do
18 that. So let's look to clarify the relationships.

19 MR. GRADISON: I fully agree with the general
20 drift of the conversation and think very highly of the paper
21 itself.

22 I am skeptical that just adding a per member per

1 month payment will change behavior unless the physician or
2 the group of physicians is involved in some kind of a risk-
3 sharing arrangement. I get more money, I don't have to do
4 anything to get it, I think I'm practicing appropriately
5 already. There's something in there that I'd like to think
6 more about.

7 Second, I absolutely agree that we should think
8 through ways to facilitate more non-face-to-face interaction
9 between providers and patients. But I want to stress that
10 this is not a primary care -- this is not limited in any way
11 to primary care, and as a matter of fact, when you think
12 about telemedicine, the great potential there is using non-
13 face-to-face contacts to bring specialists into discussions
14 where they might not otherwise be available, particularly in
15 rural areas, but not just in rural areas. So I agree with
16 the drift there, but I think we shouldn't just say, well,
17 this is just a primary care-related situation.

18 My main point is this: that Congress may or may
19 not do something about this. If they do something about
20 this, I think we only at that point in time should decide
21 what we want to write down, or even whether we want to
22 include something in the appendix. The reason I say that is

1 that I could envision the Congress doing an excellent
2 overall job of dealing with the SGR, but perhaps not doing
3 any anything significant to rebalance payments for primary
4 care and other specialists. There are other ways to deal
5 with this thing that they might do. And yet we consider
6 that, as we should, a very fundamental principle and
7 objective.

8 To be more direct about it, if they do some things
9 that we like and some things that we don't think are
10 adequate at all, and we just restate our earlier principles
11 that look like could easily be interpreted, and probably
12 correctly, that we were critical of an action they just took
13 -- and I don't know we want to get in that position. I'm
14 not suggesting anybody consciously is trying to get us in
15 that position, but let's just see what happens there, is my
16 -- just take it easy. See what happens there, and then
17 decide what we may think would be appropriate at that stage
18 to say.

19 Even SGR, which when it was first passed had its
20 critics, who turned out to be right, didn't -- including
21 this Commission, as I recall the history, it took a few
22 years before they really stepped in and said it isn't

1 working, change it. That isn't necessarily something you
2 want to do the day after the President signs the
3 legislation.

4 Thank you.

5 DR. HALL: Well, I think this whole area is to me
6 one of the most exciting things that we're doing. I think
7 we're really on the cusp of being able to make very much
8 meaningful change in the way health care is delivered in the
9 United States, and that's just huge.

10 I just want to say a word about GME, which is one
11 of the points and additional things we might want to talk
12 about. I think America's medical schools need some kind of
13 increased traction in this arena of turning out primary care
14 doctors or the new kind of primary care doctor. And I don't
15 know where that's going to come from, but to the extent that
16 we look at GME, why can't we link rewards for GME to some of
17 the other endpoints, the outcomes that we've been talking
18 about this whole Thursday and Friday? What happens in the
19 service areas around a medical school? What impact are they
20 making on population health in their service area? What are
21 they doing in terms of changing the production function that
22 you've talked about here?

1 I think we could have a profound influence on this
2 next generation of physicians by taking the paradigms and
3 some of the experience of people on our Commission here to
4 really move this whole process and rationalize in terms of
5 physicians and other providers. It really needs a boost.
6 It really needs a kick to get going.

7 DR. CHRISTIANSON: So as the newest Commissioner,
8 obviously I wasn't involved in the discussions that
9 generated the principles, but they seem reasonable and
10 worthy of support.

11 On some of the specific issues beyond the general
12 four principle, these are probably more clarification than
13 anything else.

14 On Slide 2, the panel for misvalued services, was
15 that a panel that would actually have power to do anything?
16 Or would they just recommend that CMS do something?

17 DR. HAYES: The panel would advise the Secretary
18 on RVUs for the fee schedule. The concern that the
19 Commission had was then, and even now, that the primary
20 source of advice to CMS on these matters is coming from the
21 AMA specialty society relative value scale update committee,
22 a RUC, and that that is, you know, kind of dominated by

1 those interests. And so there needs to be another group
2 that would provide some balance, some additional expertise
3 in areas of economics, technology diffusion, and so on that
4 would help --

5 DR. CHRISTIANSON: I see. On the comment on Slide
6 4 on temporary overrides of deep cuts creating instability,
7 maybe if that's going to be a basic argument, in the future
8 more detail, it seems to me like the SGR has created a
9 remarkably stable situation for price changes over time, as
10 you have illustrated in your graph. And volume has
11 increased, but on a remarkably year-to-year percentage rate.
12 So some more just discussion of that would be helpful for
13 me, whereas the instability, what is instability here? And
14 what are the problems that instability is creating?

15 Then on Slide 7 -- these are just requests, so you
16 respond. Slide 7, I would be interested in some updated
17 evidence on imaging. My sort of recollection, which may not
18 be right, is that the rate of increase in imaging costs for
19 Medicare beneficiaries has, in fact, slowed, but it would be
20 nice to see some data on that. That's a fairly intrusive --
21 the pre-certification of imaging is a fairly intrusive step,
22 and if, in fact, the rate of increase in imaging has slowed

1 substantially, I think we need to revisit that.

2 And then, finally, on the primary care blended
3 payment, I think it's an intuitively attractive proposal,
4 but I think we need to worry about the implementation issues
5 of this. On the health care home demonstrations in
6 Medicaid, there are providers who are not actually even
7 bothering to request -- going through the paperwork to
8 request the additional dollars for care management. You may
9 think that's just leaving money on the table, but it isn't
10 from the standpoint of some of them because of the changes
11 in billing processes and documentation costs associated with
12 it, and the low reimbursement for primary care anyway, the
13 10 percent doesn't turn out to be overcoming those costs,
14 and I would be happy to facilitate a conversation between
15 staff and some of those folks who aren't doing it so that
16 you can have some sense of, you know, it's not just let's
17 put 10 percent out there and everybody is going to change
18 their behavior or rush to claim it.

19 MR. HACKBARTH: Could I just go back to the RUC
20 issue? When Bill Gradison raised it earlier, I meant to go
21 back to it when it came Bill Gradison's time in Round 2.

22 I think a common misconception is that the AMA

1 specialty society sponsored RUC actually makes the decisions
2 about Medicare relative values. The decision authority
3 rests in CMS and the Secretary of HHS. The RUC is an
4 advisory body.

5 Now, in fact, a high percentage of decisions since
6 the beginning of the RBRVS have, in fact, been consistent
7 with RUC recommendations, but not all of them. And, in
8 fact, the number that are different than RUC recommendations
9 has grown somewhat in recent years.

10 What we recommended -- and what year was this,
11 Kevin, that we made our recommendations on reform?

12 DR. HAYES: 2006.

13 MR. HACKBARTH: 2006. Wow, a long time ago. What
14 we said was basically two things. One, we thought that the
15 Secretary should be less dependent on the RUC as a source of
16 expertise, and the panel alluded to here within the
17 department would be a source of expertise, and we thought
18 that people from a range of perspectives could contribute.
19 As opposed to just having the specialty society physicians,
20 we thought maybe medical directors from health plans,
21 medical directors from large multispecialty groups, et
22 cetera, had experience that would be relevant for making

1 these judgments. So another source of expert opinion.

2 Then the other path was we thought that also there
3 should be alternative sources of data. You know, the basic
4 activity of the RUC is to use surveys of physicians to
5 calculate relative values for different services. We've
6 said that we think that there are other potential sources of
7 data that might be used to calculate relative values and,
8 you know, we don't need to go into that right now. But that
9 has been the thrust of our recommendations.

10 You, the Secretary, are the decision maker, don't
11 be so dependent on the RUC for either expertise or data,
12 let's get some others.

13 And I think it's worth emphasizing that now
14 because there is a lot of interest in this Congress. There
15 are some provisions in the SGR bill that relate to this
16 broad area, and so I think maybe in our chapter sort of
17 highlighting our past recommendations on that makes some
18 particular sense.

19 MR. BUTLER: Slide 2, please.

20 I'll try to specifically answer your questions
21 here.

22 On reiterate the SGR, of course. But I would

1 reiterate again, I think that the letter that we sent in
2 2011, I wouldn't have it even as an appendix. I think we
3 talk long and hard about how we process things here and what
4 we formally vote on. And we didn't even vote on that
5 letter.

6 So embedding it, even as an appendix, kind of
7 makes it sound as if we voted on that. And even some of the
8 menu of the offsets are things that we would think, at this
9 point, are kind of stale. Some have passed and some
10 haven't. So I'm not anxious about having that letter as
11 part of the report. But I'm very supportive of the
12 recommendations.

13 With respect to other recommendations to include,
14 I am very supportive of past recommendations being advanced
15 as a principle, in general.

16 I'm a little less clear about the GME one, in part
17 -- not because I'm not pleased with what we came up with
18 some five years ago, but it's five years ago. Most of the
19 Commissioners here were not part of that. It raises a lot
20 of -- and Glenn, you well know how complicated that is.

21 I think the basic principles we would still be
22 very supportive of. But if we just put that in the

1 physician chapter, too, where it really is a hospital
2 payment issue -- we're kind of bringing in a whole range of
3 other issues that may feel -- the Commissioners that were
4 not part of that, we're going to revisit all of those things
5 as we put that right in the chapter.

6 I don't have a problem really putting it back in
7 there, but I think it might look a little awkward because
8 it's not directly at these payment issues. It's about
9 aligning and reforming the pipeline of new graduates coming
10 through.

11 So that's -- I would favor not having that piece
12 in but I wouldn't fall on my sword over it either. That's
13 just my feeling about it.

14 Lastly, on the primary care. I first thought that
15 this was -- how are we going to get them more money so we
16 can get more primary care physicians. And I was feeling if
17 that's what we're doing, it's not so great. We need to look
18 at the broader issues, as Scott was alluding to.

19 And then I got really intrigued by the primary
20 cap, actually, because it is the way to rationalize the e-
21 visits. It's the way to rationalize the pipeline of APNs
22 and Pas -- which by the way, you can produce a lot faster in

1 a hurry, compared to what you can ever do in internists and
2 family physicians. That pipeline is long. And if we don't
3 use the alternatives, we'll never get from here to there.

4 And another reason to further explore the primary
5 cap, I think, is that if you don't, these e-visits and these
6 other fee-for-service embedded in primary care may take off
7 in unintended ways on their own. We start paying for these
8 things and you may get more or less of them than would be
9 idea.

10 Whereas, if you have a kind of a cap that handles
11 all of primary care, it permits the rationalization of those
12 services and the coordination in a way that is going to be
13 better than if they fall into yet another kind of fee-for-
14 service silo.

15 MR. HACKBARTH: On the first issue about what to
16 do with the SGR letter, let me suggest this for everybody's
17 consideration. The October 2011 letter was actually a mix
18 of things on which we voted and did not vote. So it
19 included some bold-faced recommendations on which there were
20 recorded votes. But it also included, as we've discussed,
21 this menu of potential offsets which we did not vote on one-
22 by-one and said if the Congress decides to offset through

1 Medicare, here are some options to be considered.

2 So one approach would be to, in a text box in the
3 chapter, repeat the things that we voted on from that letter
4 and then don't include the other stuff, which I think
5 addresses your issue.

6 MR. BUTLER: Anything we've voted officially as a
7 Commission, I'm totally comfortable with restating. I just
8 don't want them weaving into a long list of those menu
9 options in a way that leads them to conclude that yes,
10 that's what we voted on, that's what we recommended.

11 DR. COOMBS: I just want to say something to that
12 effect, and I'm in full agreement with that. It was the
13 offsets that I had a problem with.

14 DR. BAICKER: Yeah, my take was very similar to
15 Peter's of, of course, repeating the overall SGR principles,
16 uncomfortable including the letter, again for that reason.
17 And it seems actually potentially counterproductive, given
18 the process that's going on. I don't know whether including
19 a subset of the things that were in the letter then adds
20 more confusion or not, but I don't have a problem with that
21 in principle.

22 As for the direction of the blended payments for

1 primary care, I found that intriguing as well, and it seems
2 like a great possibility to explore. You raised a number of
3 logistical issues that I think mean it's got to be on a
4 slower track to figuring out what's going on. I can imagine
5 many other issues as well, in terms of creating sharp breaks
6 between who's eligible for those payments and who isn't
7 based on the share of their care that falls into one bucket
8 versus another. Just a small thing like that seems like it
9 has the potential to create all sorts of gimmicks. Okay,
10 you take three of these patients and I'll take five of those
11 patients. And you could get a very unexpected change in
12 total spending.

13 So there are lots of little implementation issues
14 that would need to be worked out, but it seems like a really
15 intriguing and potentially great direction to go in.

16 MR. GEORGE MILLER: Yes, and I will echo what most
17 of my colleagues have already said about the repeal of the
18 SGR, while urging what Peter and Kate just said as bears
19 repeating.

20 Obviously, to preserve beneficiary access and --
21 Jon, although you weren't on the Commission at the time, one
22 of the concerns of the access issue with SGR was the fact

1 that it was just creating so much uncertainty because of the
2 fear of the potential cuts each year. And that's why we
3 addressed it that way. That was the issue. Not the fact
4 that the curve had gone up. There was no question -- but
5 the potential -- in my organization there are several
6 organizations, physicians were just concerned about the
7 uncertainty. Are we going to get our payments cut? Will we
8 have to stop seeing Medicare patients? And that whole nine
9 yards.

10 I do like the discussion that has already taken
11 place about the blended payment, new payment, but as already
12 has been stated how we do that is a cautionary tale to make
13 sure we do it to give flexibility. I, for one, have visited
14 Scott's organization. They do a great job. And the fact
15 that they've been able to be creative and have virtual
16 visits, you should give organizations that flexibility by
17 providing the framework.

18 One of the things that I think that we will be
19 able to do with that is provide the fact that we could
20 improve population health, drive quality metrics, and give
21 primary care physicians and those who treat patients the
22 tools to make decisions about what is best. And then have

1 the tools and decision not to do some things because they
2 will be compensated for providing that counseling and that
3 information versus just passing it on to someone else
4 upstream. We really will create the type of environment we
5 want to have. I think that's important.

6 So I support the recommendations.

7 DR. NAYLOR: So in terms of the March report, I
8 can't believe two years have elapsed since -- champagne
9 corks popping. I would reiterate the SGR recommendations.
10 I think the additional recommendations in terms of an HHS
11 panel on misvalued and all of the others.

12 In reforming graduate medical education, I would
13 also encourage us to look at the results -- still early --
14 of the demos on graduate nurse education as a key point.

15 On longer term and primary care, I would encourage
16 us to really think about this as an opportunity to really
17 build on what we're knowing about reconceptualizing primary
18 care and maybe even basic language of understanding.

19 Most people see comprehensive continuous
20 coordinated care as the definition of primary care. So I
21 think that making sure that we're all starting with the same
22 understanding.

1 And maybe this might be an opportunity to think
2 about primary care workforce as our language rather than
3 physicians and sometimes other health professionals.
4 Because we are talking about an opportunity -- as Alice has
5 suggested -- for workforce redesign that's aligned with the
6 changing needs of Medicare beneficiaries.

7 On the issue -- and I would also suggest, as Glenn
8 has and others -- the evidence base around this is pretty
9 robust and it grows. So we really want to be make sure that
10 we're proposing the kind of redesign aligned with people's
11 changing needs that also matches our opportunity to promote
12 access and quality and efficiency.

13 With that said, the blended payment, I am -- I
14 think we want to pay attention -- I spend my life in care
15 coordination -- but in this notion of is that the best
16 strategy as you think about getting especially to stratify
17 the Medicare population. Some need a lot of care
18 coordination, people with multiple complex conditions,
19 frailty, and so on. And others need access to a great
20 clinician who can delivery primary care services.

21 So I wonder about whether or not we also need to
22 think about a performance framework, which says -- and I

1 love the idea of quality measurement -- but a performance
2 framework that says we're paying for qualified clinicians to
3 deliver the right set of services rather than adding an
4 extra payment for care coordination, which is inherent -- it
5 should be our definition of primary care.

6 I don't know if that made any sense, but I am
7 worried about adding another payment when we have the
8 opportunity to reconceptualize what primary care is to align
9 with changing needs of people.

10 MR. HACKBARTH: I think of it not so much as an
11 extra payment, but a different way of the dollars to flow
12 potentially to support the reconceptualization of primary
13 care.

14 DR. NAYLOR: That would be great.

15 MS. OCCELLO: Okay, I am supportive of the way
16 you're framing the March chapter. I think a text box makes
17 sense. I could have gone either way on the appendix, but I
18 think where we've arrived at now is good.

19 In terms of the blended payments, I am excited
20 about pursuing this more and exploring the options and
21 really fleshing out what a lot of these different decisions
22 are and the implications of the different options underneath

1 them.

2 Some people have talked about -- I think our
3 challenge here is going to be to strike the right balance
4 between being prescriptive in terms of requirements versus
5 allowing flexibility to allow organizations to use different
6 mechanisms to achieve quality results.

7 Jack raised a good question about if we can
8 evaluate that 10 percent bonus. I'm wondering though, given
9 that it's temporary, how much stock we can actually put into
10 whatever changes there are. But it might be interesting.

11 And I just want to add one thing on the imaging.
12 I think -- and Scott can correct me if I'm wrong -- I think
13 that the growth has slowed. But I think we found that the
14 levels themselves are still pretty high in that it still
15 makes sense to be looking at this. I see Rita nodding.

16 DR. MARK MILLER: In the interest, I didn't
17 respond at the time, but that is sort of the position the
18 Commission has taken. Rightly or wrongly -- and you can
19 decide that -- there has been a slow down but still a real
20 sense that there's still a block of imaging that goes on
21 repeatedly. And we've made some payment recommendations and
22 then, in the past, we had mad the prior auth.....

1 MR. HACKBARTH: Okay, we have about 12 minutes
2 left for this session. It's okay for us to end early and
3 get out early.

4 I did want to just spend one minute on graduate
5 medical education. So in, I think it was June 2010, we made
6 a series of recommendations about GME that Peter alluded to.
7 I'm not going to go back into the specifics of those, but
8 the general thrust of it was that we think changing how
9 physicians and other health professionals are educated is a
10 really important part of getting to where we want to go in
11 terms of a better, higher performing health care system and
12 shouldn't be neglected.

13 And the basic concept that we laid out was unlike
14 some who want to cut payments for graduate medical education
15 and reap savings for the Treasury that could be used
16 elsewhere, we said keep the money in the pot but establish a
17 new framework of accountability that would help push
18 training in the direction of supporting a much higher
19 performing system in the future.

20 Now that's easy to say and complicated to do,
21 figure out exactly how you link the payments to performance.
22 And I'm not sure that we had the right answer on how to do

1 that.

2 The reason that I mention it is that I think that
3 this is very much a hot issue for reasons independent of
4 MedPAC. As everybody knows, our medical schools are now
5 producing a significant increase in U.S. medical school
6 graduates but the number of Medicare funded residency
7 positions has been basically frozen since 1997. And so some
8 tension is created, which I think potentially creates an
9 opportunity.

10 People in the graduate medical education realm
11 understandably would like to see an increase in Medicare
12 funded residencies. Our stance on that Alice, to go back to
13 your comment, was well, that may be a good thing but it
14 ought to be guided by careful analysis by organizations like
15 the health care work force that has never been funded.

16 So we were sort of agnostic on whether increasing
17 was the right thing or not. We just thought it needed to be
18 guided by analysis both on the numbers and the mix of
19 specialties and different types of health professionals.
20 Let's just not throw more money into the current system.

21 But there is this tension where people
22 understandably want more funded positions. I think a golden

1 opportunity to say okay, yes, but in exchange for
2 accountability for performance somehow defined. And I think
3 that opportunity is out there and I would love to see it
4 seized. Others in this room know a whole lot more about
5 graduate medical education than I will ever know, but this
6 is something I've taken an interest in and talked to a
7 number of people in the field.

8 And I get the sense that actually a lot of people
9 that work in the field think this is the right direction.
10 Yes, we do need to train differently and there's some
11 momentum in that way that we could reinforce with an
12 appropriate change in Medicare policy.

13 It's not on our agenda, just to be clear to people
14 in the audience. This would be a big topic for us to
15 undertake again, and we've got limited resources. But I
16 just wish that this opportunity could be seized.

17 DR. COOMBS: So one little thing, and I don't want
18 to jump ahead to the next presentation but I thought about
19 this when reading the paper. There's a number of hospitals
20 that closed and there's a number of hospitals that open.
21 And when a hospital closes and they have GME slots, those
22 slots are not necessarily reassigned to the hospitals that

1 are opened. So you're losing some capacity there for
2 training. I didn't know if the last time we visited this
3 subject, which was a while back, if that was addressed?

4 MR. HACKBARTH: My recollection is that PPACA
5 included some provisions on reassignment of unused slots.
6 Craig?

7 MR. LISK: That's correct. So now, when a
8 hospital closes, there's an application process for
9 reassigning those slots that happens now. Before that
10 didn't happen, but now that does happen.

11 MR. BUTLER: Well, Glenn you really hit nicely on
12 why it's an issue now. I think it could be an issue now in
13 the sense that you have so many more medical schools, so
14 many more unfunded slots. And you could even argue, let's
15 take some combination of the above empirically justified
16 money and do the pay-for-performance kind of -- and maybe
17 fund some of the slots. Those are all kinds of things that
18 could be -- my fear about it is that those are all good
19 issues, but they're going to take a pretty good chunk of
20 this Commission's time to formulate it for a March chapter.

21 And so I'm with you on it's ready to get teed up
22 again. I think we were on exactly the right path, but just

1 restating it without kind of getting into -- and by the way,
2 we've got new issues on the table -- is kind of half-baking
3 it. So that's my only issue with that.

4 MR. HACKBARTH: And I agree with that, Peter. So
5 I'm just sort of venting the frustration that results from
6 the realization that there probably isn't a lot that we can
7 do within our available resources in this cycle.

8 MR. BUTLER: Maybe June, if you coupled with a --
9 I don't know. But the March is going to be like tomorrow.

10 MR. HACKBARTH: March is impossible, yes, I think.

11 MR. BUTLER: So, I hear where you're headed and I
12 think it is timely.

13 MR. HACKBARTH: Yes.

14 MR. GRADISON: There's another issue. I probably
15 shouldn't even mention this, but it's the question of why
16 Medicare should be carrying such a high portion of the
17 burden of cost of this very important activity but other
18 payers aren't to the same extent.

19 MR. HACKBARTH: You know, we don't need to review
20 all of the history of MedPAC and GME, but that was actually
21 something that we discussed at some length, Bill, what would
22 be the options and implications of alternative methods of

1 funding. I won't speak for others who participated in that,
2 I came to the conclusion that although it's not a perfect
3 source of funding, it's better than the other options. But
4 reasonable people can disagree on that.

5 So let's bring this to a conclusion. Thank you
6 for your work on this, Julie and Kevin.

7 We're going to move on now to our last session on
8 hospitals. Here again, what we're doing -- for those of you
9 in the public audience -- this is sort of a prelude to our
10 discussions in December about hospital updates.

11 [Pause.]

12 DR. STENSLAND: All right. We'll try to wrap
13 things up efficiently here. I'll just start off by saying
14 there's a large difference between --

15 [Lights went off.]

16 DR. STENSLAND: All right. I'll just keep on --
17 okay. Well, all right. The mood lighting was nice, but
18 we'll go back to it. Okay.

19 There is a large difference between the rates paid
20 by Medicare and the rates paid by private insurers. The
21 primary purpose of this presentation is to explain why this
22 growing divergence between Medicare and private insurer

1 payment rates is not expected to result in a near-term
2 decline in beneficiaries' access to care.

3 First, Zach will present data showing access is
4 strong. Then I will discuss why we expect the gap between
5 Medicare and private rates to grow in 2015 but also expect
6 access to remain strong. The idea behind this discussion is
7 to give the Commissioners some time to think about how they
8 view the expected declines in Medicare profit margins in
9 light of strong access to care that we observe and expect to
10 see continuing. The discussions today can serve as a
11 foundation for your December discussions regarding the
12 payment update for 2015.

13 First, we'll show the significant decline in
14 inpatient hospital use and show that the related decline in
15 occupancy results in excess capacity in most markets.

16 Second, we'll walk through a series of payment
17 changes in current law that would result in net reductions
18 in Medicare payments to hospitals from 2014 to 2015 if
19 things continue as expected.

20 Now, I'll turn it over to Zach.

21 MR. GAUMER: Regarding beneficiaries' access to
22 hospital care, among the most important trends we're seeing

1 so far is the decline in inpatient utilization. Overall, we
2 observed a net decline of about 450,000 Medicare inpatient
3 discharges from 2011 to 2012. On a per beneficiary basis,
4 our assessment using a cohort of hospitals identified that
5 Medicare inpatient discharge volume declined about 4.5
6 percent per beneficiary. This was the most rapid decline in
7 any of the last six years and contributed to a cumulative
8 six-year decline of inpatient discharges of negative 12.6
9 percent.

10 The trend in Medicare utilization may suggest that
11 patterns of care are changing broadly in the United States,
12 because the decline exists for all Medicare beneficiary age
13 groups and across all geographic regions of the country.
14 Further, in the last year, we also see a trend in inpatient
15 volume decline for private payers and across the hospital
16 industry overall.

17 As you can see on the slide above, the utilization
18 of outpatient services increased from 2006 to 2011 by 23.2
19 percent per beneficiary. But in our December mailing, we
20 will provide you with more information on outpatient volume,
21 including the 2012 number that is not there, and, generally,
22 the extent of the demand for both inpatient and outpatient

1 care.

2 Now, embedded within the outpatient volume
3 increase, we have observed a rapid increase in the volume of
4 outpatient observation visits. Specifically, the volume of
5 outpatient observation visits per beneficiary increased
6 about 88 percent from 2006 to 2012. Some have suggested
7 that observation growth accounts for all of the inpatient
8 volume decline. We do not believe this is true.

9 As you can see by focusing on the last column of
10 the slide above, from 2006 to 2012, the number of outpatient
11 observation visits increased by 25 visits per 1,000
12 beneficiaries. During the same time period, inpatient stays
13 declined by 45 discharges per 1,000 beneficiaries, and the
14 net result is that the combined number of observation visits
15 and inpatient stays declined 20 visits and discharges per
16 1,000 beneficiaries. The implication of this is that the
17 decline in inpatient stays at hospitals reflects a decline
18 in demand for inpatient care, and not just a shift in the
19 categorization of care from inpatient to observation stays.

20 The decline in inpatient utilization should not be
21 cause for concern about beneficiaries' access to inpatient
22 care because we have also observed declining occupancy rates

1 over the same time period.

2 So, as inpatient volume has declined, we have seen
3 a decline in occupancy rates and, therefore, an increasing
4 amount of excess inpatient capacity. Excess capacity
5 appears to exist nationally and both for urban and rural
6 hospitals, but we see variation on a market level.

7 On the national level, from 2006 to 2012, hospital
8 bed occupancy rates declined from 64 percent to 61 percent,
9 on average. This statistic demonstrates that there is a
10 relatively large volume of unused hospital beds in the
11 marketplace. During the same time period, we also see
12 declining occupancy rates for both urban and rural
13 hospitals. Occupancy rates for urban hospitals declined
14 from 67 to 64 percent, on average, and at rural hospitals
15 from 48 to 43 percent, on average. As you can see, rural
16 hospitals tend to have lower occupancy rates and the decline
17 over the six-year period was a bit more in rural than for
18 urban.

19 On a market level, however, the extent of excess
20 capacity varies widely. Among the more than 400
21 Metropolitan Statistical Areas, 17 of the markets had an
22 average hospital occupancy rate of more than 75 percent.

1 Another 121 markets had occupancy rates between 25 and 50
2 percent. And one additional market had an occupancy rate of
3 less than 25 percent.

4 Now, if we had included rural markets in this last
5 box on the slide above, we would have seen far more markets
6 with below 50 percent occupancy. However, even just in
7 looking at the metro areas, we see a broad range of excess
8 capacity across these markets. And one caveat to this is
9 that in future years, hospital capacity dynamics may change
10 as insurance expansion occurs.

11 Despite inpatient volume declines and growing
12 excess capacity, the number of hospital closures was modest
13 in 2012. Overall, there are approximately 4,800 hospitals
14 in the U.S., and throughout 2012, 17 new hospitals opened
15 for business. These hospitals are smaller than average.
16 They are mostly urban, and most are located in States with
17 growing populations.

18 Another 17 hospitals closed in 2012, and they have
19 characteristics that you might expect. Their occupancy
20 rates were low, at an average of 27 percent in 2011, and
21 they had been declining -- the occupancy rates had been
22 declining for several years. Their low occupancy rates are

1 associated with poor financial performance. For example,
2 the average all-payer 2011 profit margin for these closed
3 hospitals was negative 10.5 percent. They also displayed
4 poor performance on an array of quality measures.
5 Specifically, six of the 17 hospitals had among the worst
6 patient satisfaction we observed nationally.

7 So, the aggregate impact of these openings and
8 closures translates into about 800 hospital beds being
9 removed from the marketplace in 2012. This is a very small
10 reduction of approximately one-tenth of a percentage point.
11 Given the utilization and occupancy trends and this small
12 reduction in beds, in the future, we might anticipate more
13 beds being eliminated from the marketplace.

14 So, in light of what we told you this morning
15 about utilization, occupancy, closures, we believe the
16 hospital industry possesses the capacity to absorb oncoming
17 demand resulting from insurance coverage expansion. In
18 addition, through the lens of five other indicators that we
19 use each year for determining access, we believe that the
20 hospital industry continues to expand generally and Medicare
21 beneficiaries' access to hospital care remains strong.

22 Just to go through them very briefly here, the

1 Bureau of Labor Statistics data reveals that the number of
2 individuals employed by hospitals increased approximately
3 one percent over the last twelve months. The scope of
4 services that hospitals offer to their communities, we see is
5 continuing to expand. Hospital construction spending
6 continues at a consistently high level, with spending
7 totaling approximately \$27 billion in the last three years.
8 That is in each of the last three years. Hospitals appear
9 to have access to the capital they require, as nonprofit
10 hospital borrowing increased from 2011 to 2012.

11 And, finally, merger and acquisition activity
12 accelerated in 2012. We observed a 60 percent increase in
13 that one-year span in the number of hospitals involved with
14 mergers and acquisition deals. This amounts to about 250
15 hospitals merging or being acquired in 2012. This is the
16 most in six years, and it appears, though, the trend is
17 continuing in 2013, as you have probably read in various news
18 reports.

19 In December, we will also provide you with
20 information about hospital quality trends to complete our
21 broad scope of access work.

22 DR. STENSLAND: Zach just showed that hospitals

1 had the capacity to serve Medicare beneficiaries. I'll now
2 show that hospitals have a financial incentive to serve
3 Medicare beneficiaries despite the expected decline in
4 Medicare margins.

5 This table summarizes Medicare payment changes in
6 current law. The first column presents historical data
7 through 2014. The second column shows changes for 2015,
8 which is the year in which you will be making an update
9 recommendation for in the current update cycle.

10 The first row of the slide shows that DSH payments
11 are expected to increase by an amount equal to 0.7 percent
12 of overall Medicare payments to hospitals in 2014, but then
13 they're expected to decline by an amount equal to two
14 percent of hospitals' overall Medicare payments in 2015.
15 The details on how DSH payments are changing are in your
16 mailing materials.

17 In addition, there's a series of smaller payment
18 changes. As we show in the second line, aggregate effect of
19 these policy changes decreased hospital payments by 0.2
20 percent through 2014, and then they are expected to reduce
21 payments by 1.5 percent in 2015. These smaller changes
22 include changes associated with various incentives to affect

1 hospitals' behavior, including extra payments for meaningful
2 use of electronic medical records, readmissions penalty, and
3 a hospital-acquired condition penalty. There's also a
4 recovery of past overpayments due to documentation and
5 coding changes and the expiration of two rural add-on
6 payments.

7 The third line shows that the expected updates in
8 Medicare payment rates under current law from 2011 to 2014,
9 and the update was large enough to allow payments to
10 increase by an average of almost two percent per year. But
11 from 2014 to 2015, the update under current law will be less
12 than the expected policy changes. We look at the current
13 update in more detail in the next slide.

14 In December, we will discuss a recommendation for
15 what the update in hospital payment should be in 2015. This
16 slide shows what we expect the update to be under current
17 law. The update under current law is expected to be 2.1
18 percent. Due to policy changes, the net change in payments
19 are expected to be negative. As we stated in your mailing
20 materials, this could reduce margins on Medicare patients
21 and could result in even relatively efficient hospitals
22 having a negative Medicare margin in 2015.

1 However, part of what has driven Medicare margins
2 down in recent years is the strong profits from private
3 payers, as we show in the next slide, which has allowed
4 relatively strong cost growth in some prior years.

5 As we reported this summer in our data book,
6 privately insured prices were almost 150 percent of costs,
7 on average. In contrast, Medicare prices were roughly 95
8 percent of average allowable costs. Despite the high profit
9 margins from private payers in 2011, the Health Care Cost
10 Institute reports that through 2012, private prices continue
11 to grow at a rate of five to six percent. This is
12 significantly faster than the two to three percent growth we
13 have seen in costs in recent years.

14 Given the strong price growth and the expected
15 expansion of those with insurance due to the exchanges and
16 expanded Medicaid, we expect all payer margins will remain
17 strong for most hospitals. But there will also be a growing
18 divergence in the rates paid for Medicare and privately
19 insured rates. Some have suggested that either private
20 payer rates will have to stop increasing so fast or Medicare
21 rates will have to increase faster than current law to
22 preserve access. However, over the next few years, we think

1 there are several reasons why access can remain strong, even
2 if the two payment rates diverge.

3 First, given the excess capacity that Zach talked
4 about in most markets and the fact that Medicare payments
5 are still more than marginal costs of care, hospitals will
6 have a direct financial incentive to take Medicare patients.
7 In fact, not only do we see essentially all hospitals
8 accepting Medicare patients at current rates, some hospitals
9 contract with Medicare Select supplemental plans that serve
10 roughly one million beneficiaries. These hospitals agree to
11 take discounts off traditional Medicare rates to increase
12 their volume of care. These hospitals want more Medicare
13 patients, even at rates below the standard Medicare rates.
14 Hospitals in the ACE demonstration were also willing to take
15 some small discounts off traditional Medicare rates when
16 they bundled the hospital and the physician payments.

17 Finally, there are indirect costs to not taking
18 Medicare patients. Nonprofit hospitals would risk losing
19 their nonprofit status if they do not take Medicare
20 patients, and that is one more reason why all nonprofit
21 hospitals take Medicare patients.

22 And in conclusion, given this environment of

1 excess capacity and strong all-payer margins, we expect
2 beneficiaries' access to care to remain strong, despite the
3 growing divergence in payment rates.

4 Now, I'm going to shift from talking about the
5 level of payments to talking about the distribution of
6 payments. The Accountable Care Act made a significant
7 change in how Medicare pays hospitals. Starting in 2014,
8 Medicare will not just pay for Medicare services but will
9 also pay a portion of uncompensated care costs. Over time,
10 this could have a significant redistribution effect on
11 Medicare payments.

12 There's lots of detail in your mailing materials,
13 but I'll just touch on the highlights to set the stage for
14 your discussion.

15 In 2014, Medicare will distribute roughly \$3
16 billion of traditional DSH payments and \$9 billion
17 uncompensated care payments. CMS decided to use Medicaid
18 days and Medicare SSI days -- SSI days are supplemental
19 payments given to poorer Medicare patients -- as a proxy for
20 uncompensated care. As we discussed in your mailing
21 materials, we found that Medicaid and SSI days were a poor
22 proxy for actual uncompensated care. Recall that the law

1 was written to shift payments away from being based on
2 Medicaid and DSH and toward being based on uncompensated
3 care. The 2014 implementation of the law could lead
4 payments in the opposite direction. Payments will actually
5 be more tied to Medicaid days rather than moving away from
6 being based on Medicaid payment days. The practical effect
7 is that fee-for-service Medicare will now pay roughly \$248
8 per Medicaid day to hospitals as an uncompensated care
9 payment.

10 In addition, but I don't present here but is in
11 your mailing materials, is that there's the other fact that
12 MA plans will often follow the lead on Medicare rates and
13 pay basically fee-for-service rates. So, MA plans will also
14 be paying an additional add-on payment for each Medicaid day
15 at hospitals.

16 Now, there is an option for shifting from using
17 Medicaid days as a proxy for uncompensated care. Hospitals
18 are required to report their level of uncompensated care on
19 their cost reports. However, CMS declined to use the S-10
20 in 2014 due to a concern about the wording on the form's
21 instructions and possible imprecision in reporting during
22 the first year of that form. However, they did say that,

1 eventually, they would expect toward moving toward the S-10,
2 and we do think it's possible that even the imprecise
3 measure on the uncompensated care as reported on the cost
4 reports may be better than using a poor proxy, such as
5 Medicaid days.

6 The net effect of using the S-10 would be to shift
7 a significant amount of payments toward certain hospitals
8 that have large volumes of uninsured patients. These would
9 be hospitals such as Stroger of Cook County in Chicago or
10 Grady Memorial in Atlanta.

11 There are more technical details in your mailing
12 material, but the most important point to raise for
13 discussion is the philosophical question of whether Medicare
14 payments for uncompensated care should be taken from the
15 Trust Fund and whether uncompensated care payments should be
16 measured using Medicaid volumes.

17 All right. So, we have provided some background
18 on the strength of access, the growing divergence in
19 Medicare and privately insured margins, and some reasons why
20 access may remain strong, despite the divergence in margins,
21 and this leads us to several potential discussion questions
22 that we have on the slide here.

1 These include discussion of excess capacity,
2 discussion of declining Medicare margins given current law,
3 discussions of how access may remain strong despite the
4 declining margins, and additionally this question about what
5 the appropriate payment rate is, given this combination of
6 strong access and declining margins. We could also discuss
7 Medicare payments for uncompensated care and how these
8 payments are currently tied to Medicaid volumes, and I will
9 open it up for discussion.

10 MR. HACKBARTH: Okay. Thank you, Jeff and Zach.

11 Let me just underline what has been said multiple
12 times already. We are not trying to make any decisions
13 today. This is just to get people warmed up and thinking
14 for the work that will begin next month on the update
15 recommendation.

16 Let me also -- Jon Christianson, it occurs to me
17 that this may be a little bit out of context for you, so let
18 me just briefly describe the way we approach the task of
19 recommending update factors for hospitals and other payment
20 systems.

21 We use what we refer to as a payment adequacy
22 framework, which includes multiple parts. One piece of

1 information is the Medicare margin, and in case of
2 hospitals, it's the overall Medicare margin, inpatient and
3 outpatient services and other services combined. It's not
4 an all-payer margin, in other words. Other factors in the
5 payment adequacy framework include access to care, to which
6 there's been some allusion here, access to capital, quality
7 of care. I think that's all of them, isn't it, Jeff? So,
8 no one factor is determinative. It's a consideration of
9 multiple factors.

10 With regard to the overall Medicare margin, one
11 tool that we've used, one reference point that we've used is
12 the margins of a group of efficient providers, providers
13 that we've identified that have both low costs and high
14 quality. The reason for that is that our statutory charge
15 from the Congress is to recommend updates, payment rates
16 that are consistent with the efficient delivery of services,
17 and so when we get further into this next month, you'll see
18 reports on overall margins -- you've heard some discussion
19 of that here and what the trends are -- but also the
20 efficient provider margins are a particular focal point.

21 So, that just sort of gives you a sense of what
22 we'll be into next month, not just for hospitals, but for

1 all of the various provider groups.

2 Kate, do you -- or, wait a second. I've got to do
3 round one clarifying questions first. I got ahead of
4 myself. Any clarifying questions, round one? Peter, then
5 Bill.

6 MR. BUTLER: So, you always do a great job putting
7 these data together. On Slide 8 -- and I really like the
8 way you simply summarized some of these changes -- my
9 question is the sequestration, the two percent hit on
10 Medicare. How, if at all -- that's not law. How does that
11 -- is that not in here? If that continued, is it another
12 two percent hit?

13 DR. STENSLAND: That's not in there. If it was
14 continued, it would be almost another two percent, not
15 quite, because it doesn't apply to patient cost sharing,
16 only to the government side. So think of it as almost
17 another two percent decline from 11 to 14.

18 MR. BUTLER: Okay.

19 MR. GRADISON: Is your figure for excess capacity
20 based on staffed beds?

21 DR. STENSLAND: Yes.

22 MR. GEORGE MILLER: Yes. On Slide 8, also, Peter

1 asked one of my questions. The other one, under the
2 meaningful use, that was in the second line, the negative
3 1.5, that meaningful use, but that's the government payment,
4 not our total cost for meaningful use.

5 DR. STENSLAND: This slide is just about payments,
6 so basically --

7 MR. GEORGE MILLER: Just payments.

8 DR. STENSLAND: Yes. That means that there was
9 these extra payments coming through and they'll start moving
10 down over time --

11 MR. GEORGE MILLER: That's my point. Although the
12 cost for providing will still remain the same, and we paid
13 that money in advance. The amount of money that you paid us
14 for the meaningful use was a fixed amount after the fact,
15 and it declines if you participate in a test. I just wanted
16 to make sure. And then on top of that, the sequester is not
17 included in these numbers. Thank you.

18 DR. COOMBS: So, in Table 4, can you help me
19 understand why that MA payment is 992, how it comes out? I
20 know it's a hypothetical example.

21 DR. STENSLAND: All right. So, Table 4 is
22 something actually from our mailing material. It's not

1 actually one of these slides, just for the audience to get
2 oriented. And the essential idea here is that there's going
3 to be two payments for uncompensated care coming to the
4 hospital. One will be from fee-for-service Medicare and the
5 other one will be from managed care plans. And often the
6 managed care plans set their rates the same as fee-for-
7 service Medicare.

8 But the way the law -- the way the regulation was
9 implemented for 2014 is they take this overall amount of
10 uncompensated care and they give a certain -- or, actually,
11 not -- well, not uncompensated care. They take the number
12 of, like, Medicaid days and SSI days and they say, okay,
13 fee-for-service Medicare, we'll pay you \$248 for every one
14 of those days and we're going to say that's our proxy for
15 uncompensated care.

16 So, in the one case, if you are a hospital that
17 just has fee-for-service business, you're just going to get
18 \$248 -- you're going to get enough payments from Medicare
19 fee-for-service to get \$248 for every one of your Medicaid
20 days and that's all you're going to get because you don't
21 have MA business.

22 Somebody else has MA business. The way it's

1 structured is they're still going to get \$248 just from
2 their fee-for-service side for every Medicaid day, but then
3 the MA people will come along and also give them another
4 payment because their payment rates are usually tied to the
5 Medicare rates, and they'll get -- if it was an equal number
6 of fee-for-service and MA patients, they would get another
7 \$248 per Medicaid day from those MA payments.

8 It's somewhat complicated. I don't know if that
9 was clear enough, but --

10 MS. UCCELLO: Yeah, and I have just a follow-up
11 question to that. Why is the denominator there the fee-for-
12 service discharges and not the total, fee-for-service plus
13 MA?

14 DR. STENSLAND: Yes, and I'm not sure -- that's
15 how it's implemented and I'm not sure if that was a
16 regulatory decision or if that's the law, just the way the
17 law is worded, that that's what they have to do, because the
18 law is pretty prescriptive in that it takes a set pool of
19 money on fee-for-service and it distributes all of that
20 money. They probably could have -- I'm not sure if they
21 could have done it that way or not.

22 MS. UCCELLO: So, let me ask you this. It's not a

1 lack of data on MA discharges, it's just the way it happens
2 to be written?

3 DR. STENSLAND: Right.

4 MR. HACKBARTH: Any other clarifying questions?

5 [No response.]

6 MR. HACKBARTH: If not, Kate.

7 DR. BAICKER: So, I thought this was really
8 helpful background for setting the stage for our discussion
9 of particular updates, and I really liked the way it was
10 framed.

11 The take-away that I took from this was a
12 reiteration of the general principle that payment ought to
13 be adequate to ensure access, and adequate roughly involves
14 covering the marginal cost of an admission, a Medicare
15 admission, the Medicare stay in the hospital for the fee-
16 for-service enrollees. And when there is excess capacity,
17 that strikes me as reasonably strong evidence that there
18 should be more access and probably evidence that some
19 hospitals in the long run will be closing and that that's
20 not a bad thing in the sense that if people need less
21 hospitalization, that's great, and if they're getting care
22 in other settings that's more appropriate. And the

1 challenge is the transition to those hospitals closing and
2 making sure that they're not closing because there isn't
3 sufficient payment to cover the costs of the people who
4 ought to be admitted, and that's where I think there's been
5 a little bit of struggle.

6 And we have the longstanding principle that
7 Medicare is not in the business of compensating for other
8 people's mispayments, meaning if Medicaid payment is
9 stronger in some areas and less strong in others, we don't
10 try to unwind that with our payments. Similarly, if private
11 insurance payments are stronger in one area or weaker in
12 another, we shouldn't be in the business of trying to unwind
13 that, either. We want our payments to adequately cover the
14 costs of our population and other people should be doing the
15 same thing, too, and I don't think it helps the system if we
16 try to balance their mistakes with compensating negative
17 mistakes in the other direction.

18 So, the fact that payments for private enrollees
19 are going to be potentially going up more in the coming
20 years, I'm not sure that should enter much into our thinking
21 about what our appropriate payment is except insofar as it
22 changes the fundamental cost structure of what's going on

1 within the hospital and thus the actual cost of caring for
2 our enrollees. And there was some discussion of that and I
3 want to think through more carefully how might the change in
4 the payer landscape more broadly affect the marginal costs
5 of our beneficiaries and enrollees, and that itself should
6 play into our payment changes.

7 I don't -- along with that principle is the idea
8 that if our payment is inadequate but people keep taking our
9 enrollees because otherwise we take away their tax-favored
10 status, that doesn't fit in with that general principle to
11 me. It has to be the payments in and of themselves that are
12 sufficient. And I think that's the way you framed it up and
13 that gives us a little bit of meat to chew on as we go
14 forward into the next debate.

15 Just a couple of, then, very small points to add
16 on. I was interested in the observation stay change and the
17 calculation that it is not likely the only thing responsible
18 for the decline in inpatient admissions. I'd love to see
19 that calculation on patient days as opposed to admissions or
20 visits in the sense that if the visits are of different
21 lengths, it's bodies in beds that I'd like to see
22 offsetting, thus a slight wrinkle on that.

1 Also, I think the recovery of past overpayments
2 should be thought of in a different conceptual bucket than
3 other changes that are in the law in the sense that if we
4 inadvertently lent you some money yesterday that we are
5 reclaiming today, that's not about a shift in growth rates.
6 That's a rebalancing across two adjacent time periods. To
7 me, that's different from a fundamental change in the
8 trajectory of spending going forward, and I'd separate that
9 out conceptually, even if it enters in in arithmetic the
10 same way.

11 As far as the shifting DSH to uncompensated -- to
12 focus on truly uncompensated care, that seems like a great
13 principle to me, especially because the mix of Medicaid to
14 uninsured patients is likely to shift substantially,
15 overnight, perhaps, and so the degree to which Medicaid and
16 SSI days are a reasonably proxy for uncompensated care is
17 likely to change substantially with that shift in coverage.
18 So it seems like a particularly important moment to
19 reevaluate how we're proxying for uncompensated care.

20 Then, should Medicare payments be higher for
21 hospitals that have more uncompensated care? I think
22 there's reason to think that the patient pool treated by

1 those hospitals is likely more expensive more broadly. They
2 have fewer clientele over which to spread fixed costs. So I
3 think there is a reasonable argument to be made that
4 Medicare funds, even though we're focusing on adequate
5 payment for our enrollees, ought to take that into account
6 in terms of the overall resources available to the hospital.
7 But the proxy we're using right now is not such a good one
8 and is likely to worsen come expansions of Medicaid.

9 MR. HACKBARTH: So, Kate, I want to go back to
10 your point about there potentially being a link between what
11 private payers pay and costs that are then incurred for
12 Medicare patients. I just want to remind people -- I know
13 you know this, Kate -- that, in fact, we've found
14 empirically that there is a link and that hospitals that
15 have generous levels of private payment tend to have higher
16 Medicare costs per case than hospitals that have more
17 stringent payment from all other payers, non-Medicare
18 payers.

19 Peter.

20 MR. BUTLER: So, let's go to Slide 10 first.
21 There was even a heading in the text that's in the
22 background material that says, expect strong all-payer

1 profits, and then you have, private prices have been growing
2 at five to six percent, and you have the source, the Health
3 Care Cost Institute. I don't know if there's other data.
4 It just seems higher than my gut sense of what's going on,
5 and you have one source. I'm not saying that it's not a
6 good source, but it just strikes me as higher than what I
7 would think would be actually occurring. It's a comment.

8 And the second, on the, expect strong all-payer
9 profits, you speculate -- you know, it's a little counter to
10 -- and I know you cite stock prices and things like that.
11 Moody's, I just read, the first three quarters of this year,
12 30 downgrades, 18 upgrades. So the rating agencies are
13 saying there's a lot of clouds, and when they say the
14 expansion is coming, they say, yeah, you may be newly
15 insured and you may even say they're getting higher prices,
16 but the deductibles are humongous, and so there's going to
17 be a big increase in bad debt associated with the newly
18 insured. And the other newly insured is Medicare, and
19 granted, if you're getting paid something, even if it's low,
20 when you weren't getting anything, but as you've cited,
21 you're reducing the DSH prices at the same time.

22 So, I'm just saying that the rosiness of the

1 projections on all-payer profits doesn't seem to be quite as
2 grounded in the facts that I'm reading versus that.

3 Now, go back to 14. Having said all that, there's
4 no problem with access. I would agree with that completely.
5 There's plenty -- nobody is turning down Medicare on the
6 hospital side and they're not saying, I can't take any more
7 of it. So, the bottom line is still the strong access. I'm
8 just trying to convey -- make sure we get our sources of
9 projections as thorough and accurate as we can.

10 I also agree that there's excess capacity.
11 Medicare, this has been a great deal in the sense that if
12 you look at the single biggest reason for decline in
13 Medicare spending is the number of admissions times the
14 price per admission. That's the biggest decrease in
15 Medicare spending, I believe.

16 So, just a couple other, then, quick comments
17 related to the questions. The appropriate rates is tough.
18 If you go below the efficient provider or at that level, you
19 can't kind of say, therefore, we're even going to go lower
20 because the private payer side is going so well. It just
21 would be inconsistent with our philosophy. I don't know
22 where it lands us, ultimately, for a specific

1 recommendation, but I don't think we want to abandon our
2 philosophy of paying for efficient providers.

3 And on uncompensated care, finally, the number of
4 Medicaid days is a bad measure. I think it will get sorted
5 out. But it's perfectly appropriate for us to highlight
6 that and urge us to get on to the true uncompensated care.
7 So, I like the fact that you've included that.

8 DR. CHRISTIANSON: Okay. Just a couple of really
9 quick general observations.

10 On your Slide 7, Zach, I think you just mistakenly
11 stated what was going on in the second-to-last bullet point.
12 I think you said nonprofit hospitals' borrowing had
13 increased from 2011 to 2012, but I think your slide suggests
14 a decrease from 2011 to 2012. So, if they borrowed more in
15 2011, they must have borrowed less in 2012.

16 And mergers and acquisitions increased during that
17 time, so I have a colleague who's been writing a lot about
18 what he views as the impending capital crisis for hospitals,
19 and this is a fairly arcane topic. It has to do with aging
20 physical plant. But those last two bullet points are
21 certainly consistent, although it's a big stretch, with the
22 notion that if hospitals are borrowing less, the hospitals

1 that have access to capital issues may also be the most
2 likely to be acquired or merged.

3 So, I would be happy to share with you some of the
4 material that he uses, but I think there's sort of a more
5 nuanced story here about spending capital availability and
6 so forth that you may want to be aware of before you reach
7 too many conclusions about access to capital is fine and we
8 don't need to worry about it.

9 And then the second thing I was struck by with
10 your data -- I always love your reports and they're data-
11 rich and I like that -- one of the things says that all the
12 data in the reports are prepared in the context of payment
13 changes, and I was struck by how kind of our conversations
14 often, it seems like here, get a little bit siloed. And one
15 of the things I would love to see you look at is when you're
16 looking at mergers, acquisitions, and so forth, doing it in
17 the context of we've endorsed as one of our four points
18 basically the growth and shifting of patients into ACOs.

19 There are consequences to that that could relate
20 to as ACOs grow and try to kind of right-size their delivery
21 systems, what's happening with mergers and acquisitions.
22 Are we seeing more in communities that have a bigger ACO

1 presence, and not just an ACO present, but a total ACO plus
2 total cost of care presence? And if so, which kinds of
3 hospitals are being acquired? Which kinds of hospitals are
4 being closed? What's the effect of total occupancy days and
5 bed reductions and all of that?

6 So, we need to start tracking lots of consequences
7 of us advocating this position, and one of the consequences
8 is what's the impact going to be on the hospital industry
9 and can we project based on the data we have and will have
10 what the impact will be on availability over time of
11 hospital beds, occupancy rates, and so forth. So I would
12 like to sort of advocate sort of a broad -- you know, using
13 some of these data to also address some of these, I think,
14 basic issues around consequences of what we're recommending.
15 So we had this recommendation two years ago. A lot has
16 happened since then and we have some data on what the
17 consequences of the growth are.

18 Does that make sense or not?

19 DR. HALL: Jon covered the major point I wanted to
20 bring forward. There are lots of reasons why mergers and
21 acquisitions are taking place in the health care environment
22 right now. To be sure, some of these are hospitals that

1 can't sustain themselves, and so a merger might make them
2 more sustainable.

3 On the other hand, I think in communities where
4 ACOs are being aggressively looked at, particularly if
5 there's competition, there's a lot of interest in acquiring
6 primary care practices which may be part of a hospital.
7 It's not intuitively obvious that what happens when that
8 other hospital closes.

9 Yesterday, we talked about the hospital service
10 areas and I mentioned that some of them have many, many
11 hospitals in the service area. But the flip side of that is
12 that, according to the data you provided us, about 40
13 percent of Americans live in a hospital service area that's
14 serviced by only one hospital. So, to the extent that the
15 intention of acquisition and mergers is to increase market
16 share for, let's say, the dominant or larger hospital,
17 there's no guarantee it's going to be in that service area
18 at all.

19 And so I agree with Jon. I think, although it's
20 not a warning sign right now, but I think could be a very
21 interesting and important trend relative to Medicare access.

22 MR. GRADISON: Briefly, I just want to mention

1 three points in addition to the excellent list that Jon
2 mentioned about things, at least the way I would phrase it,
3 things to keep an eye on that are going on out there.

4 One is the relatively narrow networks that are
5 being offered through the exchanges. And I appreciate that
6 even if the goals are met, we're talking about a small
7 number in terms of the country, seven million insured.
8 Nonetheless, it may be a little different than what some had
9 anticipated in how narrow they are, and particularly the
10 extent to which the narrowness affects hospitals as well as
11 physicians. I think that might have been a bit of a
12 surprise.

13 The second thing is, and this is all, of course,
14 anecdotal at this stage. I have no idea that it's very
15 general. But the use of reference pricing and Centers of
16 Excellence, both of which could have a very dramatic
17 redistribution effect on where the business goes in terms of
18 hospitals.

19 So, just things to keep an eye on that aren't
20 necessarily right down the Medicare alley, but could affect
21 the environment in which Medicare patients seek care.

22 DR. NERENZ: Yes, just to build a little bit on

1 the points that Peter made, he did a couple that I had
2 thought to say. A number of the cuts to hospitals in the
3 Affordable Care Act were based on the assumption that
4 coverage expansion would reduce the amount of uncompensated
5 care, and so rather than create a windfall that there should
6 be some compensatory cuts. In the broad level, that makes
7 sense.

8 But I think the caution and the message for today
9 is that, as Peter pointed out, for example, as people go
10 into high-deductible plans, and we could use the Bronze
11 Level Plan in exchanges as an example, they are loaded with
12 high deductibles, other sorts of cost sharing, so bad debt
13 is likely to increase both in absolute terms and as a
14 fraction of an overall uncompensated care burden.

15 And even on the Medicaid side, you could see
16 issues where it seems on the one hand that someone who was
17 uninsured who becomes Medicaid insured, all else equal, that
18 should be better for hospitals. But if there's an added
19 dynamic, the people who were uninsured were not getting
20 hospital care but now with Medicaid coverage they are, from
21 the hospital point of view, you have more Medicaid
22 admissions, say, in the same service area, all of which are

1 paid at far below cost. So, there's another potential
2 contributor.

3 Now, the complexity comes when we have these new
4 formulas that are either pegged to Medicaid days or possibly
5 to some other metric of uncompensated care. They either do
6 or do not adjust to those changing dynamics in a way that
7 ultimately ends up being fair to hospitals.

8 The problem is, I don't have the complexity of
9 intuition to sort out all these interactive factors. This
10 seems to be the time that a really good simulation model or
11 models, plural, may be necessary.

12 And I finally, then, just end up with a very
13 specific question. In the definition of uncompensated care
14 that comes in the cost report, is bad debt in that or not in
15 that?

16 DR. STENSLAND: Generally, the way -- the data is
17 in there, and generally, the way they look at it is just
18 charity care plus bad debt together.

19 DR. NERENZ: Okay. So a model hooked to that
20 rather than Medicaid days, if, again, my intuition follows,
21 would a little more fairly compensate a hospital dealing
22 with the problem Peter talked about, about a raising bad

1 debt burden. That would follow?

2 DR. STENSLAND: Right.

3 DR. NERENZ: Okay.

4 MR. ARMSTRONG: Actually, every point that I
5 wanted to make has already been made very well. I think
6 just one additional thought would be that as we get into the
7 conversation about rates for the hospitals, we've
8 acknowledged in a lot of our conversations that in the years
9 ahead, where some of the most dramatic changes as our
10 industry is reformed will likely play out will be in how
11 hospitals work and are capitalized and organized and run.
12 Some of the data shows this conversion from outpatient-based
13 services -- from inpatient to outpatient and some other
14 things.

15 It might be just good for us to find ways every
16 once in a while to put the specific decisions we have to
17 make about rates into kind of that context, and how does
18 this help take care of business for the current year, but
19 incrementally position hospitals to be better prepared to
20 take on the big changes --

21 DR. CHERNEW: A few quick things. The first one
22 is, I'm encouraged by the general tone of the sort of access

1 analysis and the related sort of analysis that you present.
2 So there don't seem to be huge problems and I basically
3 agree with that, although I found Peter's comments
4 particularly interesting.

5 Maybe related to others, I'm a bit less concerned
6 about the margins per se. I agree that the negative margin
7 for the efficient hospitals is concerning, but remember,
8 that's a relative efficiency margin. There could be
9 inefficiency in there. And more to the point, I'm always
10 cautious of sort of thinking that the costs are sort of
11 given and we need to pay what the costs are. The costs are
12 quite flexible in a variety of ways, and so knowing what the
13 right costs are is very difficult and knowing what the right
14 margin is there is difficult, even for the efficient
15 hospitals. So, I don't want to imply that I'm unconcerned
16 about that, but I'm hardened by the access portion of it, so
17 I will just say that as we go forward. I will think about
18 it more as I know it will become important in the coming
19 months.

20 The other thing that I would say, which is a bit
21 outside of this but important, is we always have the silo
22 effect in the hospitals between the inpatient part and the

1 outpatient part and how all that plays into things, and so I
2 just want to reiterate a point that I sort of made into the
3 past, which is the most important thing for me is across all
4 those things we get the relative prices right. So, we do
5 cross-sector pricing and all that stuff. It's really
6 important to me that we get the relative prices right. If
7 we think that further hurts hospitals or not, I think that's
8 not a justification for not getting the relative prices
9 right. We would adjust the payment in one sector using the
10 sort of update factor one way or another.

11 So, I think that we have a tendency to look at the
12 parts of even the hospitals in silos apart from all the
13 other silos and I think we need to be a little broader, and
14 as we try and get the relative prices right across sectors,
15 understand that if that hurts an institution, we can deal
16 with it in some other way besides keeping the wrong prices
17 in place. So, that's my view.

18 MR. HACKBARTH: So, just to pick up on that, Mike,
19 so, for a variety of reasons in the past, what we've done is
20 look at an overall Medicare margin that includes inpatient
21 services, outpatient services, and other line of business
22 and make a single update recommendation that usually applies

1 to both inpatient and outpatient. The idea that you're
2 introducing here suggests that we may want to think
3 separately about the payment levels for inpatient and
4 outpatient services. On the outpatient side, there are
5 substitutes, non-hospital substitutes, and what I hear you
6 saying is we need to make sure that we're getting those
7 cross-sector prices correct, and then if we're worried about
8 the overall financial status of hospitals and we think
9 Medicare payments are somehow too low, we ought to take that
10 into account on the inpatient side, or -- question mark.

11 DR. CHERNEW: Well, you could take it into account
12 -- even on the outpatient side, there's different services
13 that have different levels of substitutes. So, there's a
14 range of ways to do that. So, the broader -- so, basically,
15 I agree with it. "Yes" is the quick answer. But the sort
16 of broader point is, there's complexities in getting the
17 relative prices right, but I think we should work through
18 that. If there's a problem with the overall margin or
19 profitability of hospitals, we can adjust for that in ways,
20 maybe with the inpatient update factor, for example, or
21 perhaps other ways. But I wouldn't sacrifice getting the
22 relative prices right because we're trying to get certain

1 amounts of money to institutions. I view the more important
2 thing in the prices is the signal across all these various
3 things and we can worry about the amount of money going or
4 the profitability with some of these other tools. I don't
5 know if that made sense.

6 MR. GEORGE MILLER: Glenn, if I could respond to
7 that, while I appreciate what Michael is saying, I agree in
8 theory and principle from a total global perspective, but as
9 Bill Hall mentioned, 42 percent of hospitals are in markets
10 where they're the only provider. And if you weaken the
11 fundamental financial strength of a hospital by not taking
12 that into consideration for the inpatient side, it may not
13 survive and there would not be alternatives to provide
14 payments for that --

15 DR. CHERNEW: Yes, but what I'm saying is -- so,
16 say I want an efficient provision between hospital
17 outpatient department services and, say, physician office
18 services --

19 MR. GEORGE MILLER: That, I get.

20 DR. CHERNEW: -- and I do what we're doing on
21 cross-sector pricing. You might argue, that's going to
22 weaken the hospital one way or another --

1 MR. GEORGE MILLER: I would argue --

2 DR. CHERNEW: -- and it might not survive and
3 that's a big problem.

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

5 DR. CHERNEW: I understands.

6 MR. GEORGE MILLER: Yes.

7 DR. CHERNEW: So, I understand that concern. My
8 view is, the way to solve that problem is not to preserve a
9 bad incentive to push things to the outpatient department
10 setting, but instead to --

11 MR. GEORGE MILLER: If your assumption is it is
12 bad in the beginning --

13 DR. CHERNEW: -- adjust the update factor in ways
14 that might preserve the hospital in the area, and then you
15 have a separate question which relates to this presentation
16 about what that right profitability is and how much access
17 there is and all the other payment adequacy things.

18 MR. GEORGE MILLER: Yes, I wouldn't disagree,
19 except for if you assume that the current payment for the
20 inpatient in those areas, especially safety net hospitals,
21 are bad.

22 DR. CHERNEW: But, if we were concerned about

1 hospitals going out of business, or particularly safety net
2 hospitals or Critical Access Hospitals, which, incidentally,
3 have other payment issues, but anyway, if we were worried
4 about that, the right way to deal with that is through the
5 update factor-type mechanisms, not through allow them to
6 overcharge for particular types of services which then have
7 other disincentives about where the site of care is, and
8 there's issues about buying up practices simply to arbitrage
9 the payments and a whole slew of other things that happen
10 when you get the relative prices wrong.

11 MR. HACKBARTH: So, let's keep moving for now.
12 For round three, I was going to invite people to react to
13 the way of thinking that Mike has laid out here between the
14 relationship between inpatient and outpatient services. So,
15 we can come back to that, George, but let's get the rest of
16 round two done. Alice.

17 DR. COOMBS: So, I was more concerned about the
18 internal dynamics within hospitals with mergers and
19 acquisitions, specifically in that what I have observed
20 locally is that hospitals will make decisions because of a
21 volume of services within an institution. And as the
22 occupancy falls, you might envision that some services are

1 not going to have a critical level to be able to maintain
2 proficiency in that service. For instance, if you only care
3 for X-number of patients with this type of disease, it may
4 be prohibited for you -- costly for you to provide that
5 service the way it should be provided for. So, the quality
6 might suffer as a result of an inadequate number to maintain
7 competency. For the providers, the nurses involved,
8 everyone within the system that normally would take care of
9 X-number of patients, now the service is so small that it
10 doesn't make sense for a hospital to kind of continue those
11 services.

12 That usually doesn't make a difference in a
13 hospital-dense area where there are many other services
14 around. Where it might make a difference, if you're in an
15 isolated area, whether it be an isolated suburban area or a
16 rural area, if you have such services, such as time-
17 sensitive interventions that are necessary, like a code
18 stroke or code MI.

19 So, what I would be interested in with some of the
20 mergers and acquisitions, if you could see that there were
21 services that were compromised as a result of hospital
22 closures, and I think that's one of those things for -- for

1 Medicare beneficiaries, if we just kind of proceed ahead and
2 just look at occupancy rate alone, you might be blindsided
3 to the fact that there are certain services that are
4 actually being altered because of not having enough of the
5 services to maintain proficiency in those services.

6 MR. HACKBARTH: Let's stipulate that that could be
7 a problem. Do you have any thoughts on how that relates to
8 Medicare payment policy if, in fact, patients are shifting
9 for whatever reasons and hospitals are left with
10 insufficient volume of patients to provide quality care?
11 What is your thought about the link of that, how Medicare
12 pays for hospital services?

13 DR. COOMBS: Well, I guess what you would want to
14 ensure, that the Medicare beneficiary would be entitled to
15 the same standard of care that they would get no matter what
16 geographic region they were in, i.e., infrastructure for
17 things like telemedicine and all those things would be
18 available to the beneficiaries. But hospitals might make a
19 decision, a default decision because a service is so
20 expensive, and you wouldn't really know that until later in
21 the game. I mean, making changes and then seeing the
22 clinical consequences of that probably wouldn't be

1 manifested until well out, and you might see that in doing a
2 survey, what's available and how far you had to travel to
3 get to a place of reasonable interventions. It doesn't have
4 to be an emergency, either. It could be that you had --
5 this service is no longer provided, especially with things
6 that are, like, subspecialty -- specialists within a
7 subspecialty.

8 DR. SAMITT: So, this was an excellent chapter.
9 Thank you very much.

10 You know, I was most surprised, I would say is the
11 right word, by Slide 5, which really talks about excess
12 capacity, and I'd be very curious to understand, especially
13 the MSAs that have less than 50 percent occupancy. I'd be
14 curious to know, who are these hospitals? What types of
15 hospitals are they? Where are they? I'd also be interested
16 in knowing, in those markets, is the differential between
17 Medicare payment and commercial payment as profound? Are
18 the commercial payers observing this same trend regarding
19 excess capacity?

20 And I guess I'll go one step further and I'll be
21 somewhat provocative. Would we ever consider a
22 recommendation to adjust future payment based upon, linked

1 to the percent of occupancy in that MSA, in essence, with
2 the thought that in MSAs with such a tremendous excess
3 capacity, that payment adjustments are less because, you
4 know, with the concern or notion that Medicare is assuming
5 responsibility for the cost of some of this excess capacity?
6 So that would be my first comment.

7 MR. HACKBARTH: So, just on this point, and this
8 goes back to a question that Bill Gradison asked, there's a
9 disconnect for me. If, in fact, these are staffed beds and
10 hospitals are persistently operating at 50 percent of
11 capacity, and capacity is defined as staffed beds, why in
12 the world would anybody continue to staff half their beds
13 that are empty every day?

14 MR. GEORGE MILLER: No, staffed beds is not
15 occupied -- excuse me. Staffed beds is different than total
16 capacity. We staff to the number of patients --

17 MR. HACKBARTH: Well, that's what I'm saying.
18 Bill asked, are these numbers staffed beds, and I thought
19 the answer to that was yes, and we're saying that only half
20 of the staffed beds are occupied. Or am I misunderstanding?

21 MR. GEORGE MILLER: I thought --

22 DR. STENSLAND: Maybe George or Peter can correct

1 me, but what we're getting from this is the AHA survey data,
2 and the one is just the licensed beds, like, how many beds
3 could you possibly have. And then there's staffed beds,
4 which I think more about. These are the beds that are there
5 that you could have staffing for if -- it's kind of more
6 like the beds are there and you could bring in nurses to
7 staff them, but you don't necessarily have those nurses
8 there. So you might just have the beds there in your
9 facility, but there really aren't nurses running around.

10 MR. HACKBARTH: There's three categories. There's
11 licensed, then there's staffed but not really staffed, and
12 then there are staffed, really staffed.

13 DR. CHERNEW: They're staffable.

14 MR. HACKBARTH: Staffable.

15 DR. SAMITT: But, nonetheless, the staffing --

16 MR. HACKBARTH: The staffable beds.

17 MR. GRADISON: There's another element in this,
18 too, which I think is kind of hard for me to grasp, and just
19 quickly, and that is with all this surplus capacity, why are
20 the number of employees going up year after year? I don't
21 quite get that, either.

22 DR. SAMITT: I mean, nonetheless, the staffing

1 aside, there are still fixed overhead costs with the excess
2 capacity that exists in these markets. So, provocative,
3 yes, but I think we need to focus on capacity, especially in
4 some of these MSAs.

5 The third quick comment that I would make is
6 really more forward looking as it relates to ACOs, as we've
7 discussed before. I guess my philosophy is fee-for-service
8 reimbursement rates should allow the vast majority of
9 hospitals to survive, but not thrive, that only those
10 hospitals that are really exploring accountable care,
11 coordinated care, higher quality care, better safety, better
12 efficiency, are the ones that really should thrive. And so
13 we need to keep that in mind as we think about refining the
14 hospital chapter, I think, next year.

15 And then, finally, I'm glad that this slide was
16 MSA only because I'm very much concerned about safety net
17 hospitals and rural hospitals and we absolutely need to
18 preserve the viability and access of those hospitals. And
19 so the comments that I've made really exclude safety net and
20 rural, because I do think we need to assure preservation of
21 those facilities.

22 MR. HACKBARTH: One other question, Craig, and

1 maybe we can come back to this in round three, is that if we
2 stipulate that we've got an excess capacity problem, either
3 generally or in a particular market, trying to wring out
4 that excess capacity by lowering payments per admission
5 versus steering patients from low-performing hospitals to
6 high-performing hospitals, I think you get very different
7 results, because the low payment approach, and we're going
8 to squeeze it out by ratcheting down on payments, affects
9 everybody. It affects the high performers, the low
10 performers. Whereas if you can shift volume, you can reward
11 those institutions that you said you want to reward and
12 wring out excess capacity.

13 So, between those two policy mechanisms, shifting
14 volume and just ratcheting down across the board --

15 DR. SAMITT: Well, and I'm not even necessarily
16 envisioning ratcheting down across the board, but perhaps
17 capacity in the market is one element of the payment factor
18 that's considered among others. Market share may be
19 another. The question is, is can we reward those hospitals
20 and even shift within markets that have excess capacity
21 those that are clearly demonstrating higher quality, higher
22 efficiency, better service than others also in that excess

1 capacity market. It would still put downward payment
2 pressure on hospitals in high-capacity markets that are not
3 delivering on safety and quality.

4 DR. MARK MILLER: Don't abandon your provocative
5 thought, yeah, because the other way you could think about
6 this is you're saying -- your exchange of comments got to,
7 so, maybe you reward the good performers. But you could
8 also look inside these markets and kind of ask the question
9 of who are -- because this question, like, who are these
10 hospitals that year over year, and by the way, what is their
11 quality, and so you could also think about looking at both
12 ends of the spectrum, which is where I thought your thought
13 process --

14 DR. SAMITT: Well, it also underscores that we
15 need -- you know, the question is: To what degree are we
16 applying sufficient scrutiny of all hospitals to say what is
17 their capacity, their market share, their quality, their
18 safety, their involvement in ACO programs? And I don't know
19 to what degree we can do that analysis, but I'd be very
20 curious to see the makeup and the correlations of those
21 various factors market to market or hospital to hospital.

22 DR. HOADLEY: So as others have said, this is a

1 great presentation, and I really think it sets us up nicely
2 to move forward on this topic. And I won't, you know,
3 recover some of the ground that has been covered. I guess I
4 would go back to the DSH thing, and I really like the idea
5 of bringing up the question of whether we've got the right
6 proxy and the possibility of the alternative. And I don't
7 know if there's more we should be saying when we get to this
8 in the chapter, either in terms of actually recommending a
9 different way to measure this or at least talking about it
10 in some kind of terms. And I think it would be useful to
11 have that on the table when we're talking about this chapter
12 in the next month or two.

13 And the other comment, I guess, that relates both
14 to the DSH estimates that you went through but also to some
15 of the other numbers you present is there's a number of
16 cases where you're relying on the trends going forward with
17 what's going to happen in the new insurance coverage. And
18 it might be useful there because there's some considerable
19 uncertainty around those levels to do a little bit more
20 sensitivity analysis, whether that's quantitative or even
21 just qualitative, to give us a sense of so if the insurance
22 take-up is, you know, so much higher or so much lower than

1 sort of the CBO numbers that you've often used as the
2 benchmark and, you know, we won't know anything more
3 concrete by the time we're doing this chapter, but just a
4 little bit of a sensitivity discussion around that I think
5 would be helpful in making sure we understand those
6 estimates correctly.

7 MS. UCCELLO: I think a lot of great comments have
8 already been made, so I'll just make three minor comments.

9 In terms of the uncompensated care, I think you
10 did a really great job highlighting that this doesn't make
11 sense. So the extent that we can kind of encourage CMS to
12 move forward more quickly with the S-10 data I think would
13 be valuable. And also just the way the differences are done
14 between fee-for-service and MA again doesn't make sense, and
15 it seems like there's not a good reason for those
16 differences. So pushing back on that.

17 The second point, Kate and others have mentioned,
18 you know, lots of changes are going to happen in 2014, and
19 some of them overnight. I think it's important for us just
20 to kind of keep in mind that this is actually going to be a
21 multiyear process. Not all the changes enrollment-wise or
22 otherwise, even state-wide with respect to Medicaid choices,

1 I think it's going to be a few years we reach a new
2 equilibrium, so just kind of something maybe to keep in mind
3 next year.

4 And, finally, as we talk about -- Mike is gone,
5 but as we talk about whether and how to differ payments or
6 updates across different providers, it might be worthwhile
7 to remind ourselves of those principles that we put forward
8 that were part of the rural report; that, you know, how we
9 best target differential payments, because I think that was
10 very useful to me in thinking about how to do this, and I
11 think it would be equally useful as part of this
12 conversation.

13 DR. NAYLOR: So I was just wondering how you were
14 going to build a simulation model between --

15 [Laughter.]

16 DR. NAYLOR: Really, this was a great chapter,
17 stimulated a great conversation. I actually thought some of
18 the key -- I mean, I appreciate all the nuances and changes
19 that we're about to encounter, but I thought we're talking
20 about 2015, and I thought the key messages still, even after
21 this conversation, are access to beneficiaries is strong.

22 I think the decline in inpatient days and growth

1 in observation days are really -- I mean, in so many ways
2 the tools that MedPAC has advocated on the first are coming
3 into fruition, so I think that that's a really important
4 signal of positive change. But I think watching the
5 observation days is very important. So, anyway, I
6 appreciate the complexity and this conversation.

7 MR. GEORGE MILLER: Yes, thank you. Could you put
8 Slide 8 up one more time, please? I just want to be clear.
9 Did the 2011 to 2014 5.5 percent number include
10 sequestration in that number as well?

11 DR. STENSLAND: It does not include sequestration
12 there.

13 MR. GEORGE MILLER: Okay.

14 DR. STENSLAND: So if it was sequestration, you
15 know, maybe take 1.9 percent off, if it continues on in the
16 next year. And we don't know if it will or not.

17 MR. GEORGE MILLER: Yeah, we don't know. And that
18 was not 5.5 percent, is my point. Subtract the 1.9 from the
19 5.5?

20 DR. STENSLAND: Well, we don't -- it could --

21 MR. GEORGE MILLER: For 2011 to 2014.

22 DR. STENSLAND: To 2014. Right now at this point

1 in time for this part of 2014, it would be, you know,
2 roughly 1.9 percent lower or something like that.

3 MR. GEORGE MILLER: Okay. All right. I just
4 wanted to make sure I was clear in my mind. And, again, the
5 point that I will -- and I think this is a great report.
6 It's a great starting point for our discussions for the
7 update. But I do want to point out a couple of things that
8 were said. One was already said about Moody ratings in many
9 hospitals are down. And while there are 4,800 hospitals and
10 we make a decision over all of them across the country,
11 again 42 percent of them are in one-hospital towns. I'm a
12 little bit concerned, as we make the policy, we keep that
13 framework in mind. And I appreciate the statement that was
14 said, we want to preserve safety net hospitals and rural
15 hospitals. And if the efficient hospital has a negative
16 margin, I appreciate Kate's comment that we should look not
17 at cost shifting either way to help the Medicaid population
18 nor should we look at commercial. We should deal with the
19 cost of care to take care of the Medicare population within
20 that market. And I hope we keep that in mind and
21 crystallize on that point.

22 I also want to congratulate the staff on figuring

1 out the uncompensated care just does not work well for us.

2 Thank you.

3 MR. HACKBARTH: Okay. We have about 20 minutes
4 left, and for Round 3 I'd like to invite people to focus on
5 two issues, and you can really go someplace else if you
6 want, but two issues in particular I think merit further
7 consideration. One is the point that Mike made that we've
8 got an update to make for hospital as well as other
9 services. We had this other activity on cross-sector
10 pricing. You know, both have implications for overall
11 hospital financial performance. And Mike has suggested we
12 need to be thinking about these together as we work on
13 updated in December and January and think potentially about
14 pursuing accurate relative pricing for services where there
15 are substitutes for hospital outpatient departments and then
16 looking at hospital inpatient services to offset any concern
17 about overall hospital financial stability, if that's a
18 reasonable summary.

19 DR. CHERNEW: [off microphone].

20 MR. HACKBARTH: So I want to invite people to
21 react to that.

22 Then the second issue is that a number of people

1 focused on the excess capacity, Craig in a particularly
2 pointed way, as is his fashion. And I really like that.
3 And so as I mentioned, I think this is potentially a very
4 important issue. What are our policy levers if we think
5 excess capacity not only is expensive, but it could have, to
6 go to Alice's point, institutions providing services at very
7 low volumes and posing a threat to quality of care for
8 Medicare beneficiaries. What are our policy levers for more
9 effectively dealing with excess capacity where it exists?
10 Those are two issues that strike me as particularly
11 important, the excess capacity thing in part not just
12 because of updates, but because so much of our conversation
13 yesterday was about other mechanisms that might deal with
14 excess capacity.

15 So I invite comments on either of those two
16 issues, or if you really feel like you want to raise
17 something else, that's good, too. So Round 3.

18 DR. NAYLOR: So I would invite Mike to help me to
19 understand. As I understood cross-sector, thinking about
20 updates as an opportunity to think about substituting
21 outpatient for inpatient. At the same time it sounds like
22 we're trying to assure stability of the hospitals. So, you

1 know, we have looked, for example, at data that suggests
2 some minor improvements in quality for Medicare
3 beneficiaries, reductions in marginal, in hospital
4 readmission and so on. So I'm not sure I understand how you
5 do both.

6 DR. CHERNEW: I'll try and be clear, but I'm
7 obviously not that good at it. One of the barriers to
8 getting the cross-sector pricing stuff right is that it
9 adversely affects hospitals. I was simply trying to say we
10 shouldn't perceive that to be a barrier. We can surmount
11 that concern through the update lever and still do the
12 cross-sector pricing stuff.

13 DR. NAYLOR: In the past our updates for inpatient
14 and outpatient have been together. So I thought the cross-
15 sector opportunity was to think about perhaps using a lever
16 of separating those two updates in a way that might say if
17 the data were to support it, updates could advantage
18 outpatient over inpatient if the quality data and access
19 data and so on, and I'm wondering if that were the case, how
20 you would do it in a way that would -- what I thought was
21 the second point -- make sure a hospital continued to be
22 viable.

1 DR. CHERNEW: I would have said the cross-sector
2 pricing was more about some of the specific services as
3 opposed to the updates. So our cross-sector pricing with
4 very specific categories of services as opposed to just the
5 updates. So there were some very specific not update things
6 but service code things, and so we were adjusting not the
7 update factors in the cross-sector pricing section at all.
8 We were adjusting the payments for very specific codes. And
9 so when you adjust those very specific codes so that the
10 RVUs are the same across sites, you bring down some of the
11 ones that had separate facility payments. And so that is
12 the issue more so than doing cross-sector pricing through
13 updates.

14 MR. GEORGE MILLER: And that's why I wanted to
15 challenge because I'm a little bit -- not confused, but on
16 the hospital side, you have all data. We had to do cost
17 shift for what we have data. But if you're comparing across
18 silos, we don't have data for physician office practices or
19 ASCs. We just don't have that data yet.

20 So I'm a little confused how you would say we
21 ought to shift payments to another mechanism that doesn't
22 provide us data. So how do we know which one is correct or

1 appropriate?

2 MR. HACKBARTH: Well, you're absolutely right that
3 we don't have cost data on physicians or ASCs, but we do
4 know that there are people that are willing to provide the
5 services at the current prices, which are lower than
6 hospital outpatient department services.

7 MR. GEORGE MILLER: But that doesn't necessarily
8 make them right because they undercut --

9 MR. HACKBARTH: People are willing to provide it.

10 MR. GEORGE MILLER: Okay.

11 MR. HACKBARTH: You know, most markets don't work
12 on cost reports and analyzing margins. Are people willing
13 to provide high-quality service at that price?

14 MR. GEORGE MILLER: Then why do you have us do it?

15 [Laughter.]

16 MR. HACKBARTH: I'm sorry, George. I didn't --
17 [off microphone]

18 MR. GEORGE MILLER: Why do you have us do it? Why
19 do you have the hospitals provide all this data?

20 DR. CHERNEW: There's a separate discussion about
21 what the right price is in the cross-sector --

22 MR. GEORGE MILLER: Absolutely.

1 DR. CHERNEW: So you could discuss how you deal
2 with that. My only point was once you work through all of
3 that, you shouldn't use a barrier that the outcome of that
4 process is bad for certain types of facilities. You can
5 adjust for that part in other ways.

6 You might decide that the prices are justifiable.
7 Now, I think we've seen a lot of evidence that suggests
8 that's not the case. But you could anyway have that
9 argument. But once you resolve that argument for what the
10 right relative prices are across cross-sectionally, once
11 that's resolved, you shouldn't use as an argument, oh, but
12 it will be bad for one group of people. We have an level to
13 deal with that.

14 MR. GEORGE MILLER: I totally agree with that
15 because, again -- and I've said this publicly, that the
16 ultimate goal is the Medicare beneficiary, and if they've
17 got to pay more money from one side to the other, I have no
18 problem with that. But you said that the payment shift
19 should be because of site specific -- because of cost. We
20 don't have the cost for those other providers. Do I have
21 that correct?

22 MR. HACKBARTH: Yeah, we don't. And you heard my

1 explanation already. I want to go back to the point about
2 hospital cost reports, George, because I think this really
3 is a fundamental issue. I think actually providing cost
4 reports works to hospitals' advantage and documents pressure
5 on margins and all that. Just think what the world would be
6 like if we didn't have hospital cost reports. Then the
7 metric that I would go to is can we get hospitals to provide
8 it for this price? It would be strictly access-driven, and
9 my guess is the prices fall significantly from where they
10 are today, much more closer to the marginal cost of
11 producing the service. The cost report focuses on average
12 costs. And so, you know, rather than worry about the burden
13 of cost reporting, I think it actually works to hospitals'
14 advantage in holding up rates compared to the alternative
15 metric that would exist.

16 MR. GEORGE MILLER: Not in these cases it doesn't.

17 MR. HACKBARTH: Well, in these --

18 DR. MARK MILLER: In these cases they do.

19 MR. HACKBARTH: Yeah.

20 DR. MARK MILLER: I'm sorry you said that. I [off
21 microphone].

22 DR. CHERNEW: The cross-sector pricing issue

1 wasn't because there was a cost -- I think Glenn said it.
2 It wasn't because I observed or thought there was any type
3 of thing. In fact, I wasn't making a comment about how you
4 would do it. I was making a comment about conceptually why
5 you would want to get the prices right. The cross-sector
6 pricing argument was just under the principle of the same
7 price for the same service, regardless of the silo. That
8 was --

9 MR. GEORGE MILLER: I agree with it, except for
10 the hospitals who have put together all the standby capacity
11 in the ER and all that, and if you change prices in the ED
12 to cover that, I think I would be fine. But you decided not
13 to. And I don't disagree fundamentally with wherever the
14 site is it is provided, it should be the same payment. I
15 don't have a fundamental problem with that.

16 MR. HACKBARTH: Yeah. So we're not going to
17 resolve this, and we don't need to try to resolve it today,
18 George. But part of what is at least attractive at a high
19 level to me about the framework that Mike has suggested is
20 that there are extra costs that hospitals have. A lot of
21 those were attributable to their functions as the emergency
22 department and the inpatient providers. And to say that

1 those higher costs, which are legitimate and important in
2 protecting quality, should also carry over to outpatient
3 services like E&M visits where they really don't apply and
4 serve to hold up hospital prices, that doesn't make sense to
5 me. So we do need to cover the legitimate, important costs
6 of hospitals. The current structure I don't think does that
7 very efficiently or effectively.

8 MR. GEORGE MILLER: Well, I would agree with that,
9 but then you've already addressed the uncompensated care
10 being wrong, too, and that's where we could pick that up and
11 deal with that. We'd deal with that effectively and true to
12 our cost, and I'd feel better about it.

13 MR. HACKBARTH: So this has been good. I invite
14 others to jump into this.

15 MR. BUTLER: So on the excess capital, first, we
16 overdo the occupancy rates, but when I said clearly excess
17 capacity, if you look at the capital invested in inpatient
18 units, we've got way too many inpatient units and beds than
19 we need, and not all of it's convertible to the growing
20 demand for outpatient care.

21 When I look at the -- so what do you do about
22 this? Do you use lower prices? I kind of have two of these

1 hospitals in mind. More of them -- we already handled the
2 rurals in our rural report, so let's put those aside for a
3 second. In the urban market, on one end there's kind of the
4 average size hospital. They do really lousy on value-based
5 purchasing. They've got bad HCAHPS and core measures, bad
6 readmission rates. They've got a bunch of independence
7 doctors that tend to churn away without a lot of oversight.
8 And they don't have very good management, and they're just
9 lousy hospitals, and they're -- right?

10 [Laughter/off microphone discussion.]

11 MR. BUTLER: That's one extreme. Then there's
12 others that -- I could --

13 DR. SAMITT: Are you thinking of one in
14 particular?

15 MR. BUTLER: I could name -- I've been in three
16 urban markets, and I've seen these. Okay?

17 Then you have the safety nets that have a
18 passionate workforce, an engaged physician group, they're
19 doing the best they can. They may fall behind on things
20 like readmission rates due to socioeconomic factors and so
21 forth. But you know that they're critical to the access in
22 that community, and they have sustainable presence and

1 community support.

2 What I find is actually the Medicare program is
3 kind of driving that first group out of there, and then it's
4 actually states often that come along and throw them some
5 dollars to keep them in operation. At least that's happened
6 in a couple states I've been in.

7 So, you know, I don't know how you get at it, but
8 I know it when I see it. But how you could categorize those
9 two somehow is -- you know, and we've seen Denver Health
10 here, for example, as a high performer and -- so that's the
11 comment on access.

12 On the other one, I like Mike's -- where he's
13 headed on this. I also try to think practically, too, like
14 what the heck are we going to do in the next month with
15 this? And I think the best you can probably do -- we'll
16 limp along with some of the same across-the-board kinds of
17 things we've done, but maybe you can get some of these
18 principles, you know, starting to frame up in there so that
19 you kind of philosophically were headed this way, but
20 practically what we can do with these update factors this
21 year may be limited.

22 Now, the comment I would make on Mike's is that

1 there's some obvious ones that just, you know, you get them
2 so much cheaper somewhere else, so why are you paying so
3 much, and it's not inconvenient for the patient and all the
4 rest, and we've already addressed some of those in
5 recommendations. But then what you're left with, how could
6 you characterize both -- I don't know how you get at the
7 contribution of the hospital beyond just the range of
8 services and looking at it that way, but the fact that more
9 often than not these are nonprofit boards, looking at the
10 population of the health that they're serving, embracing
11 community agency, school-based this, a range of things that,
12 if just left to pricing, you know, you wouldn't find anybody
13 kind of embracing that kind of mission in the same way that
14 hospitals do.

15 Now, how you quantify that in an update to kind of
16 keep that kind of infrastructure and positive mission going
17 forward, I don't know. But I do like the idea of separating
18 these things and then even within outpatient, as Mike
19 pointed out, there are some that, you know, if we have a
20 huge HIV clinic and XYZ that nobody else would kind of do,
21 how do you factor something like that in versus, you know,
22 paying E&M codes or something like that at ridiculous

1 prices?

2 So I'm wandering around, but I think that somehow
3 if we can get the philosophy rolling with some of these, I
4 think it at least gives the ground work for better guidance
5 in the future instead of just saying, guess what, everybody
6 gets half a percent, 1 percent, 2 percent, zero, whatever
7 the number is.

8 MR. GRADISON: Peter, I am, I'm sure like others,
9 have been trying to think through the implications of the
10 charts you shared with us, which talked about possible move
11 from fee-for-service to population health as a basis. What
12 I can't sort out in my mind -- and I'll relate this right
13 now to what you're talking about -- is what that might look
14 like, that possible movement, if we really get some price
15 competition. And we really haven't had a lot of price
16 competition, and there are reasons to think we could have
17 more, particularly as -- and this hasn't really to do so
18 much with Medicare these days, but as more and more people
19 have significantly increased deductibles, co-pays, co-
20 insurance, and perhaps as there's greater transparency.

21 I have not studied up on the new Massachusetts
22 law, which, as I understand it, would require insurers on

1 request to tell patients ahead of time what their co-pays
2 are going to be. But I could envision a world in which that
3 kind of information, which generally is known by the
4 providers but not by the patients, if known by the patients
5 could significantly affect their choices of where to seek
6 care.

7 So my sense of all this is that the basic
8 assumption that fundamental economic considerations that we
9 apply to other fields of endeavor don't apply or don't apply
10 very directly to health care may just be proven wrong over
11 time, and I wouldn't roll out that possibility in trying to
12 think about what the future might look like.

13 DR. HOADLEY: I was trying to think in concrete
14 terms about, you know, what Mike was talking about and
15 thinking back to our discussion of the E&M codes and then
16 the other codes that we looked at comparing the physician's
17 office charges versus the outpatient. If those changes were
18 implemented and not in a budget-neutral manner so that
19 reductions were made on the outpatient side, and then we
20 took up the update with that already having happened or
21 doing these simultaneously, and then you either put some of
22 that money back in through the update, whether you do it on

1 the outpatient side or skew it toward the inpatient or any
2 of these other things, is that --

3 DR. CHERNEW: That's exactly, that's exactly--
4 [off microphone].

5 MR. ARMSTRONG: So a couple of random comments I
6 hope will add to this discussion. One would just be, you
7 know, it would be interesting to know where in our country,
8 whether urban or rural markets, hospital beds have actually
9 been closed and what were the circumstances under which they
10 were closed. I say that in part because part of what we're
11 experiencing is this dilemma where our policy lever is a
12 price per unit of service, and we want to pay an adequate
13 amount on a per unit of service basis. The problem is it's
14 the numbers of services that is going up.

15 And then here's the relatively random part. So in
16 the last 12, 15 years of my career, I have closed a 200-bed
17 hospital and a 300-bed hospital, and I did that in part
18 because there is more than enough hospital bed capacity in
19 the markets that these hospitals used to be in. I converted
20 to 100 percent variable cost my inpatient services. These
21 are very well run hospitals. It's part of a system. But
22 those days were all paid 100 percent on a capitated basis.

1 And so how is it that we can replicate the dynamic
2 that leads to those kinds of decisions to more rationally
3 use the built capacity that already exists in our
4 communities. And I think that's, you know, maybe an
5 anecdote that helps frame, you know, at worst case, the
6 dilemma around using price per unit of service as the policy
7 level, but best case, sort of creates, again, kind of a goal
8 if you will for the sort of evolution that we're trying to
9 inspire.

10 MR. HACKBARTH: So yesterday in our conversation,
11 we talked about Medicare Advantage as being one way that
12 Medicare can encourage that activity. And we discussed at
13 some length, without conclusion, whether ACOs could be
14 configured in a way that they would also apply similar
15 pressure and dynamics.

16 Any final comment? We're just about at the end
17 time.

18 Hearing none, thank you, Jeff and Zach. And we'll
19 now have our brief public comment period.

20 So I'm trying to get a sense of who else, in
21 addition to Sharon, is going to the microphone. Anybody?

22 [No response.]

1 MR. HACKBARTH: Okay, Sharon, you've got the
2 floor. You know the rules.

3 MS. McILRATH: I know the rules. Usually, I think
4 I'm always within -- this is a little longer, but I'll be
5 brief.

6 So on the volume issue. In 2000 to 2005 there was
7 a jump and it was higher than it had been in the past. It's
8 higher than it has been since then. Starting in 2007 the
9 numbers vary, depending on which period you're using and
10 exactly which services you're including. I'm using the ones
11 that I happen to have on my Blackberry.

12 2007 it was 2.7 increase. Then it fell, it was
13 2.5 in 2009; 0.8 in 2010; 0.7 in 2011; zero in 2012. And in
14 2013, if you look at the premium announcement, it looks like
15 it was probably negative.

16 Advanced imaging also slowed to nothing, fell at
17 one point. I think if you looked and compared those to the
18 HOPD rates, because physician offices also were having the
19 impact of care shifting out of the hospital, that they
20 probably look pretty similar.

21 On the RUC and the CPT, we can send you more
22 details on what it was that they've done and how that was a

1 change. Mostly it's just to make people more aware of what
2 was actually happening. There was a change on the way they
3 do the surveys in that it's going to be uniformly
4 administered by the RUC staff.

5 They have reviewed \$76 billion worth of services
6 for potentially misvalued codes. That's out of a pot of
7 about \$90 billion. So when you start about taking a lot
8 more money and having it to redistribute, you're talking --
9 I mean, you could eliminate all of those services and you
10 couldn't get there. One of the reasons is that E&M is such
11 a big piece of the total pot that in order to make these
12 changes and make them all budget neutral, it's going to be
13 hard to do it without touching E&M again.

14 I also wanted to say that they have recommended
15 budget neutral or things they knew were going to be budget
16 neutral. They've done a lot of work on the non-face-to-face
17 area, some things that go way back and were never approved
18 by CMS, and more recently some things that they went and
19 actually sold to CMS, one of them being this new complex
20 chronic care management code that is in the proposed rule to
21 start in 2015.

22 The surgeons -- actually, they also reviewed

1 medical home and actually came out with resources that would
2 have actually paid more than in the demo that CMS was doing
3 but didn't do, than what is generally being paid out there
4 in the world today.

5 So I just want to say that when you start looking
6 at making this all budget neutral and some of the stuff on
7 the Hill is taking the money from those targeted misvalued
8 codes out of the pot entirely or partially, you're going to
9 have to make some cuts that are going to affect other
10 specialities that also have shortages. Those have been
11 talked about here, psych, some that you wouldn't think of as
12 much, urology. They're just -- general surgeons. It's not
13 just primary care where you have shortages.

14 MR. HACKBARTH: Okay, we are adjourned and we will
15 see you next month.

16 [Whereupon, at 12:03 p.m., the meeting was
17 adjourned.]

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