

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
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Thursday, September 11, 2014
10:04 a.m.

COMMISSIONERS PRESENT:
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SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
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WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
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DAVID NERENZ, PhD
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CRAIG SAMITT, MD, MBA
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1 PROCEEDINGS [10:04 a.m.]

2 MR. HACKBARTH: Good morning. Welcome to our
3 guests in the audience. I see a lot of familiar faces, but
4 maybe also some new faces as well.

5 As those of you who follow our work know, this is
6 our first meeting in what is for us a new cycle that runs
7 through our April meeting in 2015. For those of you who are
8 new to MedPAC, we produce two major reports -- one in March
9 and the other in June. An important component of our March
10 report is our recommendation on updates of the Medicare
11 payment rates for the different payment systems for
12 hospitals, physicians, home health agencies, et cetera. And
13 then in June typically we cover a broader range of issues,
14 in recent years often related to new models of payment
15 measuring quality of care and the like.

16 This is the beginning of my 15th year on MedPAC,
17 and it will be my last year on MedPAC. When we finish our
18 report in late April/early May and finish the work on our
19 June report, that will be the end of my service as Chairman.

20 It has been a wonderful experience working with
21 many different Commissioners over the years, including this
22 very special group that we have now, and working with a

1 wonderful group of staff colleagues who are spectacular in
2 ways that you folks can't appreciate but all of us around
3 the table do.

4 So we have an exciting year ahead of us with lots
5 of challenging issues, and this has been our practice in the
6 past. We will kick off the new year talking about our
7 context chapter, as we call it. Part of our charge from the
8 Congress is to consider the budget implications of our
9 recommendations for Medicare, and this is part of the way by
10 which we meet that charge. It is a broad overview of what
11 is happening not just in the Medicare program but in the
12 broader health care system.

13 Julie, whenever you're ready.

14 DR. SOMERS: Good morning. As Glenn just
15 mentioned, part of the Commission's mandate is to consider
16 the budgetary impacts of its recommendations and to
17 understand Medicare in the context of the broader health
18 care system.

19 As one of the ways of meeting these elements of
20 its mandate, the Commission's March Report to the Congress
21 includes an introductory chapter that places the
22 Commission's recommendations for Medicare payment policy

1 within the context of the current and projected federal
2 budget picture and within the broader health care delivery
3 landscape.

4 The chapter is valued by MedPAC's committees of
5 jurisdiction, and it is intended to frame the Commission's
6 upcoming discussions regarding payment updates.

7 While there are no policy recommendations in the
8 chapter, we are seeking your comments today on scope,
9 substance, and tone.

10 In today's presentation we'll discuss the main
11 topics of the chapter. Those include: health care spending
12 growth and the recent slowdown;

13 Medicare spending trends; Medicare spending
14 projections; and Medicare's effect on the federal budget.

15 Kate will also discuss drivers of health care
16 spending and provide evidence of inefficient spending.
17 Inefficient spending provides an opportunity for policy
18 makers to reduce spending, extend the life of the program,
19 and reduce pressure on the federal budget.

20 Finally, note we are not discussing
21 characteristics of the Medicare population in this session's
22 presentation because starting this afternoon and continuing

1 over the next few months, we have several sessions focused
2 on Medicare beneficiaries in response to questions that
3 Commissioners have raised at previous meetings.

4 Historically, health care spending has risen as a
5 share of GDP, but recently its growth rate has slowed. As
6 shown by this graph, that general trend is true for health
7 care spending by private sector payers as well as by the
8 Medicare program.

9 Total health care spending as a share of GDP --
10 the yellow top line -- more than doubled from 1972 to 2012,
11 increasing from about 7 percent to a little over 17 percent.

12 Private health insurance spending as a share of
13 GDP -- the middle purple line -- more than tripled over that
14 same time period, increasing from about 2 percent to about 6
15 percent.

16 And Medicare spending as a share of GDP -- the
17 bottom green line -- almost quintupled, increasing from
18 about 0.7 percent to about 3.5 percent.

19 However, the shaded portions of the spending
20 curves highlight that health care spending as a share of GDP
21 has remained relatively constant for the past several years.

22 Taking a closer look at Medicare, per beneficiary

1 spending growth has slowed in traditional fee-for-service,
2 in Medicare Advantage (or MA), and in Part D. This chart
3 shows average annual growth rates for the last decade (from
4 2004 to 2013) in 3-year periods.

5 As shown by the yellow patterned bars in the
6 chart, per beneficiary spending growth was particularly low
7 in the last period (from 2010 to 2013). The lower growth
8 rates were generally due to a slowdown in the use of health
9 care services as well as restrained payment rate increases.

10 In fee-for-service, growth averaged 1 percent
11 annually. In addition to the slowdown in use, the
12 Affordable Care Act (or ACA) reduced annual payment rate
13 updates for many types of providers beginning in 2012.

14 Next up is MA, where growth averaged 0 percent
15 annually. The ACA reduced payments to MA plans in order to
16 bring costs more in line with costs in fee-for-service. The
17 growth rate could have been lower, but the ACA payment
18 reductions were offset somewhat by quality bonus payments
19 and more complete coding by plans.

20 Lastly in Part D, growth averaged 1 percent
21 annually. The slowdown in Part D was in part due to the
22 increase in low-priced generic drugs on the market and due

1 to the efforts of plans to steer beneficiaries to generics
2 and other low-priced drugs.

3 And now taking a closer look at fee-for-service,
4 generally, we see a slowdown across all settings; however,
5 the impact is not uniform.

6 For example, for inpatient hospital care, the
7 average annual growth in per beneficiary spending fell from
8 3 percent in the first two periods to negative 1 percent in
9 the last period.

10 The growth in outpatient hospital care came down,
11 but was still growing robustly in the last period at 9
12 percent annually.

13 Furthermore, despite the recent slowdown, per
14 beneficiary spending grew over the last decade in almost all
15 settings and grew quite substantially in some settings.

16 For example, per beneficiary spending on inpatient
17 hospital care grew 14 percent over the last decade, while
18 per beneficiary spending on hospital outpatient services
19 grew 126 percent.

20 Per capita spending growth has also slowed
21 recently in the private sector according to an analysis by
22 the Health Care Cost Institute (HCCI) of health care

1 spending for people covered by employer-sponsored health
2 insurance.

3 And like Medicare, the private sector experienced
4 a bigger slowdown for inpatient hospital care while
5 outpatient hospital care continued to grow at relatively
6 high rates.

7 However, the slowdown in the private sector was
8 primarily due to a slowdown in the use of health care
9 services and occurred despite robust price growth.

10 One key driver of higher prices in the private
11 sector is provider market power. Hospitals and physician
12 groups are increasingly consolidating, in part to gain
13 market power over insurers with the aim of negotiating
14 higher payment rates.

15 For the private sector, that resulted in a per
16 capita spending growth of about 4 percent annually from 2009
17 to 2012.

18 By comparison, per enrollee spending for Medicare
19 increased by about 1 percent annually over that time period.
20 So while both Medicare and the private sector experienced
21 low growth in the use of health care services, Medicare also
22 experienced restrained payment rate increases contributing

1 to its lower growth rate.

2 What do these current trends portend for Medicare?

3 From the yellow patterned portion of the bars, we
4 see the slowdown that has been the subject of much
5 discussion in the news media. Per beneficiary spending
6 growth has fallen from average annual rates of 9 percent in
7 the '80s and 6 percent in the '90s and 2000s to 0 percent
8 over the last three years.

9 For the next ten years, as shown by the right-hand
10 side of the graph, the Trustees and the Congressional Budget
11 Office project that growth in per beneficiary spending will
12 be higher than the recent lows, but lower than the historic
13 highs, with an average annual growth rate of 4 percent for
14 the Trustees and 2 percent for CBO.

15 What probably has not received as much media
16 attention is the increase in enrollment growth from about 2
17 percent per year historically to 3 percent. That increase
18 occurred over the last few years and is projected to
19 continue throughout the next decade as the baby-boom
20 generation continues to age into the Medicare program.

21 So despite the slowdown in spending per
22 beneficiary, the Trustees project growth in total spending

1 to average 7 percent over the next decade and CBO projects 5
2 percent.

3 Keep in mind that GDP is projected to grow at
4 about 4 percent per year over the next decade. So Medicare
5 spending is still projected to grow 1 to 3 percent faster
6 than GDP.

7 Just to emphasize the effect of the increase in
8 enrollment growth, the left-hand graph shows that by 2030
9 (the year by which all baby boomers will have aged into
10 Medicare) Medicare is projected to have 80 million
11 beneficiaries -- up from 54 million beneficiaries today.

12 And as the right-hand chart shows, as Medicare
13 enrollment rises, the number of workers per beneficiary
14 declines.

15 Workers pay for Medicare spending through payroll
16 taxes and taxes that are deposited into the general fund of
17 the treasury.

18 However, the number of workers per Medicare
19 beneficiary declined from 4.5 at the program's inception to
20 3.2 today. And by 2030, the trustees project there will be
21 just 2.3 workers for every beneficiary.

22 So what are the implications of the current

1 demographic situation on the overall financial health of the
2 Medicare program?

3 The white line at the top of this graph depicts
4 Medicare spending as a share of GDP. The layers below the
5 line represent sources of Medicare funding.

6 All the layers up to the red layer represent
7 dedicated funds collected specifically to finance Medicare
8 spending such as payroll taxes (which fund Part A) and
9 premiums paid by beneficiaries (which help fund Parts B and
10 D).

11 The blue area below the Medicare spending line
12 represents the Part A deficit created when payroll taxes
13 fall short of Part A spending.

14 The yellow layer represents the large and growing
15 share of Medicare spending funded through general revenue.
16 Today general revenues fund over 40 percent of Medicare
17 spending. And keep in mind, general revenue includes both
18 general tax revenue as well as federal borrowing since, with
19 few exceptions, federal spending has exceeded federal
20 revenues since the Great Depression.

21 So the takeaway here is that it is the combined
22 blue and yellow areas (the Part A Deficit and general

1 revenue transfers) that are financed through general tax
2 dollars and federal deficits -- the same dollars and deficit
3 spending for which education, infrastructure investment, and
4 other national priorities are competing.

5 As well, with its reliance on general tax dollars
6 and federal deficit spending, Medicare has a substantial
7 impact on the federal debt.

8 The yellow line on this chart shows debt as a
9 share of GDP. Debt equaled 35 percent of GDP at the end of
10 2007 as the economy entered the last recession. In response
11 to the recession, the debt soared, reaching 72 percent of
12 GDP in 2013 -- a higher percentage than at any point in U.S.
13 history except for a brief period around World War II.

14 Under baseline assumptions, which generally
15 reflect current law, CBO projects the debt will reach 100
16 percent of GDP in about two decades (or by 2035).

17 The baseline assumes that per beneficiary spending
18 for Medicare and Medicaid increases more slowly in the
19 future than it has during the past several decades.

20 The purple and green lines vary that assumption
21 slightly.

22 If per beneficiary spending growth were three-

1 quarters of a percentage point higher than in the baseline,
2 then the federal debt would be 114 percent of GDP by 2035,
3 as represented by the purple line.

4 In contrast, if per beneficiary spending growth
5 were three-quarters of a percentage point lower, then the
6 federal debt would be 89 percent of GDP by 2035 (as
7 represented by the green line).

8 So under all three scenarios, the debt projections
9 are at levels not seen since the aftermath of World War II.

10 Now I'll turn it over to Kate to discuss drivers
11 of health care spending and evidence of inefficient
12 spending.

13 MS. BLONIARZ: So Julie just showed you a chart
14 that indicated that the government's finances is sensitive
15 to assumptions about health care spending growth, and we are
16 in the middle of a historic slowdown in health care
17 spending. So what do we expect in the future?

18 Official projections, as Julie mentioned, assume
19 that health care spending will reaccelerate, but not to
20 historical levels. Health care spending is the result of a
21 number of factors, and it's really hard to detangle their
22 relative importance in the recent slowdown. But regardless,

1 there's no evidence that the slowdown only occurred among
2 low-value care. Or, in other words, there is still low-
3 value and wasteful care, which could potentially be
4 eliminated.

5 So turning to the drivers of health care,
6 technology -- and by this I mean all changes in the practice
7 of medicine -- is generally agreed upon to be the largest
8 single driver of health care spending. But I want to be
9 really clear. The studies that identify "technology"
10 generally literally count all changes in the practice of
11 medicine in that definition. So this is not just drugs or
12 devices, but also who does the treatment or how the medical
13 office is organized.

14 So some researchers have posited that the recent
15 slowdown may be in part a result of fewer medical
16 innovations over the past few years, which is the technology
17 piece of it. Income, specifically national income, is
18 another driver of health spending. And while GDP has grown
19 from its recessionary level, real median income has not,
20 which may be one reason that health care spending growth is
21 still low. And then health insurance, consolidation, and
22 demographics are a few of the other factors that can affect

1 health care spending.

2 The relative importance of these factors probably
3 vary for Medicare. For example, Medicare has
4 administratively set prices, and when those change,
5 Medicare's spending will change. But Medicare is still
6 purchasing care in the same health care delivery system.

7 Debates about health care spending growth and
8 whether it will reaccelerate or not does not address the
9 central problem that some health care spending is wasteful
10 and inefficient. We see wide variation in health care
11 spending across the country. First, there is variation in
12 private sector prices both across and within markets. And,
13 second, there is variation in service use across markets.
14 When prices are taken out of the equation, different levels
15 of services are provided for populations with a comparable
16 illness burden. And this is true in Medicare as well as the
17 private sector.

18 Then, there is the research talking about the
19 higher level and growth rate of health care spending in the
20 United States as compared with other countries. This
21 research tells us a couple of things. The U.S. spends
22 significantly more on health care than other OECD countries,

1 and this doesn't appear to be because we use higher amounts
2 of services overall. It seems more to be driven by higher
3 prices for comparable services. But the higher spending
4 does not result in either better outcomes or better access
5 to care.

6 Then I'll go through a few of the features of the
7 Medicare program specifically that can result in inefficient
8 spending.

9 First is Medicare's fragmented payment systems.
10 In December and January, the Commission will discuss nine
11 different settings for which Medicare must administratively
12 set prices. And that's not even all of them.

13 Second, Medicare has limited tools to restrain
14 fraud and overuse.

15 Third is the benefit design of the program.

16 Fourth are different prices for the same or
17 similar services.

18 And fifth is that, as a result, there is often
19 under- and overvalued services.

20 The Commission's approach to this has been as
21 follows:

22 First is to pursue accurate prices that reflect

1 the efficient provision of services. This is part of the
2 Commission's mandate and reflects the work you do on payment
3 accuracy.

4 Second is to pursue policies that encourage high-
5 quality care, and particularly improve the coordination of
6 care across settings.

7 Third is to improve the information that
8 beneficiaries and providers receive.

9 Fourth is to pursue workforce policies that ensure
10 that the health care delivery system can evolve and improve
11 the care it delivers.

12 And fifth is to engage beneficiaries in the
13 decisionmaking about their health care.

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

17 MR. HACKBARTH: Okay. Thank you, Julie and Kate.

18 I think what we'll do on this in terms of
19 discussion is not go around the table one by one, but just
20 have Commissioners raise your hands if you have a comment or
21 a question to ask. Let me kick off with a question.

22 So, there's been a lot of discussion about the

1 recent low rate of growth in Medicare per capita
2 expenditures, and it seems to me that there are logically at
3 least three different potential reasons for a decline in the
4 rate of growth. One is a change in utilization of services,
5 utilization in intensity of service. A second would be
6 change in payment rates, for example, from the Affordable
7 Care Act. And, a third is a demographic shift, the fact
8 that we've got this influx at higher than historical rates
9 of new beneficiaries who, being younger, tend to have lower
10 average costs than the older population. So, the average
11 age of the Medicare population is being pulled downward. Is
12 it possible for us to separate out the magnitude of those
13 three factors?

14 MS. BLONIARZ: Sure. Yes, we could do that. I
15 think that, generally, the Trustees have found that it's
16 more the first two that you mentioned. The average age --
17 there is a larger group of people coming into the program
18 who will be 65, but the average age --

19 MR. HACKBARTH: It's not enough --

20 MS. BLONIARZ: -- it doesn't change all that much
21 over the next decade.

22 MR. HACKBARTH: Yes.

1 MS. BLONJARZ: And, so, I think it's the first
2 two. And, we know what the prices are and you could back
3 out -- and we know what utilization is, but I'm going to
4 turn it over to Cori.

5 MS. UCCELLO: Yes, and I was going to make the
6 same point, and I think that the relative share of these
7 different components changes over time, and I do think over
8 the next few years that the age shift is a bigger part of
9 things compared to the other, the cost utilization kind of
10 share itself, and that over time, that's going to change.
11 But, I think it is really important to be able to
12 distinguish between these parts.

13 And, I would add, you know, on the cost side, it's
14 what's kind of excess cost above general inflation and
15 looking at just what the growth in GDP is, and then of the
16 other parts, what is -- what's the age/gender profile, what
17 is the excess cost, what is excess utilization, I think. I
18 mean, I've done some preliminary looks at how this is going
19 to change over 75 years. We don't need to do that here.
20 But, I think if we can get some information on that, it
21 would be helpful.

22 MR. HACKBARTH: Just quickly, sort of a somewhat

1 related question. On Slide 9, on the workers per
2 beneficiary side of this, in other contexts, there's been a
3 lot of discussion about the decline in the labor
4 participation rate. My assumption has been that although
5 that may be a significant policy issue for other reasons, it
6 doesn't really affect this picture much. This is being
7 driven down because of broader demographic shifts and the
8 incremental impact of declining labor participation would
9 just be a blip. Is that a safe assumption?

10 DR. SOMERS: Right. I think that's right. The
11 decline in labor participation over the historic average is
12 --

13 MR. HACKBARTH: A few percentage points.

14 DR. SOMERS: -- a few percentage points.

15 MR. HACKBARTH: Yeah.

16 DR. SOMERS: So, maybe big for the overall
17 economy, but this is really about Medicare enrollment.

18 MR. GRADISON: But, it does have an implication,
19 because on the supply side, a smaller labor force simply
20 means, over time, other things being equal, a smaller growth
21 in GDP, and, therefore, it does have an impact, however
22 small it might be.

1 DR. BAICKER: I thought the discussion --

2 DR. COOMBS: I had a question about, just about
3 this question regarding this. I just wanted to ask, but
4 when you're over 65 and you're still working and you have
5 greater than 50 or so employees, those projected numbers
6 don't include that aliquot of people who are still working
7 at age 65, 70 years of age.

8 DR. SOMERS: I think they do. The estimate of
9 workers include all tax paying workers, and so they make
10 estimates of -- or projections about who's working by age
11 category into the future.

12 MR. HACKBARTH: Okay. So, let me see hands. I
13 have Kate and Jon -- so, Kate and then we'll just go down
14 this row, starting with Jay and over here. And, what I will
15 try to do is after somebody makes a point, if you have a
16 comment related to the issue that's just been raised, feel
17 free to put your hand up and jump the queue. So, Kate and
18 then we'll go with Jay and down this way.

19 DR. BAICKER: So, the chapter is always filled
20 with a ton of interesting information and I hate to suggest
21 augmenting something without also nominating something for
22 shrinking, but I'll do it anyway. The out-of-pocket

1 discussion was very interesting and there is some debate
2 about the extent to which the change in recent, very recent
3 years in insurance coverage and cost sharing is responsible
4 for the slow down, and there's some really interesting
5 longer-run historic pie charts looking at a 30- or 40-year
6 span.

7 But, I wonder if it would be helpful to show some
8 graphs for especially the most recent ten or 20 years
9 showing how cost sharing has changed, because my perception
10 is that the public view of the change is much different from
11 what the data actually support, and particularly the
12 important point you raised in the chapter about the
13 difference between cost sharing in the form of premium
14 contribution versus cost sharing in the form of incremental
15 cost sharing per service, because both contribute to how
16 insured enrollees either in Medicare or the private sector
17 perceive what they're contributing, although we know it all
18 washes out differently in the long run. But, it also --
19 those have very different effects on utilization on the
20 margin and the potential contribution of those out-of-pocket
21 dollars to a slowdown. So, I'd love to see included a
22 little more granularity on that, because that is one of the

1 explanations that you hear bandied about a lot for the
2 recent year slowdown.

3 DR. CROSSON: Yeah. Thank you. It's a great
4 chapter. I just have one question, and it relates to the
5 relationship between GDP growth or contraction and health
6 care spending. And, you did mention that there's a
7 relationship, and I think we all understand that, but do we
8 know -- is there a formulaic approach to that sensitivity
9 that is reasonably predictable, because in the past, we've
10 speculated on what a tolerable rate of health care growth is
11 -- GDP, GDP plus one. I know the President at one point
12 mentioned that. And, we're using the projections here by
13 CBO of four percent GDP growth, and hopefully, that's what
14 it's going to be, or higher. But, if we look at what's
15 going on in Europe, for example, we're looking at the
16 potential for GDP contraction coming up in the next few
17 years.

18 And, so, when we talk about, well, maybe we have a
19 one to three percent problem, if, in fact, we had a
20 different experience with GDP growth, say, over the next
21 five to ten years, the problem, which seems to be controlled
22 now, could more rapidly balloon in relative terms.

1 So, if we -- I mean, does anybody know, if we were
2 to go to one percent GDP growth for three or four years,
3 would health care spending come down concomitantly, 50
4 percent of the way, or is it not known?

5 DR. SOMERS: So, I think, historically, health
6 care spending growth and GDP growth has had a rather tight
7 relationship, I think the Trustees say, although with a
8 pretty large lag, maybe as much as a five-year lag, and so
9 they have been -- the Trustees have been saying that this
10 current slowdown is still largely due to the Great Recession
11 and that we're still feeling the effects of that and we're
12 still in that lag portion. So, if GDP declined -- if the
13 growth wasn't as high as what the Congressional Budget
14 Office projects, health care spending wouldn't adjust
15 instantaneously. You know, negotiations with health
16 insurers and employers are set in advance, so it would take
17 time.

18 So, you're right. These assumptions about how
19 much Medicare growth -- well, that wouldn't account for
20 Medicare, but how much health care spending grows faster
21 than GDP is quite sensitive to assumptions about GDP growth
22 as well as assumptions about health care spending growth,

1 which can be quite variable.

2 MR. HACKBARTH: So, it seems to me that there are
3 a couple issues here that are hotly debated right now,
4 although if you look at the long trend, as you say, Julie,
5 there seems to be a reasonably tight link between GDP growth
6 and health care growth. But, the debate is, A, does that
7 apply as strongly to Medicare as it does to the overall
8 population, given that Medicare people have constant
9 insurance, don't lose it because of unemployment, et cetera,
10 and second, whether, whatever the historical relationship
11 was between GDP and health care spending, whether that has
12 now been broken for whatever reason you describe,
13 potentially, a lot of different reasons. But, even before
14 the Great Recession, there seemed to be a slowing of the
15 rate of growth in health care expenditures. So, whatever
16 the historical relationship might have been, there's a lot
17 of uncertainty about whether it will continue into the
18 future. Is that right, Kate?

19 MS. BLONIARZ: Just a small add-on. I think all
20 of that makes a lot of sense. I might separate out the
21 cyclical versus the structural. In any given year, if the
22 economy is looking better or worse, that affects

1 discretionary allocation, and there, you'd think there'd be
2 a difference between Medicare and private expenditures in
3 how sensitive it is to the given year's fiscal
4 circumstances, how much money there is to devote to health
5 care versus other less income sensitive components. In the
6 long run, as GDP rises, as nations get richer, you expect
7 them to spend more of their GDP on things like health care
8 because they don't need to spend as much as a percentage on
9 things like food. So, there's the sort of long-run trend as
10 nations become wealthier, and then there's the short-term
11 cyclicity, if it's a good year versus a bad year and the
12 differential between private and less discretionary public
13 spending.

14 MR. HACKBARTH: Rita, you had your hand up.

15 DR. REDBERG: Thanks. It was a great and
16 interesting chapter. I just wanted to see if we could get
17 information on Slide 6, and I think it's Figure 6 in the
18 mailing materials, because we look at the cumulative changes
19 and relative, but it would be helpful if we could add the
20 absolute numbers, because, for example, hospitals and
21 hospice both went up 126 percent, but I have a feeling
22 that's a much bigger number on the hospital side than on the

1 hospice side, and it's important for us to keep that,
2 obviously, hospice has only been around for a few years and
3 we always want to consider what's the right number and
4 what's the right rate of growth, and for some things like
5 hospice, we might expect a big growth. So, I just think the
6 absolute numbers would be helpful.

7 And then my comment is just -- well, I wrote it on
8 page four of the mailing materials, but when I think about,
9 yes, as we get wealthier, we spend more on health care, but
10 I think we also want to keep in mind what's our return on
11 investment, because you also make the points in that
12 chapter, you know, we're spending more because we think we
13 might be feeling better or living longer, so it's important,
14 because the data suggests that's not true, that we're
15 spending more but we're not feeling better or living longer,
16 at least compared to other Western countries. And, so, I
17 think it's helpful to have that in context.

18 MS. UCCELLO: Yeah. I just want to give the kind
19 of high-level take-away from this that, you know, in recent
20 years, spending has slowed down, but I think what this
21 chapter does a really great job of highlighting is that we
22 really still need to focus aggressively on spending issues

1 to make sure that this slowdown that we have now is --
2 continues, and that we need to, like, find ways of different
3 payment or delivery to help just sustain this slowdown, so -
4 -

5 MR. GRADISON: First, picking up on Kate's point,
6 it might be interesting to take a look at a table, or maybe
7 even include a table that shows over a period of years what
8 parts of spending have gone down at the time that health
9 care's percentage has been going up. I haven't looked at it
10 for a while, but the last time I did, I was very struck by
11 the drop in the percentage going for food, which was a point
12 that was mentioned by Kate, also household expenditures.
13 There were several categories of significance that -- and it
14 raises an interesting question. Just to say it's going up
15 and we're not sure if we're getting our money's worth isn't,
16 to me, entirely satisfying, because it may -- as an
17 explanation, because this may -- the spending habits
18 represent a collective judgment of people who have income,
19 about how they spend it, and there may very well be a
20 preference. So, over a long time, to go into percentages,
21 for example, for health care or education or whatever,
22 travel, that are kind of off the charts historically but do

1 represent a collective societal direction or choice.

2 I want to call attention on page 36 to the portion
3 that has to do with provider and insurance market power.
4 Twice in this stack of documents, there is reference to, as
5 there is here towards the bottom of 36, the hospital
6 purchasing of physician practices. I think the more
7 significant point isn't that it is hospital employment of
8 physicians who previously operated independent of the
9 hospitals. More to the point, and I do not have data on
10 this, but my impression is that there was a lot more
11 purchase of practices back in the early 1990s than there is
12 today.

13 What prompts this comment is a conversation I had
14 recently with a cardiologist whose whole practice signed
15 onto a hospital. That would be a large hospital in Tampa,
16 Florida. And, I was asking about this. He said, "We didn't
17 sell our practice. We just closed our practice and all got
18 hired by the hospital." And, so, I just want just to --
19 maybe this is more significant than I realize, but, I think,
20 referring to it as purchasing of physician practices really
21 doesn't, in my mind, capture what's going on out there.
22 It's the employment of these folks, whether you buy the

1 practice or you don't buy the practice, and it may be that
2 there are less practices being purchased, but the proportion
3 of doctors moving into hospital employment is going up. So,
4 you might want to take a look at that one.

5 MR. HACKBARTH: Although, presumably, to the
6 extent that the practice had equity, presumably, the new
7 compensation arrangements for the physicians compensate them
8 for whatever equity they're giving up in the closed
9 practice. And, so, it's legally --

10 MR. GRADISON: Not necessarily. That's my point.
11 Not necessarily. In the case that I am familiar with, the
12 answer was zero for the -- they got an employment contract
13 and they got so many --

14 MR. HACKBARTH: But, the amount of dollars they
15 are paid under the employment contract is, by definition,
16 enough to get the physician to say, oh, I'm willing to give
17 up this economic enterprise, and, so, implicitly, they've
18 made a trade, oh, I'll give up this for that. And, my point
19 is that the legalities of whether it's a purchase of the
20 practice or a closure of the practice are just that,
21 legalities. The underlying economics are what matter.

22 MR. GRADISON: Well, certainly. The amount of

1 money has to be sufficient to induce them to make the
2 change.

3 DR. HALL: I guess I just want to pick up on
4 Cori's point and link it to Slide 8, where we look at the
5 projection that CBO and the Trustees do. Putting the dark
6 bar or the bottom pink or whatever color that is aside,
7 because that's the predictable part, I mean, that's the part
8 we can all, and obviously CBO and the Trustees can agree, I
9 mean, the difference, just in a sense, symbolized by the
10 fact that the Trustees say four percent, CBO says two
11 percent in terms of the spending difference, is that issue
12 of -- I mean, obviously, there's all kinds of things going
13 on in what they estimate, but as we sort of look at it at
14 that high level, where we expect the trend to go, how much
15 of the slowdown is some kind of a permanent change versus
16 just the cyclical kinds of things is captured here.

17 You know, there's been a tendency, I know, in the
18 prescription drug world to constantly -- the Trustees would
19 always say, oh, it's going to be back to the normal old
20 growth rate, and then we've gone through five or six or
21 seven years where, oh, then the next year, no, it actually
22 didn't. It kept going down or it kept staying low.

1 So, when you look at this kind of a projection, it
2 really is just a guess of what some of the trends are, and
3 that's the part, I think, that we have the potential to
4 influence, or the bigger political system has the potential
5 to influence.

6 MR. HACKBARTH: Warner, did you have your hand up?

7 MR. THOMAS: I just had one comment on the per
8 beneficiary cost. I was wondering, do we have the trend of
9 what that looks like over the past 20 to 30 years? We look
10 at it as a percent of GDP, but -- and I think we saw it in
11 different segments of time, but we didn't see the trend. Is
12 that something that is available?

13 DR. SOMERS: Well, do you mean this chart here
14 shows spending per beneficiary growth --

15 MR. THOMAS: I am looking at trend over time to
16 see, because we looked at -- in chart -- on page 3, we look
17 at percentage of GDP and kind of trend is over time, and you
18 are looking at time periods where it's flat and time periods
19 where it's growth, and I guess the question is can we see
20 the same time period on a per beneficiary, because, once
21 again, growth could be driven by cost. Growth could be
22 driven by more beneficiaries. So I think it would be

1 helpful to understand what the differential is.

2 MR. HACKBARTH: As opposed to having years
3 clustered together to show a year by year trend.

4 DR. SOMERS: Year by year.

5 And which page are you on? In the report or in
6 the paper?

7 MR. THOMAS: Slide 3. Slide 3 of the slides.

8 DR. MILLER: Yeah. I'm taking this as he wants to
9 see an annual breakout instead of the cost you would have --
10 that we have for others like this.

11 DR. SOMERS: Sure.

12 MR. THOMAS: Because, once again, how does it
13 basically trend with this information? What is driven by
14 actually cost increases versus what's driven by population
15 and additional beneficiaries?

16 MR. HACKBARTH: Okay. Let me see hands on this
17 side. Most everybody, so Mary.

18 DR. NAYLOR: So just a terrific report, and I
19 especially appreciated the attention to the impact of
20 federal and states' health spending on individual and family
21 income.

22 On page 25, you mention 43 percent of seniors

1 delay accessing care, and so senior -- fewer seniors
2 skipping care due to cost concerns, so maybe that was -- but
3 I think that's a really -- you know, despite the fact that
4 we have people who report access to, when they needed
5 primary or specialist care, you have this information that
6 suggests that at least some seniors are delaying. Forty
7 three percent is not inconsequential.

8 And my question is, Do we know? I'm assuming that
9 that includes the seniors, the 20 percent that rely 100
10 percent on Social Security for their income, but do we have
11 a sense of who those seniors are that may be delaying or
12 skipping due to cost concerns?

13 MS. BLONJARZ: So let us confirm what these
14 numbers are representing. I think I just want to make sure
15 that it's not of those people who report that they delayed
16 care, but the reasons are things like cost or things like "I
17 could not find a physician." We just want to make sure that
18 it's not -- it's not only of those people who report having
19 an issue because, as you are pointing out, this is not -- it
20 doesn't read as if it's totally consistent with other stuff
21 we have reported on beneficiary's access to care. So let us
22 confirm this, and we will get back to you.

1 DR. NAYLOR: But I think it's an important
2 distinction that you are making, which is even when there
3 are present and available resources, people may choose not
4 to use them because of real cost concerns, so I'm covering
5 that. In understanding those whose individuals are, I think
6 it will be very important.

7 MR. HACKBARTH: An interesting provocative
8 statistic. As you say, it's a really big number. I'm
9 trying to think of what the mechanism would be.

10 From other things, we know that 90 percent,
11 roughly, of Medicare beneficiaries have some form of
12 supplemental coverage, whether Medigap or employer sponsored
13 or Medicaid, and if you have insurance, Medicare, and you
14 have supplemental coverage filling in deductibles and
15 copays, what is the mechanism by which cost becomes a
16 deterrent to care? That's a question I --

17 DR. NAYLOR: Well, actually, first of all,
18 clarifying this information, but secondly, to Kate's point
19 about how much is the perception that cost sharing is really
20 driving people away from accessing care when they need it
21 versus the reality and whether or not there are different
22 people that are making those decisions, I mean, is it the

1 really low income? I mean, if 20 percent rely 100 percent
2 on Social Security for all of their income, then they have
3 to make very different tradeoffs. So I think understanding
4 that going forward is real important.

5 MS. BLONJARZ: I'm sorry. Can I just make like
6 one other point? Ninety percent of beneficiaries have some
7 form of other coverage, but some of that is Medicare
8 Advantage where there is cost sharing, and there also can be
9 cost sharing in employer or private supplements.

10 DR. SAMITT: This is a great chapter, and it is a
11 reminder for all of us regarding how much additional work we
12 have to do to control the costs of our industry.

13 I have one comment and one question. On Slide 5,
14 I really do wonder about the correlation between GDP and
15 health care costs, and I know we talked about the fact that
16 you can't necessarily interrelate what's happening in
17 Medicare with what's happening in commercial or private pay,
18 but as I look at the areas where costs are rising,
19 outpatient hospital, for example, some would argue that that
20 is a very discretionary area, that that would be an area
21 that you would see rise in the setting of a more robust
22 economy. And so you do wonder whether the story goes a

1 little deeper.

2 Again, you can't correlate Medicare with
3 commercial, but I would imagine that from the provider
4 perspective, what's happening in one is likely happening in
5 the other, as well. That if we looked in the commercial
6 side, we're also see a rise in outpatient hospital.

7 So I'm not so sure I buy the correlation between
8 the two, and it makes me wonder whether there are other
9 drivers for what is suppressing costs and what is driving an
10 increase, which may highlight opportunities for us.

11 My question is on Slide 8, on the right, in terms
12 of the projections between the Trustees and the CBO. The
13 chapter talked about the reasons for the distinction between
14 the two. I think it is probably SGR related, if I read it
15 correctly, but I wonder if we have greater detail in those
16 two categories. So can we get a sense of what the
17 projections look like by subsector in the industry? So is
18 there a graph that shows what do the Trustees estimate for
19 inpatient hospital, outpatient hospital, and so on and so
20 forth, or is it more global and bundled in terms of their
21 projections?

22 It would be intriguing to see what they estimate

1 going forward because that may provide information for us as
2 a Commission to think about in the coming year.

3 DR. SOMERS: Yes, we can break that out, and the
4 difference between Trustees and CBO, they do make a
5 different assumption on the SGR. As you said, CBO follows
6 current law and so assumes that there's a 24 percent cut in
7 Part B, in the Part B Physician Fee Schedule in April.

8 That doesn't make up the majority of the
9 difference there. It's more that in the near term, CBO has
10 put more weight on the recent slowdown and lowered their
11 assumptions about growth because of the recent slowdown than
12 the Trustees have, but then you see if you go out in the
13 next decade that both the Trustees and the CBO assume that
14 per beneficiary spending growth is at 5 percent.

15 DR. SAMITT: Do you know offhand what the trustees
16 estimate the primary driver of the inflation is that makes
17 up that 4 percent?

18 DR. SOMERS: I think -- so they have a model that
19 is largely based on GDP and income and when they expect
20 those to recover, so the expectation is that those are
21 recovering, and spending -- and spending per beneficiary
22 growth will recover, as well. So it's just a bit of a

1 difference on how persistent the recent very low rates of
2 spending growth will persist into the future.

3 MR. HACKBARTH: Well, are there any Commissioners
4 who sit on advisory panels, either Trustees, CMS, or CBO?
5 Mike used to do that.

6 My impression of this process is as what I think
7 Julie is describing. It's that they don't build these
8 numbers from the ground up, and the really big factors are
9 macro factors like how strong do you think the relationship
10 is between GDP growth and health care spending, and how much
11 weight do you give to the recent past versus the more
12 distant past experience. Those things are really what
13 dominate as opposed them trying to figure out what's going
14 on between shifting patterns of care and the like.

15 DR. BAICKER: I don't know the Trustee's process,
16 and the CBO panel doesn't have direct input into the
17 process. So just speaking from my more general
18 understanding, it is exactly those big picture issues, not
19 the under the hood, real granularity, and also, I do think
20 the different assumptions about current law versus current
21 policy are first order in driving distances.

22 MS. BUTO: I can speak a little bit to the

1 Trustee's process. It is much more of a building up of the
2 individual silos within Medicare and assumptions they have
3 about changes going forward in those particular silos,
4 either in utilization or other trends.

5 MS. UCCELLO: Yeah. Let me just add to that,
6 because Mike and I sat on the Medicare Trustees -- whatever
7 that was called.

8 That's true in the short term that it is the more
9 granular, but then in the long term, the trustees are more
10 similar to CBO in that they do these more macro.

11 DR. NERENZ: If we can go back to Slide 5, please?

12 The thing that I found striking here was
13 outpatient hospital and its apparent -- it seems to be
14 immune from or very robust of the other downturns. It is
15 the only area in which the growth is really big, even in the
16 most recent time period, and that seemed remarkable, because
17 if I recall our update discussions from last year, the
18 outpatient hospital is the area that perhaps has the lowest
19 average margins, at least as the bookkeeping is done, sort
20 of double digit negative. So it seems odd.

21 The question then is, when we look at these sets
22 of bars, is there some shifting actually going on here that

1 actually affects part of the behavior? I'm thinking, for
2 example, procedures that used to be done inpatient that now
3 can be done outpatient, just take an activity and they move
4 it from the left to the outpatient, or short stays that used
5 to be stays but are not observation would have the same
6 thing. And if a hospital buys a physician practice, at
7 least under some circumstances, it goes from Part B to --
8 okay.

9 Is there a unique story there that is about
10 shifting, or are these really behavioral dynamics strictly
11 within the silos?

12 DR. SOMERS: I'm going to look around for Dan --

13 DR. MILLER: I'll help you out.

14 DR. SOMERS: Oh.

15 DR. MILLER: So I think that the dynamic -- and I
16 think Craig -- this is, in some ways, what he was saying.
17 If you look across Medicare in the last years, you do see
18 pretty broadly stated slowdown in utilization, but then silo
19 by silo, you can see differences.

20 I think you are correct that, probably, part of
21 the outpatient explanation is the technological shift, a lot
22 of surgery moving from the inpatient side to the outpatient

1 side. That will make that look a little bit anomalous
2 relative to the more general trend.

3 And I think there was a statement earlier on over
4 here -- Rita -- on the hospice, where that kind of
5 represents a different phenomenon, people choosing that over
6 more straight care at end of life. So you get some other
7 patterns that are reflected here. It's not strictly silo
8 specific.

9 The other thing I just wanted to say, keep in mind
10 on the margins, we have talked about this notion before. We
11 do an all Medicare margin in the inpatient setting, because
12 we think the allocation between the inpatient and outpatient
13 is a bit flawed, but your point is taken.

14 DR. SOMERS: I was just going to add, I think
15 there, as well, has been an increase in price per service
16 above what you see in just the update, given a different
17 shift or a mix of services, as well. So it is not just
18 governed by the update. It is also as the mix of services
19 change and they perform more pricy services.

20 DR. MILLER: The notion of an MRI instead of an x
21 ray or something like that.

22 DR. NERENZ: And that just illustrates some of the

1 complexity of trying to really understand this, because as a
2 particular service, for example, moves from one category to
3 another, it will have an effect on -- the one cost
4 utilization fraction goes down. Another goes up. But that
5 service may be cheaper in the new setting than the old, or
6 it may be more expensive in the new setting than the old.
7 That is what is hard to track as we go through there.

8 DR. HALL: On Slide 9 again -- and incidentally,
9 like the other Commissioners, I think this is an incredibly
10 important chapter. This is a real keeper. This type of
11 graph can be looked at, at virtually every developed country
12 in the world right now, and my question had to do with the
13 potential impact and how much we can predict on not how many
14 beneficiaries are going to be in Medicare, but what is the
15 nature of that population, and particularly, it's probably
16 going to be skewed toward a much older population. So when
17 we stop having 10,000 people a day enrolling in Medicare,
18 those people are aging, and the trends show a tremendous
19 increase in the number of people over age 85, millions of
20 people over or centenarians around the world.

21 So one of the countries that I looked at, just to
22 kind of understand this better, was Japan, which is about 30

1 years ahead of us in terms of demographic change, and they
2 are seeing all kinds of strange things going on. For
3 example, in Japan now, more money is spend on adult
4 incontinence products, diapers, than are spent on infant
5 diapers by almost a factor of 50 percent higher, and the
6 same trend is just starting in the United States right now.

7 More importantly, though, along with the changing
8 dependency ratios between workers and beneficiaries, this is
9 a really expensive population of people, really, really
10 expensive, and we know that most of that money is spend on
11 the last one or two years of life.

12 So is there any way to factor that on, not only in
13 terms of the numbers that are going forward, but the
14 predictable clinical characteristics and therefore costs of
15 this growing population over age 85?

16 DR. SOMERS: We will be, throughout the fall,
17 having sessions trying to examine the Medicare population
18 today and how it's changing on into the future, and you're
19 correct. Initially, over the next 10 years, the population
20 is becoming younger, as the baby boomers are aging in. But
21 then as the baby boomers age, the 85 and over population
22 grows. We will be examining that in some later sessions.

1 DR. HALL: Thank you.

2 MR. KUHN: So let me join with others in
3 complimenting the two of you on a very good chapter, and in
4 particular, I want to compliment you on that section that
5 begins on page 38 where you talk about the challenges to
6 Medicare.

7 I think we all know what those challenges are, but
8 I thought the narrative that you put together here was nice,
9 concise, and well done, so again, another compliment on
10 that.

11 The other thing I wanted to just kind of raise, as
12 I was looking at this chapter, there was only a really scant
13 reference, and if I missed others, I apologize, but one
14 scant reference in terms of payment reductions and the
15 interaction of payment reductions and how that is impacting
16 all that is out there.

17 The reference that I saw in there had to do with
18 the changes in the MA plans, but then also, there was also a
19 conversation in there about how that was being backfilled,
20 at least temporarily, by the new quality program in the MA
21 area. But beyond that, we know that there are update
22 constraints. They're rebasing. There's been a lot of

1 things since the Affordable Care Act that have gone forward,
2 and nothing about any of that stuff as a narrative in terms
3 of what the impact of that is, how that's also helping to
4 constrain cost and all that as part of that.

5 We usually put that in our update chapter, at
6 least the one year where we say the current update is X, but
7 I think it would give us some more context if something like
8 that was included in this chapter, as well.

9 DR. COOMBS: So thank you very much for an
10 incredibly well done chapter.

11 I was looking at Slide 16, and in the reading
12 material, I looked at the fact that we have the cost
13 drivers, if there is a way to put how the challenges and the
14 Commission's approach actually addresses some of the cost
15 drivers, especially technology.

16 One of the issue I have is the whole notion of key
17 cost drivers and what we do to make beneficiaries empowered
18 to deal with the cost drivers, because we have focused a lot
19 on providers in terms of providers impacting cost, but this
20 whole notion of what do we do for beneficiaries in terms of
21 just health care literacy and going forward. And there have
22 been a lot of pilot programs that actually looked at

1 antibiotic use, just MRI scanning with the back injury and
2 CT scanning, and I'm wondering if that is probably a more
3 efficient way of actually putting an agency on the ground
4 for really changing the paradigm.

5 I am not optimistic about what we do from the
6 10,000 foot level. I am more optimistic if a plan could
7 actually input some kind of empowerment program.

8 And I honestly believe that there is a tipping
9 point within communities, that if this message is really,
10 really done well, that that tipping point actually results
11 in the greatest cost reduction and inappropriate therapy
12 than any of the other initiatives that we do. So if it was
13 a priority of all the things that we -- we look at the
14 challenges. We look at the Commission's approach. If there
15 was a priority, I would say that that would really drive
16 home the message, and it would become a uniform language
17 within communities.

18 And maybe Scott could speak to that in terms of
19 some of the innovation that he's done, but I know that I'm -
20 - where I work, I don't see that there is a stop gap for if
21 the patient doesn't take agency to say, "Well, maybe I can
22 wait a week before I get this expensive test," or maybe,

1 "Can I get a second opinion before I pursue this next step?"

2 I think that it would be nice to see a chart that actually
3 says the Commission approach and how it interfaces with the
4 cost drivers and link them.

5 MR. ARMSTRONG: I, too, would affirm this is an
6 interesting chapter, and it offers great context for the
7 work that we have going forward. I would say I have nothing
8 I could contribute to make the projections any better than
9 they have been.

10 I would say, echoing Cori's comment, that this
11 affirms that we have a lot of work ahead of us, and that we
12 have serious problems. I mean, we can't afford 5 to 7
13 percent inflation going forward, and so, obviously, that is
14 our challenge.

15 I, frankly, turn to page 14 and just ask, as I
16 think about our agenda going forward, if there isn't more we
17 can do to confront some of these things. We talk a lot
18 about them. It's juxtapose to Slide 15 where we describe
19 our various tools, and they don't really seem to stand up to
20 the issues on page 14.

21 But one thought -- and it may have been done
22 already. If it's a lot of work, it may not be worth it, but

1 it just strikes me what if we were to imagine projecting
2 forward a future where the most expensive markets in our
3 country were 25 percent closer to the lower expensive or
4 more efficient markets in our country, and what kind of
5 inflation rate would that imply?

6 And that it just begins to, on a more local level,
7 give you a better sense for, beyond our patient policy
8 tools, what are some of the changes that you could emulate
9 in high-cost markets that are more like the more efficient
10 markets, and my suspicion is that if you close the gap, that
11 actually, you're talking about a pretty significant impact
12 on the future inflation rates.

13 So just -- I don't know -- kind of a sober
14 reflection on the fact that while things seem to have been
15 relatively good in the last couple of years, relatively good
16 in the last couple of years, relative to previous years, we
17 are still in deep trouble, and that the nature of and the
18 drama of the recommendations that we need to be pushing
19 forward need to stand up to and match the significance of
20 the trends that we face.

21 MS. BUTO: Yeah. One of the things I wondered
22 about was whether the Trustees or the CBO projections

1 included an assumption about the existence of fee-for-
2 service going forward versus more managed options. I'm
3 assuming they looked at today and had fairly conservative
4 assumptions about the distribution of beneficiaries in fee-
5 for-service versus a more managed environment, but I would
6 be interested to know that.

7 Then the other piece -- and it's partly related to
8 something that others have said -- is this whole issue of
9 kind of increasing the engagement of beneficiaries through
10 whether it's evidence-based information or other information
11 and more of a shared decision-making mode is something which
12 I think you allude to on page 42 in the Engaging
13 Beneficiaries. But it would be good to be, I think, a
14 little more proactive about what do we imagine that doesn't
15 exist now that would be helpful in having beneficiaries make
16 some of these decisions, but I would be interested in the
17 managed care and fee-for-service breakout in the two
18 assumptions.

19 DR. CHRISTIANSON: I think we've, as a Commission
20 in the last year, reaffirmed the notion that we want to pay
21 for value. This is the kind of chapter that we have had in
22 previous reports, previous years, where we talk about cost

1 trends. We talk about drivers of costs, Medicare costs
2 versus other costs. But part of what we pay now depends on
3 people -- it depends on organization's performance on value
4 measures and quality measures.

5 So I think an important context, chapter title
6 context for Medicare payment policy, and increasingly
7 important will be what's happening in terms of trends in
8 quality indicators that are used in the program. There's
9 really nothing on that. There's a half-a-page discussion on
10 page 37 that sort of says, "Gee, a lot of spending is
11 inefficient," but I don't think that does the job. I think
12 we need to broaden our sense of context to be consistent
13 with what we're saying as a Commission, which is we pay on
14 value. We think it's good to pay on value, so part of that
15 is cost. Part of what is what we are getting for our money,
16 and we are tying payment to that. So I think to have a good
17 understanding of overall context, we need to have some
18 tracking of value or quality indicators over time someplace
19 in this chapter.

20 MR. HACKBARTH: Several Commissioners have said
21 that while things have been somewhat better, i.e., rates of
22 growth have been slower, that we still have a big challenge

1 ahead of us. Scott made that point. Craig made that point,
2 and several others have, as well.

3 I share that point of view. I sometimes get a
4 little bit worried that people look at the recent very low
5 rates of growth per beneficiary, Medicare growth in
6 particular, and are ready to declare victory.

7 Of course, there is a very big debate about the
8 reasons for the slowing of the rate of growth and how much
9 of it is due to changes in health care delivery, changes in
10 the drug pipeline versus the economy versus other things,
11 and I don't know enough to meaningfully participate in that
12 debate.

13 The one point that I would like to see come
14 through in this chapter, if others agree, is that whatever
15 the cost, we shouldn't assume that the recent low rate of
16 growth will be enduring. I am old enough that I have been
17 through -- this is the third cycle. It happened in the '80s
18 -- Bill, I know remembers this -- where actually the
19 Secretary of HHS declared victory over the health care cost
20 dragon, much to the dismay of those of us who worked for --
21 Kathy remembers that too.

22 And then in the '90s, we had another slowdown and

1 then an acceleration and here another. Again, I don't
2 profess to know what the reasons are. I'm pretty confident,
3 though, that it's not immutable, that the circumstances that
4 brought it about, whether it has to do with drug innovation
5 or changes in care delivery or the economy can change, and
6 so nobody should be declaring victory. Vigilance and more
7 effort is required, regardless of the reasons.

8 Do people agree with that as a message? And if
9 so, I think we ought to have that in here.

10 Okay. I know there were a couple other hands, but
11 we are behind schedule already, so we need to move ahead.
12 Good work on this, Julie and Kate.

13 So our next topic is developing payment policy to
14 promote use of services based on clinical evidence.

15 MS. RAY: Good morning. Medicare's payment
16 policies generally reflect the cost of a service, not its
17 clinical effectiveness relative to its alternatives.
18 Policymakers are looking for ways to better ensure that
19 beneficiaries are getting the best value for their health
20 care dollar. One policy direction is to base certain fee-
21 for-service payment rates on comparative clinical
22 effectiveness evidence.

1 At the March 2014 meeting, we discussed linking
2 Part B drug and biologic payment to comparative clinical
3 effectiveness information. During your discussion at the
4 March meeting, there was some consensus among Commissioners
5 that the Congress should restore the Secretary's authority
6 to implement such policies for Part B drugs rather than a
7 broad application of the policy.

8 Katelyn and I are here to follow up with you on
9 this discussion. First I will summarize how Medicare pays
10 for Part B drugs. Then I will describe Medicare's policy
11 applied before 2010 that set the payment rate for some Part
12 B drugs based on clinical evidence. Next, Katelyn will
13 present examples of how this policy is used by other
14 organizations here in the U.S. as well as internationally.
15 Last, I will present a policy option for your consideration
16 that would restore the Secretary's authority to link payment
17 to comparative clinical evidence for Part B drugs and
18 biologics. We are looking for your feedback about whether
19 you wish to proceed with this policy option.

20 First, here is some background on the Part B drug
21 payment system.

22 Most Part B drugs are administered by physicians

1 in their offices or hospital outpatient departments.

2 Medicare pays physicians generally 106 percent of
3 a drug's average sales price.

4 Average sales price, or ASP, is the manufacturer's
5 average price for sales to all purchases net of rebates,
6 discounts, and price concessions. Physicians have the
7 incentive to seek the lowest price available for a product
8 since they are paid 106 percent of ASP regardless of their
9 acquisition costs.

10 In 2012, Medicare spending for Part B drugs
11 furnished in physicians' offices totaled about \$13.2
12 billion, an increase of nearly 3 percent from 2011. The top
13 five products, which account for about 30 percent of
14 spending, are infusion drugs (for cancer and autoimmune
15 disorders) and injection drugs for eye disorders.

16 Medicare between 1995 and 2010 set the payment
17 rate for two or more Part B drugs with evidence showing
18 their comparative clinical effectiveness based on the least
19 costly drug. Referred to as the least costly alternative
20 policy, it is a type of reference pricing policy, and its
21 intent is to obtain the best price for beneficiaries.
22 Beneficiaries' coinsurance on Part B drugs is 20 percent.

1 The LCA policy affects a drug's payment rate.
2 Medicare used the statute's payment policy -- average sales
3 price since 2005 -- to determine the payment rate of each
4 product and then set the payment rate for all products based
5 on the least costly one. Prior to 2010, the policy was
6 usually implemented by the medical directors of Medicare's
7 contractors -- in local coverage decisions regionally. In
8 one instance, Medicare implemented a least costly
9 alternative-type policy, referred to as the functional
10 equivalence policy, nationally under the Hospital Outpatient
11 Department Prospective Payment System for erythropoietin
12 stimulating agents.

13 The contractors' medical directors implemented the
14 least costly alternative policy based on the statutory
15 provision that requires Medicare to pay only for services
16 that are reasonable and necessary for the treatment of an
17 illness. A beneficiary and the manufacturer of an
18 inhalation drug challenged the policy in federal court,
19 arguing that the drug should be paid based on its own
20 statutorily determined payment rate -- average sales prices
21 plus 6 percent.

22 The court held that the drug manufacturer had no

1 legal standing and dismissed the manufacturer from the case.

2 Two federal courts agreed with the beneficiary.

3 In April 2010, Medicare rescinded the least costly
4 alternative policies that had been applied to Part B drugs.
5 At that time it was applied to two groups of drugs.

6 So now let's look at three case studies that show
7 that linking Part B drug payment to clinical evidence could
8 potentially help beneficiaries obtain the best price and
9 would improve the value of spending for Medicare.

10 The first case concerns five drugs used to treat
11 osteoarthritis of the knee. CBO estimated savings of \$500
12 million in mandatory program spending over 10 years if
13 Medicare had implemented a least costly alternative policy
14 for these drugs. Before 2010, Medicare did not apply the
15 least costly alternative policy to these drugs, and
16 currently each drug is paid according to its own average
17 sales price.

18 The second case study concerns the least costly
19 alternative that Medicare prior to 2010 applied to four
20 products used to treat prostate cancer. The OIG estimated
21 one-year savings of \$7 million for beneficiaries and nearly
22 \$27 million for the program if the least costly alternative

1 policy had not been rescinded in 2010.

2 We expanded the OIG's analysis and estimated that
3 if the least costly alternative policy was applied to these
4 drugs between April 2010 and December 2012, beneficiaries'
5 spending would have been reduced by about \$24 million and
6 the program spending would have been reduced by nearly \$98
7 million. Since 2010, each drug is paid according to its own
8 average sales price.

9 The last case study concerns two products that
10 physicians prescribe for wet age-related macular
11 degeneration. The OIG estimated savings of \$275 million for
12 beneficiaries and \$1.1 billion for the program if payment
13 was based on the lower-cost product in 2008 to 2009.

14 An OIG survey found that the majority of
15 physicians (about 70 percent) who administered the lower-
16 cost product reported the substantial cost difference
17 between the two products as a primary factor in their
18 decision. In addition, 40 percent of physicians cited
19 patient insurance as the reason for administering the lower-
20 cost product. We analyzed 2011 claims data and found that
21 patients with Medigap were more likely to be prescribed the
22 higher-priced product and beneficiaries dually eligible for

1 Medicare and Medicaid were more likely to be prescribed the
2 lower-cost product. These findings suggest that some
3 clinicians are prescribing the drug based on patients' out-
4 of-pocket costs. Currently each product is paid according
5 to its own ASP.

6 Katelyn will now summarize the use of reference
7 pricing policies by other organizations and arguments
8 against and for such policies.

9 MS. SMALLEY: As Nancy mentioned earlier, LCA is a
10 type of reference pricing, which is itself a somewhat broad
11 topic. Different groups have devised different ways to
12 establish the reference price (for instance, the least
13 costly, the weighted average, or the average price in
14 another country). It has also been used for different
15 products and services. In the U.S., most reference pricing
16 programs involve hospital services, but some programs also
17 use reference pricing for drugs. Internationally, it is
18 common to price drugs based off of a reference price. On
19 the next slide, I will go into detail on a few examples.

20 The Drug Effectiveness Review Project, or DERP,
21 headed by the Oregon Health and Sciences University,
22 completes systematic reviews of the clinical effectiveness

1 of drugs in specific classes. Currently, 12 states
2 participate in the program, meaning they help decide
3 research priorities and receive the final reports. Each
4 state uses the information from DERP differently, but some
5 Medicaid programs do use the information on clinical
6 effectiveness to set payment policy.

7 An international example of reference pricing is
8 Germany's system for approving new pharmaceuticals. Germany
9 has a multipayer health care system, but their nonprofit
10 sickness funds often work together to establish prices.
11 Since 2010, prices for new drugs have been established in
12 the following way:

13 First, the manufacturer submits peer-reviewed
14 evidence on their new product to an independent committee
15 made up of physicians, hospitals, insurers, and patients.

16 Next, the committee commissions a report on the
17 clinical effectiveness of the new drug. This process takes
18 up to one year. For that time period, the drug may enter
19 the market at a price established by the manufacturer.

20 Finally, the evidence from the clinical
21 effectiveness review is used by the sickness funds to
22 negotiate a discount off of the initial price. Importantly,

1 this negotiation only takes place if the drug is found to be
2 superior to the existing treatment. If not, reference
3 pricing is used to set the price for the new product at the
4 price of the current treatment.

5 As an example of reference pricing for procedures,
6 CalPERS and Anthem began a program in 2011 to control costs
7 for hip and knee replacement surgery. They set a threshold
8 reference price based on what low-cost hospitals charged,
9 and if beneficiaries chose to get their procedure done at a
10 higher-cost facility, they would have to pay the difference
11 in price, in addition to their standard cost sharing. This
12 resulted in higher market share for the low-cost hospitals
13 and also in the higher-cost hospitals lowering their prices.

14 Some observers have raised concerns about
15 reference pricing policies in general and LCA in particular.
16 First, some are concerned that LCA may reduce manufacturers'
17 incentives to produce innovative products, but there is not
18 consensus in the industry on this point. In fact, some
19 argue that in a system in which new drugs are judged based
20 on their superiority over the standard treatment,
21 manufacturers are rewarded for innovative products.
22 However, some worry that such a policy would reduce the

1 incentive to invest in incremental improvements over those
2 products and may affect the diseases that manufacturers
3 choose to focus on.

4 Others are concerned about the transparency and
5 predictability of the process used to establish the least
6 costly alternative. The previous LCA policy was implemented
7 through local coverage decision processes and after evidence
8 was assembled and reviewed by the medical directors and was
9 subject to public comment.

10 Finally, there are concerns that LCA policies may
11 reduce clinicians' flexibility in treating their patients.
12 The previous LCA policy accounted for both provider-based
13 medical exceptions and opportunities for patients to access
14 higher-cost products if that is their preference.

15 On the other hand, some observers have argued that
16 the Medicare program should help beneficiaries get the best
17 value for their health care dollar. They contend that
18 payment should not vary for products that clinicians
19 prescribe for the same condition and produce a similar
20 outcome. By dissociating payment from comparative clinical
21 effectiveness, Medicare has sent distorted signals to the
22 market. Observers also contend that the LCA policy would

1 further the sustainability of the Medicare program.

2 Finally, there is somewhat of a precedent for
3 Medicare linking payment to clinical evidence. The
4 inpatient and outpatient prospective payment systems have
5 temporary add-on payments for new technologies, which
6 increase the payment amount for technologies that can be
7 shown to be a substantial improvement over existing
8 treatments. These payments are temporary and are intended
9 to be used in cases where the use of the technology would be
10 substantially underpaid by the payment system.

11 With this in mind, Nancy will now present a
12 potential policy option regarding LCA.

13 MS. RAY: Okay. At the March 2014 meeting, there
14 seemed to be some consensus among Commissioners for the
15 policy option that the Congress restore the Secretary's
16 authority to apply the least costly alternative policy to
17 Part B drug and biologic payment.

18 This policy option is consistent with the OIG's
19 conclusion that the least costly alternative policy may be a
20 useful tool for conserving taxpayer funds, provided that
21 patients retain access to appropriate care and the OIG's
22 recommendation that the Secretary seek legislative authority

1 to use the least costly alternative policy for Part B drugs.

2 Restoring Medicare's least costly alternative
3 authority could be coupled with statutory language that the
4 Secretary evaluate opportunities for its application.

5 Commissioners could discuss some of the
6 implementation issues we raised in your briefing paper that
7 include development of a transparent and predictable process
8 for considering and presenting comparative clinical
9 effectiveness evidence, a process that permits input and
10 comment from beneficiaries and a wide range of stakeholders,
11 permits beneficiaries to purchase a more costly product if
12 it is not deemed medically necessary, and a process for
13 revisiting the policy as evidence changes.

14 This concludes our presentation. To summarize,
15 the least costly alternative policy is a way to improve the
16 value of spending for beneficiaries and the program. The
17 Secretary would need statutory authority to implement such a
18 policy for Part B drugs. We seek Commission feedback on the
19 policy option to restore the Secretary's authority to apply
20 the least costly alternative policy to Part B drugs and
21 biologics.

22 MR. HACKBARTH: Okay. Thank you, Nancy and

1 Katelyn. Well done.

2 What I propose we do is have an opportunity for
3 clarifying questions. We won't go around. We'll just ask
4 for a show of hands. And so we'll do that in Round 1.

5 Round 2, I will again ask for a show of hands and
6 people who have questions or comments that they wish to
7 make. And after somebody makes a comment, I'll see if
8 anybody wants to build on that. And failing that, we'll go
9 off in a new direction with another comment.

10 At the end of this discussion, I'm eager to have a
11 sense of direction. This is a topic we've talked about
12 several times now, and I feel the need to make a plan. So -
13 - even better, carry out a plan.

14 So let me start with clarifying questions. Are
15 there any clarifying questions? I have Alice and Dave and
16 Cori.

17 DR. COOMBS: I just wanted to ask a question.
18 Before the case in 2010 when the LCA was active, how often
19 were there appeal processes or a process whereby, say, the
20 LCA was not optimal for a patient for various reasons? How
21 often was there an appeals process or an alternative sought
22 by a beneficiary?

1 MS. RAY: I don't have an answer to that question.
2 I would have to get back to you on that.

3 DR. MARK MILLER: Some of the issue is that it
4 took place at the local level.

5 MS. RAY: Right, at the local level. I could -- I
6 mean, one way I can go back and at least get a feel to
7 address that is by talking to a couple of the medical
8 directors. So we will get back to you on that one way or
9 the other.

10 MR. HACKBARTH: Dave, just before you start, it
11 occurs to me that for our new Commissioners, I ought to
12 clarify what we mean by "clarifying questions." So when we
13 have an initial round of clarifying questions, the idea is
14 really pointed questions, like, "What does Table 2, Row 1,
15 Column 3 mean? What is that?" So that's what we have in
16 mind about clarifying questions, real targeted stuff.

17 DR. NERENZ: Do generic drugs have any special
18 standing in this policy, or if there's a generic that is low
19 cost and effective, does that become the reference?

20 MS. RAY: So if there's a generic -- okay, so you
21 would have I guess what you would call the innovator drug
22 product. That would be assigned its own HCPCS code.

1 Subsequent generic drugs that are considered generic by the
2 FDA, those would be included in that same code. So the ASP
3 for that code -- so the ASP for the innovator drug plus the
4 generics would reflect the weighted average of all the drugs
5 within that code.

6 MS. BUTO: I just want to -- I think what Dave was
7 getting at is would you apply an LCA-type policy where there
8 is a generic drug, and at least in the paper what I read was
9 the criteria that you at least put forward is big
10 disparities in the prices when a generic drug is present,
11 those disparities shrink. So they may or may not be good
12 candidates, but the way I read the paper was they would --
13 with a generic they're less likely to be the candidate. But
14 I don't know if you decided that or not.

15 MS. RAY: Again, I think that's partly a process
16 issue. But, you know, one could content that when generics
17 become available and they get included in that same HCPCS
18 code, that that sort of is a mini de facto reference
19 pricing.

20 Now, in the case of the prostate cancer drugs
21 which were covered under the least costly alternative, two
22 of the drugs were in one HCPCS code. So you did have an

1 example, at least prior to 2010, where you had four drugs,
2 but three HCPCS codes covering the least costly policy.

3 MS. UCCELLO: I'd just like some clarification on
4 the beneficiary out-of-pocket sharing responsibility and how
5 it changes under this, or is that like a Round 2 issue? But
6 there were a couple slides that showed, well, estimates of
7 what the savings to beneficiaries would be, and is that
8 their 20 percent, or whatever, based on that new reference
9 price? Or is it if they stuck with the higher-priced one,
10 they'd have to pay more?

11 MS. RAY: Okay, so I think that's a clarifying
12 question.

13 [Comment off microphone.]

14 [Laughter.]

15 MS. RAY: Our estimates and the IG's estimates
16 were -- is based on if the price had been based on the
17 lower-cost product.

18 DR. REDBERG: Great chapter. My question is on
19 Slide 10 that you presented today. I was interested in the
20 German example, and I just wasn't clear on where the EMA
21 approval came in. So if we were -- is that something that
22 the independent board evaluates the effectiveness of new

1 drugs that are already -- not on the market yet, if I
2 understood that correctly. Like if we were going to do
3 this, where would FDA approval come in in this process.

4 MS. SMALLEY: So my understanding is that the
5 safety approval happens first, and then this process for
6 comparative clinical effectiveness comes after that.

7 MS. RAY: Yes, that is the process. It gets
8 approval by the European equivalent to the FDA. Then for
9 the first year, the manufacturer sets the launch price.
10 That is paid. And then after that one year is up, then the
11 rate can -- either is set at the reference price, if there's
12 -- if it's not found to be superior, or there's some
13 negotiation off of the price if it is found to be superior.

14 MR. HACKBARTH: Are we ready to move to Round 2?

15 [off microphone]

16 So let me see the hands of Commissioners who have
17 a Round 2 comment to make. Let me start over here. We'll
18 go down and up that side. We've got quite a few hands, and
19 so, let's see, we're running a little bit behind. I'd just
20 ask people to be cognizant of the time. Kathy, be as
21 concise as possible. I know you have a lot to say.

22 MS. BUTO: Well, first of all, I want to say I

1 think it's a good idea to move toward evidence -- you know,
2 evidence-based practice in Medicare, regardless, whether
3 it's drugs or procedures or whatever, and it's a good way to
4 go.

5 I also know there's a lot of frustration about
6 pricing, and it's very much directed at drugs, and
7 beneficiaries tend to feel it more because they pay a bigger
8 share than they do, say, of some other procedures.

9 I think there are really three very quick points I
10 would make, and I have questions as well. One is that, back
11 to I think it was Cori's question, once an LCA is
12 established, I think it's pretty clear it's the least costly
13 drug that's going to be selected. If not, the beneficiary
14 will pay the difference. As I understand the policy you're
15 putting forward, they would pay, if they wanted to get or if
16 their physician believed they should get the other drug, and
17 somehow it didn't meet the program's medical necessity
18 requirement, they'd either have to go through an appeals
19 process, which takes a while, or they'd have to pay the
20 difference, as I understand the proposal.

21 So there is a beneficiary impact, and the research
22 question I would ask you, if it's easy to find out, is:

1 What actually happened -- it's sort of an add-on to someone
2 else's question, not just about what did -- how many
3 patients got the other drugs, but also what was the
4 additional cost sharing that people -- or appeals that
5 people were willing to go through? So I don't know if
6 that's easy to find out, but I think it's important to
7 understand how the burden would fall on a beneficiary if
8 this policy were actually more widespread than it was back
9 in the day.

10 The second point I would make is that -- because I
11 was there when the initial LCA was implemented. It was
12 really hard to do. Now, granted, we did not have
13 legislative authority, and maybe that would make it easier.
14 But it is difficult because of the line drawing that has to
15 happen. You've got to define or be able to defend the
16 criteria around which drugs are comparable or equally
17 effective or whatever terminology you want to use. Maybe
18 PCORI can help on something like that, but it's tough
19 because you're going, you know, drug by drug for certain
20 drugs and trying to draw those distinctions, and there's
21 always contention and dispute around those boundaries.

22 So it's tough to do. It takes a while. I cannot

1 remember -- and, again, a research question -- how long it
2 took to put those policies in place. They were even done at
3 the carrier level because it's so much harder to do at the
4 national level that we actually asked the carriers to look
5 at it as an approach. But it's very, very tough to get
6 done, even for them.

7 The third and in some ways the point I think
8 probably is unique to my experience is that I think it will
9 affect companies' willingness to innovate in the areas of
10 those categories, whatever they are, and the example that I
11 think of is an incremental innovation sort of has a bad
12 name, but I think it's childhood leukemia where we wouldn't
13 be where we are today if it hadn't been for the smaller
14 steps. So to deter innovation -- and I don't mean just
15 breakthrough but innovation generally -- is a dicey thing to
16 get into. And obviously it's very irresistible, and a lot
17 of countries on budgets want to do it. But it's tough to
18 take on because you don't know what the unintended
19 consequences are. You may not know what wasn't developed,
20 or you may not know how venture capitalists chose to spend
21 their money, to put money into another area. And I think
22 we're already facing -- and you've heard Sovaldi mentioned a

1 number of times -- that now there's concern about
2 breakthrough drugs and how you finance those over time as
3 well in the health care system.

4 So I think it's not an easy area to get into, and
5 it's particularly difficult for the government. So I'll
6 just leave you with that.

7 MR. HACKBARTH: Kathy raised three categories of
8 issue: impact on beneficiaries, the difficulty of making
9 the comparative assessments and where you draw lines, and
10 the effect on innovation. Anybody want to pick up with the
11 beneficiary impact thread? Jack and then Alice, and then
12 we'll go to the others as well.

13 DR. HOADLEY: Yeah, and I was going to talk about
14 that anyway, and so this seems like the right place to do
15 it. I think there are some other ways we could think about
16 these policies. I mean, I think the ability for a
17 beneficiary who may need one of -- the drug that isn't the
18 preferred product in this case, isn't the LCA product, the
19 appeals route is obviously one, but that's not something
20 that generally seems like it works very well. If there's
21 evidence from this policy in the past, that would obviously
22 be helpful. But overall we don't have a sense that appeals

1 processes are -- they're burdensome on beneficiaries,
2 they're burdensome on providers, and we don't really know
3 how often they work and how many of the people who really
4 should get them get them. And without that, the proposal
5 sort of sits with the idea that the beneficiary would pay
6 the total difference in the cost, which obviously it's
7 better than saying that drug isn't covered by Medicare, as
8 you might do in, say, a Part D formulary arrangement where
9 suddenly that's off formulary so you're paying the total
10 price. At least you would get the reference price amount
11 applied toward it and you'd only pay the difference. So
12 that's one perspective to get on that.

13 There seems like some basis elsewhere where you
14 say we're not just setting it as a reference price, but
15 we're actually saying that's what we're going to pay for the
16 drug. So if you want Product 2, you know, we'll pay -- and,
17 in effect, there's no balance billing. You don't pay the
18 difference. The manufacturer will get the reference price
19 value regardless of which product you use.

20 One way that might happen -- as has been seen at
21 least in some of the Australian experience -- is that
22 manufacturers of the second drug readjust their price. I

1 think you mentioned an example of that in the paper. And so
2 some of that might happen on its own, but you could also
3 create policy by which you say this is going to be the
4 payment for any of the products in the cluster, and, you
5 know, no matter which one you get, that's the price that the
6 manufacturer gets. So you'd sort of take away that paying
7 the difference issue. It kind of changes the dynamic on it.
8 And obviously, depending on actually the amount of
9 difference, you know, that could have some differential
10 effects.

11 DR. COOMBS: So, my question earlier was directed
12 at the whole process of the appeals process, because if it
13 was something that really worked well, then I would be more
14 apt to support this in terms of the Secretary having this
15 jurisdiction for LCA policies.

16 One of the things that I think is important, it
17 sounds like Germany did something that's kind of innovative
18 in terms of being able to say, this is a new drug. Let's
19 see how effective it is and go with it.

20 I'm thinking about Hepatitis C and the innovation
21 and just how it's been totally revolutionized in terms of
22 treatment, eight-week treatment, and you have 94 percent

1 clearance of Hepatitis C. It's things like that that should
2 be amendable to whatever policies we try to implement.

3 And, so, something needs to be done, because when
4 you see the argument with macular degeneration, it's clear
5 that something needs to be done. How to stratify it, you
6 know, based on what Jack has said and Kathy, I think, is
7 probably part of the details. But, maybe when you bring
8 back the other information, we may be more apt to support
9 it, as well.

10 MR. HACKBARTH: Other comments on the beneficiary
11 issues raised by Kathy or any related beneficiary issues?

12 [No response.]

13 MR. HACKBARTH: Seeing no hands, let's move on to
14 the issue of what Kathy characterized as line drawing and
15 determining when things are sufficiently different. Let me
16 see hands on that. Let's start with Craig and we'll come
17 down this way.

18 DR. SAMITT: So, I think in terms of the issue of
19 process, what I was going to ask was have we studied the
20 manner by which MA plans manage this issue, or even other
21 sectors on the commercial side, because, obviously, these
22 parts of the industry have developed a process today and

1 have been able to institute a line drawing methodology that
2 works in a subsector of the industry already. So, have you
3 had a chance to take a look at that, because that may
4 address the concern about methodology and process.

5 DR. MILLER: I mean -- and I might need some D
6 people to join this -- in previous conversations -- and we
7 can bring some of this information back -- early on, when
8 the Part D process was cranking up and shortly after in
9 trying to explain it, we did get inside by talking to a
10 bunch of MA plans about how they establish their committees,
11 go through the evidence, decide which ones are in preferred
12 tiers and less preferred tiers, and they kind of work
13 through a process like that. We've talked to people at
14 Kaiser and a couple of other different organizations on how
15 they did it, and that is a set of words and information that
16 we could bring back to the discussion. And, there are
17 pretty established processes inside those kinds of actors.

18 MS. RAY: And, we could also bring back, in terms
19 of enhancing the process part of this, you know, if the
20 Secretary opted to, she could use academic evidence-based
21 practice centers that many now are in the business of
22 looking at clinical evidence and coming up with evaluations

1 for AHRQ as well as for Oregon and other States.

2 MR. HACKBARTH: You know, there are potentially
3 two reasons to look at the private plan experience. One is
4 just lessons learned about how to do it mechanically and
5 that maybe Medicare could learn from. The other is a
6 philosophical belief that it's better to handle issues like
7 this on a decentralized basis, and the mechanism of bundling
8 payment or going to full capitation and then having it
9 worked out at a more local level is desirable. Which of
10 those, or both, are you interested in, Craig?

11 DR. SAMITT: I mean, I think it's -- as we look to
12 alternative models, it's absolutely the latter, recognizing
13 that we're going to always have some degree of preservation
14 of fee-for-service and alternative models. I think
15 providing some reassurances that a process that already
16 works in another sector of the industry can also work in
17 fee-for-service Medicare would be applicable. So, I would
18 say it's both.

19 MR. HACKBARTH: Yes.

20 MR. ARMSTRONG: I just would add to that list,
21 we'd want to see what the outcomes are, as well, I mean,
22 what kind of expense trends do we have in health, but --

1 MR. HACKBARTH: So, we are building on the line
2 drawing thread. I have Dave and then Bill and Herb.

3 DR. NERENZ: Just very quickly, I'm curious in
4 examples we have already how personalized medicine or
5 pharmacogenomic considerations get worked into this, so that
6 a physician argues, for example, that two drugs are
7 comparable on average, but not for this patient. How does
8 that play out?

9 MS. RAY: Well, again, that would be handled
10 through a medical exception process. I mean, what could be
11 done -- and this is just hypothetical, of course -- is that
12 -- I mean, for example, if the contractor -- if Medicare's
13 contractors were implementing the LCA policy, in that
14 policy, it could be very specific as to here are the types
15 of candidates who we would acknowledge would -- could -- it
16 would be valid to do a medical exception, you know, people
17 with purple hair and pink eyes and, you know, whatever,
18 green hair, and so forth. So, that could be one way to deal
19 with this issue.

20 DR. MILLER: I would also just say, like -- and,
21 we can go and look at what kinds of processes were pursued
22 before, but also we can kind of come back through with what

1 happens in Part D. There may be a statement of, these are
2 fairly common exceptions, but there would also, presumably,
3 we would contemplate, always a process where a physician can
4 say, I want to make the case for this specific patient
5 regardless of their hair color because I have an issue here.

6 DR. HALL: Just tying onto what Craig was saying,
7 there might be some lessons from the commercial world. If
8 you look at this from the standpoint of the prescriber as
9 opposed to the prescribe, which is what I think we're saying
10 this line is, there's not a physician in the country that
11 isn't used to being regulated in terms of choice of
12 pharmaceuticals for a whole variety of things. That's the
13 world the way it is right now.

14 So, I think the notion that there's going to be
15 push-back about the line isn't really terribly relevant.
16 But, what really bothers people is the sort of inconsistency
17 of these lines that are being drawn. Formularies change
18 every year. You think you have your patient on the right
19 set of drugs and then one day you find out that the same
20 people who said the evidence shows that Drug A is better
21 than Drug B just disappears overnight.

22 To some extent, it's a regulatory nightmare, but

1 it's probably just a humbling experience, and I think before
2 we get too far into this, we ought to try to understand this
3 whole notion that we can actually do this in a way that
4 isn't going to have to change every six months or every
5 year. I think it's a very formidable task to be
6 undertaking. That doesn't mean we shouldn't do it, but we
7 don't have to make all the mistakes that have been made in
8 this regulatory apparatus. We can learn from the mistakes
9 of others before we take it on.

10 And, the other thing is that the gold standard --
11 the people who are setting the gold standards often don't
12 agree inherently within themselves, and if you look at any
13 medical procedure or any class of drugs, you know, experts
14 aren't always so expert. So, again, I think there's a lot
15 of deep diving we could take on this line drawing.

16 MR. HACKBARTH: Bill, that strikes me as a really
17 important point. And, so, what I'm trying to think is which
18 way does that cut from the vantage point of a practicing
19 physician? Is it better to have a highly decentralized
20 process where your patients might be covered by, you know, a
21 dozen different insurers and they're all making different,
22 ever-shifting judgments about these things, and maybe it

1 would be helpful to have Medicare leadership on it, or does
2 it make you even more leery of any sort of centralized
3 Medicare decision?

4 DR. HALL: Well, I'm sort of a decentralist, I
5 suppose. But, on the other hand, if this is going to work,
6 I think it has to work on a national basis. We have in one
7 of our data books the ten most expensive drugs prescribed
8 for Medicare patients are not anti-cholesterol drugs or
9 drugs for congestive heart failure. They're invariably
10 biologics because these are very, very expensive drugs, and
11 there will be "me too"s on those. And, I just think about
12 trying to do this on an individual basis. Unless there are
13 some solid gold standards that we're not doing this just to
14 make money for a -- well, we're not in Medicare, but there's
15 some profit incentive going on here, I think we just have to
16 understand what mistakes have been made already in this very
17 vast world of regulatory apparatus for pharmaceutical
18 products. But, then I would think, once that's set up, if
19 there could be a national standard, it would probably
20 simplify all medication prescribing globally, well beyond
21 Medicare, because Medicare is oftentimes the leader in these
22 things.

1 MR. HACKBARTH: To rephrase my point -- or it's
2 really a question -- a little bit differently, in general,
3 my instinctual reaction is to decentralization, especially
4 of difficult choices. I like decisions to be made as close
5 to the patient as possible with the engagement of the
6 patient's clinician. That almost always trumps other
7 things, in my mind.

8 But, trying to think about the other side of that
9 is that, as you point out, that means that clinicians are
10 often faced with varying judgments by many different
11 carriers and they've got to deal with all these different
12 ever shifting judgments. And, it also may be that from a
13 patient perspective, it's less transparent than a public
14 process would necessarily be. And, so, there are great
15 aspects about decentralization, but, also, some of the rigor
16 required for public decision making may be a plus, as well,
17 so --

18 DR. HALL: Mm-hmm.

19 MR. HACKBARTH: -- that's just something rattling
20 around in my head.

21 MS. BUTO: Can I comment on your comment, which is
22 I think you've put your finger on another aspect of this

1 that doesn't come up so much in the pricing, is the
2 beneficiary lack of information about -- after all, this was
3 about payment policy promoting the use based on clinical
4 evidence, and patients don't have that information. And,
5 so, at least one aspect of this that I think could be better
6 brought out in the discussion is how do you get -- even if
7 you don't go to LCA, how do you get that clinical evidence
8 at the level that the patient understands -- and the
9 physician is compelled to share with that patient -- the
10 information about the comparable both therapies and costs to
11 that patient of one versus the other. I mean, that's sort
12 of where we'd like to go anyway, I think, with patients.
13 So, regardless, it seems to me, that's an important aspect
14 of this that could be brought out.

15 MR. HACKBARTH: Let's continue through. We're
16 commenting on line drawing. Herb, did you have your hand
17 up?

18 MR. KUHN: I did, yes. So, I think we've all
19 struggled with this is a hard thing for government, because
20 government has to basically buy everything when it comes to
21 these services. And, so, it passes the reasonable and
22 necessary test. The question is, what price and how they go

1 about doing that. So, the conversation we've had here about
2 drawing the line, transparency is absolutely key. It has to
3 be part of that.

4 I, too, am one of those folks that I think the
5 decentralization, the LCD process -- like Kathy, I was at
6 CMS and so I think that decentralization process works, but
7 I think there are some ways to give it some national scope,
8 as well, and maybe to bring in some different kind of
9 objective criteria through MEDCAC, which is the Medicare
10 Evidence Development and Coverage Advisory Committee. You
11 know, it's to supplement the internal expertise that CMS
12 already has and it's supposed to be an unbiased examination
13 of some of the information out there. So, I could see how
14 the agencies could come through and construct a better way,
15 I think, with information centralized through external
16 experts, but also using maybe an LCD process to move this
17 forward.

18 And, I think, too, there's even a growing body of
19 evidence and ways to continue to advance health care policy
20 in an important way, because a lot of folks think about this
21 as just a price per pill or a price per milligram. But, I
22 think we really need to start thinking about this as a way

1 to price for the therapy, and I think about prostate cancer
2 and is this a way to price for a month worth of therapy for
3 prostate cancer. And, if you look at the guidance of the
4 American Urologic guidelines out there, they said between
5 Lupron and Zoladex, they're basically interchangeable. So,
6 I think there's even further evidence coming from the
7 physician specialty societies that can be used that probably
8 wasn't there when this authority was lost even four years
9 ago, and we can have some of the clinicians around the
10 table, but I think more of those organizations are getting
11 more involved in this, helping to do the evaluation. So, I
12 think there's even a greater body of evidence to give the
13 objective criteria.

14 And, I think, if we think about this beyond just
15 the price per pill, the price per milligram, but the price
16 per therapy, I think it takes us down the road towards
17 bundling, towards the things that we're after to get more
18 efficiency in the program. So, I think there's even greater
19 opportunities here.

20 MR. ARMSTRONG: Yeah. I think this is the right
21 time to do this. Speaking a little bit to the complexity of
22 making these decisions, I would just very briefly and simply

1 say organizations like the one I work for have been doing
2 this for decades and it works very well. The value to our
3 beneficiaries, both in terms of cost, but quality of care
4 and, you know, knowledge about the drugs that they're
5 taking, is considerably higher.

6 I'm not sure I have a point of view on this
7 centralization versus decentralization idea, although I feel
8 like organizations like Group Health can do it better than
9 the Federal Government can do it and I kind of like that
10 local, but I don't really know the operational implications
11 of that.

12 I would just say, though, that we've described the
13 various ways in which this is complex and you need
14 transparency and a good appeals process and so forth, but in
15 the context of all the other issues that we can manage for
16 the program, this seems like one of the more straightforward
17 ones, and that, to me, this is a no brainer, that we really
18 need to move forward with this. And, I, frankly, wonder why
19 it has taken so long.

20 MR. HACKBARTH: [Off microphone.] Okay. So,
21 continuing on line drawing. Continuing comments on line
22 drawing.

1 DR. CROSSON: Well, feel free to throw a yellow
2 flag if you want --

3 [Laughter.]

4 DR. CROSSON: -- but I think this is on point in
5 the context of the other discussions, because when I looked
6 at this -- I mean, I feel exactly the same way Scott does in
7 terms of environment in which you're providing capitation to
8 an organized system and they can manage it under that. But,
9 the question here is, what about fee-for-service Medicare, I
10 think, in general. And, when I looked at this and I thought
11 about, well, how would it be to try to administer this, it
12 did seem very complicated and likely to be a cause of
13 constant frustration and argument drug by drug and the like.

14 And, it did seem to me -- I was a little surprised
15 to read in the text a little short paragraph about bundling
16 which concluded it would not be feasible nor necessary to
17 establish bundles for all drugs or biologics amenable to
18 LCA, which probably is literally correct. But, I just
19 wonder whether or not bundling might not be the better
20 solution and might be more broadly applicable, because as I
21 started thinking about it, you know, of the kind of drugs
22 we're talking about, most of them occur in a clearly defined

1 clinical situation which, to me, would be amenable to
2 bundling. It would be easier to administer. The Secretary
3 already has at least a pilot authority to do it.

4 And, I just wonder -- I apologize. You may have
5 already discussed this previously in the spring, but where I
6 -- just based on what's written here and what I heard over
7 on the other side of the table, if I were going to jump into
8 a pool, it would be the bundling pool.

9 MR. HACKBARTH: So, let me explore what you mean
10 by bundling. Sometimes, we mean that as a generic term, you
11 know, anything other than paying fee-for-service, and
12 capitation is the ultimate bundle. Sometimes, we use it to
13 mean things like paying for an episode of illness on a lump-
14 sum basis. Which sense are you using it?

15 DR. CROSSON: So, in the latter sense. So, for
16 example, for the management of macular degeneration --

17 MR. HACKBARTH: Yeah.

18 DR. CROSSON: -- it would be a fee and it would
19 include the drug fee.

20 MR. HACKBARTH: And, so, in order to construct
21 that bundle, don't you need to make a judgment about what
22 the money should be in the bundle, which implicitly, at

1 least, includes a judgment about whether the high-cost drug
2 or the lower-cost drug should be used?

3 DR. CROSSON: Absolutely. So -- well --

4 MR. HACKBARTH: So, you have the same decision --

5 DR. CROSSON: -- well -- well -- well --

6 MR. HACKBARTH: You just --

7 DR. CROSSON: No. No. Sorry. But, I'm just
8 thinking about the way we would have managed this at Kaiser
9 Permanente. We would make the assumption that for a
10 majority of patients, the less-expensive drug would be
11 effective. We would ask our clinicians, you know, what
12 percentage of patients do you think would require, for one
13 reason or the other, the expensive drug, do a mathematical,
14 you know, weighted summation, and that would feed into the -
15 -

16 MR. HACKBARTH: Right.

17 DR. CROSSON: -- in our case, in the budget of the
18 facility, but in this case, into the payment rate.

19 MR. HACKBARTH: Yeah. And, a corollary of that
20 would be that regardless of which decision the clinician
21 makes, to use the expensive or inexpensive drug, the
22 beneficiary would have the same cost sharing. They would be

1 protected.

2 DR. CROSSON: Yeah. I think that's right.

3 MR. HACKBARTH: Okay. I'm not trying to be
4 antagonistic and pick your idea apart, just simply to
5 understand what you have in mind. Okay. Rita.

6 DR. MILLER: And, actually, just to say one other
7 thing, it's correct to say the Part B drugs that we're
8 talking about are dominated by the cancer drugs, right?

9 MS. RAY: Yes.

10 DR. MILLER: All right. And, so, that may be the
11 other point you're making --

12 DR. CROSSON: And, I may be overly simplistic
13 about it --

14 DR. MILLER: No --

15 DR. CROSSON: -- obviously, but it would seem to
16 me that you have a clear diagnosis. You have, generally, a
17 clinical protocol. And, you have a set of choices, in some
18 cases, that you can make within that, particularly for the
19 cancer ancillary drugs, which would have enormous
20 implications for expense. So, even though drawing the rules
21 around the bundle is difficult, it just seems to me it may
22 be less difficult than trying to reimplement the LCA.

1 MS. BUTO: Can I just mention that back in the, I
2 think, 1990s, Medicare did create a bundle for radiation
3 oncology precisely because there was some variation in the
4 use of drugs, in the use of some of the ancillary services,
5 and technicians and the oncologists and radiation
6 oncologists wanted greater flexibility to be able to use two
7 technicians for more difficult -- whatever it was -- and
8 that was very successful both from the beneficiary
9 standpoint and from the standpoint of quality.

10 MR. HACKBARTH: I think that I read in the
11 materials that United Health Care has, in fact, for
12 oncology, done an experiment with this sort of bundle and
13 had the somewhat surprising result that total costs were
14 dramatically lower, but actually, use of high-cost drugs
15 went up, and were sort of trying to figure out why that
16 might be.

17 DR. CROSSON: I didn't understand that. I didn't
18 understand it, either --

19 MR. HACKBARTH: Yes.

20 DR. CROSSON: -- but I'm not sure that would
21 necessarily be representative of every --

22 MR. HACKBARTH: Yeah. No. I was just making the

1 observation that people are working on this.

2 Rita.

3 DR. REDBERG: My comment is somewhat on that, but
4 also on innovation, I just want to say --

5 MR. HACKBARTH: [Off microphone.] If it's on
6 innovation, I'm going to come back to that.

7 DR. REDBERG: I didn't have my hand up. Okay.

8 MR. HACKBARTH: Right now, I want to focus on the
9 line drawing and determining when things are different and
10 sufficiently different.

11 Kate.

12 DR. BAICKER: So, my comment is on that point, but
13 I think it is very difficult to extricate that from
14 innovation because I think those two are inherently
15 intertwined, but I'm going to try to frame it so that I
16 don't get in trouble.

17 DR. MILLER: [Off microphone.] That's how you're
18 supposed to do it, Rita.

19 [Laughter.]

20 DR. BAICKER: Learn from the master.

21 [Laughter.]

22 DR. BAICKER: So, this -- in thinking about this,

1 I want to distinguish between three different things that
2 sometimes get intertwined, and in the chapter, I thought
3 sometimes got intertwined in a way that I think have very
4 different effects on how -- the incentives for innovation
5 and how different things get lumped together.

6 One is direct negotiations between Medicare writ
7 large and manufacturers. The second is reference pricing
8 where international prices are taken into account, so it's
9 the lowest price paid for this drug in the world or in a
10 bundle of countries. And then the third is, within country
11 reference pricing or least costly alternative available
12 within the system.

13 And, I think it's pretty important to distinguish
14 between systems that have an international price brought in
15 and systems that look within the U.S. at what's being paid
16 for this, because, in essence, you import other countries'
17 price controls when you put other countries in the bundle,
18 and that's a very different scheme from saying, what's the
19 most affordable way we can buy this outcome for our
20 beneficiary in our system. So, I think that is the one that
21 has the most promise and I want to focus on that.

22 MR. HACKBARTH: [Off microphone.] And, just for

1 the record, I think that's where we ought to focus. I think
2 importing international prices is probably just never going
3 to fly, so --

4 DR. BAICKER: And, I just thought it was important
5 when in the chart in the chapter where we list the different
6 modes of -- they're sort of mushed together in a way that
7 I'd like to keep separate.

8 But, focusing, then, on how do we get the best
9 outcome for beneficiaries with the most affordable price,
10 and if -- the easy case is when things are truly equivalent
11 and it makes no sense to pay more for the same likely
12 effectiveness, the same set of patients who are getting the
13 treatment, all of that. That's the easiest case. The much
14 harder case is when there's an incremental improvement and
15 this drug or this device or this treatment performs a little
16 bit better on one dimension out of 12 different dimensions,
17 or maybe it's better on two dimensions and worse on three in
18 terms of side effect profiles, the tales of survival versus
19 the average survival. There are so many different
20 dimensions that it will always be easy for somebody to argue
21 that these things are not the same.

22 And, on a centralized basis, if the whole system

1 hinges on being able to say, these things are exactly
2 equivalent, therefore, we have a reference price, I think
3 you're doomed to failure and losing the great efficiencies
4 that might be gained by trying to maximize value. So, the
5 less centralized that decision making is, the more
6 beneficiaries are able to choose among profiles for things
7 that get them the outcomes they value most and manufacturers
8 are paid to improve some of those outcomes so that there is
9 innovation, even if it's step-wise, and even if it's in some
10 dimensions, not the other, it seems like the happy outcome.
11 How do you achieve that? The less centralized the
12 bucketing, probably the more flexibility there's going to be
13 on that.

14 And then, I think, having people have the ability
15 -- having producers of these services be able to be paid
16 more for things that beneficiaries value more is important.
17 Now, there's a bit of a discussion to be had about who
18 should be paid more. If it's a bundled payment, the
19 beneficiary is then going to be insulated from one type of
20 care costing more or less than the other, and then that's
21 about whoever's getting paid the bundle negotiating with
22 whoever they're buying the stuff from. Or, if you do an LCA

1 where there's balanced billing and the beneficiary says,
2 yes, I know these are roughly equally efficacious, but I
3 really can't tolerate that side effect and I'm willing to
4 pay the extra, and insulating low-income beneficiaries from
5 not being able to make that trade-off, that's another way to
6 go. But, I think, maintaining a reward for incremental
7 improvements is important, while not paying, on average,
8 more than one needs to to get for a population an average
9 good outcome.

10 MR. HACKBARTH: Since you destroyed my three-part
11 framework --

12 DR. BAICKER: Sorry.

13 [Laughter.]

14 MR. HACKBARTH: -- of bene impact and line drawing
15 and innovation, I guess I would just make the observation,
16 in fact, all three are interrelated. To the extent that you
17 prevent an option of paying more for a drug, presumably that
18 has innovation effects, as well. So, really, all three of
19 these things are interconnected with one another.

20 Now that Kate has sort of busted down my
21 framework, Rita, why don't you go ahead and finish the job.

22 [Laughter.]

1 MR. HACKBARTH: Kick around the rubble.

2 DR. REDBERG: Thank you for busting. So, because
3 I did want to follow on with the line drawing and just say
4 that I like sort of the German approach and Herb's
5 suggestion, perhaps because I was thinking, you know, we
6 make those decisions all the time in clinical practice. I'm
7 always deciding, is this new drug better, I mean, so we're
8 always doing it, and I think it's very possible to do it.

9 What I think is important is just to have an
10 independent body do it, and so MEDCAC, I think, is an
11 interesting suggestion. Just as full disclosure, I am the
12 Chairperson of MEDCAC --

13 [Laughter.]

14 DR. REDBERG: -- but I don't set our agenda at
15 all. That's done by CMS.

16 And, professional societies, I think, are getting
17 more interested. I know my own, the American College of
18 Cardiology, is definitely getting more interested in issues
19 of cost and quality and not just in quality, and the
20 guidelines and performance measures, and certainly the whole
21 "choosing wisely" movement is about making comparisons and
22 deciding what is new.

1 But, why I wanted to focus on innovation is
2 because I hear about innovation a lot, and I just think we
3 need to be really careful, because I hear innovation a lot
4 more than I see innovation. Every time a new thing is on
5 the market, someone -- usually the manufacturer or the
6 industry -- says, this is an innovation. I think if we're
7 looking at the evidence, we know when it's innovative, and
8 then the least costly alternative would pay more for it.

9 But, for example, the letter we have up there from
10 BIO, I mean, the industry always says, this will stifle
11 innovation. In my own area of research, which is medical
12 devices, always, whenever you talk about getting evidence
13 for new devices, the industry says, you'll stifle
14 innovation. I don't think there's any evidence that you
15 stifle innovation by asking for evidence of innovation.
16 And, the problem is that, like the examples in the chapter,
17 when we're not really looking for evidence that things are
18 new and, therefore, should be paid more, we end up paying a
19 lot more for things that are not new, they're not
20 innovative, and, in fact, they may not even be necessary at
21 all. I mean, when you look at the prostate cancer examples,
22 right, if you compare it to doing nothing, I mean, how many

1 of those are better?

2 So, I think the least costly alternative makes a
3 lot of sense because we only -- we would then be doing a
4 comparison and actually understand, what are we spending
5 money on, and it would be clear what offers an advantage in
6 terms of outcomes and what those outcomes are, and if it
7 doesn't, then we shouldn't be paying more for it. And, so -
8 - but, I just think we need to be very careful about saying
9 things will stifle innovation and that we really need to
10 look at the evidence.

11 MR. HACKBARTH: To me, just saying "innovation" is
12 a bit of a red herring, even though I think we would all
13 agree that, for sure, we don't want to do anything that
14 discourages really important innovation that helps patients.
15 Almost anything you do will affect innovation, but that
16 doesn't really answer the question. What you want to do --
17 if you have a system that creates more innovation in
18 developing low, really cost effective therapies, that could
19 be a good thing, as opposed to innovation that is producing
20 lots of very high-cost marginally improving therapies. And,
21 so, in a way, yeah, we want to affect innovation. It's just
22 that we want to affect it in a constructive way and not a

1 bad way. Just to say, oh, innovation will be affected
2 really doesn't get you very far, I don't think.

3 Okay. So, the door is open now, Bill, to --

4 MR. GRADISON: I'm still on this track of, if I
5 may, that Bill and others have talked about with regard to
6 the physician's role, so that's what I'd like to do.

7 MR. HACKBARTH: Go for it.

8 MR. GRADISON: I have been a little disappointed
9 in two aspects of this paper. First of all, while it
10 focuses understandably on Part B, it seems to me that in
11 terms of thinking about this in the Commission, we should
12 tie it into Part D thinking and, in particular, the LIS.
13 There, we have been concerned about the fact that a much
14 lower percentage of generics are used in the LIS with no
15 evident, clinical reason for that. Part of it is, of
16 course, they don't pay anything, but really, that's not the
17 patient's choice. It's the physician. The physicians are
18 writing those scripts for LIS patients with using brand
19 names more than the non LIS, and I think it is related to
20 this issue.

21 I mean, what I'm asking myself about this paper is
22 and I will support the LCA. That's not my issue. I think

1 its chances of success legislatively are very dim, if
2 history means anything, and therefore, I am asking myself
3 how can we do this through trying to affect the behavior of
4 the physicians.

5 I'd like to hear a discussion or have some work
6 done on why are physicians using the more expensive
7 alternative. Now, granted, if it is something specific like
8 they are getting a kickback or giving speeches or something,
9 you can prohibit anybody from writing the more expensive
10 prescription if they are getting any financial reward from
11 the company that puts it out. That is the black and white
12 thing. That would not be that hard and probably easy to
13 defend.

14 But more basically, I really feel a gap in my
15 understanding of why physicians are doing this and what
16 could be done to influence the way in which they go about
17 it, which is the ultimate decentralization.

18 The same question, in a sense, will arise in our
19 later discussion tomorrow with respect to the short stays.
20 The physicians admit people, the patients. The hospitals
21 don't admit people, patients. Why are they doing -- on
22 margins, apparently, increasing the number of patients that

1 are admitted for very short stays.

2 So trying to understanding physician motivation
3 and how to influence it is high on my list, and maybe that
4 is a digression, but I don't think so.

5 DR. HOADLEY: I have several points, and I will
6 try to make them quickly.

7 One that came up when we were talking about the
8 bundling, the HCPCS coding that Nancy had talked about and
9 the examples where the generics and the brands and a couple
10 of other cases, there is kind of almost like a micro bundle
11 example. Once they are put together, the price -- now, in
12 this case, the price is empirically derived. You could
13 merge the concept of the HCPCS bundle with something like an
14 LCA, so you don't necessarily have to derive the price for
15 that HCPCS based on the ASP calculation, but instead by
16 something like LCA or some other variant on that, so you
17 could say we are only going to pay the generic price of the
18 three drugs that treat this, we are only going to pay the
19 least costly alternative price. So I think that is one way,
20 to sort of maybe come up with something that is a little bit
21 of a different mix.

22 The other thing, in terms of this line drawing

1 issue, you guys talked about Oregon and the Drug
2 Effectiveness Review Project, the DERP. What that offers is
3 probably similar to what Herb had in mind and Rita had in
4 mind, is a scientific look at the evidence and what they
5 really do is go over and look at the literature that's out
6 there to say is this a case where the drugs really are
7 equivalent, getting equivalent outcomes.

8 In some cases, they may say the literature doesn't
9 tell us. That maybe kicks you into PCORI territory where
10 you need to generate more research.

11 Then the question is what do you do. So if you
12 have one superior product, if you have several equivalent
13 products, that leads you to different choices of what you do
14 next. That either leads you back into the bundle or the
15 least costly alternative or one of these other things or in
16 something like Part D, where formularies are driven. And
17 the formulary examples are often not so much one overall
18 pricing but on what particular negotiation does that plan
19 make with that particular manufacturer.

20 So that once you are into the private plan
21 element, you are getting a negotiation thing on. If we are
22 looking at things from the broader Part B program, we are

1 not going to get into that part of the game, presumably, but
2 that is where you might go into a least costly alternative
3 price or something else. But the kind of consensus,
4 scientific consensus, seems like it gives you the starting
5 point and determines which products this is an appropriate
6 thing to go on.

7 The other point I want to make quickly is when you
8 start to get into the innovation issues. I think maybe
9 there is even a broader issue about sort of drug pricing,
10 and we have seen sort of a shift recently in either the
11 reality or the rhetoric around how prices are set for drugs.

12 We used to hear a lot more that we are recouping
13 the innovation, we are recouping the R&D, and the prices are
14 set based not just on this product, but because we had all
15 the unsuccessful leads, and somehow the price we are setting
16 is recouping overall that price. And that kind of created
17 that direct channel to saying if we can't recoup that, we
18 are not going to be able to continue to do the R&D to
19 innovation.

20 With a drug like Sovaldi, we are hearing at least
21 the rhetoric a lot more around, "Well, this is being priced
22 so high because this is the money it is saving the system,"

1 and this is something I think that maybe it's not really
2 this topic but something that really should take some
3 looking, because that is going to be potentially -- and a
4 bunch of other drugs like that, that are priced at these
5 very high price points, that may be priced on the idea that
6 they are saving money from the Medicare perspective in Parts
7 A and B, and yet they are being paid for in the Part D or in
8 the Part B drug silo, and how do we begin to think about
9 that? How do we sort of challenge that sort of pricing
10 rhetoric or pricing mechanism, whichever it is?

11 I don't think this mechanism is going to work,
12 because if we have three products for hepatitis C and they
13 are all priced up at that \$1,000 a pill kind of range, well,
14 the least costly alternative is going to be \$1,000 a pill.
15 That is not going to get us there. That is going to require
16 us to go in and sort of say at some other level, what is a
17 fair price to pay, and should we be doing this, or do we
18 totally rely on -- the private payers don't seem like they
19 are having any more success. They are taking more means,
20 like we are going to limit who gets the drug as opposed to
21 we are trying to deal with the price on that.

22 MR. HACKBARTH: Although, where it connects here -

1 - and you are way ahead of me on this, Jack -- is that
2 Sovaldi -- it may be that for drugs, Sovaldi, and similar
3 drugs that are going to come to market soon that \$1,000 is a
4 legitimate price or \$100,000, whatever the right number is.

5 DR. HOADLEY: Right. \$1,000 a pill.

6 MR. HACKBARTH: Because they are so effective in
7 both improving patient health and reducing other costs. So
8 you're making my head hurt, Jack.

9 DR. HOADLEY: Yeah. I'm sorry.

10 [Laughter.]

11 MR. HACKBARTH: But after Warner's comments, I
12 want to make a proposal on where we might go from here.

13 Warner.

14 MR. THOMAS: I will just be very brief. I would
15 agree with Scott's point. I mean, to me, if you take this
16 discussion in context with our previous discussion of the
17 future and kind of what's out there, this seems to me like
18 these are decisions that are made every day by physicians,
19 by pharmacy and therapeutic committees, by managed care
20 plans, and frankly, if we are looking out for the food of
21 the beneficiary, I think this is something that just makes a
22 lot of sense to make sure that they are charged fairly and

1 consistently based upon the drugs that have a very common
2 efficacy.

3 MR. HACKBARTH: Last word before we try to sum up?

4 DR. SAMITT: Sure. Bill and Jack's comments sort
5 of instigated for me a question about how much an LSA policy
6 would supplement some momentum that is already building, and
7 what I am referencing is in the ACO space.

8 If ACOs are essentially now accountable for the
9 broadest possible bundle -- I have to say that I am not a
10 big fan of diagnostic specific bundles -- it just enhances
11 the complexity of our payment structure. But if the
12 ultimate broad bundle, whether it is ACOs or Medicare
13 Advantage, is really what will influence high value clinical
14 decision making, the question is should we be feeding ACOs
15 information of this sort.

16 So I would ask if ACOs that are not accountable
17 for a broader quality and efficiency outcome were made aware
18 of the Part B discrepancies in terms of drug choices, would
19 we accelerate the use of the more efficient alternatives?
20 In the absence of any kind of legislative solution, is that
21 a very simple way to accelerate this?

22 We bring forward all these discussions about

1 shared decision making and team based care and now LCA
2 policy, and we deal with them in isolation, when the
3 question is do we feed all of these innovations of sorts to
4 ACOs and then let them run with it because we think that
5 will change the industry faster than just staying silent.

6 MR. HACKBARTH: Well, I think always a lot could
7 be done to accelerate that process of people identifying
8 opportunities, but to the extent that they have claims data
9 and they are trying to figure out how to beat their cost
10 target and they are looking through claims data for
11 opportunities, presumably, sooner or later this jumps out to
12 them as one to make the list. But they could be
13 accelerated.

14 DR. SAMITT: Yeah. Do we instigate it by, in
15 essence, not having each ACO, a vote on their own bottom,
16 identify these opportunities on their own?

17 MR. HACKBARTH: Yeah.

18 So at the risk of making a fool of myself, I am
19 going to try to identify the potential paths that I hear in
20 this discussion. One is to do what I will call traditional
21 LCA as described in the paper and the history of how this
22 authority was used and then taken away and just recommend

1 that the Secretary's authority be restored. I'll call that
2 the traditional LCA path.

3 A second path would be what I will call Jack's
4 HCPCS bundling, and it is basically grouping together drugs
5 and developing an average price based on that grouping.

6 Just to be clear, I am not saying any of these
7 solves all the issues that have been raised. I am just
8 trying to think now in terms of paths that we can
9 systematically analyze the pros and cons of each alternative
10 path.

11 A third path is Jay's sort of illness episode
12 based bundling, which in some way involves a calculation of
13 an average price, but as Jay described it, based on a
14 clinical assessment of how many patients really need the
15 expensive thing versus a lower cost alternative.

16 The fourth path is to say all of this is just too
17 hard for traditional Medicare, and we really ought to look
18 to ACOs and Medicare Advantage Plans to do this work,
19 because they're closer to the patient, it's decentralized,
20 et cetera.

21 Now, on that fourth path, those of you who have
22 worked with me know that the question that I then ask is if

1 we are going to not to anything in traditional Medicare and
2 say traditional Medicare ought to be low intrusion and not
3 do this hard stuff, what happens if traditional Medicare
4 costs weigh more than other available options, whether they
5 be MA Plans or ACOs over the long run? Who is going to have
6 to pay for the higher cost, traditional Medicare?

7 The politically convenient thing is, well, let's
8 just send it to our kids and grandkids. I'm not much in
9 favor of that option. So if you want to not do hard stuff
10 in traditional Medicare, you also have to tell me who is
11 going to pay when it's expensive.

12 So those are the four paths that I see, and what
13 I'd like to do is sort of break them down and analyze the
14 relative merits and demerits of the different alternatives.

15 MS. BUTO: Glenn, can you say which ones? I don't
16 know if the HCPCS option requires legislative authority, and
17 I don't even know if the bundling one does. I know it's
18 been done without legislative authority, but I don't know if
19 you can still do that.

20 MR. HACKBARTH: Well, we'll look at that.

21 MS. BUTO: So it would be helpful to know which
22 ones are, in a sense, easier versus harder --

1 MR. HACKBARTH: Yeah. We'll look at that as we --

2 MR. BUTO: -- and the beneficiary impacts as we
3 assess them.

4 MR. HACKBARTH: Yep.

5 So what I've offered is obviously not a solution
6 but just a way to try to get a grip on this and figure out
7 what our collective belief is about the most effective path.
8 Does that make sense as a way to frame this and move forward
9 to the next step?

10 Jay, you look a little hesitant.

11 DR. CROSSON: No, no, no.

12 MR. HACKBARTH: Okay. Good.

13 DR. MILLER: The only thing I will say from a
14 process point of view, if it was more just a straight ahead,
15 okay, bring us back, the next round of LCA, I could tell you
16 that we could hit that next meeting, no problem. There's
17 several more cats and dogs that have been added here, so the
18 timing over the flow will get adjusted a little bit.

19 I got to figure out if I can get these two to work
20 nights and weekends, and so just --

21 MR. HACKBARTH: Nancy, you look like you have a
22 headache.

1 [Laughter.]

2 DR. MILLER: You mistake that. That's the look of
3 death from -- and that's being directed.

4 MR. HACKBARTH: Okay. Thank you very much, Nancy
5 and Katelyn.

6 We will now have our brief Public Comment period
7 before lunch.

8 [Pause.]

9 MR. HACKBARTH: Before you begin, is there anybody
10 else who wants to get in line here, just so I have a sense
11 of how many?

12 [No response.]

13 MR. HACKBARTH: Okay. Before you start, please
14 introduce yourself, the organization that you are with, and
15 you have two minutes, and when the red light comes back on,
16 that signifies the end of your two minutes.

17 As I always do, let me remind people that this
18 isn't your only or your best opportunity to provide input on
19 our work. Your best opportunity is to work with our staff.
20 Another one is to send letters to us, the Commissioners, and
21 we are pretty good about reading those. A third is to post
22 comments on our website.

1 So I apologize for the brevity of this, but that's
2 the way it needs to be.

3 MR. McCARTHY: Thank you, Chairman, and thank you
4 to the Commission for this great discussion. It was very
5 thoughtful this morning. My name is Shea McCarthy. I am
6 commenting on behalf of the Partnership to Improve Patient
7 Care, a broad coalition of health care stakeholders.

8 As the Commission examines cost cutting techniques
9 to ensure the taxpayers and beneficiaries are getting the
10 most for their health care dollars, it is also important to
11 recognize that clinical CER is not intended as a cost
12 cutting tool, but it is intended to provide personalized
13 patient care. To that end, of improving patient care, CER
14 will ultimately support a cost effective health care system.

15 Payment systems focused on treating to averages
16 often fail to account for differences in individual
17 patients, both in preferences of those patients and the
18 effectiveness of any therapy or medication.

19 While comparative effectiveness research can lead
20 to doctors and patients that are well positioned to make
21 decisions that are best for an individual's health care,
22 policies that look to constrain patient and provider choice

1 will prove to be penny wise and pound foolish.

2 We already know that engaged and active patients
3 are more compliant in their treatment protocol because they
4 are given a meaningful role in defining the care that is
5 best for them. Engaged patients fill prescriptions and take
6 them. They make appointments with rehab specialists, and
7 they go in for their follow ups. While we know that
8 meaningful patient engagement requires that they trust in
9 the system and their care providers, they embrace the
10 principles of shared decision making and recognize the
11 benefits of being activated.

12 As the Commission moves forward in their
13 deliberations to improve outcomes and reduce cost in the
14 Medicare program, PIPC hopes that you will pursue policies
15 that activate patients that lead to the long term health
16 improvements, rather than focusing on those that may
17 jeopardize the patient provider relationship.

18 I appreciate the chance to comment. Thank you for
19 the discussion, and thank you for your time today.

20 MR. HACKBARTH: Okay, thank you.

21 Let's see. We will reconvene at -- we're on time
22 -- 1:30. How about that?

1 [Whereupon, at 12:35 p.m., the meeting was
2 recessed, to reconvene at 1:30 p.m., this same say.]

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1 To briefly review -- and you have seen this before
2 -- ACOs are an organization accountable for both cost and
3 quality for a defined population of Medicare beneficiaries

4 Beneficiaries are attributed to the ACO by CMS;
5 there is no enrollment. The beneficiary can still choose
6 any provider inside or outside the ACO.

7 CMS pays the claims. Providers both inside and
8 outside the ACO are paid normal fee-for-service rates. And,
9 finally, if the total of all Medicare payments for the
10 attributed beneficiaries are below target spending, the ACO
11 and Medicare share the savings.

12 As I said there are two models of ACOs in
13 Medicare, so, first, let's look at MSSP.

14 The Medicare shared savings program was specified
15 in PPACA. It is a full-fledged program, not a pilot or a
16 demonstration. Each cohort so far has been bigger than the
17 last, and there are about 340 ACOs in the program now, with
18 almost 5 million beneficiaries.

19 Primary care physicians are the key to attribution
20 of beneficiaries, and beneficiaries are passively attributed
21 to the ACO based on their use of primary care. Again, there
22 is no enrollment.

1 So let's look at how they did the first year.

2 We're using preliminary data from CMS on the first
3 year of performance for the 114 ACOs starting in 2012. We
4 looked at the distribution of ACOs according to their
5 savings, which is defined here as the difference between
6 their spending benchmark for the year and actual
7 expenditures for the year.

8 We divided the ACOs into two groups: the green
9 bars are ACOs with more than 10,000 aligned beneficiaries,
10 and the yellow bars those with fewer than 10,000
11 beneficiaries. As you can see, for many ACOs their
12 expenditures were within 2 percent plus or minus of their
13 benchmarks. So 45 percent of the larger ACOs and 30 percent
14 of the smaller ACOs are in that middle category.

15 Both sets of ACOs look to be about normally
16 distributed around 0 although the smaller ACOs are more
17 widely dispersed, and this is what one would expect if there
18 is some random variation in performance which that takes on
19 a greater role in the smaller ACOs.

20 We found that savings was positively correlated
21 with the historical service use of the area in which the ACO
22 was located. In this slide, we divided the ACOs into groups

1 depending on the historical service use of the area where
2 they're located. This is the service use we calculated a
3 few years back for our regional variation work which
4 measures relative service use after removing the effect of
5 variation in prices, special payments, and health status.

6 The yellow bars are areas where service use is
7 over 102 percent of the national average. The green bars
8 are areas with service use less than 98 percent of the
9 national average. We have omitted those in areas with
10 service use within 2 percent of the average service use for
11 clarity. Note that the distribution for ACOs in areas with
12 above average use (the yellow bars) are shifted to the right
13 and account for all ACOs with savings over 10 percent, for
14 example.

15 The point of all this is that ACO savings are
16 correlated with service use. That is, ACOs where service
17 use is high have a better opportunity for extracting some
18 savings by reducing excessive use than ACOs in areas where
19 service use is average or low.

20 In summary, the ACOs in the MSSP program had
21 aggregate savings of about 0.3 percent. However, ACOs in
22 areas with historically above average service use had

1 savings that were statistically significant. Whereas, ACOs
2 in areas with below average service use did not.

3 We also note that, as we discussed in your mailing
4 material, ACOs in the South were more likely to have savings
5 than those in other regions of the country, and the South
6 had high service use in our work on regional variation.

7 Turning now to the Pioneer ACO model, the Pioneer
8 demonstration started over two years ago. There were 32
9 ACOs in the program with about 670,000 beneficiaries.

10 CMS reports that 13 of the ACOs had enough savings
11 to meet the minimum savings threshold, which was generally
12 around 1 percent. Two ACOs shared in losses. The other 17
13 had either savings or losses below the minimum threshold or
14 were in a payment arrangement that did not share losses in
15 the first year. Overall, CMS reports the program saved
16 about 0.5 percent.

17 CMS also reported that quality was better for the
18 Pioneer ACOs than fee-for-service for 15 comparable
19 measures. The Pioneers seem to be doing a little bit better
20 than random would predict.

21 Nine of the 32 ACOs withdrew from the
22 demonstration in July, leaving 23 ACOs in the demo in 2013.

1 Now, since we last talked about ACOs, we did some
2 case studies and focus groups, and I want to tell you about
3 what we found.

4 To better understand what is going on in the
5 Pioneer program, we contracted with the University of
6 Minnesota to do a series of case studies for us. We asked
7 them to compare pairs of Pioneer ACOs with similar
8 characteristics to one another in three markets and see if
9 we could get some idea of how the program was developing,
10 what issues were showing up, and what characteristics of
11 ACOs seemed to be correlated with success.

12 One key finding was that uncertainty about
13 financial benchmarks was a big issue. The ACOs were not
14 sure what their financial target was, how it was computed,
15 and the target kept changing. We think that CMMI has made
16 some modifications that will help create some certainty, but
17 this was the number one issue for many of the ACOs in the
18 case study.

19 Quality was an issue for all the ACOs. The
20 reporting of measures (particularly, chart based process
21 measures) was expensive and difficult, as was the auditing
22 of those measures. This was particularly true for

1 independent practice association sort of ACOs if the
2 physicians were not part of the same organization and did
3 not share the same electronic medical record system.

4 The ACOs used many of the same savings strategies
5 although the details differed. For example, many ACOs
6 placed an emphasis on high-cost beneficiaries that used case
7 managers or other methods. Some also have started to target
8 excessive post acute care costs. For example, one noticed
9 that certain SNFs had very long lengths of stay for almost
10 all their patients. They were working to give their
11 patients better alternatives.

12 Many desired to find ways to better engage the
13 beneficiaries with the ACO and felt somewhat frustrated by
14 some of the limitations in the program. A summary of the
15 study report is on our website.

16 Now, Christine and Joan will tell you about this
17 year's round of focus groups and site visits during their
18 afternoon session, but I'll go over their key findings on
19 ACOs, which reinforce many of the findings we just
20 discussed.

21 They held focus groups with Medicare beneficiaries
22 and primary care providers, and they visited health systems

1 and ACOs.

2 One of their key findings was that the out of the
3 59 beneficiaries in the focus groups, only one had heard of
4 an ACO. And the ACO executives said that they were not
5 engaging in any beneficiary awareness beyond the initial
6 notification.

7 MedPAC staff asked the health systems why they did
8 or did not decide to participate in ACOs. Executives at two
9 MSSP ACOs said they preferred capitation over fee-for-
10 service and that they were using the ACO as a stepping stone
11 towards capitation. However, both said patient attribution,
12 patient churning, and influencing beneficiary behavior are
13 challenges to the ACO model.

14 Executives at one system that is not an ACO said
15 that retrospective attribution did not permit real-time
16 patient activation and that historically low Medicare fee-
17 for-service costs in their case left little room for them to
18 achieve savings. Executives at another system said they did
19 not form an ACO because they preferred upfront payments to
20 finance care coordination activities rather than delayed
21 savings. And Christine and Joan can answer questions about
22 these findings later today.

1 So drawing on the lessons learned from the case
2 studies, our conversations with ACOs, an earlier survey of
3 ACOs we had performed, the focus groups, and ongoing
4 conversation with CMS staff, we can summarize the findings
5 as follows:

6 First, uncertainty about which beneficiaries were
7 attributed to the ACOs and uncertainty of the financial
8 benchmarks were a serious problem.

9 Second, the burden and expense of quality
10 reporting was excessive, and this is particularly an issue
11 for process measures that require chart abstraction -- that
12 is, for measures that cannot be calculated from claims data.

13 Finally, ACOs found that engaging beneficiaries
14 with the ACO is difficult. This becomes an issue if the ACO
15 is trying to prevent use of providers who are outside the
16 ACO and not operating under the same incentives. ACOs often
17 mentioned that they would like to offer some more tangible
18 extra benefits to the beneficiaries such as lower cost
19 sharing.

20 In light of these findings, we formulated a
21 comment letter that the Commission sent to CMS in June. It
22 raised five issues.

1 First, we remarked on the issue of increasing the
2 certainty of financial benchmarks and attribution. We
3 suggested moving to prospective attribution and benchmarks
4 to increase certainty.

5 We also suggested a way of including all
6 practitioners (including nurse practitioners and physician
7 assistants) in the assignment algorithm and identifying
8 practitioners by their individual NPI as well as their
9 practices ID.

10 We also reiterated the Commission's position that
11 CMS should move to a small set of outcome measures for
12 assessing quality. This would concentrate the ACOs' focus
13 on things that matter while allowing them freedom to
14 accomplish it and greatly diminish the reporting burden by
15 eliminating many process measures.

16 Another point we raised is that CMS should
17 encourage movement to two-sided risk for ACOs because it
18 greatly strengthens the incentives. Going to two-sided risk
19 also would allow the possibility of regulatory relief, such
20 as recommending certain post acute care providers, and
21 enable ACOs to provide more tangible benefits to
22 beneficiaries such as reduced cost sharing.

1 As the ACO model evolves, in the longer term the
2 program needs to move ACOs to two-sided risk concurrently
3 with moving to more equitable benchmarks and giving ACOs
4 more tools to manage care.

5 For example, ACOs in the same market could all
6 transition to the same benchmark for similar beneficiaries.
7 Right now, ACO benchmarks are historically based for each
8 ACO. This means that two ACOs in the same market could have
9 very different benchmarks. One could be rewarded for the
10 same performance at the same time as another is not.
11 Another step in this progression could be to move ACOs and
12 MA plans in the same market to the same benchmark, as we
13 discussed in last June's report.

14 The move to two-sided risk should also be
15 accompanied with tools to manage care such as lower cost
16 sharing in the ACO and perhaps relaxation of the three-day
17 rule for SNF admissions or other methods.

18 Finally, the program could retain a one-sided
19 model for new ACOs that might not be ready for bearing risk
20 but would like to gain experience with an ACO model of care.

21 A good question at this point is: What is the
22 role of ACOs?

1 In past conversations we think the Commission has
2 moved toward articulating that ACOs are a low-overhead
3 approach to care coordination and that their role is as a
4 third model, an option between pure fee-for-service and MA.
5 Its low overhead is what differentiates the ACO from an MA
6 PPO, for example.

7 The attribution model requires no marketing by the
8 ACO and is therefore less expensive to run than MA. In
9 addition, CMS continues to pay claims and set rates so the
10 ACO does not have to develop the capability to pay claims or
11 negotiate rates with providers -- again less overhead than
12 MA. They also do not take full risk and therefore do not
13 need an insurance license.

14 The attribution model does not require any action
15 by the beneficiary. It is passive. This could result in
16 larger numbers of beneficiaries in ACOs than an enrollment
17 model. Larger numbers are crucial to getting statistically
18 valid performance and quality results. In addition, larger
19 numbers of beneficiaries in a physician's panel can mean a
20 greater incentive for that physician to make the investment
21 to change.

22 From the beneficiaries' perspective, they retain

1 free choice of provider, and in a fully prospective two-
2 sided ACO model, the ACO has a strong incentive to keep them
3 happy within the ACO, as we discussed in the mailing
4 material.

5 But a key question is whether there is sufficient
6 incentive under this model to organize care delivery or is
7 the chance for meaningful savings too small to be effective.

8 To wrap up, we will continue to keep you informed
9 about the progress of the ACO programs as CMS releases
10 information and as we have discussions with ACOs.

11 We are conducting a case study of MSSP ACOs,
12 similar to what we did for Pioneer, and will let you know
13 the results when they come in.

14 And we're going to simulate the impacts of using
15 different benchmarks for ACOs and MA plans as we discussed
16 in the June report.

17 Thank you, and we look forward to your questions
18 and discussion.

19 MR. HACKBARTH: Okay. Thank you very much.

20 So what we will do is use a format similar to the
21 last discussion, clarifying questions, narrowly defined, and
22 then we'll go to a round where somebody will lead off, and

1 we'll see if we can build from there. So let me, clarifying
2 questions?

3 MR. KUHN: So on Slide 4, you talk about the fact
4 that we have 340 ACOs, about 5 million beneficiaries, and
5 then also in a subsequent slide you talked about the
6 historical service use, and those are the ones that are a
7 little more profitable. Are we seeing some clustering of
8 these in different parts of the country? Are we seeing a
9 reasonable distribution between urban and rural areas? What
10 is kind of what we're seeing out of these 340 so far?

11 MR. GLASS: Well, they are distributed across the
12 country. In the mailing material, there's one with bars for
13 the different regions of the country. I think more are
14 showing up in the South, I think a little bit. And I think
15 -- there are some rural ones, and there's some kind of
16 interesting rural cases where they've -- where small rural
17 groups in different parts of the country have banded
18 together into one ACO that's non-contiguous. But that way
19 it gives them enough people, enough scale to meet, you know,
20 the 5,000-beneficiary minimum.

21 DR. MILLER: And could you guys [off microphone] -
22 - did you already say and I just missed it, there's kind of

1 a weak correlation between high-cost areas and ACOs showing
2 up there?

3 MR. GLASS: Yeah. We haven't really looked to see
4 whether there are more of them there or not. There is with
5 savings -- there's a correlation with savings.

6 DR. HALL: I'll stay right here on Slide 4. So
7 historically, then, the evaluative component of this is
8 really limited to a period of about one to two years. Is
9 that correct? So --

10 MR. GLASS: Right, so far that's all we have [off
11 microphone].

12 DR. HALL: So this bears some superficial
13 similarities to the HMO movement, where in the first couple
14 of years, companies showed that they could produce a product
15 at a lower cost, and these were generally in areas where
16 there was over -- or higher utilization of services, which
17 is exactly the pattern that is seen here.

18 So when do you think we'll be able to have data
19 that is present over a more substantive time frame to make
20 really important decisions? This seems like it's very
21 premature right now, even though there has been general
22 acceptance of the ACO movement. Or can you say anything --

1 MR. GLASS: Well, we should have more data on the
2 Pioneer, we hope pretty soon, for their second year. And
3 I'm not sure when the -- July, maybe, for the MSSP, we'd
4 have two years.

5 DR. STENSLAND: I think about one year from now we
6 should have a big sample from the MSSP and two to three
7 years of Pioneer, so that should be pretty good.

8 DR. HALL: Okay. Thank you.

9 DR. NERENZ: Slide 14. This is where you used the
10 phrase "low overhead," and I'll say, guys, this is good work
11 and really interesting, and I appreciate it.

12 I think what we are saying here, it's low overhead
13 in principle or in theory. Is it low overhead in practice?
14 Do we know anything about that?

15 DR. STENSLAND: I think it's low overhead compared
16 to the cost of running an MA plan. So people we talk to and
17 the data we have seen, it looks like maybe 1 to 2 percent of
18 your spend, that that's what they're spending on their ACO
19 to operate it; whereas, an MA plan, when they put in their
20 bids, you're seeing 10 percent or more in their
21 administrative cost bucket.

22 MR. HACKBARTH: And the big difference is -- one

1 of the big differences is marketing expense. Because of
2 passive enrollment, ACOs are not spending on marketing;
3 whereas, MA plans spend a lot on marketing.

4 DR. SAMITT: A quick question about the
5 demographics of the ACOs. I don't believe I saw it in the
6 chapter. How do the geographies of the ACOs compare to MA
7 penetration? Have you taken a look at where the ACOs are
8 relative to MA percentages in those same or different
9 markets?

10 DR. STENSLAND: We don't have a quantitative
11 analysis of that, but if you just look at where they're at,
12 there is a fair amount of overlap. But MA is pretty broadly
13 spread across different types of areas in terms of low
14 spending and high spending, in part because the low-spending
15 areas get higher benchmarks, and so that's why they're kind
16 of able to operate there.

17 DR. HOADLEY: You had talked about the geography a
18 minute ago, and you say on Slide 7, savings higher in the
19 South and you have more of that in the chapter. Is there
20 any sense that's more than just the underlying cost
21 difference, that there's actually a regional difference? Or
22 is it maybe all attributable to the underlying cost

1 difference?

2 MR. GLASS: I don't know if I'd call it cost
3 difference. The difference in service use.

4 DR. HOADLEY: Or service use, sorry. I said the
5 wrong word.

6 MR. GLASS: Those are areas with higher service
7 use.

8 DR. HOADLEY: Do you think there's any regional
9 effect left after you control for service use? I guess
10 that's really what I --

11 MR. GLASS: We did not do that.

12 DR. STENSLAND: We have not done a multivariate
13 regression where they fight it out.

14 DR. HOADLEY: Okay.

15 DR. STENSLAND: As two independent variables.

16 MR. GRADISON: On page 15, you mentioned the
17 possibility that ACO patients would pay higher cost sharing
18 for going outside of the ACO. I was trying to understand.
19 It sounded to me like it really would be a major change. It
20 would be like a PPO really. Do you think you'd have to --
21 would you still have the current attribution system, though,
22 with the opt-out, and the opt-out point would be where the

1 beneficiary would decide whether to join, with full
2 knowledge that going outside of the ACO network would cost
3 them more?

4 MR. GLASS: Okay. This is in the context of
5 saying they might be given lower cost sharing within the
6 ACO. So their cost sharing outside the ACO would not be any
7 higher than normal fee-for-service cost sharing.

8 MR. GRADISON: Oh, okay.

9 MR. GLASS: It would be typical fee-for-service
10 cost sharing. We're just giving them a break on the cost
11 sharing inside the ACO.

12 MR. GRADISON: Thank you. I misunderstood.

13 MR. GLASS: And it's for that very reason you
14 raised. They're not actively choosing an ACO, so you can't
15 punish them for being in one.

16 MR. GRADISON: Thank you. I missed that. Thank
17 you.

18 MR. HACKBARTH: Any other clarifying questions?

19 MR. ARMSTRONG: It may have been in the report,
20 but most of the slides and our conversations focused on the
21 impact on expense trends. You make a reference to the
22 burden of quality reporting. But what do we -- do we know

1 anything about differential outcomes with respect to some of
2 the population or quality metrics?

3 MR. GLASS: No. The -- I don't think we -- the
4 MSSPs, they were simply in the reporting. They were getting
5 -- they just had to report. The Pioneer, CMS says they did
6 better than fee-for-service on the measures that they could
7 compare them on. And we haven't calculated the measures
8 that we might find of interest. That would be an
9 interesting thing to do, if we can do it.

10 MR. HACKBARTH: Any other clarifying questions?

11 [No response.]

12 MR. HACKBARTH: Seeing none, let's go to Round 2.
13 Who has a Round 2 -- let's start with Alice and then Dave,
14 Jay, Kathy, but as before, we'll slice and dice Alice's
15 comment and give people an opportunity to pick up on ideas
16 that she's presented. Are you ready for that, Alice?

17 DR. COOMBS: So one of the comments in the paper
18 alluded to the fact that providers could be involved in
19 ACOs, MAs, and fee-for-service at the same time. So in the
20 big scheme of looking at synchronization of payments and
21 looking at quality, how can we actually be able to -- it's
22 not a clear break if you have multiple providers

1 transcending multiple systems, and then we say we're going
2 to look at the fee-for-service and benchmark things against
3 fee-for-service. And maybe you guys have thought about
4 this. But I think it's like a real hurdle to climb because
5 it's not a clear-cut division between. It's possible that a
6 large group, ACO, might be taking care of a number of fee-
7 for-service for which they're being graded for in the same
8 system for their ACO.

9 MR. GLASS: That is correct. The same physician
10 may have patients that he's seeing under contract with an MA
11 plan or, you know, being paid MA rates for that patient. He
12 could be seeing a fee-for-service patient. And some of his
13 patients may be -- may have been attributed to the ACO that
14 the physician is a member of, and he would have three
15 different kinds of patients, Medicare patients. So it's a
16 complication.

17 DR. COOMBS: The other dynamic is that -- and I
18 may be intersecting with one of the other presentations, but
19 as MA plans increase, enrollment seems to be relatively
20 small compared to MA plans. And then the residual fee-for-
21 service is still being benchmarked against that, and then
22 that residual population changes. How do we intend to

1 address that piece?

2 DR. STENSLAND: I think the way we've always
3 talked about this in the past is we have one big bucket of
4 fee-for-service which consists of pure fee-for-service ad
5 people who are on fee-for-service and also in an ACO. And
6 so that big bucket is your ambient fee-for-service
7 community, and that can be your benchmark for quality, that
8 can be your benchmark for cost per member per month. And
9 you could evaluate ACOs against that and MA against that.

10 DR. COOMBS: So it might work better for costs
11 than it does actually for quality, especially when you have
12 an integrated practice, and that piece I think we don't have
13 clear. It's possible that if you have multiple providers
14 with intersections between multiple groups, and then the
15 quality piece of that, it doesn't seem to be very clear to
16 me that we're able to actually look at quality in a
17 comparison fashion.

18 MR. HACKBARTH: I think the basic observation,
19 Alice, that you're making is a really important one.
20 Typically -- and I don't even think it's an unusual case.
21 Typically, any given physician or group of physicians or
22 hospital will be participating across these different

1 categories. And they'll be in fee-for-service and have some
2 fee-for-service patients. They'll have some ACO assigned
3 patients and probably an MA contract as well.

4 To the extent that changes in patterns of care
5 happen and they spill across -- because physicians don't
6 like to treat patients based on their insurance or what
7 delivery system they're enrolled in. If it's a good thing,
8 they do it for all their patients. I think what that means
9 is there's a challenge in getting your ACO to be much better
10 than the ambient fee-for-service environment or challenge
11 for an MA plan to do that.

12 If you're the type of MA plan that is built on
13 open networks, you know, Kaiser Permanente and Group Health
14 of Puget Sound are different because they've got more
15 exclusive providers, although Scott has some open networks
16 as well. And so really making yourself stand out either on
17 quality or cost, you have to overcome this spillover
18 tendency that exists.

19 Now, even within that environment, I think there
20 are opportunities to improve quality in an ACO or an MA
21 plan, MA in particular because of differences in benefit
22 structure and the like. But this is a challenge.

1 DR. COOMBS: The only reason why I bring this up
2 is because many of the ACOs have exclusivity contracts with
3 primary care physicians, and so if that's the case, it's
4 going to -- patient panels are going to look very different
5 in different regions, different geographic regions.

6 MR. HACKBARTH: Tell me more about that. So what
7 do you see in terms of exclusive ACO contracts? What does
8 that mean?

9 DR. COOMBS: So that means that you're with a
10 group, say you're with -- well, a group, I won't name a
11 group, and you sign a contract with that group that you're
12 going to be exclusive to take care of this group of patients
13 in this area.

14 MR. HACKBARTH: And you won't participate in
15 another ACO?

16 DR. COOMBS: Right, you won't participate in
17 another ACO.

18 MR. HACKBARTH: But you still may have fee-for-
19 service or MA?

20 DR. COOMBS: You may, but the bulk of your
21 patients are under the ACO umbrella.

22 MR. GLASS: Yeah, because of the assignment

1 algorithm in the ACOs, primary care physicians have to be
2 exclusive to a single ACO, or you couldn't assign them --
3 you couldn't assign people. That's --

4 MR. HACKBARTH: You also will have --

5 MR. GLASS: But they can still be--

6 MR. HACKBARTH: -- fee-for-service patients.

7 MR. GLASS: Sure.

8 MR. HACKBARTH: And most likely MA contracts as
9 well.

10 DR. MILLER: Notwithstanding the impact of the
11 individual [off microphone] physician being in one system or
12 another, I don't want to lose the point that Jeff was
13 driving at, and we talked about this in March and April, and
14 some of it got written up in the June report. This notion
15 of calculating at a population level what the fee-for-
16 service population -- you know, admission rates, readmission
17 rates, whatever the case may be, looking at that for ACOs,
18 looking at that for MA, and asking if those MA plans can
19 distinguish themselves from the population-based measures
20 for fee-for-service in their market.

21 And, you know, there would be the usual risk
22 adjustment issues there, and you might say, "But that's not

1 enough," and fair enough. But the attempt would be to say
2 those would be put on a comparable basis by risk adjusting
3 across the different populations.

4 But you are right. Any individual provider could
5 find themselves in all three pots.

6 MR. HACKBARTH: I think, Kate, in some of your
7 research, you've found empirical evidence of these spillover
8 effects, correct?

9 DR. BAICKER: Mostly focusing on the degree of
10 management in an area. You know, does the penetration of,
11 whether it's commercial managed care or Medicare Advantage-
12 type managed care affect system-level delivery, and a lot of
13 that is motivated by physicians treating their panel in a
14 consistent way and hospitals treating their admissions in a
15 consistent way.

16 MR. HACKBARTH: Okay. Anybody want to pick up on
17 the issues that Alice has raised? If not, Dave, you're next
18 up.

19 DR. NERENZ: Yeah, if I could go back to the
20 overhead cost issue, I just want to back-of-the-envelope
21 arithmetic and see if I'm thinking about this correctly.
22 If, say, Jeff, as you said, two percent of overall spend

1 might be administrative -- you said one to two, but let's
2 just use two -- in order, then, for the ACO to make money
3 net, it would have to achieve four percent savings if the
4 shared savings ratio is about 50 percent. I realize it
5 depends on how you hit your quality targets, but just for
6 rough thinking, you'd have to have a savings of four percent
7 to get two percent back and at that point you break even.
8 And, then, there's also something about the savings are
9 also, perhaps, your revenue losses.

10 I'm just trying to figure out, in the data you've
11 seen, are there ACOs who have actually made money net of
12 overhead cost? Do we know that yet?

13 DR. STENSLAND: Yeah. There would be some that
14 would make money net of overhead costs, but it would be a
15 small share. I would think maybe a three percent is
16 probably more realistic if you look at -- because most of
17 them are getting more than 50 percent share of the savings
18 based on their quality scores, so -- on average, a small
19 share are generating savings, and if you averaged everybody
20 so far, at least in the first year of the program, the share
21 of savings, on average, that they get is going to be less
22 than their administrative costs of being in it, at least for

1 the first year.

2 DR. NERENZ: Okay, and that's what I was trying to
3 get to. It's just about the sustainability of the model and
4 I just was trying to figure out how these flows were
5 balancing. Thank you.

6 DR. MILLER: Can I get one layer past that? One
7 of our recommendations in the comment letter is to change
8 how the quality process works, and at least in all of our
9 case studies and conversations and focus groups and all of
10 that, there was a lot of carrying on about that. And, we
11 don't have a quantified number on it, but a lot of people
12 pointed that to a cost. If CMS were to adopt that or the
13 Congress were to adopt it, that would give some relief.

14 And then I want to just ask you guys, and I know
15 this isn't science, we're just talking one to two percent,
16 but this is also the first, second year. Would you expect
17 that to go down over time, or do you not even want to have
18 this conversation and it's just awkward that we started it
19 in public?

20 [Laughter.]

21 MR. GLASS: We should probably move on now, Mark.

22 [Laughter.]

1 DR. MILLER: I could tell by your body language
2 there.

3 MR. HACKBARTH: Okay. Craig.

4 DR. SAMITT: Now, I'll jump onto Dave's comment,
5 and you may not be able to answer this question, but my
6 interest is finding a way to assure that the ACO model is
7 sustainable, even if it's viewed as a platform to broader
8 accountability in the form of Medicare Advantage. We don't
9 want to lose offering providers the opportunity to learn
10 expertise in coordinated care rather than in fragmented
11 care. So, my question is, these recommendations, either the
12 short-term or the long-term, do we feel they're enough to
13 sustain interest by the current ACOs in staying in the ACO
14 program going forward?

15 DR. STENSLAND: I think they would help. There is
16 -- I would divide the things we can do to make ACOs more
17 attractive into four buckets. I think one bucket is let's
18 reduce the administrative cost, and I think a lot of what
19 we're talking about, simplifying the reporting, trying to
20 minimize that, can bring those expenses down. That makes it
21 more attractive.

22 Another bucket you could move is you could move

1 the gain sharing up or down. You know, if they are actually
2 gaining and they're beating the threshold, maybe they could
3 get more than they're getting now.

4 Another thing we're talking about is this greater
5 incentive to align the beneficiary with the ACO, and
6 certainly there's a plan to do that with Medigap plans in
7 Massachusetts, where they would have lower cost sharing if
8 they stay in the model. So, then, if you have the
9 beneficiary more somewhat aligned within your network, you
10 probably can generate more savings because you have more
11 influence over where they decide to go. It's still purely
12 the beneficiary's decision, but you have more influence over
13 where it's to go.

14 And, all of those mechanisms are either reducing
15 costs or increasing your savings in ways that are aligned
16 fully with the system and they're also aligned in a way that
17 they only get those extra monies if the ACO actually does
18 something.

19 Another thing we've heard is some people would
20 want just some extra money up front. Let's just give us
21 some extra care coordination money up front. But, that's a
22 different kind of a model because then you get it whether

1 you actually perform or don't.

2 I think those are kind of the buckets, and if you
3 -- you know, it's a judgment call that everybody can make as
4 to whether there's enough action in those first three
5 buckets to get people to stay in the program, but I think
6 that there could be.

7 MR. HACKBARTH: So, just to sort of complete the
8 list, though, so reducing administrative costs by changing,
9 for example, the quality measures, more means of beneficiary
10 engagement, higher share of the savings, directionally, I
11 think we can say with confidence that makes participation
12 more attractive. On the other hand, we've talked about
13 downside risk, changing the benchmarks so that there is not
14 a penalty for being historically efficient, or
15 alternatively, a reward for being historically inefficient.
16 They will cause some people to drop out. And, how those
17 factors net out, I think, is open to question. I wouldn't
18 hazard a guess. If I had to guess, I would say that
19 probably fewer participants, but maybe more robust
20 participants. That would be my hope.

21 But, what's your goal? Is the goal a lot of ACOs?
22 You make one set of decisions to assure maximal

1 participation. If your goal is to actually change patterns
2 of care, you make maybe a different set of decisions.

3 DR. SAMITT: And, I think the reason I ask is I
4 think depending on the performance today of the system,
5 you'll get very different answers to your hypotheses. So,
6 the experience that I have, that the ACOs that are actually
7 choosing to step out of the ACO world are those that are
8 high-performing today. So, they're the ones that likely
9 have high quality and are more efficient today. Those that
10 will likely stay in the ACO program are the ones that are
11 actually generating substantive savings, which are those in
12 the South or those that have a higher utilization of
13 services.

14 So, the question is, is that an acceptable state
15 of affairs today? It goes back to, I think, the comment
16 that Scott made earlier in the day, that we see great
17 geographic variation in performance. If the ACO space is
18 instigating change in the less efficient part of the
19 country, well, maybe that's a good place to be right now.
20 The question is, we don't want to lose the sort of the
21 attention and the support of the current high-performing
22 systems. What do we do to help support them, as well?

1 MR. GLASS: And, I think that's why we were
2 talking about transitioning benchmarks eventually to the
3 local fee-for-service or something like that benchmark
4 rather than the ACOs' historical service, because that would
5 bring the more efficient ones, give them something to look
6 forward to. And, also, I think the recommendations on
7 increasing certainty for the alignment and the benchmarks
8 will certainly calm some nerves.

9 MR. HACKBARTH: Right. Jon.

10 DR. CHRISTIANSON: So, to Glenn's point about what
11 the goal is, I think we've learned from the MA program that
12 if you pay more, there will be more participants, and that's
13 a big bucket that you didn't mention. So, if our goal is
14 initially to get as many providers in the system as we can,
15 and, along the lines of Craig's comments, learn how to
16 manage care under this budget and so forth, we pay them
17 more. I mean, that's the simplest way to increase -- but, I
18 don't know that that's the goal. I mean, I sort of -- I
19 hear what Glenn is saying, too, and maybe where the goal is
20 not to have a large number of ACOs at all. Maybe we should
21 be prepared to have a smaller number of ACOs in the future.

22 MR. HACKBARTH: You know, this sort of goes back

1 to the point that Warner raised this morning directly on
2 point. Presumably, what happens is the question is, what
3 are my alternatives? If I don't do this, what can't I do?
4 And, Warner's concern, as I understood it this morning, was,
5 well, if they just go back to fee-for-service and run the
6 old revenue model, that's not good for the Medicare program.
7 I think we would all agree with that.

8 And, so, what we need to do is structure a menu of
9 choices that may include making, as I suggested this
10 morning, making traditional Medicare tougher to run the old
11 revenue model and making that refuge less attractive to both
12 providers and beneficiaries. So, this isn't a discussion,
13 ACOs, that can be had in isolation. It needs to be part of
14 a broader strategy for how you put together this playing
15 field.

16 Warner, you look like you're --

17 MR. THOMAS: I just had a -- one is a clarifying
18 question, and then I want to build on Craig's comment. So,
19 in Figure 3 in the write-up, where you have the ACOs with
20 greater savings more likely in the South, and I just want to
21 make sure I understand this. So, if you look at -- I'm not
22 sure on the minus-two to plus-two, because that's broken

1 down, but it looks like if you look at two percent and
2 above, only about 30 percent of the ACOs are two percent or
3 above. So, about 70 percent are around break-even or
4 better, if I'm kind of roughly looking at those numbers. Is
5 that -- is that roughly correct?

6 MR. GLASS: [Off microphone.] Are you just on the
7 --

8 MR. THOMAS: So, I'm adding up the two to five
9 percent to five to ten, and then the more than ten percent,
10 so --

11 MR. GLASS: [Off microphone.]

12 MR. THOMAS: Just in general, just in total. So,
13 roughly, it looks about 30 percent are two percent and
14 above. So, with all the components you mentioned of, you
15 know, they don't know who the beneficiaries are, the
16 beneficiaries don't know that they're in this, there's
17 infrastructure costs, that it really doesn't make a lot of
18 sense for people to do this, they have to save a lot of
19 dollars to break even. But, even with that, 70 percent of
20 them broke even or did better, roughly, if you kind of look
21 -- I'm just trying to make sure I understand --

22 DR. NERENZ: Not broke even in the sense I was

1 asking.

2 MR. THOMAS: Well, didn't break even on
3 necessarily their cost, but broke even, roughly, on the
4 medical trend, if you will, right, because -- I mean, we
5 don't know because it's negative-two to plus-two. So, the
6 point I'm trying to make is even if with the program set up
7 the way it is, which is relatively difficult to operate
8 within, you've got 70 percent of the ACOs that actually
9 about broke even or did better.

10 So, then, the question would be, if you really did
11 know who the beneficiaries were, if you really could reach
12 out to them, if there really was the right upside, I mean,
13 could these entities really change the medical cost? And,
14 in your discussions with the ACOs, and, I guess, with your
15 analysis of the data, what are your thoughts around that?
16 You've made some recommendations on how to improve the
17 program, so you've obviously analyzed the challenges with
18 the program, but in your opinion, I mean, do you feel like
19 with those changes and what you've seen that there is the
20 opportunity to move the medical cost down, because it looked
21 like, just kind of looking at the data, with all the things
22 that have been challenging in the program, it's been

1 relatively -- relatively successful, given the challenge in
2 the program, given that it's only been out there a couple of
3 years.

4 MR. GLASS: Well, some of them certainly feel they
5 can do this, and some of them have some statistics on
6 lowering, I guess, rates of admission and readmission and ED
7 visits.

8 MR. THOMAS: Right.

9 MR. GLASS: So, we -- I think we can look at that
10 and see if we can come up with some data to whether that's
11 true or not, because if they can really cut utilization,
12 then presumably, they should do well against these
13 benchmarks or slightly different benchmarks.

14 MR. THOMAS: Maybe going to Alice's point, where
15 you've got a physician who's taking care of people in three
16 different buckets -- traditional fee-for-service, ACO, and
17 MA -- I mean, probably in MA, they know who the folks are
18 because they may have risk. They've probably got the plan
19 that's intervening with them. But, in ACO and traditional
20 Medicare, I mean, they probably don't really know the
21 difference in the folks that they're taking care of,
22 frankly.

1 So, I think my point is, going and building on
2 Craig's issue or comment, is that I think if we build more
3 capability and incentive in here and also create an
4 opportunity to interact with the beneficiary more, my guess
5 is we're going to see the results potentially get better,
6 because just looking at this -- I've never seen this data
7 prior to looking at the paper -- but, just looking at this,
8 I would think it's relatively positive, given the challenges
9 that the ACOs have been against to kind of put this
10 together, and the fact that they're in their infancy, one to
11 two years, so --

12 MR. HACKBARTH: Warner, does Ochsner have an ACO?

13 MR. THOMAS: We just were like a few months into
14 it, six to 12 months. But, we have a lot of experience in
15 Medicare Advantage.

16 MR. HACKBARTH: Mm-hmm.

17 MR. THOMAS: And, I think, building on Craig's
18 point, the idea of having responsibility for the whole
19 medical cost of a patient versus kind of looking at it on a
20 fee-for-service basis, I mean, you can just -- you can be
21 much more creative and innovative in how you want to take
22 care of folks. So, I think that's the point I would make

1 here, and I would agree with Craig, we don't want to lose
2 that.

3 The other thing is, it is more effective in areas
4 in high cost, is that maybe that's a good thing. Maybe we
5 should build upon -- if there's ACOs that are doing well in
6 high-cost areas, how do we help them lead the way, and then
7 start to compare them to the other providers in those
8 markets that are high-cost, because my guess is there's
9 high-performing providers in high-cost areas just like
10 there's probably low-performing providers in low-cost areas,
11 so how do we build upon it.

12 MR. HACKBARTH: And that's a really important
13 point. So, in general, I would say if we can have more ACOs
14 in the regions of the country that are very high cost, in
15 general, that's a good thing. But, then there's the
16 variation among providers within markets. So, within the
17 high-cost areas, some are higher-cost providers than others.
18 And, there, we run into this equity issue of within a given
19 market, you don't want to give the historically high-cost
20 providers easier targets, more generous bonuses than the
21 efficient providers.

22 MR. THOMAS: I would totally agree with that, and

1 I think it's interesting. To me, it would be interesting to
2 look at some of the results of ACOs that are in higher-cost
3 markets to see, did they really stand out compared to the
4 market and how can you build upon that to have them be a
5 leader to try to drive the change in those markets and do
6 more comparison to the others in those areas to see if you
7 can try to drive change, because it seems like, also reading
8 about MA, it seems like MA is more effective in higher-cost
9 fee-for-service markets, as well, so --

10 MR. HACKBARTH: Okay. So, I have Jay and Kathy
11 and Cori in the queue. Jay.

12 DR. CROSSON: Just a couple of points, and some of
13 it relates to what's been discussed already. You know, I
14 look at the same data and I'm sort of disappointed, to be
15 honest with you, compared with what we thought we were going
16 to get four years ago when we came out with the ACO report.
17 Now, maybe that's a function of time, as David said. Maybe
18 -- and Warner implied -- maybe it's just too early. You
19 know, we haven't really given these things a chance to show
20 what they can do, and that may well be true. But, I think
21 if you look at the MSSP chart, it's not much more than a
22 random walk. And, I would have expected more.

1 So, the question is -- and, I guess, you know, the
2 first question is, do we care? Should we take action, as
3 you were saying earlier, to try to see that there are more
4 ACOs? And, I would say, from my perspective, I think so,
5 because I think -- not just to try to lower the cost in the
6 high-cost areas, which appears to be working to some degree,
7 but because -- and I think it's been mentioned already -- I
8 think we've seen for a long time that this may be a stepping
9 stone to get to another place, which would allow population-
10 based prospective payment to be more universal than it is
11 through the MA program by bringing physicians together and
12 bringing physicians and hospitals together and learning the
13 techniques about how to manage cost, which are not
14 supported, generally, by typical fee-for-service Medicare
15 payment.

16 The question I have looking at it is, like, well,
17 why? I mean, what are the factors? Are they these that
18 we're recommending we change? I think these would all be
19 helpful. But, are there some more substantive things that
20 we should think about? Is there something about the issue
21 of the physician culture, the issue of the closed panel
22 thing? Is that achievable in something like a different

1 model? Is it even measurable? That's one thing.

2 To what degree are the ACOs effective in managing
3 hospital costs compared with an organization that has
4 hospitals as integrated completely into their delivery
5 system and their cost management system? What do we know
6 about that?

7 Is this really all about money, as Jon said? Is
8 it just simply that everybody is smart after a while and
9 they figure out where the money is and there's not enough
10 money available here, so people don't really try and they
11 say, you know, well, let's do this, but let's switch as soon
12 as we possibly can to Medicare Advantage because there's
13 more money in Medicare Advantage?

14 So, I'll conclude, but I think, from my
15 perspective, we should think hard about this. It's worth
16 the work. I would be happier to see more ACOs rather than
17 less for the reasons I said. But, I think we need some
18 understanding, and one way of maybe getting to that is
19 trying to look at those situations in which organizations
20 have decided not to become an ACO and chose to go to MA.
21 What are exactly the reasons, and are they the same all over
22 the country or are they different?

1 MR. HACKBARTH: Here's one other barrier to
2 performance that I would add that we haven't touched on
3 today, and that's that ACOs are built on the fee-for-service
4 chassis. If you're talking about an ACO that is an
5 integrated multi-specialty group practice, that may not be
6 as big an issue because all the revenue is coming to one
7 place and reallocated in accordance with whatever the
8 compensation program of that integrated practice might be.

9 If, however, you're trying to build an ACO out of
10 previously unintegrated parts, the fact that the dollars
11 still flow on a fee-for-service basis, I think, is
12 potentially a huge problem. So, if you're the CEO of the
13 new ACO and you're trying to stitch together these
14 previously independent parts, but they're all still
15 receiving their fee-for-service checks directly from
16 Medicare, you're not getting anything as the ACO. All the
17 flow is still to the separate providers. The only leverage
18 you have is, well, if you do well, I may give you a share of
19 this very small bonus after I cover my start-up costs. Your
20 levers as that ACO's CEO are really, really weak.

21 And, so, if you want to move to a much more
22 powerful model, you have to move away from fee-for-service,

1 have the dollars flow to the ACO. Of course, that's a
2 double-edged sword. If your goal is to maximize
3 participation, that's going to knock out a bunch of
4 organizations right there because people aren't going to
5 give up their fee-for-service revenue flow for a fledgling
6 ACO. And, so, there's a real dilemma there in how you make
7 it more powerful under the existing payment rules.

8 DR. CROSSON: Can I just add one thing, and this
9 is a little bit of a sideline, but along the lines that
10 you're talking about, there is in Medicare Advantage that
11 option, the Provider Sponsored Organization. And, one of
12 the things that I've always wondered about is why that
13 program never advanced and are there elements to that that
14 could be fixed to fit in that space you're talking about.

15 MS. BUTO: Provider Sponsored Organizations --
16 offline, I'll give you some of the history, because I was in
17 the -- there was a managed negotiation, or negotiated
18 rulemaking around that that I think, in the end, resulted in
19 virtually no PSOs. Yeah.

20 My question was really about whether there was a
21 way to create for those ACOs that were achieving savings,
22 maybe over a two-year or three-year period, some additional

1 kind of -- I call them benefits rather than payment
2 increases -- where things like episode-based payment would
3 be more available to those successful organizations that
4 want to simplify the way they do things. And, it would be -
5 - if you want to look at sweetening the pot for making life
6 easier to actually manage care, there are tools like that
7 that might not violate the fee-for-service system but would
8 actually be welcomed by physicians within an organization
9 like that.

10 So, I just wonder if we've thought about those
11 kinds of enhancements that would make the ACO -- a
12 willingness to join and become part of an ACO with the hope
13 that if you achieve certain levels of savings over time, you
14 would get the additional benefits, freedom, lack of
15 micromanagement, whatever it is that physicians and
16 physician organizations would really value, and whether
17 we've thought about that.

18 MR. GLASS: Well, we did talk about if you were
19 two-sided ACOs, getting regulatory relief from various
20 things, but I don't think we had thought of moving to
21 episode payment.

22 DR. MILLER: [Off microphone.]

1 MR. GLASS: That's an idea, yeah. That's a good
2 idea. I mean, that's a -- we just hadn't thought about it.
3 that's a good idea.

4 DR. MILLER: I mean, it's very much, though, in
5 the spirit --

6 MR. GLASS: Yeah.

7 DR. MILLER: -- that you're saying. So, it would
8 be things like saying, okay, if the three-day rule for SNF
9 doesn't make any sense, you can take the risk of putting the
10 people into SNF right off. We talked about the notion of
11 some RAC relief. And, here, this was not a lot of deep
12 science or anything like that, but sort of in the letter
13 saying, these are some roads we think we ought to look down,
14 and it's very much in the spirit of what you're saying. If
15 you're willing to take risk, then the fee-for-service
16 program is willing to step back, because when you think
17 about it, a lot of that stuff was put in place because the
18 fee-for-service environment encourages a certain kind of
19 behavior.

20 MS. BUTO: Right, and we're going to get to this
21 tomorrow, but the whole issue, the one-day stay and the
22 outpatient observation days, if an ACO can manage that

1 according to certain agreed upon parameters, there may be a
2 way to share savings around that discrete issue. So,
3 actually saying to the ACO, you're a partner, over and above
4 just being expected to coordinate care, we're going to allow
5 you to, in a sense, experiment or try things that are not
6 available in regular fee-for-service.

7 MR. HACKBARTH: Okay. I have Cori, Mary, and then
8 Warner, then I think we're going to need to move ahead.
9 Cori.

10 MS. UCCELLO: What's interesting kind of along
11 these lines is that there's really this range of
12 organizations. In the focus groups, you had two saying,
13 hey, we want capitation, and on the other hand, you have a
14 lot saying, we don't want to go to two-sided. So, it's just
15 interesting.

16 But, my actual point was I just want to reiterate
17 my interest -- I think this is probably a secondary issue
18 compared to some of what we've been talking about -- but
19 pursuing more the idea of the lower cost sharing for the
20 beneficiaries and how, you know, we talked about some
21 methods or options for this in the past and I think further
22 fleshing them out and understanding how they interact with

1 the other components in terms of physician exclusivity to
2 particular ACOs and how that may differ by primary versus
3 specialist, beneficiary attestation, how all of those
4 different things interact. You already know I'm interested
5 in this, but I think it's worth looking into some more.

6 DR. NAYLOR: So, on this slide, it says ACOs is
7 low overhead approach to better care coordination, and,
8 obviously, understand that low overhead to the ACO. But,
9 I'm wondering -- it is built on the fee-for-service chassis
10 -- what it means in terms of cost for the total program as
11 we're pursuing fee-for-service and CMS is also pursuing all
12 the efforts. Do we have a sense of the overhead cost for
13 the Medicare program as we're doing this model development?
14 It's just something that I think is really important.

15 The other is on better care coordination. So, we
16 are now going to be, January, implementing a new per member,
17 per month care coordination fee, and I'm wondering how those
18 new costs intersect with our efforts to try and build a
19 continuum -- a synchronized set of models around care
20 coordination.

21 And then the last thing I would ask is, what is
22 success, because Warner and Jay looked at the same data and

1 came away with a different sense of, we're doing well. So,
2 we have a point-five percent savings, very early data, and
3 with a high-risk group, and we might not see that next year.
4 So, a year from now, do we have a definition ourselves about
5 what are the benchmarks that we would look at and say, this
6 is a successful program, both quality and cost?

7 MR. HACKBARTH: I don't think that was a
8 rhetorical question.

9 [Laughter.]

10 MR. GLASS: They were very good question.

11 DR. MILLER: I think that's a question for the
12 Commissioners, and I think some of it goes back to what goal
13 do you think this is --

14 MR. HACKBARTH: That goes exactly back to --

15 DR. MILLER: I'm sorry. Well, I didn't mean to
16 get --

17 DR. STENSLAND: I think it's kind of --

18 DR. NAYLOR: Make it rhetorical.

19 [Laughter.]

20 DR. STENSLAND: It's in the eye of the beholder, I
21 guess. The longer I look at this, the more I think -- or,
22 the longer I'm in this whole circle of friends here, the

1 more I think a --

2 [Laughter.]

3 DR. STENSLAND: I'm using it liberally, but --

4 [Laughter.]

5 DR. STENSLAND: The longer I'm here, the more I'm
6 thinking, you know, we should be pretty happy with singles
7 rather than home runs, because a lot of times, we just
8 whiff, and --

9 [Laughter.]

10 DR. STENSLAND: And, so, if we ended up with
11 something that saves something, and it was big enough
12 savings to recoup people's overhead costs, I think that
13 would be a good thing. And, if we got something where the
14 quality measures were better than the ambient fee-for-
15 service metrics, that would be a good thing.

16 So, if you ask me, what is the benchmark of what
17 is good, I would say better than zero. I think the old
18 benchmark used to be there's 30 percent waste in the fee-
19 for-service system, and I think if you're looking at that
20 kind of thing, you're thinking double-digit savings. It's
21 probably just not going to happen.

22 DR. NAYLOR: And, I actually would agree with you,

1 but I would say that in assessing whether or not we got to
2 zero or better, we have to look at the total program costs,
3 not just to the ACOs, but to the programs.

4 MR. HACKBARTH: Jeff, I think that was a nice
5 summary. You know, the only thing that I might add to it is
6 that as we move down the road and the program matures a
7 little bit more, then sort of the next strategic decision is
8 could we -- there's a trade-off to be made by, for example,
9 two-sided risk. Can we make the potential savings more
10 significant with an acceptable level of defection? And, in
11 part, that will depend on what goes along with two-sided
12 risk in terms of new benchmarks, freedom from fee-for-
13 service regulation, et cetera. But, for now, any -- I'm
14 with Jeff. Any progress is good progress. But, not too far
15 down the road, you've got to make some strategic choices
16 that will inherently involve trade-offs, maybe smaller
17 participation for more robust participation.

18 So, unless there's -- oh, Warner, you had a
19 concluding comment. I'm sorry.

20 MR. THOMAS: I was just going to say, I think,
21 going to Jay's point, I understand why he could look at this
22 data and be disappointed. But, also building on your

1 commend, Glenn, a lot of these are built on a fee-for-
2 service chassis. So, I mean, they're not the Kaiser
3 Permanentes of the world. They're not the Group Health
4 Cooperative of Puget Sound organizations. I mean, they're
5 built on a fee-for-service chassis. So, to create some
6 savings and to start -- and to basically blunt -- to me, if
7 they're beating the medical trend of the rest of the
8 beneficiaries, that, to me, is a win. And then the question
9 is, how do you build upon that, and this is where they're
10 giving up the first two percent of savings, right?

11 So, I just come back to -- I mean, I think if we
12 can build upon that -- you've got folks that are interested
13 in the right incentive, which is to reduce cost, and I think
14 we ought to be doing everything we can to build upon that
15 program and make it attractive, not to get as many ACOs as
16 we can. I don't think that should be the goal. I think the
17 goal should be to get folks that have the right view of the
18 future and want to drive medical costs down and take waste
19 out of the system versus maximize the fee-for-service
20 system, so --

21 DR. SAMITT: Glenn, can I make one -- one idea
22 that we haven't discussed, because I think we've often

1 talked about making the two-sided risk model mandatory
2 except for new ACOs, one of the other things that we could
3 consider is not make it mandatory, that, in essence, we
4 offer it as an option, but an option that comes with
5 additional perks to the delivery system, both a higher gain
6 share plus greater ability to engage the beneficiary.

7 The question is, would you actually grow your ACO
8 interest, that those that are in the one-sided stay in one-
9 sided if they're doing well, or if they're in the higher
10 service areas, and those that have reservations that the
11 return is not high enough, they may be the high-performing
12 systems today that are very willing to take on a degree of
13 risk for an added degree of gain with greater flexibility.
14 So, that would be another alternative that we could
15 consider.

16 MR. HACKBARTH: Okay. Thank you, David and Jeff.

17 Next, we will turn to Medicare Advantage.

18 [Pause.]

19 DR. HARRISON: Good afternoon. First, we would
20 like to thank Rachel Schmidt for her assistance with this.

21 This session was primarily motivated by questions
22 from Commissioners, specifically Glenn and Bill Gradison,

1 about widespread press reports that half of new Medicare
2 beneficiaries were enrolling in MA plans as soon as they
3 were eligible. Our analysis finds that those reports were
4 not correct.

5 This presentation aims to provide richer detail on
6 the composition and growth of MA enrollment and to evaluate
7 the reports about new enrollees and other common notions
8 about enrollment patterns.

9 First, we evaluate the claim that half of new
10 Medicare beneficiaries enroll in MA, so we will look how
11 many new beneficiaries sign up for MA and the timing of
12 those sign-ups. And we also will look at how participation
13 varies by age. Then we look at other demographic factors
14 and focus on patterns among subsets of beneficiaries in more
15 detail, namely Hispanic beneficiaries, beneficiaries who are
16 under-65 disabled, and those who are dually eligible for
17 Medicare and Medicaid. And we look briefly at disenrollment
18 from MA plans. Finally, we raise some policy implications
19 that the Commission may wish to discuss.

20 For this demographic presentation, we looked at a
21 snapshot of CMS administrative data in August of each year
22 from 2009 to 2012. In August 2012, 26 percent of all

1 Medicare beneficiaries were enrolled in the MA program.
2 However, the 26 percent penetration rate is measured across
3 all Medicare beneficiaries, including the 4.6 million
4 beneficiaries who were not eligible to enroll in MA because
5 they were enrolled in either Part A only or Part B only, and
6 coverage under both Part A and Part B is required for
7 enrollment in MA. Thus, for the purposes of analyzing who
8 enrolls in MA, a more focused statement is that in August
9 2012, just over 28 percent of eligible beneficiaries
10 enrolled in MA. For the purposes of this presentation, we
11 will measure the participation rates including only
12 beneficiaries that have both Part A and Part B.

13 As I mentioned, there is a widely reported claim
14 in the press that half of new Medicare beneficiaries were
15 signing up for MA. Our data analysis does not support this
16 claim.

17 We looked at beneficiaries new to Medicare,
18 defined here as beneficiaries who did not have both Medicare
19 Part A and Part B in December, but did have both by August
20 of the following year. 600,000 beneficiaries new to
21 Medicare in 2012 were enrolled in MA in August 2012, out of
22 a total of 2.5 million new Medicare beneficiaries, resulting

1 in a 24 percent participation rate. In essence, this is the
2 answer to the question, What share of beneficiaries sign up
3 for MA as they become eligible for Medicare? In 2012, the
4 answer was 24 percent, not 50 percent, as had been reported.

5 More surprising than not reaching 50 percent is
6 that new beneficiaries do not even reach the average
7 participation rate. So we followed some beneficiaries for a
8 few years to see when they did enroll. The last line of
9 this table traces the MA enrollment for the cohort of
10 beneficiaries who were newly eligible for Medicare in 2009.

11 At the end of 2009, 21 percent were in a plan. By
12 the end of 2010, 26 percent of this 2009 cohort were in MA
13 plans, 28 percent in 2011, and 29 percent were in plans by
14 the end of 2012.

15 So while the beneficiaries new to Medicare in 2009
16 participated in MA in below-average rates in 2009, enough of
17 them joined plans later, so that their participation rate
18 was above average by 2011.

19 The previous slide showed the enrollment for all
20 new beneficiaries, regardless of age. This slide focuses on
21 the age of beneficiaries.

22 The data show that age appears to be a factor in

1 MA participation. Participation rates in 2012 climb
2 steadily by age until peaking at 32 percent for ages 70 to
3 74.

4 For beneficiaries age 65 to 79 in 2012, the
5 participation rates were higher than the average rate of 28
6 percent, and the participation rates for the under-65 and
7 over-85 groups were lower than average. Carlos will discuss
8 the relatively low participation rates for the under-65,
9 disabled beneficiaries in more detail shortly.

10 The last two columns of this slide show the age
11 composition of the overall Medicare population, with both
12 Parts A and B, and the MA population. The MA population is
13 clustered in the age groups from 65 to 79; 67 percent of the
14 MA population is in this age range, while the same age range
15 contains about 61 percent of the overall Medicare
16 population. The under-65 population is about 13 percent of
17 MA enrollment and about 16 percent of the overall Medicare
18 population.

19 So this reinforces the findings on new
20 beneficiaries, illustrated by the fact that the 65 to 69 age
21 group doesn't not have the highest participation rate.
22 Again, this suggests that beneficiaries often switch into MA

1 after some years in fee-for-service.

2 Now Carlos will continue.

3 MR. ZARABOZO: Our analysis indicates that there
4 are persistent differences in MA participation among racial
5 and ethnic groups and differences by age and Medicaid
6 status.

7 Among major ethnic or racial groups, at a national
8 level, the ethnic group with the highest participation level
9 are Hispanics, at 39 percent participation in 2012, as shown
10 in the first box of the second column of data. This is well
11 above the overall average of 28 percent. Looking at other
12 categories of beneficiaries that are less likely to enroll
13 in MA, the same column of data shows that in 2012, the
14 participation rate among Medicare-Medicaid dually eligible
15 beneficiaries was 23 percent, and the rate among
16 beneficiaries under age 65, as Scott pointed out, those who
17 were entitled to Medicare on the basis of disability, is at
18 22 percent, 6 percentage points below the overall average of
19 28 percent.

20 Moving to the middle column, with a couple of
21 numbers that are shaded, you see that for the major ethnic
22 groups, enrollment growth has been highest among Asian

1 Americans, at 14 percent, or twice the overall average.
2 Among dually eligible beneficiaries, even though their 2012
3 participation is relatively low, the growth in MA
4 participation in this population between 2009 and 2012 was
5 11 percent, or about 1.5 times the overall average of 7
6 percent.

7 As shown in the last two columns of data, with
8 regard to the white population, despite their lower
9 participation and growth rates in MA, whites still make up
10 about 80 percent of MA enrollment in 2012, compared with 83
11 percent of the overall Medicare population.

12 So at an aggregate level, we see that three groups
13 of beneficiaries that have either very high or very low
14 penetration rates in MA are Hispanics, which have very high
15 participation rates, and Medicare-Medicaid dually eligible
16 beneficiaries have low rates, as well as beneficiaries under
17 the age of 65 also have low rates. However, looking more
18 closely at these populations, there is more to the story.

19 With regard to the high participation rates among
20 Hispanics, this can be thought of as a function of
21 geography. Hispanics have very high participation rates in
22 areas where all racial and ethnic groups have high MA

1 participation rates. In such areas, such as Miami-Dade
2 County, MA plans are very successful at attracting
3 enrollees, and the participation rates among Hispanics are
4 still higher than, but very close to, the rates among other
5 racial or ethnic groups. At the same time, however,
6 Hispanics are less likely than other racial or ethnic groups
7 to enroll in MA in counties where the participation level in
8 MA in general is below the national average.

9 For Medicare-Medicaid dually eligible
10 beneficiaries, who as a group have a low participation rate
11 of 23 percent, we see big differences between two categories
12 of dually eligible beneficiaries. One group, which tends
13 not to enroll in MA, are the beneficiaries with full
14 Medicaid eligibility. As Medicaid beneficiaries, they
15 receive the kinds of extra benefits that are a major feature
16 attracting beneficiaries to MA.

17 The other dual eligibility group is the
18 beneficiaries with partial coverage under Medicaid, whereby
19 they are entitled to payment of their Medicare Part B
20 premium and in some cases protection from Medicare cost
21 sharing. These low-income individuals with partial Medicaid
22 coverage have the highest rate of MA participation of any

1 subgroup that we have looked at. By enrolling in MA, they
2 receive extra benefits, but it is also to the advantage of
3 plans to enroll such individuals because of the current
4 method of MA payment for the dually eligible. The MA risk
5 adjustment system pays more for dually eligible
6 beneficiaries, but there is no distinction made between the
7 full and partial categories in the risk adjustment system.

8 Last year, Dan Zabinski presented an analysis
9 showing that there should be a separate risk adjuster for
10 each of the two categories of dually eligible beneficiaries.
11 This would recognize the difference between the two
12 categories in their average Medicare fee-for-service
13 spending, as the full dual group is more costly.

14 We would also note that MA participation rates
15 among duals has grown over the last few years, in part
16 because of the incentives for enrollment of the partial
17 eligibility group and in part because of the special needs
18 plans for dual eligible beneficiaries. Enrollment is likely
19 to grow more with the Medicare-Medicaid dual demonstrations
20 that are underway.

21 Looking now at the under-65 population as a group,
22 they are less likely to enroll in MA. However, in looking

1 more closely at the data, the major factor affecting the
2 participation rate among beneficiaries in this age group is
3 their status as dually eligible Medicare-Medicaid
4 beneficiaries. Almost half of Medicare beneficiaries under
5 the age 65 are dually eligible.

6 If we look only at beneficiaries who are not
7 dually eligible, we see that the participation rate among
8 the under-65, at 29 percent, is very similar to the
9 participation rate among beneficiaries 65 or older, at 31
10 percent.

11 Moving now to a related topic, we have also looked
12 at MA disenrollment rates among beneficiaries voluntarily
13 leaving an MA plan; that is, excluding beneficiaries who had
14 to leave a plan because they moved, for example. On an
15 enrollment-weighted basis across all MA plans, the voluntary
16 disenrollment rate was under 10 percent. When beneficiaries
17 did disenroll, in the large majority of cases -- 80 percent
18 of the time -- it was to join a different MA plan. In 20
19 percent of the cases of voluntary disenrollment, the person
20 left MA for traditional fee-for-service Medicare. This
21 translates to 2 percent of people leaving MA for fee-for-
22 service, or put differently, 98 percent of beneficiaries

1 remaining in the MA program either in their current plan or
2 in a different MA plan. We should also note that in past
3 work, the Commission found that beneficiaries who left MA
4 for fee-for-service had higher average costs than
5 beneficiaries who had not had any MA enrollment; that is,
6 higher cost beneficiaries were disenrolling from MA to go to
7 fee-for-service.

8 While we can't tell you exactly what motivated
9 beneficiaries to switch plans, to the extent that we could
10 analyze what motivated plan switchers, we found that a
11 substantial majority of beneficiaries switched plans to
12 enroll in a plan with a lower premium. This finding is
13 consistent with what the Commission has reported about plan
14 switchers in Part D based on Shinobu Suzuki's work that
15 found that in Part D, beneficiaries switched to plans where
16 they were better off financially.

17 So in summary, as always, we would like to know
18 whether there are additional analyses that you would like us
19 to undertake, and here, we have also presented a number of
20 policy issues that arise, which you may wish to discuss.
21 One issue relates to beneficiaries new to Medicare. The
22 fact that many individuals do not enroll in MA immediately

1 upon their eligibility for Medicare, but instead switch into
2 MA after spending a few months or years in fee-for-service,
3 suggests that beneficiaries may not focus on that choice
4 until they have some experience with cost-sharing in fee-
5 for-service or go through the experience of the widespread
6 marketing in MA that occurs during the open enrollment
7 period.

8 These experiences may be important for
9 beneficiaries to understand fully the options between
10 traditional Medicare and MA. Medicare may wish to ensure
11 that marketing materials for new entrants to Medicare
12 explain these options more clearly.

13 We identified two issues related to rate-setting,
14 one being the difference that is not currently recognized in
15 the risk adjustment system between the fee-for-service
16 expenditures of dually eligible beneficiaries with full dual
17 status and those with partial status. The other issue,
18 discussed more fully in the mailing material, is that if MA
19 participation rates continue to rise at their current clip,
20 at some point the program will have to face the issue of
21 whether the beneficiaries that remain in fee-for-service
22 Medicare are a sufficiently representative group for

1 determining MA payment rates that are based on fee-for-
2 service expenditures.

3 Thank you.

4 MR. HACKBARTH: Okay. Thank you, Scott and
5 Carlos.

6 Could you put up Slide 10 for a second?

7 So I assume that the under-65 population here does
8 not include beneficiaries who have become eligible by virtue
9 of ESRD.

10 MR. ZARABOZO: Correct.

11 MR. HACKBARTH: And on 11, Slide 11, how does this
12 compare to FEHB-P disenrollment rates CalPERS or other sort
13 of benchmarks that we may see?

14 MR. ZARABOZO: I think FEHB is very low in terms
15 of switching plans, switching especially among the new
16 against the older population.

17 MR. HACKBARTH: Okay. So lower than this is what
18 you're saying?

19 MR. ZARABOZO: I would say lower, yeah. I don't
20 know --

21 MR. HACKBARTH: If we could look that up, it might
22 be useful to know that.

1 MR. ZARABOZO: Yeah. Okay.

2 MR. HACKBARTH: So could I see hands for
3 clarifying questions? I have Mary, Herb, Alice, and we will
4 go around this way. Mary?

5 DR. NAYLOR: Slide 5.

6 So I can see differences in rates in MA
7 participation by age cohort between '09 and 2012, but is the
8 decline -- so will we expect that that will continue,
9 meaning will the current 75 to 79, which has 31 percent?
10 Would we expect when they are at 85 to continue to decline?
11 Okay.

12 MR. ZARABOZO: Actually, one point sort of related
13 to this is we did look at the disenrollment rates by age
14 groups, and we found that the older age groups are less
15 likely to disenroll from MA than the younger age groups.

16 But Scott has more to say, I think.

17 DR. HARRISON: So the people who are now 70 to 75
18 have been in the program about 10 years, and participation
19 rates were lower in general at that point. So when the
20 first came in, they were less likely to come in than now.

21 Right now, new people are coming in at higher
22 rates than new people used to come in. So I wouldn't expect

1 a big fall-off necessarily because, one, they don't
2 necessarily disenroll, and they are higher now to start
3 with.

4 DR. NAYLOR: Thank you.

5 MR. ZARABOZO: But the other point also is you
6 have more institutionalized people who are older, who tend
7 not to enroll, and you have people becoming dually eligible
8 later on in life, so who tend, as we pointed out here, not
9 to enroll. So you have sort of a number of factors that can
10 affect how much the older population, the very old, will be
11 enrolling in MA. Right.

12 DR. NAYLOR: Thank you.

13 MS. UCCELLO: Can I just follow up on that? I'm
14 sorry.

15 So the question is, Is this kind of higher rate
16 going to follow through as they age, or are you saying that
17 there is like a special higher disenrollment as people age
18 because they become dually eligible or something like that?
19 I am hearing different --

20 MR. ZARABOZO: Potentially yes. We can look,
21 particularly the institutionalization situation, when people
22 are institutionalized, and sometimes it's the same time they

1 are becoming dually eligible.

2 DR. MILLER: Wait a second.

3 [Laughter.]

4 DR. MILLER: I heard two different answers.

5 MR. ZARABOZO: That was two different answers.

6 DR. MILLER: Okay. Well, at least we're off to --

7 DR. HARRISON: So your ears are still good.

8 DR. MILLER: Yeah, hold on. Is there any aspirin?

9 Oh, okay.

10 MR. HACKBARTH: Fruit Loops?

11 DR. MILLER: Yeah. Those are going to go to Mike.

12 [Laughter.]

13 DR. MILLER: For those of you unaware, Mike

14 Chernow used to eat these regularly.

15 Okay. I thought the first answer was, given the
16 higher participation rates in '75 to '79, you do expect to
17 see some carryover into the aging process, okay? So if that
18 was where the conversation stopped at that point, you might
19 expect those higher participation rates to carry through as
20 people age. First thought? Okay.

21 The second thought -- and this is where I think
22 things got a little bit more hairy for me -- is to the

1 extent that people switch out of fee-for-service and into
2 MA, that propensity will fall as people get older because
3 institutionalization or they become dual and therefore fall
4 into a category that's less likely. That was the second
5 thing that I could have potentially heard you say.

6 MR. ZARABOZO: Yes. But it's also they may be
7 leaving MA because they become institutionalized or because
8 they had become dually eligible, so it's a variety.

9 DR. MILLER: Oh, I see. Yeah, I was thinking of
10 it more of a switching into MA.

11 MR. ZARABOZO: Yeah, but this is just based --

12 DR. MILLER: So it sounds like on that, what you
13 may be saying is, yeah, it's higher. You might have an
14 expectation to carry through, but there might be some puts
15 and takes that won't say it will stay at that level. Can
16 you live with that?

17 All right, thank you.

18 MR. ZARABOZO: Now, the third answer --

19 [Laughter.]

20 MR. HACKBARTH: Herb.

21 MR. KUHN: Just a quick question on Slide 10.

22 When you talk about individuals with disabilities, I just

1 want to make sure I am correct on the definition. This is
2 just the population that has gone through the 24 months and
3 are classified as disabled. We are not talking about also
4 folks with chronic conditions here, right?

5 MR. ZARABOZO: No. This is just the under-65.

6 MR. KUHN: Under 65.

7 MR. ZARABOZO: Correct.

8 MR. KUHN: Thank you.

9 MR. ZARABOZO: Yep.

10 DR. COOMBS: I have a question about ESRD. So do
11 we have any kind of spread of ESRD under MA systems in terms
12 of geography, age --

13 DR. HARRISON: So you have to remember that ESRD
14 beneficiaries are not allowed to join MA plans --

15 DR. COOMBS: Okay, okay.

16 DR. HARRISON: -- unless they were already in the
17 plan when they became ESRD.

18 DR. COOMBS: When they became --

19 DR. HARRISON: So you won't find, you are really
20 not going to find any under-65 ESRD folks in MA, for
21 instance.

22 DR. COOMBS: Okay. And then Slide 6, you did a

1 great breakdown with racial distributions. What does the
2 dual eligible look like under that 23 percent? Is there a
3 disproportionate number of minorities? I know that --

4 MR. ZARABOZO: Yes. That is --

5 DR. COOMBS: -- you have done the D-SNP before,
6 and I have always asked about what does the breakdown look
7 like in terms of subtracting Latinos and African Americans
8 from the dual eligibles if -- they're in MA. Are they
9 mostly disproportionate minorities under the dual eligible
10 versus the walkie-talkie, healthy, older African Americans
11 and Latinos walking in and enrolling in MA plans?

12 MR. ZARABOZO: The minorities are more likely to
13 be dual eligibles -- that's correct -- both African
14 Americans and Hispanics.

15 DR. COOMBS: So when you take a 23 percent, it's a
16 large number, and I am wondering whether or not these other
17 numbers are skewed by them.

18 MR. ZARABOZO: Yes. They are influenced. The
19 Hispanic, for example, if no Hispanics were dually eligible,
20 you would probably expect more than 39 percent to be
21 enrolled in MA. So, yeah, there's sort of an interaction.

22 DR. COOMBS: So we will be able to get a breakdown

1 on that?

2 MR. ZARABOZO: We can do --

3 DR. COOMBS: Okay.

4 MR. ZARABOZO: -- who are the dually eligible,
5 yes.

6 DR. COOMBS: Thank you. Thank you.

7 MS. BUTO: I wondered if you had data on the sort
8 of reasons for dual eligibility. In other words, I remember
9 a while ago that a large proportion of the dually eligible
10 were dually eligible by virtue of mental disease, and that
11 could matter a lot in terms of whether or not there are MA
12 plans that meet those needs particularly. And I would be
13 interested to know if we have that breakdown and if that's
14 one of the reasons why you don't see the same extent of
15 enrollment. And then secondly, whether that's different for
16 special needs plan; in other words, are they able to better
17 meet those needs of the dually eligible? Are there more
18 enrolled in those plans than regular MA plans?

19 MR. ZARABOZO: Yes. The dually eligible are more
20 enrolled in special needs plans than in other plans,
21 although there are some in the non-special needs plans.

22 Kate in October is going to have a session on

1 disability, on the disabled. I think on the mental health
2 issue that is particularly under 65, more common than the
3 eligibility is based on mental health for disabled. So that
4 number, the 29 percent of under 65 that are non-dual,
5 enrolling in MA could bear some looking at underneath that
6 number, what is happening with that 29 percent.

7 DR. CHRISTIANSON: Yeah. Just a few comments
8 here. One is the 2 percent disenrollment from MA plans into
9 fee-for-service.

10 On page 23, you reference a CMS survey, page 23 of
11 the document you prepared, with possible reasons for
12 disenrollment, but I couldn't tell. I would assume from
13 those reasons that this was disenrollment in general from MA
14 plans and not necessarily disenrollment into fee-for-
15 service?

16 MR. ZARABOZO: I think that's just disenrollment
17 in general because --

18 DR. CHRISTIANSON: Yes. It would be really nice
19 to know the reasons for disenrollment into fee-for-service,
20 because I would suspect they are a lot different than "I am
21 leaving this plan to go to another plan."

22 MR. ZARABOZO: Yeah. I think if we get the data,

1 the survey data that CMS will produce on the disenrollees,
2 we can see who were the ones that went to fee-for-service
3 and kind of --

4 DR. CHRISTIANSON: Yeah. So on a to-do list,
5 maybe take a look at that.

6 And the other two things that really struck me as
7 I looked at the numbers you presented was -- one was the
8 maligned star system, where everybody is above average and
9 so forth. Apparently, it tells us something when you look
10 at the -- just voluntary disenrollment, right?

11 MR. ZARABOZO: Right.

12 DR. CHRISTIANSON: And that was quite striking, 17
13 percent among plans, three stars there below, versus 4.9
14 percent among four stars or above. That's a big, big
15 difference. The interesting thing is whether that's just
16 capturing a general bad experience or whether people pay
17 attention to the star system, right, so we don't --

18 MR. ZARABOZO: Yeah. Well, of course, it is
19 people who are enrolled.

20 DR. CHRISTIANSON: Yeah. Yes.

21 MR. ZARABOZO: So I don't think that they would
22 decide to disenroll because the star changed, let's say.

1 DR. CHRISTIANSON: Well, maybe. I would guess
2 you're right, but I don't know.

3 MR. ZARABOZO: I mean, they might, because to go
4 to another plan that's a higher rated plan.

5 DR. CHRISTIANSON: Yeah. Yeah, to another plan.
6 That's what this is.

7 And then the other thing that I thought was
8 interesting was the for-profit/non-profit. Disenrollment
9 rates are so dramatically different between for-profit plans
10 and higher than non-profit plans? And that's pretty
11 interesting, as well.

12 MR. ZARABOZO: Yes.

13 MR. HACKBARTH: Remind us again, Jon.

14 DR. CHRISTIANSON: Oh, I'm sorry. Disenrollment
15 rates among for-profit plans were 10.5 percent and among
16 not-for-profit plans, 3.9 percent, so more than twice as
17 high among the for-profit plans, which is again a pretty
18 striking result.

19 I would also offer another possibility, which you
20 sort of offered in your chapter, but in a different place,
21 which is when you had your sort of three reasons for why
22 enrollment might increase as among later age cohorts, and

1 one possible reason is just simply as you are moving from
2 that 65-year to 70, 75-year age group, you do the math on
3 the coverage, and you say, "I project I'm not going to" -- I
4 think you said this at some place here, but, "I project I am
5 not going to be as healthy as I have been in the future, and
6 I really need to pay more attention to drug coverage and
7 out-of-pocket stuff."

8 But the focus group certainly -- results which
9 we'll talk about in a minute -- certainly reinforced the
10 notion that there's confusion about Medicare for initial
11 enrollees. I think the focus group conclusion was people
12 understood health insurance terms pretty well, but they
13 didn't understand Medicare at all. So it just may be -- I
14 mean, that's sort of indirect reinforcement to your
15 supposition that maybe it's just getting to know Medicare
16 and what the options are over a period of time.

17 MR. HACKBARTH: Clarifying questions here? Bill?

18 MR. GRADISON: Well, first, I want to thank you
19 for your work on this. I apologize for being one of the
20 troublemakers that urged you to look into this, but it has
21 been fascinating to me because I have been anticipating
22 actually, as I think many had, a decline in participation

1 over the last few years. I acknowledge that with the
2 bonuses, the cuts that had been anticipated that might have
3 accelerated a decline haven't happened really, and maybe
4 that's what's going on.

5 I am interested -- on page 11, you mentioned
6 differences among states and counties. Do you have any data
7 on how the participation rate varies, depending on whether
8 there are high Medicare cost counties or high Medicare
9 states, if you have it broken down that way, versus other
10 cost categories?

11 DR. HARRISON: Back last year, we did things on
12 the different quartiles, and I think we, if I recall -- I
13 think there were like 60 percent of enrollment was in the
14 top quartile counties, and it might have been 40 percent of
15 overall population, so definitely higher participation in
16 the high-cost counties.

17 MR. GRADISON: Thank you.

18 MR. HACKBARTH: Any other clarifying questions?

19 [No response.]

20 MR. HACKBARTH: Okay. Let's go to Round 2
21 comments.

22 Let me just offer one. Would you put up slide 12?

1 This second bullet, which Jon has raised about the
2 relatively low MA participation among the new, newly aging,
3 and enrollees. That really does strike me as anomalous and
4 something worth exploring further to try to understand it or
5 examine things that might potentially address it. It just
6 seems so logical to me that people who have experienced
7 various forms of managed care in their lives previously are
8 thoughtfully electing fee-for-service Medicare initially and
9 then moving out again. That's just a peculiar pattern to
10 me. It may indicate an opportunity for doing something.

11 Herb.

12 MR. KUHN: On that, we will hear more, I guess, in
13 the next session from Christine and Joan on the focus group
14 and the survey work. Is that a question that we are
15 currently asking as part of that panel of questions or
16 something we can do in the future to get additional
17 information on that? It might be helpful.

18 MR. HACKBARTH: Christine, first of all, did you
19 want to answer [off microphone]?

20 MS. AGUIAR: Can you repeat your question? [off
21 microphone]

22 MR. HACKBARTH: Go ahead, Herb.

1 MR. KUHN: Yeah, the question is: This issue of
2 why they're not enrolling in the program, is that part of
3 the panel of questions you're asking beneficiaries in the
4 focus group work now?

5 MS. AGUIAR: It's not at the exact moment one of
6 our questions, and as we'll discuss more in the next
7 session, one of the difficulties I think in us adding that
8 to the protocol is that we've found that lots of
9 beneficiaries are confused about whether or not their plans
10 are Supplemental or MA. So I think it's something that we
11 could consider adding, but then we'd have to probably select
12 and recruit for a specific set of beneficiaries that had
13 that specific experience.

14 MR. HACKBARTH: Kate.

15 DR. BAICKER: Just following up on that same
16 point, I was also really struck by that in the chapter. I
17 had in mind this false stylized fact that every year more
18 and more people were electing, because they had more
19 experience and that this was just something they were more
20 familiar with. So I was surprised by the pattern, and a
21 better understanding of whether this is just a transition
22 blip and that each generation is at higher rates, but the

1 time profile for everybody is it takes a little time.

2 What's going on with that?

3 And an extra fact that I thought might help shed
4 light on the patterns, which I would have thought would go
5 the other way but maybe I'm wrong on that, too, like so many
6 other things, that the underlying rates of employer-
7 sponsored, wrap-around plans or other options that are
8 substituting for what MA might provide, how are patterns of
9 that changing? And is that affecting the time path -- no,
10 not in a formal, you know, causal estimate kind of way, but
11 just in sentences describing what that pattern looks like
12 and if it seems to argue -- it seems to be moving in this
13 direction or moving in the opposite direction, I think would
14 add some extra context.

15 MR. ARMSTRONG: Just to build on that point, just
16 in our own experience, which is anecdotal but may offer
17 insight into a question we had asked about this, is that we
18 are -- there are more and more people who are 66, 67, 68,
19 first of all, who are eligible for Medicare but are still
20 covered through their employer's plans because they're still
21 working, which I would just ask, How is that handled in this
22 evaluation, but that they're continuing with some kind of

1 COB or extension of their employer-sponsored programs?

2 And then we're finding 68, 70, for whatever
3 reason, they're switching into an MA plan, which they happen
4 to be very familiar with because they had been previously
5 Group Health beneficiaries, but technically they wouldn't
6 count toward that goal until they were well after the age of
7 eligibility.

8 DR. BAICKER: [off microphone].

9 DR. HARRISON: If they weren't -- if they didn't
10 have both A and B, they weren't in the denominator or the
11 numerator. But if they -- maybe they're still working and
12 they also buy B, that's possible. And then they only switch
13 in maybe once they fully retire.

14 DR. HALL: I may have missed this in the
15 materials, but is there any gender difference in terms of --

16 DR. HARRISON: Not really. There's a very slight
17 propensity for women to join MA.

18 DR. REDBERG: I was just interested to follow up
19 on Christine's comment on the focus groups, because it makes
20 sense to me that it would take a little while for people
21 when -- obviously people default into fee-for-service, and
22 then to figure out what that means and what the choices are.

1 But I imagine that the take-up is higher right away on
2 supplemental plans, on the Medigap plans, and I'm wondering
3 how they market and why they have a higher take-up, I'm
4 imagining, right when you enter Medicare.

5 DR. HARRISON: All right. So drawing together a
6 few different things, like from the focus groups and other
7 things we've done, people do look at Medicare before they're
8 65, but it's usually the more well off people. They've got
9 financial advisors who send them to a broker who typically
10 sell Medigap. So it could be -- and your only open -- I
11 think you have a six-month open enrollment period to get
12 Medigap without being underwritten. So there is some
13 pressure, if you're going to join Medigap, to join quick.

14 You know, as far as -- and you're right, people
15 default into fee-for-service, which is, you know, if you
16 said, well, I'm not going to do anything just yet, or if you
17 haven't -- I also looked at a little more nerdy stuff where
18 I looked at the month you were eligible. So you're more
19 likely to join right away if you're eligible in January.
20 Well, yeah, because all of the open season marketing's going
21 on and so you're really engaged. Later in the year you're
22 less likely to join right away. But people do switch on

1 that next January, a pretty high switch rate.

2 DR. BAICKER: I'm sorry. I want to be sure I
3 understand this. For the people we're saying don't join
4 right away when they're eligible, what share of those is it
5 less -- is it really just until the next open enrollment
6 period that they join? I should be able to infer that from
7 the pattern, but I'm not --

8 DR. HARRISON: Yeah, so look at the cohort
9 analysis right there. Look at the last line there. So you
10 had 21 percent joined right away -- "right away" here is
11 within the first year -- I'm sorry, within the calendar
12 year. And then you go to the next open season, now it jumps
13 from 21 to 26.

14 DR. BAICKER: So that almost sounds like -- if
15 this is a matter of it's a few months where people are --
16 they just haven't had a chance to get all the materials yet,
17 I think of that as a different story from I wait a couple of
18 years and then I switch over, versus I became eligible in
19 October but I didn't deal with it until January.

20 DR. HARRISON: I think there's definitely some of
21 that -- a lot of that, even.

22 MS. UCCELLO: And this is picking up on both of

1 that. I just want to confirm that this table, the bottom
2 line here, so the people in 2012, they have a 29-percent
3 penetration rate. That is of people who were newly eligible
4 in 2009 and had A and B, so there's no new people coming in
5 over time that now had A and B who maybe didn't have A and B
6 in two thousand --

7 DR. HARRISON: That's correct.

8 MS. UCCELLO: Okay. So I do -- and you've already
9 mentioned this, but I was thinking, you know, what is the
10 difference in marketing materials that someone gets in June
11 versus what they're getting during open enrollment? I think
12 that's the question here.

13 DR. HOADLEY: I mean, I guess one thing, as I
14 listen to this conversation, I do worry we may be
15 overanalyzing relatively small differences here. I mean, it
16 is an 8-percentage-point jump from one, and that's not
17 trivial, but it's also the difference between 21 and 25 in
18 the original cohort, the overall average participation of 25
19 percent and the 21 percent, I mean, this is not a sample,
20 this is full population, so it's not a sampling error thing.
21 But we could be overanalyzing this in terms of relatively
22 small differences. So I just sort of would put that in.

1 And, you know, it does strike me that some of the
2 initial confusion of, you know, what are all these programs
3 people don't know, and, again, we'll get more of that in the
4 next session. They don't really understand what Medicare
5 Advantage is. They may think that's the same thing as
6 Medigap things, and so there are some of those factors, and,
7 yes, some better education might do that. But I don't know
8 that I would be inclined to go too far on that.

9 I don't know. Do you want to get on to other
10 issues now?

11 MR. HACKBARTH: Yeah, sure [off microphone].

12 DR. HOADLEY: So the other two things I wanted to
13 mention were on the discussion of the duals, and you know
14 this because there are some of the things in the footnotes,
15 but with the demonstrations, the financial alignment
16 demonstrations, we're going to be auto-enrolling a fair
17 number of dual eligibles into Medicare plans, Medicare
18 demonstration plans over the next -- well, this year and
19 over the next several years. So as we track this over time,
20 it's going to be tricky to look at trends and what might
21 happen in that population. So I just, you know, think
22 that's worthy of note.

1 Then my other comments are on the whole voluntary
2 disenrollment. I was a little struck by the terminology and
3 sort of CMS looking at this as a star rating factor, what
4 we're calling voluntary disenrollment. And I've always
5 heard that term over time. I always think of it as people
6 are really like rejecting their plan and leaving to probably
7 go back to fee-for-service. But as I look at what you're
8 analyzing here and what CMS is using, this is just anybody
9 switching out of a plan.

10 So it's one of those things where it has a very
11 different flavor as to what this means if it's -- the notion
12 of a market-based system is that people are supposed to be
13 reevaluating their choices. CMS tells you every year you
14 should reexamine your choices and you switch. And so it
15 seems actually a little odd that it's being used potentially
16 as a star rating measure when it's -- yes, it does mean
17 somebody liked another plan better. But it might only be
18 just because it was cheaper, and that's not really a
19 rejection of their existing plan.

20 So I do wonder about sort of how that's used, and
21 then even just terminology as we talk about it, because the
22 switching rate, as you noted, is very similar to sort of the

1 Part B switching rate, which I guess I could also call
2 voluntary disenrollment. And you noticed that premium was
3 certainly one of the factors, and I don't know whether
4 you've looked at any of the other plan characteristics, out-
5 of-pocket limits or cost sharing. I wouldn't suspect a lot
6 of difference because they're not such a huge variation
7 among plans on those, but it might at some point be worth
8 taking a look at if you haven't already.

9 And then also, not so much maybe in this period of
10 time, but in the next couple years, provider network changes
11 and, you know, anecdotally we're hearing that there could be
12 big exits from a couple of the plans that have reduced their
13 provider network, and it will be interesting when we catch
14 up to that point with the data to see whether there's any
15 evidence of that happening. But that could also be a proxy
16 of other kind of measures of things that change about
17 people's existing plans.

18 MR. HACKBARTH: Jack, your point -- oh, I'm sorry,
19 Carlos.

20 MR. ZARABOZO: I had a comment to my response to
21 John about the star ratings, the difference in the star
22 ratings. Of course, a big difference between high stars and

1 low stars is the bonus payments, so they have much better
2 benefits in the high-star plans than they do in the lower-
3 star plans.

4 MR. HACKBARTH: Yeah. Your point, Jack, about
5 voluntary disenrollment is a good one, and what you think
6 about the statistic depends on, you know, what angle you're
7 looking at. If you're a plan and you look at voluntary
8 disenrollment, you know, that may be an indicator of an
9 opportunity to improve member satisfaction and improve your
10 retention and ultimately your overall membership.

11 On the other hand, as you point out, it could be a
12 sign of a robust marketplace if you look at it from a
13 different direction. And to include it as a star element is
14 very much the first perspective and not the second.
15 Interesting. Interesting point.

16 DR. HOADLEY: And you'd almost want to -- if you
17 really were trying to think -- you know, and this goes
18 beyond probably what is easy to do from a data perspective,
19 but are there other changes in that market? So were there
20 two new plans that entered the market that year and suddenly
21 offered either lower price alternatives or, you know,
22 offered a more rich benefit package or a more integrated

1 system or whatever it is that people found attractive. And
2 if in one market that happened and in another market that
3 didn't, you might get very different rates, which would be
4 nothing the plan did except for what the external market was
5 doing.

6 MR. HACKBARTH: So let me ask this: So I think
7 the original plan here was to see this as an informational
8 chapter, you know, updating, providing some additional
9 information, addressing some of the issues like Bill
10 Gradison's and my question about what percentage of new
11 enrollees are going into MA, et cetera. We didn't see it, I
12 don't think, as, you know, raising major policy issues that
13 could lead to recommendations.

14 DR. MILLER: That's correct. In fact, I was
15 thinking of, you know, it might just be integrated into the
16 March chapter that we do in general on MA. That's one
17 possibility, depending on how much your questions build it
18 out or not, as the case may be.

19 MR. HACKBARTH: Yeah, so what I want to do is make
20 -- ask the question explicitly. Has anybody seen anything
21 here that leads them to think, well, boy, we ought to pursue
22 that further? It is something that we may want to put into

1 a recommendation.

2 DR. NAYLOR: The last slide, the last bullet on
3 the summary slide talks about how we will want to look at
4 whether or not the evolving fee-for-service population is
5 representative in establishing payment rates. And I think
6 lessons learned -- I thought it was an amazing chapter, the
7 context chapter, and the two pieces that came along with
8 that, and so wondering whether or not we should continue to
9 monitor, is we're going to watch an increasingly diverse
10 population over the next few decades, and whether or not
11 simultaneously we are going to watch a growing population
12 over 85 who may be the nursing home residents, who will
13 require extraordinary support. And I think it might be
14 important to monitor that because that may be a different
15 population coming into fee-for-service than we've seen.

16 MR. HACKBARTH: Let me ask this. So one obvious
17 way that large MA enrollment could cause the system to go
18 out of whack is that there are just -- the numbers remaining
19 in fee-for-service get small, and so the geographic
20 adjustments in the payment system get unreliable, there's
21 more statistical noise in them.

22 My understanding is that all of the other

1 adjustments in the risk system are not based locally.
2 They're all on national factors. So the fact that in some
3 local markets there's a decline in fee-for-service
4 membership would not affect their calculation so long as
5 nationally there's a significant fee-for-service population.
6 Is that correct?

7 DR. HARRISON: I think that would be correct. I
8 think the other -- the small numbers might particularly be
9 exacerbated if the remaining population is A-only or B-only,
10 because we found a few years ago that people with A and B
11 are more expensive than A-only or B-only. And, currently,
12 CMS uses A-only or B-only people separately and then adds up
13 the A and B costs.

14 DR. MILLER: Which is the other point I was going
15 to make. If you'd felt like in some way your estimation and
16 your baseline setting was becoming unrepresentative, just
17 like you make adjustments for health status differences, you
18 could begin to make adjustments for the fact that, oh, I
19 have more A-onlies in this baseline population, and, you
20 know, there are estimation adjustments that you can think
21 about making.

22 But we put it up there, Mary, because it struck us

1 as well, and in our larger conversations that got into the
2 June report about looking at common benchmarks and
3 baselines, we want to keep an eye on this kind of thing. So
4 I think your point is well taken.

5 MR. GRADISON: In a sense, this report -- this
6 very helpful report -- is focused on the people who choose
7 to go into the MA plans or to stay in MA plans. It would
8 seem to me, looking forward, since I assume one of our
9 objectives is to get more people into managed care -- I
10 mean, that's sort of the transition towards which we've been
11 talking all the time. I think it might be helpful over time
12 to try to figure out a way to get a sense of why people
13 don't go into the MA plans because that might inform us
14 about whether there are any impediments, any hurdles that we
15 might consider changing in the future in order to speed the
16 transition that I think we are all supporting.

17 MS. BUTO: And I just wanted to ask whether
18 there's going to be a specific chapter on the dually
19 eligible in one of your reports, because it strikes me they
20 are the most expensive cohort of Medicare beneficiaries,
21 right? And the opportunities are great there, and yet they
22 are underrepresented in the MA population.

1 I think Jack's point earlier was there are all
2 these dually eligible demonstrations that are starting up
3 that could change, but it seems to me to be a mixed bag of
4 things we should be aware of, including this issue of the
5 different payment rate adjustments for the partially dually
6 eligible and the fully dually eligible.

7 MR. HACKBARTH: Kathy, in recent years -- "recent"
8 being defined as the last maybe three or so -- we've done a
9 fair amount of work on the demos, special needs plans,
10 including dually eligible SNPs, and I also think we --

11 DR. MILLER: A couple other things. We put
12 together -- and there was a lot of work done here -- a joint
13 data book on dual eligibles because part of --

14 MS. BUTO: [off microphone].

15 DR. MILLER: Right, and so part of the issue has
16 always been you could see half of the population, and so
17 we've done that and are about to redo that. We do keep up
18 with the dual-eligible demonstrations.

19 And then on the very point that I think you were
20 referencing of what about this difference between full and
21 partial dual, Dan did some work in the 2012 report or 2013,
22 I forget, in which we said, you know, the risk adjustment

1 system really needs to partition and make a separate
2 adjustment on this basis because it's not quite accurate.
3 So we've got some footprint here.

4 MS. BUTO: Right. I think there is something to
5 be mined in the area of mental health. My sense is -- and I
6 guess we'll get that at the October meeting, but it strikes
7 me there may be an additional area to focus on in terms of
8 why aren't people signing up. It could be that that really
9 doesn't meet -- MA plans currently do not meet their needs
10 that way.

11 MR. GRADISON: Something else, too, about the
12 Medicaid population. A number of states, as we all know,
13 are moving or trying to move large numbers of their
14 Medicaid-eligible people into managed care. So that
15 population's experience may affect -- may not -- might have
16 some effect on the next step. Once they become age-wise
17 Medicare eligible as well as Medicaid eligible, they might
18 affect their movement into MA.

19 MR. THOMAS: One of the things around the
20 beneficiaries joining, have you looked at -- or just maybe a
21 comment to make as you look at this report is the duration
22 of the sign-up period, which I know over the past several

1 years has been modified, been shortened, actually. I think
2 in the past two, three, four years, something like that.
3 Scott may know. It's a relatively short period of time.
4 Building on Bill's point, if the goal is to try to get more
5 folks into these types of plans, that may be something that
6 you want to consider.

7 And then also a comment maybe to think about, as
8 the trending of the premiums continues to change, what
9 impact will that have on enrollment over the next several
10 years, you know, for the existing enrollment, not even
11 considering whether there would be a growth in enrollment
12 going forward.

13 MR. HACKBARTH: So if I could, I'd like to offer a
14 friendly amendment to what Bill Gradison said about what our
15 objective here is. Our objective is not to promote MA in
16 particular but, rather, to offer beneficiaries a fairer
17 choice, a financially neutral choice between options. MA
18 certainly has features that have been attractive to us in
19 that, for example, it has the potential to coordinate,
20 integrate care across the separate silos that frustrate us
21 so much in traditional Medicare. But I want to be clear
22 with the audience that, you know, our goal has not been to

1 promote MA per se but to assure a neutral system and allow
2 beneficiaries and providers to choose between the
3 alternatives.

4 MR. THOMAS: So, Glenn, maybe just to modify my
5 comment then, given the discussion earlier that this appears
6 to just be a complicated decision for people when they go
7 into Medicare, you know, and the amount of information
8 that's available is challenging sometimes, that that may
9 play into, you know, how folks go to make this decision,
10 because it is difficult to get information for a
11 beneficiary, and, frankly, it's confusing as to what the
12 options are. So time to be able to evaluate that could be
13 helpful for a beneficiary when they go to make the right
14 decision for themselves.

15 DR. SAMITT: So, Glenn, given your clarifying
16 comments, one of the things that I'd be interested in seeing
17 more of and I didn't see it in the chapter -- perhaps it's
18 in another resource -- is the geographic diversity in MA
19 penetration. So we still see great variation from state to
20 state, with the largest being in the Southwest and the Upper
21 Midwest in MA. My question is: Why don't we see large
22 penetration rates in the other markets? Are we not creating

1 sufficient incentives for plans to be established in those
2 other markets? And are we not creating a forum to provide
3 better choice to beneficiaries that way?

4 So I don't know if there's more information that
5 analyzes the geography-related issues here or not. Maybe
6 there isn't much there.

7 MR. HACKBARTH: One of my things that I always say
8 to my kids is it is never just one thing. You know, it is
9 never a problem or something that has a single cause. And
10 I'm sure that applies here as well.

11 You know, we already touched on one of the reasons
12 for that, and that is the level of underlying fee-for-
13 service costs. It is much easier for MA plans to enter
14 markets that have high fee-for-service costs, produce
15 savings, and share those savings with beneficiaries. And I
16 have actually been okay with that. I don't think we ought
17 to have the policy objective -- and this goes back to Bill's
18 comment. I don't necessarily want to generate MA plans in,
19 you know, parts of Oregon that already have rock-bottom per
20 capita fee-for-service Medicare expenses, because MA plans
21 are inherently good in and of themselves. That is a way to
22 jack up Medicare expenditures, not to reduce them.

1 DR. SAMITT: To that point, I guess my question
2 is: Are there any higher fee-for-service markets where
3 there is still low MA penetration?

4 MR. ZARABOZO: Chicago comes to mind.

5 DR. SAMITT: And those would be the examples that,
6 you know, what does that say about those markets that would
7 suggest there may be an obstacle to choice that we should --
8 perhaps there are some policy implications there.

9 DR. HOADLEY: I mean, just on this geographic
10 point, I think you've also got to definitely take into
11 account what's the underlying market in these different
12 areas. I mean, if you look at the ACA marketplaces, there
13 are some states that mostly have, you know, one Blue Cross
14 plan or maybe one other plan, and there are some that have a
15 vibrant market. I think some of that correlates with the MA
16 -- although not totally. Chicago may be an example that
17 doesn't fit that pattern.

18 The other point I was going to make going back to
19 this sort of education, I mean, you know, the Commission has
20 looked at some of these questions before about what's the
21 best way to help beneficiaries think about their choices,
22 whether it's a choice of MA versus other kinds of Medicare

1 options or whether it's within Part D to look at where they
2 only can pick a plan to look among choices of plans, and the
3 relative role of the SHIPs, and I know you've looked a lot
4 at SHIPs in the staff work, or, you know, the materials,
5 whether the online plan finders and whether the Medicare and
6 You book -- and some of this, again, was mentioned in the
7 chapter. And I do, from my sense of talking to people in
8 the beneficiary community, you know, do not have sort of an
9 obvious what's the best thing to do to get beneficiaries
10 more up to speed on those things. So I don't know quite how
11 we'd go at it, but, you know, maybe some good thinking about
12 which of those things work.

13 The one-on-one counseling seems very effective but
14 very hard to make available on a broad-based basis to 50
15 million beneficiaries. You know, the material, the handbook
16 is great, as sort of -- I think in the focus group
17 discussion or this chapter, you know, people talk about it
18 as the book that they want to have but not the thing that's
19 really going to educate them. The online tools can be very
20 powerful, but also can be very overwhelming, especially for
21 less Internet-savvy audiences.

22 So, you know, are there other alternatives out

1 there? Maybe that's something we could spend a session
2 talking about at some point.

3 MR. HACKBARTH: So to pick up on Jack's initial
4 point and Craig's about why there's variation in MA
5 penetration, another hypothesis would be that market
6 concentration on the provider side makes a difference, that
7 presumably, my hypothesis would be, that it's easiest to
8 enter and build an MA plan in a market where there's
9 fragmentation on the provider side because you can negotiate
10 and get better rates, play one off against the other;
11 whereas, if you're facing a highly concentrated provider
12 market, that's just much more difficult. And I don't know
13 if there's any way to look at that issue, you know, using
14 the Herfindahl Index or something, to see to what extent
15 that is a factor influencing MA enrollment patterns.

16 DR. HALL: Oh, I'm sorry. Go ahead, David.

17 DR. NERENZ: Well, just right on that point, is
18 there any meaningful difference in the geographic variation
19 MA penetration versus HMO penetration in general? I would
20 think they are essentially the same thing.

21 DR. HARRISON: It's been a long time since I've
22 looked at that, but it seemed like there was less than --

1 less variation in Medicare than there was in the private
2 market, but --

3 DR. NERENZ: I mean, just in terms of where it's
4 high or low.

5 DR. HARRISON: Yeah.

6 DR. NERENZ: I would just presume it is almost
7 perfectly correlated, but maybe not.

8 DR. HOADLEY: My sense on that is that it's
9 definitely correlated, but it's not 100 percent correlated.
10 Because of different companies who have been active in the
11 Medicare market and some companies more active in the
12 commercial market, you can have some markets that are high
13 penetration in one but not the other, but yes, there's
14 obviously going to be a correlation, so some of the rural
15 states or states where managed care has just never generally
16 been very successful or low in both.

17 DR. HALL: I wonder if it would be useful as we go
18 forward with this to maybe give all of us some kind of
19 orientation as to where people actually do get information.
20 Anecdotally, my experience is that everybody gets a Welcome
21 to Medicare booklet starting at age 64.5. It's a very, very
22 good resources. It's tied to a very good website, but not

1 every American at age 65 will be able to utilize that
2 resource, just because it's a technology they are not
3 familiar with.

4 On the other hand, a large proportion of people
5 reaching age 65 hear about SHIP plans, and particularly,
6 those SHIP plans that have nationwide penetrants. A good
7 example would be the plans that are endorsed by AARP. That
8 starts at age 50, and if you haven't reached age 50, you
9 will certainly know about that very soon.

10 And then there's, I suppose, a number of people
11 who are lucky enough to be employed at an enlightened
12 employer who helps people make the decisions. But I don't
13 know really how that all fits together when you look at it
14 on a national basis. I think a 5- or 10-minute primer on
15 how people get that information might be very useful.

16 DR. MILLER: Just to wrap up a couple of things, I
17 think you are going to get another opportunity to talk about
18 that a little bit in the next session, because in some of
19 the focus -- or in the focus groups, there was some
20 discussion of this, and so that will give you another
21 opportunity to work around this.

22 There was also some stuff that we did in the

1 spring where we were looking at -- and some of you guys will
2 remember this. We were looking at what actually came up on
3 the website and what seemed to be. So there's some of that
4 and some of that that we're thinking down the road, but keep
5 these comments top of mind because the next session is going
6 to get us right back into this set of question.

7 Just to clean up a couple of things over here,
8 back on the mental health, the other thing we can do, Kathy
9 and to anyone else who has lots of free time, we did have a
10 comment letter, and Glenn referred to it, the dual eligible
11 demonstrations and sort of what we thought about that. And
12 we can shoot that to you and anybody else who doesn't have
13 HBO or however you spend your time.

14 [Laughter.]

15 DR. MILLER: And then keep the mental health thing
16 top of mind too, because I think Christine is going to
17 trigger a couple of comments in the focus group there about
18 primary care doctors talking about how they are dealing with
19 it. We have some hallway conversation and some ideas about
20 some directions we are going to go in, but your comments on
21 that will also give us some more shape to the kinds of
22 things that we chase down.

1 Is that a good commercial? Okay. Christine
2 wanted to make sure all that got in there.

3 MR. HACKBARTH: Okay. Any concluding comments?
4 I'm sure we could go on in this vein for a long time and
5 generate evermore work for people to do, but my sense is we
6 have reached the point of diminishing returns.

7 Thank you, Scott and Carlos.

8 So now we will move on to our concluding session
9 on the focus groups.

10 Joan, you're back.

11 DR. SOKOLOVSKY: I think it's very anti-climactic.

12 MR. HACKBARTH: Yeah, that's kind of what I was
13 thinking.

14 [Laughter.]

15 MS. AGUIAR: It's my fault. I insisted that she
16 come back. I really did.

17 MR. HACKBARTH: Yeah. Welcome back, Joan.

18 DR. SOKOLOVSKY: Thank you.

19 MS. AGUIAR: So, today, Joan and I will discuss
20 the findings from the annual focus groups with beneficiaries
21 and primary care providers.

22 This year, we held focus groups with

1 beneficiaries, individuals between the ages of 55 and 64,
2 whom we refer to as near-beneficiaries, primary care
3 physicians, and nurse practitioners in three cities,
4 Albuquerque, New Mexico, Harrisburg, Pennsylvania, and
5 Nashville, Tennessee. In addition to the focus groups, we
6 also visited health systems in each market.

7 This slide gives an overview of the presentation.
8 First, Joan will discuss the evolution of the focus groups
9 and the historical findings on access to care. Then, I will
10 review new findings on access and discuss primary care
11 providers' perspectives on access and organization of care.
12 Lastly, I'll discuss how beneficiaries and near-
13 beneficiaries approach plan choice.

14 Now, over to Joan.

15 DR. SOKOLOVSKY: Although we had done focus groups
16 before, our annual round of focus groups came out of a large
17 project we did in 2006 on the implementation of the Medicare
18 drug benefit. Since then, the focus group project has
19 evolved. We started with beneficiary groups and quickly
20 added focus groups of practicing physicians. We later added
21 site visits to facilities located in the city or regions
22 where the beneficiaries in those groups lived.

1 The Part D project was designed to understand a
2 lot of what you've been talking about now, how beneficiaries
3 learned about the drug benefit and how they made choices.
4 It consisted of three parts: A large, nationally
5 representative beneficiary survey; structured interviews
6 with beneficiary counselors; and beneficiary focus groups in
7 three cities.

8 We found that although the survey had a much wider
9 reach, it could be misleading without the qualitative
10 findings from the focus groups. For example, many people
11 didn't know if they were in a managed care plan, they
12 confused Medigap supplements with Medicare Advantage, and
13 didn't know the meaning of many of the terms needed to pick
14 a drug plan, for example, formulary. The focus group
15 enabled us to know what aspects of the survey were
16 unreliable and added depth to our understanding of the
17 beneficiary decision process.

18 While we were in the field, we asked beneficiaries
19 about their access to medical care, something we've done
20 every year since. We began to hear about issues before they
21 fully emerged. For example, in our very first group, we
22 heard discussion about concierge medicine.

1 This led to the organizing of physician focus
2 groups to learn more about the perspectives of practicing
3 physicians. We learned of concerns they had that were not
4 necessarily the top issues being discussed in the policy
5 world. Sometimes, issues related to things like coding or
6 perceived fraud or other types of local issues. And,
7 physicians seemed to appreciate the chance to air these
8 concerns, knowing that it would get back to the Commission.

9 Our work on the rural report in 2010 led us to
10 incorporate site visits to local facilities with our focus
11 group trips. Visiting hospitals, FQHCs, and other
12 facilities gave us a better sense of local markets and an
13 alternative perspective on issues raised in the focus
14 groups. Given our limited resources, we could not
15 generalize from our results, but we tried to choose cities
16 each year in different regions of the country.

17 We also looked for places reporting greater access
18 difficulties in the CMS annual CAHPS survey. Occasionally,
19 we go back to a city after a few years to see if anything
20 has changed. Even in places with the lowest CAHPS access
21 scores, almost everyone in our groups every time had a usual
22 source of care and could get appointments for primary care

1 in waits they considered reasonable. This was true even
2 after we began screening just for people looking for new
3 doctors.

4 We found great consistency from place to place and
5 year to year concerning access to specialists. Nearly every
6 physician group mentioned issues or problems referring
7 patients to psychiatrists and dermatologists. In recent
8 years, difficulty getting referrals to neurologists has also
9 been widely reported.

10 Although we ask beneficiaries and doctors about
11 access every year, we alter the protocol to address issues
12 that the Commission is currently working on. For example,
13 in the past, we focused on comparative clinical
14 effectiveness, medical homes, and benefit design. These
15 findings have been incorporated in our work on these issues.

16 Now, Christine will report on the findings from
17 our most recent round of focus groups and site visits.

18 MS. AGUIAR: This slide highlights three themes
19 that emerged during this round. The first is the use of
20 urgent care centers. Although we did not specifically ask
21 beneficiaries about their use of urgent care centers,
22 beneficiaries in most focus groups said that they use the

1 centers for routine and urgent care. This generally occurs
2 when they cannot get appointments with their usual providers
3 right away or when they think it will be less expensive or
4 more convenient to visit the urgent care center.

5 The second finding is that most beneficiaries have
6 received primary care from nurse practitioners and the
7 beneficiaries generally expressed a positive opinion of
8 them. Beneficiaries also said that nurse practitioners
9 improve their access to same day appointments.

10 The third finding is related to Medicare
11 Advantage, or MA, network changes. A few beneficiaries said
12 that their MA plan made changes to the provider network
13 during open enrollment. These beneficiaries expressed
14 concern about having to find new providers. In another
15 instance, we heard from beneficiaries and providers that one
16 MA plan changed their provider network outside of the open
17 enrollment period. The few beneficiaries that were affected
18 by this change described the situation as confusing and said
19 it caused delays in their treatment.

20 We also asked primary care providers about
21 beneficiaries' access to care. The vast majority of primary
22 care physicians and nurse practitioners in the focus groups

1 said they accept Medicare. They also reported difficulty
2 securing referrals to certain specialists, particularly
3 dermatologists and psychiatrists. The providers said they
4 are increasingly treating behavioral health conditions the
5 best they can when they cannot find a psychiatric
6 specialist. Some providers said they feel comfortable
7 treating certain behavioral health conditions, such as minor
8 depression and anxiety, but are not comfortable treating
9 complex cases, such as major depression and psychosis.

10 Moving on, during the focus groups and site
11 visits, we asked about organization of care, specifically
12 about medical homes, ACOs, and hospital employment of
13 physicians. David discussed the findings on ACOs during
14 this afternoon's session, so I will focus on the other
15 topics.

16 Primary care physician reactions to the medical
17 home model were mixed. Some said that medical home
18 certification has not changed the way they practice
19 medicine, but others said the model has improved their
20 quality of care. Physicians said the biggest challenge is
21 the cost of the resources that are necessary to become a
22 medical home. Most of the focus group physicians that were

1 in medical homes had their certifications paid for by large
2 health systems. Physicians also emphasized that patient
3 buy-in was important to making the medical home work.
4 However, in our focus groups, only one beneficiary of the 59
5 was familiar with the concept of a medical home.

6 Let me just pause a moment to give you some
7 context on why we include hospital employment of physicians
8 in the focus group protocol. The Commission has been
9 focused on this area because it impacts the private and
10 public sectors. On the private side, market consolidation
11 raises the trade-off between the potential increase in
12 provider coordination and higher prices. For Medicare,
13 market consolidation raises issues such as site neutral
14 payment. We recruited a mix of employed and solo
15 practitioners in every physician focus group in order to
16 hear their points of view on this issue. The physicians'
17 perspectives on the pros and cons of being employed were
18 consistent across markets, and those pros and cons are
19 listed on this slide. Having autonomy over the way they
20 practice medicine was cited as the main advantage to working
21 in a solo or small group practice. On the other hand,
22 providers who are employed said they appreciate the

1 financial stability and logistical support such a system
2 creates.

3 Now, I will move on to how beneficiaries and near-
4 beneficiaries approach plan choice. But, first, I will note
5 that this is a topic that we intend to revisit in the
6 spring.

7 First is understanding of the Medicare program.
8 Overall, many beneficiaries and near-beneficiaries were
9 confused about or unfamiliar with aspects of Medicare. Two
10 areas in particular cause much confusion. One was the
11 difference between supplemental plans and MA plans, which is
12 consistent with what Joan spoke about earlier. In most of
13 the focus groups, at least some beneficiaries did not know
14 if their health plan was a supplemental plan or an MA plan.
15 The Part B and D late enrollment penalties were another
16 source of confusion. Many beneficiaries were unaware of the
17 penalties.

18 The next key finding relates to sources of
19 information on Medicare. Beneficiaries' most common cited
20 information sources were health plans, both supplemental and
21 MA. Most beneficiaries said they did not use 1-800-MEDICARE
22 or the Medicare website or handbook. Part of the reason

1 beneficiaries tended not to rely on these resources is
2 because they find them to be confusing. Some beneficiaries
3 suggested that the information on the Medicare website and
4 handbook be summarized and be made simpler, and some SHIP
5 counselors agreed with the suggestion.

6 Some of the near-beneficiaries, however, said they
7 are likely to use these CMS resources when they become
8 eligible for Medicare. This may suggest a generational
9 shift in the sources of information on Medicare.

10 The final key finding is about decision factors.
11 When choosing a health plan or deciding between fee-for-
12 service and MA, the beneficiaries and near-beneficiaries
13 cited many of the same decision factors, which are listed on
14 this slide. The majority of both groups cited out-of-pocket
15 costs as a mean factor, and some said that this was their
16 most important factor. Others said being able to see their
17 current physicians was most important. Some beneficiaries
18 that chose fee-for-service said they factored in whether
19 they will have coverage while traveling, while few other
20 beneficiaries that chose MA said they assessed which choice
21 seemed simpler. Finally, all of the near-beneficiaries said
22 they will use their existing approach to choice when they

1 join Medicare, and most said that they will consider both
2 fee-for-service and MA.

3 Moving forward, instead of a freestanding chapter
4 in one of the Commission's reports, the focus group findings
5 will be woven into the relevant chapters of other Commission
6 projects, such as the ACO focus group findings were woven
7 into the earlier ACO presentation.

8 This concludes the presentation and we are happy
9 to take your questions.

10 MR. HACKBARTH: Thank you, Christine and Joan.

11 So, clarifying questions. Bill Hall.

12 DR. HALL: Were you able to get any hint of the
13 level of satisfaction that many of these people had with
14 their providers of health care, which is a slightly
15 different question as to whether they're able to get into a
16 specialist or not, or not?

17 MS. AGUIAR: I'm just conferring with Joan. I
18 mean, I would say yes. We -- I would say yes, that -- I
19 can't quantify how many are many, but we definitely did hear
20 satisfaction with the care that they are receiving. We
21 heard some instances where beneficiaries were dissatisfied
22 with their provider. We didn't probe on that issue, which

1 is why I'm hesitating. Where we did probe on that, it was
2 in the case of the nurse practitioners. And, so, there,
3 that's where -- the area where we heard most clearly how
4 beneficiaries are quite satisfied with their care that they
5 receive from nurse practitioners, and some even prefer nurse
6 practitioners to physicians.

7 DR. HALL: Right, and I would agree with that. I
8 think that the most common complaint I get from older
9 patients is, "My doctor doesn't listen to me." "He or she
10 is constantly wedded to a computer screen." "They're
11 looking at their watch constantly." This is so prevalent
12 that, at some point, you have to think it probably affects
13 people's -- the quality of people's care, but it's very hard
14 to quantify. But, the focus group is one way to do that.

15 DR. SOKOLOVSKY: It's hard to say, because in
16 previous years, we did hear that quite a bit, and we didn't
17 hear it really this year. I even think one person mentioned
18 that their doctor has learned how to use the computer
19 without staring at it the whole time --

20 [Laughter.]

21 DR. SOKOLOVSKY: -- and it made it --

22 DR. HALL: No, I hear that a lot. People say,

1 thank goodness I took what was called typing in sixth grade,
2 because now I can actually look at my patients and do what I
3 have to do. Okay.

4 MR. HACKBARTH: Of course, the other source of
5 information is CAHPS and the satisfaction scores from CAHPS.
6 It's been so long since I've looked at those questions, I
7 can't remember whether any of them get to the sort of issues
8 that Bill is raising or not.

9 DR. HALL: I think the problem there is that
10 there's a ceiling effect with CAHPS, so that when you start
11 -- the rhetoric around most places is to ask patients, how
12 did you like your care, but with an editorial comment about
13 how we really hope that it was excellent, not just very
14 good, because it's -- the difference between excellent and
15 very good pretty much summarizes the entire scale that's
16 available to --

17 [Laughter.]

18 MR. HACKBARTH: What degree of excellence did we
19 achieve in your --

20 [Laughter.]

21 DR. HALL: I could ask Jon, it's sort of like Lake
22 Wobegon, right, that all the doctors are above average.

1 [Laughter.]

2 MR. ARMSTRONG: With respect to your reference to
3 CAHPS, whether it's service or, frankly, quality
4 information, there is a lot of information available to
5 beneficiaries. I think on Slide 12, it's kind of stunning
6 to me that it doesn't seem to have any relevance, though, to
7 people when they're making these choices. Is that true, or
8 did you ever hear anyone talk about, you know, whether or
9 not the confidence in the clinical decision making would
10 have some bearing on the choice that they make?

11 MS. AGUIAR: I think we heard that in the sense
12 where it was very important to some of the beneficiaries and
13 near-beneficiaries to keep their current providers.

14 MR. ARMSTRONG: So, they assume that if they have
15 a good relationship, that they're a good quality provider?

16 MS. AGUIAR: Yeah. I would say so, yes.

17 DR. CHRISTIANSON: Yeah. So, I heard both of you
18 say this, too, but I'll kind of repeat it. I think focus
19 groups are really interesting, and I've run my share, but --
20 so, we have to be careful what we take from them. We don't
21 want to generalize from the couple of respondents at each
22 site what's going on generally in the Medicare program.

1 But, I think they're very useful in identifying areas where
2 there might be some flags that we wouldn't have seen until
3 we saw data three years from now, or two years from now, or
4 something like that.

5 So, one of the things I would look for in this
6 chapter is your interpretation of where the two or three
7 areas are where you found something in the focus groups that
8 made you sit up and say, wow, here's something the
9 Commission hasn't paid enough attention to, should pay more
10 attention to. The two things that stood out to me were the
11 access to mental health services, and I just -- I'm throwing
12 these out to get your reaction and any others you might add.
13 And then the issues around networks from the beneficiaries'
14 point of view. Of course, we're hearing a lot of that
15 around ACA right now, but the whole issue of networks
16 changing, trying to find out then who's in your network,
17 calling the health plan and they're not able to tell you
18 whether your doctor is in the network. So, you've got
19 networks is one of the primary things that people worry
20 about when they make a choice, but it seems to be and also
21 just a source of frustration to sort of keep track of
22 whether you're in or whether you're out and where the bill

1 is going to go and so forth.

2 So, those are two -- as I read through this, those
3 were two things that made me think, gee, maybe as a
4 Commission, here are things that, going forward, we need to
5 spend some more time talking about. What would -- are those
6 on your list, or what would you add to those?

7 DR. SOKOLOVSKY: And I just want to say, as far as
8 mental health is concerned, it's been so strong every year,
9 from one place to another place. We talk among ourselves
10 about, you know, if we should be doing more work on that,
11 and it sounds like the Commission is thinking about that
12 now.

13 The network, and Christine probably has more to
14 say about it, but that was really a new issue.

15 MS. AGUIAR: Yeah, I agree. The mental health,
16 that came out very much in this focus group. It came out, I
17 feel, almost more so in the last year's rounds of focus
18 groups, where it came out just pretty much every site during
19 the site visit, everyone we spoke to. And, as Mark had said
20 earlier in the MA session, that is something that we are
21 beginning to think about sort of projects around that.

22 I think that the network issue, that's something

1 that we always are interested to keep paying attention to.
2 This did happen in one specific market, and so I don't want
3 to underplay those beneficiaries' experience, because there
4 was few that were affected. Those that were affected, it
5 was a very difficult situation for them, I think. The
6 example that we heard, which is in the paper, is that one
7 beneficiary was told her providers are in the network -- I'm
8 sorry, are not in the network, and then she had to scramble
9 to find new ones, but then they were back in the network and
10 she just didn't know what was going on. So, again, it was
11 somewhat of a very specific situation.

12 We also heard, interestingly, from the physicians
13 in that market that it was difficult for them to absorb all
14 of these patients. So, I think that that is something that
15 we would agree to continue to keep an eye on.

16 The other topics that sort of stood out to me as
17 something perhaps worth continuing to work on or look at,
18 one was really the use of urgent care centers, because we
19 just -- we didn't ask. We did not prompt that, and it came
20 up in almost every single focus group. At least some
21 beneficiaries were using that, and it really seemed to be a
22 substitute for primary care. And, so, you know, there has

1 been also a lot on the news, more about these sort of retail
2 clinics and urgent care centers. So, that, I think, is
3 something that we could -- you know, should perhaps look at
4 a little bit more.

5 And, then the final thing that I think that struck
6 me as really important, and this was what, Jack, you spoke
7 about in the last session, was how beneficiaries do get
8 their information. We did hear from beneficiaries and from
9 SHIP counselors, and the information from the SHIP
10 counselors is in the mailing materials. We just weren't
11 able, interest of time, to include it in this presentation.
12 But, we did hear some, you know, what I thought were very
13 interesting recommendations on how to just simplify the
14 Medicare handbook or the Medicare website, even just
15 including one or two simple pages right up front. So, if
16 somebody doesn't look through the whole book -- and the
17 beneficiaries that we spoke with, most are not -- at least
18 they could sort of just get a sense of the difference
19 between traditional fee-for-service with and without a
20 Medigap, Part D, and MA. And, I think what we've heard,
21 again -- and, as you said, it's a very limited sample --
22 there is confusion around all of those areas, and even some

1 confusion where some beneficiaries would refer to their
2 supplemental plan as if it was traditional Medicare.

3 So, those, I guess, were the four things I would
4 say.

5 MR. HACKBARTH: So, Jon, that was a very helpful,
6 to me, way of thinking about looking at these results. In a
7 minute, I'm going to ask others to sort of think -- reflect
8 on what's in the chapter in the same way. Are there things
9 that jumped out at you, like Jon's items.

10 Before I do that, though, I wanted to ask about
11 the network issue. My recollection is that there -- as the
12 result of some specific cases where there were last-minute
13 changes in networks, CMS was looking at changing the
14 regulations on that. Carlos, could you tell us where that
15 stands?

16 MR. ZARABOZO: [Off microphone.] Yeah. They did
17 announce [inaudible].

18 MR. HACKBARTH: So, that suggests that there can
19 be no changes during the contract year. They have to happen
20 --

21 MR. ZARABOZO: [Off microphone.] I think
22 [inaudible].

1 MR. HACKBARTH: Yeah. Well, I understand a
2 preference, but if it's not a requirement, it won't do much
3 good.

4 MR. ZARABOZO: [Off microphone.]

5 MR. HACKBARTH: Okay. Yeah. If you could track
6 that down, that's an issue that interests me.

7 Okay. So, let me --

8 DR. SAMITT: Can I just comment on the network-
9 related issue? I would certainly encourage the Commission
10 not to make a theme out of this particular case. That
11 particular example strikes a high degree of familiarity to
12 me in my former organization's, one of our markets -- I'm
13 sorry? So, I think that that, I suspect, is an anomaly and
14 not something that we would consider a theme going forward,
15 if I'm thinking of the right market.

16 MR. HACKBARTH: So, the question on the table --
17 if you want to talk about networks, you can do that, but I
18 also invite comments on what jumped out at you in the focus
19 group results. Rita.

20 DR. REDBERG: I'll say that, and then I just
21 wanted to pick up particularly on the urgent care center.
22 But, I thought it was very helpful, first of all, very

1 reassuring, I think, to hear that most Medicare
2 beneficiaries still feel like they're able to see their
3 doctor and see them in a timely fashion, because that's
4 clearly a high priority for all of us.

5 I wasn't sure what to make of the difficulty
6 referring to specialists and I'd be interested to know more,
7 particularly dermatologists. I mean, are we -- are they
8 asking for more referrals to dermatologists, because I would
9 think a lot of dermatologists' business is Medicare
10 beneficiaries, but no, you're shaking your head, so I guess
11 not.

12 DR. SOKOLOVSKY: I think the issue is -- I mean, I
13 think this is true in Washington, D.C., as well. It's very
14 hard, because so many of them are moving on to plastic
15 surgery and so on and don't --

16 DR. REDBERG: I see. Thanks.

17 The comment -- I'm interested in what you had just
18 said about urgent care centers, because it strikes me when
19 I'm inpatient attending that a lot of patients that come to
20 the emergency room are coming because they weren't able to
21 get through to their primary care doctor, or if they did,
22 they got a triage person who didn't really know them and

1 suggested they go to the emergency room, particularly for
2 chest pain. So, I'm wondering whether there's some way we
3 could look at what is driving those urgent care. Are those
4 people -- like, are primary care visits dropping? Are ED
5 visits dropping? Or, are those just in addition, now we're
6 seeing more visits overall, which I don't know that we can
7 get at, but I'm wondering if it's relieving something or
8 just -- and not --

9 MR. HACKBARTH: [Off microphone.] Others? Not on
10 the narrow question of clinics, but what jumped out at you
11 in these results? We'll do this side --

12 MR. ARMSTRONG: [Off microphone.] -- on the
13 clinics.

14 MR. HACKBARTH: Okay. Let Scott go on the
15 clinics, and --

16 MR. ARMSTRONG: So, just specific to the issue of
17 urgent care, I mean, for me, the reaction to that was to
18 ask, well, is that good or bad? I mean, implied in here, it
19 was bad. What's bad is if the urgent care clinic is
20 disconnected from an integrated, coordinated care system
21 that you're trying to create around primary care. But, the
22 truth is, our health care systems have to accommodate the

1 fact that different people are going to access them
2 differently, whether it's through their iPhone, or by
3 telephone, or with a scheduled primary care visit, or
4 showing up unexpectedly on a Saturday in an urgent care
5 clinic. So, I just would -- this implied urgent care visits
6 were bad, and they're not necessarily unless it's
7 disconnecting a connected relationship between the patient.
8 So, as we figure out how we might understand better and take
9 a position on that, I just think it's a slightly more
10 complicated question.

11 MS. AGUIAR: Sure. And, I think that this is
12 helpful feedback, because I think we did not intend for it
13 to come across as bad, and so I think I'll look at how it's
14 phrased and see if I have to change the tone. You know,
15 when the beneficiaries spoke about the urgent care clinic,
16 it was in the positive. It's another resource for them, and
17 they could get a same day appointment and some like to go
18 there. And, so, it really was from a positive, another
19 resource for them. So, we'll revisit the tone for that so
20 that that comes across more clearly.

21 DR. MILLER: And, I will just reinforce it,
22 because in the hallways, we weren't talking about it that

1 way, and I think more the way I was thinking about it is you
2 were getting reactions where it was saying, well, if I
3 couldn't get an appointment exactly when I wanted it, I
4 might go to the urgent care center. And, then, also, I can
5 get an appointment with an NP and that's just fine. I'm
6 going to go and get that. You know, I can get in the door
7 quicker that way, and I saw it all in kind of that context.
8 I'm not completely off, right?

9 MS. AGUIAR: I agree with that, yeah. That's
10 correct.

11 MS. BUTO: Same point. I hate to prolong it, but
12 has the Commission done an analysis of -- I mean, in some
13 cases, these, if not urgent care, in-store clinics and such
14 actually save money and will catch an issue early on that
15 may not -- somebody who's having trouble getting to a
16 physician may not otherwise be caught? Have we ever done an
17 analysis of the role they play in --

18 DR. MILLER: [Off microphone.] We have not.

19 MR. HACKBARTH: Yeah. In claims data, can we
20 reliably determine when a provider is an urgent care clinic
21 or not? I wouldn't think we could.

22 DR. MILLER: No, we can't.

1 MS. AGUIAR: I don't believe we can, but I'm
2 looking to see if Kevin or Kate -- yeah, Kate's shaking her
3 head that, no --

4 MR. HACKBARTH: Yeah.

5 MS. BUTO: Cannot, okay. So, they're treated as a
6 physician's office, basically, is that what -- paid as if
7 they were a physician's office?

8 DR. MILLER: Yeah. So, say, if you went there and
9 you saw a nurse practitioner, it would be just like a nurse
10 practitioner bill showing up anywhere else, so --

11 MS. BLONJARZ: One other point I was going to make
12 is that there were -- there was a really good study a couple
13 years ago that some people from RAND did on the quality and
14 cost of care across a couple settings. It didn't find
15 differences in quality or -- I believe --

16 MS. BUTO: [Off microphone.] For basic primary
17 care --

18 MS. BLONJARZ: For the types of services that are
19 treated in different settings.

20 MR. HACKBARTH: Okay. Anybody else on urgent care
21 clinics?

22 DR. MILLER: One other thing. We're going to look

1 at the place of service codes. There may be some sense that
2 there might be a new one showing up in the -- as they update
3 files. So, there might be some ability. But, at the moment
4 -- sorry, Glenn.

5 MR. HACKBARTH: On urgent care clinics?

6 DR. CROSSON: [Off microphone.] A related --
7 [Laughter.]

8 MR. HACKBARTH: Okay --

9 DR. CROSSON: Yellow flag possibility.

10 DR. MILLER: On the context --

11 DR. CROSSON: Early in the presentation, you
12 mentioned physician concerns with concierge clinics, but I
13 didn't hear it in the body of the presentation.

14 MR. HACKBARTH: That's like the opposite of an
15 urgent care --

16 DR. CROSSON: No, no, no --

17 [Laughter.]

18 DR. CROSSON: No, no --

19 MR. HACKBARTH: Where's my yellow flag?

20 DR. CROSSON: Now, you're going to get a seminar.

21 [Laughter.]

22 DR. CROSSON: Now, you're going to get a seminar.

1 In some work that I've been doing, there's another emerging
2 model, which some people are calling the subscription model.
3 And, instead of being pitched at wealthy people and paying a
4 lot of money every month, it's just the opposite. It's
5 middle- to lower-income people, you know, premiums, if you
6 will, about \$50 to \$60 a month, primary care, and panel
7 sizes of 600 to 700 with very good access. Limited
8 services, very good access. And, I actually visited one in
9 Seattle. So, it's kind of a semi-urgent care setting.

10 But, the question really is, you know, having
11 visited one and spent a day in one, I didn't see very many
12 Medicare -- what I thought were Medicare beneficiaries, and
13 I just wondered, did that come up in the focus group at all,
14 or what was the issue with respect to concierge medicine?

15 DR. SOKOLOVSKY: The first time it came up, it was
16 a beneficiary group and it was in Richmond, I believe, and
17 it was really a new issue for us at the time because the
18 beneficiary was describing, "Well, my doctor has me pay a
19 certain amount each month and I have great access to him,"
20 and we were really, you know, puzzling over what this was.
21 Nobody -- that he just mentioned it as, you know, a nice
22 thing his doctor did that really improved his access.

1 [Laughter.]

2 DR. SOKOLOVSKY: But, then we started --

3 DR. MILLER: [Off microphone.] This was several
4 years ago.

5 DR. SOKOLOVSKY: Yes. This was very, our very
6 first focus groups, yeah. But, since then, we have done a
7 report on it and we ask physicians every year their
8 perspective on it, and we get very polar opinions on it,
9 that some say, if I can get enough patients, this is the way
10 I want to do it. I can practice medicine the way I've
11 always wanted to, give enough time to people. And, other
12 physicians are saying, I didn't go to medical school to
13 provide --

14 MR. HACKBARTH: [Off microphone.] To be a
15 concierge.

16 DR. SOKOLOVSKY: Yeah, to wealthy people, and be
17 at their beck and call.

18 MS. AGUIAR: And, I would just add that the focus
19 groups that I have -- in this past round, and then the
20 previous two rounds, when it came up from some of the
21 beneficiaries, it was more in the context that their
22 physician, primary care physician, was going concierge and

1 so they had to find a new one because they were going
2 concierge, that they just weren't able to afford it. Most
3 were not able to afford the services.

4 MR. HACKBARTH: Okay. Cori, Bill, and Jack have
5 been waiting patiently, or, actually, impatiently for a
6 while now, but Cori.

7 MS. UCCELLO: Yeah, and I can't believe I'm going
8 to stay on this topic, but I am. I think your tone on the
9 urgent care actually came across as you intended, at least
10 to me, but it still raised the red flag of, oh, this is --
11 it makes it sound like it's a good deal. I mean, this is a
12 place where people can go. But, should we still be worried
13 about this? And, I think, as Scott said, I think a concern
14 for me, at least, as well -- especially if they're using
15 this as a typical place of primary care -- is there any
16 connectedness to their other providers, and to what extent
17 can these clinics be part of ACOs or other types of
18 organizations, because I think they can, right? So --

19 MR. HACKBARTH: There's nothing that I'm aware of
20 that would prevent them --

21 MS. UCCELLO: Yeah. So, just kind of as we move
22 forward, monitoring how they fit into more organizationally-

1 based care.

2 Another -- this chapter, as well as the MA
3 chapter, talked about the decline in Part B take-up, and so
4 just understanding more of what was going on there. Is it
5 people that are working or have other sources, so they're
6 still covered, or are these people going without, just kind
7 of what's going on there.

8 MS. AGUIAR: This really came out, this finding,
9 anecdotally from the SHIP counselors, and the reasons for
10 that that some of them gave -- I remember in one market,
11 they said that it was just a lack of understanding of the
12 Part B penalty. And, in another group, I believe they said
13 the reason was somewhat a poor education for those who had
14 employer coverage about when they have to then join Part B
15 and the penalty. And, then, they also gave other instances
16 where beneficiaries were fully aware of the penalty and
17 still chose not to. So, it's sort of a mix of different
18 reasons.

19 MS. BUTO: Could I just add a point to this, too?
20 I think the income-related premium may have an impact on
21 this. At least, that's what I'm hearing.

22 MS. UCCELLO: Well, and I think that's going to be

1 important in moving forward, is that keeps being proposed as
2 a policy option.

3 I did -- I want to raise a green flag. I think
4 there was some encouraging news. I thought that the
5 beneficiaries did at least claim to understand kind of the
6 trade-offs between premiums and the cost sharing, so that
7 was kind of nice to hear.

8 On the flip side, it seemed like the word that was
9 used most in the chapter was "overwhelming," and, so,
10 obviously, that's troubling, and so --

11 DR. HALL: That's not a good word.

12 MS. UCCELLO: That's not a good word. So, you
13 know, it's just that there are lots of choices. There's
14 lots of material. They don't know what to do, you know.
15 And, so, we still need to kind of keep our eye on the ball
16 here in terms of trying to figure out ways to engage
17 beneficiaries in a way that's not overwhelming.

18 MR. HACKBARTH: In -- on that topic, which is way
19 beyond my expertise, but I think that one of the key issues
20 here is when you provide information. You know, the old
21 model that we're going to give people a handbook when
22 they're 64-and-a-half and they're going to read it and

1 understand it, that's just totally unrealistic. And, the
2 challenge is to provide ready access at the time people need
3 it and they're more receptive to learning because they've
4 got a specific need. And, I don't know to what extent CMS
5 has looked at its educational methods with an eye towards
6 making it more real-time need specific as opposed to some,
7 here's the handbook on your doorstep.

8 MS. UCCELLO: I can --

9 DR. SAMITT: Can I add on to that, because I'm not
10 so sure it's just -- I wanted to tag onto that comment, as
11 well. I don't think it's just the timing. I think it's the
12 method, as well. You know, people reference the fact that
13 the website and the handbook are way too complex. You know,
14 many of the present day seniors are as savvy with social
15 media and technology as the younger generations. The
16 question is, does the educational mode altogether need to be
17 modernized in a way that engages and educates Medicare
18 beneficiaries more effectively?

19 MS. AGUIAR: I would, and then I'll turn it over
20 to Joan -- this was -- again, it was so overwhelming, and I
21 actually cut back the number of "overwhelming" comments. I
22 toned it down -- tried to tone it down a little bit. But, I

1 think that there is just a lot going on here, and it really
2 does differ by market. So, as you were saying, it's really
3 hard to generalize just across.

4 We definitely heard that the Medicare book --
5 people called it "the big book" -- the Medicare book, or 1-
6 800, or the Medicare website, it is just overwhelming for
7 some beneficiaries. In one of the previous focus groups
8 that we did about last year or the year before that, I
9 remember we had a group that was much more comfortable -- at
10 least, some of the beneficiaries in the group were much more
11 comfortable with looking at the website and being able to
12 compare.

13 To me, one of the comments from a near-beneficiary
14 that just really resonated -- and, you know, all the near-
15 beneficiaries in our groups, most of them -- all of them had
16 insurance. Whether it was employer insurance or through the
17 marketplace or they were self-insured, they had insurance.
18 And, one of them says, "Well, why can't Medicare just give
19 me sort of a side-by-side comparison the way that my
20 employer does?" And, we heard a similar concept from one of
21 the SHIP counselors, which doesn't say eliminate the
22 Medicare book, but is there something they could be getting

1 to -- and especially for the near-beneficiaries -- that's
2 consistent with how they're accustomed to seeing and
3 comparing health care plans and their options.

4 MR. HACKBARTH: If that comparison happens to have
5 34 MA plans and 55 Part D plans, it could be the same
6 format, but it's still going to feel overwhelming.

7 MS. AGUIAR: Right. Right. Exactly. And, so, we
8 also heard that. So, I guess, basically, the -- not
9 solution -- one solution that we heard to that could be some
10 document that simplifies what is traditional Medicare, what
11 is supplemental plans, what's a Part D plan, and how could
12 you have those arrangements, and then MA and how that
13 differs and that sort of thing.

14 Joan.

15 DR. SOKOLOVSKY: I just want to say that this is
16 one area where Christine and I really have different
17 perspectives, because even though people did say they were
18 overwhelmed and these things, compared to when we started
19 out on this, many more people are computer savvy. Many more
20 people are saying, well, I called 1-800-MEDICARE and they
21 actually gave me a good answer. So, even though you may say
22 that a lot of people are still overwhelmed and it's still

1 impossible, to me, there's a very noticeable, particularly
2 computer savvy, increase in that.

3 MR. HACKBARTH: [Off microphone.] I need to get
4 to Bill Gradison and Jack, and then I'll come to this side.
5 Bill.

6 MR. GRADISON: Okay. I have a couple of
7 underwhelming comments.

8 [Laughter.]

9 MR. GRADISON: First of all, with regard to trying
10 to figure out what's happening in some of these urgent care
11 centers, if the claims data would support it, it would be
12 very interesting to look at the proportion of certain
13 benefits, or shots, really, that are done through the big
14 drug store chains -- Walgreen's, CVS, and RiteAid, in
15 particular, the flu shots, the pneumococcal, pneumonia, and
16 the shingles, and to see what proportion are in and out and
17 what the trends have been. I mean, that's a short-cut way.
18 It isn't the same thing, but I think it might be indicative.

19 I want to compliment you on your comments in here
20 about patient-centered medical homes, particularly on page
21 ten. I've been spending a lot of time on this outside, and
22 it rings true, particularly the importance of the larger

1 health plans helping to finance the work toward
2 certification, and the challenges for smaller physician
3 groups participating. There's a whole lot of reasons for
4 that.

5 But, I want to add, based upon what I picked up
6 outside, is that the participation rate may be even lower
7 among small groups of just a few physicians who specialize
8 in caring for safety net folks, and I think -- that's a very
9 -- it's a small -- it's a niche, but it's a very important
10 one in terms of our objectives and I wanted to -- I just
11 wanted to flag it.

12 DR. HALL: So, first, in full disclosure, I used
13 to be one of the contractors that worked on these site
14 visits before I was a Commissioner, so I have certain biases
15 in favor of this approach. But, on the issues, I am struck
16 by this urgent care and so forth discussion, and I guess the
17 one thing I would just add to what's been said, because a
18 lot of it has already been said, is that to the extent it's
19 possible, and the data may not allow much of this, I mean,
20 there is a big difference between a retail -- the retail-
21 type clinics and the urgent care clinics, the ones that are
22 sort of set up more as emergency rooms outside the hospital

1 for things that are a bit crisis related, to the ones that
2 are more, you know, inside the CVS or whatever to deal with
3 much more, you know, yes, maybe the sinus infection, but
4 also the flu shot or the routine check-up for some ongoing
5 monitoring of diabetes or whatever. And, so, I mean, we
6 shouldn't necessarily lump those into one category and kind
7 of talk about them as if they're the same thing.

8 But, I do think it's interesting, and the one
9 thing where it could be a negative is if it affects
10 continuity of care with sort of people's regular physicians,
11 if they do some things there, some things with their regular
12 physicians, and if there's not communication, which is often
13 a problem.

14 MR. GRADISON: Well, many of them, as I understand
15 it, will send a copy of the report right on to your
16 physician if you give them the information. I think that
17 may even be fairly standard these days.

18 DR. HALL: And, if that's the case, that solves
19 part of that, so --

20 And, the second one I wanted to mention was the
21 stuff, and we talked about it a little bit already, on the
22 ACOs and the medical homes and the sort of low beneficiary

1 awareness. We kind of made these points this morning when
2 we talked about the ACOs. But, it's striking here again to
3 think about that even medical homes, which are different,
4 they're more local, you know, operate within your local
5 primary care practice, that people aren't aware of that, and
6 maybe because it's an odd term that isn't very consumer
7 friendly is part of why that term is not being used. But,
8 any of the issues of whether we expect people to become
9 aware of what's going on in these things, I think these are
10 sobering reminders that that's not a simple thing.

11 And then the last one is really a follow-on to
12 what I was saying in the last session about this issue of
13 beneficiary education. And, I guess what I was trying to
14 think of in between the last discussion and this one, you
15 know, there really probably is a list of policy options that
16 we could put together and sort of think through and decide
17 if any of them are worth -- and, again, some of these have
18 been agendas of meetings earlier, in the last year or two,
19 or even many years ago -- that range from funding for SHIPs
20 and other similar sort of one-on-one kinds of resources, the
21 Medicare and You handbook that several people have talked
22 about, should it be changed, redesigned.

1 I was in HHS when one of the previous redesign
2 rounds went on at the time of, what was it then, Medicare
3 Plus Choice, and it was kind of a politically charged
4 discussion at the time, and how do you in a balanced way
5 compare the managed care option and the fee-for-service
6 option, and I remember the whole thing had to go back to the
7 drawing board and restart. So, it's not easy, but that's
8 maybe something where we could contribute some thinking on.

9 Other kinds of simplification, as you guys already
10 talked about. And then, as a couple of people brought up,
11 just what are the different approaches. And, I'm the last
12 person to talk about social media, but social media, should
13 there be YouTube videos run by CMS that are really quick
14 kinds of things. I mean, I don't pay attention to a lot of
15 those things, but a lot of people do. And, what I do get is
16 the notion that people aren't as patient as they used to be
17 to read long book-length kinds of treatments of things, and
18 I think just thinking about are there creative ways that
19 don't just rely -- I mean, we're not going to reduce it to a
20 tweet, but, you know, little videos that people can access
21 online might be great. Maybe some of that's being done. I
22 mean, I'm sure some of the groups like Medicare Rights and

1 the Center for Medicare Advocacy probably have some good
2 ideas on how they feel, like just as your SHIP counselors
3 that you have talked to would do. So, I think, if we could
4 sort of lay out some options and see if some of these things
5 -- some of them may be costly, some of them may not.

6 MR. HACKBARTH: [Off microphone.]

7 DR. NAYLOR: So, since I raise this so much, a
8 shout out to Joan and Christine and the Commission for
9 paying attention to the role of nurse practitioners in
10 primary care. I often come on to remind everybody, but this
11 is really extraordinarily important, and particularly to
12 capture the beneficiaries' perspectives on the contributions
13 of this growing workforce.

14 MR. KUHN: So, kind of a couple clarifying
15 questions here still, because that's where I am in the queue
16 here --

17 [Laughter.]

18 MR. KUHN: I've been very patient. I've been very
19 patient.

20 So, the three sites you went to, Nashville,
21 Albuquerque, and Harrisburg, all urban settings. Were you
22 able to reach out into the rural areas and get any -- both

1 providers, physicians, as well as beneficiaries from the
2 rural areas to come in to be part of this conversation?

3 And, the reason I'm asking -- and, if not, I mean, I'm not
4 saying it's good or bad, but I just wonder if there was any
5 differentiation you saw in terms of access points, things
6 like that, in urban versus rural areas.

7 MS. AGUIAR: Right. In this round, I believe that
8 most, if not all, of the beneficiaries were from the
9 surrounding urban/suburban area, as well as were most of the
10 primary care physicians and nurse practitioners. I do
11 believe in one market, we got some nurse practitioners that
12 were a little bit outside -- I'm not sure how rural, but
13 outside of really the sort of the crux of the urban setting.

14 In instances where we did hear anecdotally about
15 care in rural areas, it was from the beneficiaries and the
16 providers that are really -- I'm sorry, that are in the
17 urban areas. So, we didn't hear directly from those
18 beneficiaries in this round. But, I do believe there are
19 previous focus groups, yeah.

20 MR. KUHN: And that's what I thought. And,
21 particularly, I'm reflecting back, I think was it the 2010
22 rural report where we saw access in terms of utilization

1 pretty well equal in urban and rural areas, but some of the
2 rural folks were having to drive further in order to access,
3 and I'm just wondering if we're still seeing that kind of
4 information, but we didn't have that at this time, but --

5 MS. AGUIAR: We --

6 MR. KUHN: -- something we can continue to watch
7 in the future.

8 DR. SOKOLOVSKY: Right. We didn't have that same
9 thing --

10 MR. KUHN: Okay.

11 DR. SOKOLOVSKY: -- but a few years ago --

12 MR. KUHN: Right.

13 DR. SOKOLOVSKY: -- we did do that.

14 MR. KUHN: So, the second thing is on this urgent
15 care center. So, I'm just wondering if folks
16 differentiated. So, obviously, we know what the retail
17 urgent care centers look like, but also, some emergency
18 departments in some hospitals in some communities are also
19 kind of mimicking urgent care behaviors. They're
20 advertising on billboards. Some of them have websites where
21 you can see you can actually make an appointment and then go
22 in at a certain time. Did beneficiaries differentiate

1 between the kind of the retail sites you might see in a
2 strip mall versus going to the emergency department and
3 using those urgent care centers differently?

4 MS. AGUIAR: I did not hear that differentiation,
5 no. I don't know if, Joan, you picked up on that. They
6 referred to them as urgent care centers.

7 MR. KUHN: Okay. And then, finally, when you
8 asked about the issue of surprise, you know, on the
9 behavioral health issues and the ones you pointed out in the
10 paper, where a lot of folks are referring the more complex
11 ones to emergency departments for care, that doesn't
12 surprise me, based on the data that we're seeing. And, the
13 sad joke you hear from hospital CEOs around the country is a
14 lot of them will say, "I just opened my new behavioral
15 health unit. It's called my emergency department."

16 They're just overwhelmed, both for mental health
17 as well as substance abuse. And, when you look at the major
18 diagnostic codes for both of those, the numbers are just
19 tracking up dramatically to the point where you start to see
20 more security and many things in a lot of emergency
21 departments around the country. It's getting -- we say
22 overwhelming. It's overwhelming. It's just remarkable out

1 there. So, that one didn't surprise me, but it's
2 interesting that a lot of physicians are acknowledging that
3 going on pretty aggressively.

4 DR. COOMBS: So, Glenn asked what -- I'm sorry.
5 My turn? So, he asked, what was the chapter missing. I
6 think you guys did a great job in terms of giving us, like,
7 a snapshot, a picture. But, I was looking for a movie.
8 And, so, one of the things I thought about in reading the
9 chapter was there's -- on Slide 12, you talk a little bit
10 about what the beneficiaries and near-beneficiaries would
11 like as a priority, things that they thought were important.

12 But -- and, I guess other people might feel this
13 way, as well -- one of the things that I thought was really,
14 really sad was that the beneficiaries didn't mention that
15 their care was better, their blood pressure was better
16 controlled, their diabetes was under better control, their
17 Hemoglobin A1c was better. Those kind of things never rose
18 to the surface, but it was -- if I was reading this as a
19 physician, it's almost a soft science in that these are some
20 of the things, the real important things in terms of actual
21 care and how the beneficiary perceives it in terms of being
22 able to say, "My doctor got my blood pressure under good

1 control."

2 And, I tell you a story of a nephrologist once who
3 said that a patient came to him in renal failure, and the
4 nephrologist said to the patient, "Your blood pressure is
5 very high," and the patient told the nephrologist, "My
6 doctor that I had last year told me that I run high," and
7 that was the response, so that a lot of times, I think, this
8 whole perception of what good quality care is -- I don't
9 know how to get to it, but I would love to see some analysis
10 of patients actually responding to the fact that I get good
11 quality of care, what you can perceive, what you understand
12 from whether it's a nurse practitioner or whether it's a
13 physician. There's some endpoints that I know that I am a
14 better person health-wise because I'm under this health care
15 system, because I think access is access, but you should
16 have access to good care and so that you might be under some
17 care, but what concerns me -- and it is really, really sad -
18 - is that we didn't hear language about the actual quality
19 of care and endpoint of care, and that to me is -- it's not
20 overwhelming. It's compelling.

21 DR. SOKOLOVSKY: I think the research in general
22 supports that that isn't how -- unfortunately, how

1 beneficiaries tend to seek quality of care.

2 DR. MILLER: I think this is the point that Scott
3 was making earlier, "I want to stay with my doctor," as the
4 proxy for this must be good care.

5 MS. AGUIAR: And I think in -- again, this was in
6 a few anecdotal instances where beneficiaries did have
7 negative comments about their primary care physicians. It
8 was in the context of something was misdiagnosed or there
9 was clearly some sort of -- an episode of care was not
10 handled right. So we hear a few anecdotes of that, but
11 again, the way that I think the beneficiaries perceive their
12 quality of care is different than how we are defining it,
13 which isn't to say that we can't try to think of how to
14 probe on that in a way that we could sort of try to get to
15 what you are asking for.

16 MS. BUTO: Two points. One is on mental health,
17 and I look forward to the conversation, I guess, with
18 Christine and Kate about some of the ideas they have, that
19 you all have for addressing some of those issues. But it
20 strikes me that if the -- I don't know if the Commission has
21 already done this, but it is going to require a full-body
22 analysis that goes to what has been happening to access to

1 psychiatrists and other mental health professionals, do we
2 have enough physician assistants or nurse practitioners in
3 that area, just more than just cries that there are
4 difficulties referring to psychiatrists, because there is
5 something else going on that is much more fundamental at a
6 time when I think we are going to have a long-term need for
7 a more robust way to address mental health services in the
8 context of MA and ACOs and otherwise. So that's just one
9 thought I had. I hope we'll look at some of the data around
10 that over time, so we can see what's been happening.

11 But my concern came out of the comments that you
12 were getting on the Part B penalty because people are
13 default-enrolled into Part B unless they opt out, which
14 tells me they are opting out without knowing about the
15 penalty, which makes no sense to me.

16 And so I think what we could use also in that area
17 -- and maybe we will find there isn't a problem -- is what
18 has been going on with the rate of disenrollment from Part
19 B. Has that been accelerating, or are we just hearing from
20 a few people who didn't know about it, and it's really been
21 pretty steady, and there are good reasons why people opt out
22 of Part B? So some data behind that would be helpful, too,

1 just to analyze what's going on and then deciding how it
2 affects us, whether it's in doing the baseline analysis for
3 spending per capita or whatever it is.

4 We may be okay if there are other sources of
5 insurance that people are going to, but I just think we
6 would like more information on what's going on there,
7 because there shouldn't be a lack of knowledge, particularly
8 if people are falling into a penalty, because you actually
9 have to opt out. I think for Part D, you actually have to
10 opt in, but I know for Part B, you are automatically
11 defaulted in unless you elect to be out.

12 MS. AGUIAR: These are all suggestions, but just
13 to clarify something about the Part B penalty, we heard from
14 SHIP counselors and in one market in particular that they
15 are observing, amongst the clients that come to them, a
16 decline in people that are choosing to stay in Part B.

17 What we heard in our focus groups was an awareness
18 of the Part B and Part D penalty, and some --

19 MR. KUHN: Unaware or aware?

20 MS. AGUIAR: Unaware. They were unaware of the
21 penalty, and so it's sort of those two, not to -- I don't
22 want to leave the impression that those who were in our

1 focus groups who were unaware of the Part B penalty were not
2 signed up for Part B.

3 MS. BUTO: [Off microphone.]

4 MR. HACKBARTH: Any concluding comments on this?

5 [No response.]

6 MR. HACKBARTH: Okay. Good work, Christine and
7 Joan.

8 So we had some very different sessions today. We
9 had, I think three including this last one, the Context
10 Chapter and the Medicare Advantage demographics that were
11 sort of informational and can we learn more about XYZ. Then
12 we had the two, one on LCA, the clinical evidence issue, and
13 on ACO, which we were more policy-oriented and sort of what
14 are our levers that we want to deal with. I think that is a
15 good mix, especially for the first meeting.

16 I want to urge you to get a good night's sleep and
17 put your thinking caps on, because tomorrow morning when we
18 talk about this short stay issue and observations, you will
19 need to be sharp because that's not sort of, "Oh, let's
20 think about questions." That's really a brain teaser, so
21 get a good night's sleep.

22 Just want to check. Anything else the

1 Commissioners want to add before we have our public comment
2 period?

3 [No response.]

4 MR. HACKBARTH: Okay. The microphone is now open
5 for the public comment period.

6 [No response.]

7 MR. HACKBARTH: Seeing nobody going to the
8 microphone, we are adjourned until 8:30 tomorrow.

9 [Whereupon, at 4:38 p.m., the meeting was
10 recessed, to reconvene at 8:30 a.m. on Friday, September 12,
11 2014.]

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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, September 12, 2014
8:30 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
FRANCIS "JAY" CROSSON, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA

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1 P R O C E E D I N G S [8:30 a.m.]

2 MR. HACKBARTH: Okay. Good morning. We have two
3 sessions this morning, first on hospital short stays and
4 then complete our work on the mandated report on home health
5 payment.

6 So, Zach, are you leading the way on hospital
7 short stay?

8 MR. GAUMER: Yes. We're ready.

9 Well, good morning, everyone. Today we are here
10 to begin a discussion about hospital short stay policy.
11 Before we start, the three of us want to thank Jeff
12 Stensland, Julian Pettengill, Carol Frost, Dan Zabinski, and
13 Valerie Aschenbach for their contributions. This has been a
14 team effort.

15 There has been a lot of news in the last year
16 about RAC audits, hospital observation status, and CMS' two-
17 midnight rule. The common thread linking these three topics
18 is that hospitals have a financial incentive to admit
19 patients because for clinically similar patients they
20 generally receive higher payments in the inpatient setting
21 than the outpatient setting. Medicare's auditors recognize
22 this incentive as well as the ambiguity of admission

1 criteria and have focused on the one-day stays. In
2 reaction, hospitals have diverted more stays to outpatient
3 observation. This action has had ramifications on
4 beneficiary liability, and in turn CMS created the
5 controversial two-midnight rule. Ultimately we will discuss
6 whether or not there are payment-based policy solutions.

7 This presentation has two pieces. First I will
8 talk a little bit about the background information and lead
9 you through the story. And then Kim is going to shift into
10 a discussion about payment policy changes that we could
11 explore to address these issues.

12 Over the years, changes in technology and medical
13 practice patterns have allowed many inpatient services to
14 migrate to the outpatient setting. As a result, the issue
15 of whether or not a patient requires inpatient care has
16 received increasing attention.

17 Historically, Medicare's admission criteria has
18 been fairly open-ended, purposefully, in deference to the
19 physicians' clinical judgment. The same can be said of CMS'
20 guidance to providers for what constitutes observation
21 status. You may also notice that the time-based definition
22 of both types of stays overlap and are both relatively

1 inexact. While the open-endedness of these criteria provide
2 physicians with flexibility, others view the criteria as
3 ambiguous and the source of wide-ranging admission behavior
4 and auditing behavior.

5 Keep in mind that the criteria displayed on this
6 slide are historical in the sense that the two-midnight rule
7 technically amends the criteria. However, RAC enforcement
8 has been delayed statutorily until March 2015.

9 Short inpatient stays are both common and
10 profitable, providing hospitals with the incentive to admit
11 potential short stays. In 2012, nearly 1.2 million
12 inpatient discharges were for one-day stays, and this
13 represents 13 percent of all discharges.

14 The inpatient payment system was designed
15 purposefully as a system of averages, which makes one-day
16 inpatient stays profitable. Medicare pays a fixed amount
17 per case for patients who fall within a specific DRG,
18 regardless of their length of stay. Therefore, hospitals
19 have the incentive to efficiently deliver care and control
20 costs in a variety of ways, including shortening stays.

21 The slide above displays that short inpatient
22 stays are quite profitable, and profitability does decline

1 as length of stay increases. In 2012, just as an example,
2 payments for one-day stays exceeded costs by about 55
3 percent. And, by contrast, stays lasting eight or more days
4 had the lowest mean payment to cost ratio of about 0.72.

5 Profitability does vary across different types of
6 one-day inpatient stays. For example, one-day medical stays
7 received payments that were more than twice their costs.
8 And overall, surgical one-day stays exceeded costs by a
9 lower margin of about 17 percent. Payments for
10 beneficiaries who died in the hospitals were nearly two and
11 a half times the costs. The two inpatient transfer policies
12 result in profitable stays, but to a lesser degree.

13 Another important point is that while almost every
14 DRG includes some one-day stays, one-day stays do tend to
15 concentrate into certain DRGs.

16 So payments for these one-day inpatient stays were
17 higher in 2012 than the payments for clinically similar
18 outpatient observation stays. This payment differential
19 reinforces the financial incentive to admit.

20 For example, on the slide above, you can see that
21 for chest pain cases, the average aggregate payment for a
22 one-day inpatient stay was approximately \$3,700 and the

1 comparable payment for a chest pain case served in
2 observation was about \$1,600 or \$1,700. Therefore, the
3 observation payment was about 45 percent of the inpatient
4 payment, and this comparison includes, just so you are
5 aware, all the add-on payments such as IME and DSH on the
6 inpatient side and beneficiary cost sharing for both the
7 inpatient and the outpatient side. So that is a total
8 payment number. That is what the hospital is receiving.

9 Also, the last DRG on the slide is for cardiac
10 stent cases, and the reason I point this out is that it is
11 the only surgical DRG on the list before you. And as you
12 can see, the difference between inpatient and outpatient
13 payments is smaller.

14 Now to the RAC program. It appears that
15 Medicare's RACs are targeting short inpatient stays due to
16 financial incentives that I have described and the open-
17 ended nature of admission criteria. Congress has tasked
18 RACs with identifying and correcting overpayments and
19 underpayments made to providers on behalf of the Medicare
20 program. RACs are permitted to review claims dating back
21 three years, and they are reimbursed on a contingency fee
22 basis. We have come to believe that RACs are focused on

1 one-day stays. In 2012, 87 percent of all RAC payment
2 denial dollars were attributable to hospital inpatient
3 claims. With regard to inpatient denials, CMS stated in a
4 recent report to Congress that RACs focus on short inpatient
5 stays and that the majority of RAC-related appeals involve
6 short inpatient stays denied on the basis of medical
7 necessity. In addition, we know from AHA's RACTRAC survey
8 that one-day inpatient stays account for 71 percent of the
9 dollars associated with medical necessity denials.

10 While this program does have its supporters, it
11 has received criticism. First, hospitals have appealed a
12 large share of RAC denials. The appeals process has been
13 slow, which had tied up hospital revenues. In addition, we
14 have seen large growth in the appeals backlog in 2013 in
15 particular. Hospitals cite significant administrative
16 burden in dealing with the RAC program. And, finally, the
17 ability of RACs to review claims that are three years old is
18 inconsistent with Medicare's rebilling policy, which allows
19 hospital to rebill for denied claims back just one year.

20 In response to scrutiny of short inpatient stays,
21 hospitals have increased their use of observation. On the
22 slide above, you can see that over the course of six years

1 outpatient observation utilization increased from 28 stays
2 per 1,000 beneficiaries to 53 stays per 1,000 beneficiaries.
3 This is an increase of about 88 percent. The red line above
4 displays observation stays that preceded an inpatient stay,
5 so that is a little bit different type of stay, but this
6 also increased rapidly. And together these two lines
7 demonstrate that observation use in general has increased.

8 I also want to note that in the last six years we
9 have observed a large increase in the length of outpatient
10 observation stays. Specifically, the number of stays that
11 are 48 hours or longer has increased by over 200 percent.

12 Observation stays are somewhat concentrated by
13 diagnosis. Chest pain is by far the most common diagnosis,
14 accounting for 23 percent of all observation stays, and
15 chest pain is also the most common diagnosis of one-day
16 inpatient stays. In fact, many of the DRGs that are common
17 to observation stays are also common to one-day inpatient
18 stays.

19 The other note here is that we observe
20 considerable overlap between diagnoses that are common to
21 one-day inpatient stays and diagnoses that are common to RAC
22 denials. And this diagnosis overlap issue is relevant as we

1 consider short-stay payment policies, but Kim will get into
2 this in a little bit.

3 Beneficiary advocates have concerns that the
4 migration to outpatient observation has negatively impacted
5 beneficiary financial liability. We believe beneficiary
6 liability is less when they are served in observation,
7 except for a small group of beneficiaries. And the key
8 facts are as follows:

9 The median beneficiary liability for an
10 observation stay in 2012 was about \$900 lower than a one-day
11 inpatient stay. In addition, less than 4 percent of
12 observation stays had liabilities that exceeded the
13 inpatient deductible of approximately \$1,100.

14 Also, it is likely that the majority of
15 beneficiaries have supplemental insurance, which may shield
16 them from inpatient or outpatient liability in full or in
17 part.

18 There are two issues which may increase the
19 liability associated with observation stays. First,
20 beneficiaries served in observation may be at greater risk
21 of not qualifying for SNF coverage because the time they
22 spend in observation does not count towards the three-day

1 SNF threshold. If these beneficiaries were discharged to a
2 SNF, they may face very high financial liability. We
3 estimate that in 2012 there were about 13,000 of these
4 stays, which in the broader context is relatively small.
5 Second, Medicare Part B does not cover self-administered
6 drugs. Beneficiaries served in observation are liable for
7 some or all of these costs.

8 Now, the sum of these issues brings us to the two-
9 midnight rule. CMS established the two-midnight rule in an
10 effort to address many of the problems that I've described
11 except for the payment differential between inpatient and
12 outpatient stays. The rule itself instructs auditors to
13 deem inpatient stays crossing two or more midnights as
14 appropriate for the inpatient setting and to exclude them
15 from the audit process. It also instructed them to presume
16 that stays of less than two midnights are more appropriate
17 for the outpatient setting, with a few specific exemptions.

18 Stakeholders have expressed several concerns about
19 this rule, such as that the rule changes the historical
20 admissions criteria from 24 hours to two midnights, and that
21 it supersedes physicians' medical judgment. Others believe
22 the two-midnight rule's time standard is uneven. There is

1 concern that the new rule added new requirements related to
2 physician documentation that go beyond what was previously
3 required. There is concern that the rule may create
4 financial incentives for hospitals to lengthen their
5 inpatient stays or their observation stays in order to cross
6 the two-midnight threshold. And there is also concern that
7 the new rule will have a mixed effect on the volume of
8 observation stays. What I mean by that is it's a good thing
9 that the rule will end the 48-plus-hours long stays on the
10 observation side, but on the other hand, the rule may
11 encourage hospitals to start more patients in observation,
12 which could, therefore, affect SNF eligibility.

13 Hospitals have also stated that they are concerned
14 that all their one-day inpatient stays will be deemed
15 inappropriate for inpatient care under this rule. And,
16 finally, there is concern that the rule will not alter the
17 RAC's focus on the one-day inpatient stays.

18 Kim will now walk you through the various short
19 stay payment policy alternatives.

20 MS. NEUMAN: The issues related to short inpatient
21 stays that Zach just described stem from concern about the
22 appropriateness of inpatient admissions for conditions that

1 may often be successfully treated in the outpatient
2 department.

3 Since payment differences between similar
4 inpatient and outpatient stays are a key driver of these
5 concerns, addressing this solely through administrative
6 actions like the two-midnight rule and RAC audits may not be
7 optimal.

8 Given this, we could explore whether payment
9 policy changes might have potential to help address the
10 situation.

11 Specifically today we'll talk about approaches
12 that could be explored to reduce payments for short
13 inpatient stays in a budget-neutral manner.

14 Reducing payments for short inpatient stays would
15 reduce the payment difference between similar inpatient and
16 outpatient stays and could lessen the need to audit one-day
17 inpatient stays.

18 While today we are approaching this issue through
19 the lens of payment policy options, an alternative approach
20 could be to explore whether improvements could be made to
21 the administrative rules and auditing activities for short
22 inpatient stays. And if there's interest, we could come

1 back and talk with you about that in the future.

2 To develop a short stay payment policy, decisions
3 would need to be made about many issues. A few of the key
4 decisions include:

5 How would a short stay payment policy be designed?
6 Which DRGs would it apply to? How would the payment rates
7 structured? What type of auditing would be needed with a
8 short stay policy? And would any changes be made to related
9 policies?

10 So next I'll walk through these issues and a few
11 of the options.

12 For the first question, which DRGs would a short
13 stay policy apply to, one option is that it could apply to
14 just a subset of DRGs -- for example, DRGs for conditions
15 that can often be successfully treated in the outpatient
16 department.

17 An advantage of focusing on a subset of DRGs is
18 that we would not disturb the averaging principle that
19 underlies the DRG system for those DRGs where inpatient and
20 outpatient substitution is not an issue. Also, there might
21 be potential to tailor the structure of a short stay payment
22 policy toward the DRGs where it is most needed.

1 Alternatively, a short stay policy could apply to
2 all DRGs. Short stays are profitable across the DRGs. An
3 all-DRG approach would bring payments closer to costs no
4 matter what the reason for the short stay. This could have
5 administrative advantages in that a decision wouldn't have
6 to be made each year about which DRGs the policy should
7 apply to.

8 The second design question is how would a short
9 stay payment policy be structured. One option could be a
10 policy that reduce payments for one-day inpatient stays.
11 This could be done by creating DRGs specifically for one-day
12 stays. A way to think about this is that you're carving the
13 one-day stays out the existing DRGs and you're putting them
14 into their own DRGs. And these charts depict what would
15 happen.

16 On the left, we have the current payment system,
17 which has a payment cliff between an outpatient observation
18 stay and an inpatient stay.

19 On the right, we see what happens with a one-day
20 stay DRG policy. The observation payment rate is unchanged.
21 The payment rate for an inpatient one-day stay goes down.
22 And the payment rate for inpatient stays of two days or more

1 goes up. So the payment cliff between an outpatient
2 observation stay and a one-day inpatient stay goes down.
3 But a new payment cliff is created between one-day and two-
4 day inpatient stays. And under this structure, two-day
5 stays on average will be the most profitable, potentially
6 creating a financial incentive to keep patients for a second
7 day.

8 Another option would be a graduated reduction for
9 inpatient stays that are shorter than average by some
10 threshold.

11 An example of this type of approach is the post-
12 acute care transfer policy. Under that policy, stays that
13 are shorter than average by more than one day and that are
14 transferred to certain post-acute care settings receive a
15 reduced payment based on a modified per diem approach.
16 While that specific formula might not work for our purposes
17 here, the general approach of a graduated payment reduction
18 for stays that are shorter than average could be considered.

19 Note that for DRGs with an extremely short average
20 length of stay of less than two days, the one-day stay DRG
21 approach and the graduated approach would give the same
22 result.

1 So this chart shows the current policy compared to
2 a graduated policy for a hypothetical DRG with an average
3 length of stay of two and a half days. The graduated policy
4 reduces the payment for one-day stays but creates two cliffs
5 within the inpatient payment system in this example between
6 a one-day and two-day stay and between a two-day stay and
7 stays of three or more days.

8 Here on this next slide you see the one-day stay
9 DRG and graduated policies next to each other. Both reduce
10 the payment difference between an outpatient observation
11 stay and a one-day inpatient stay, but they also create
12 additional payment cliffs.

13 The one-day stay DRG approach has a relatively
14 larger payment cliff between a one-day stay and a two-day
15 inpatient stay. In contrast, the graduated approach has a
16 smaller payment cliff between a one-day stay and a two-day
17 stay, but has an additional payment cliff for longer stays.

18 As this suggests, there is unlikely to be a
19 perfect payment structure. Any option will involve
20 tradeoffs, and the question will be to what degree do the
21 various options result in an overall improvement in the
22 financial incentives.

1 As we evaluate the financial incentives, we would
2 need to consider not just the number and size of payment
3 cliffs, but what happens to profitability depending upon the
4 decision to admit and the patient's length of stay, as well
5 as how responsive we would expect providers to be to any
6 profitability differences.

7 So far, we've discussed two payment approaches.
8 There are two other ideas in the environment that some have
9 advocated for that I want to mention.

10 One is taking a site-neutral approach. This could
11 mean the setting the payment rate for short inpatient stays
12 based on the outpatient payment rate for similar care. Or,
13 alternatively, it might mean setting the same payment rate
14 for short inpatient and outpatient stays based on combined
15 inpatient and outpatient payment or cost data.

16 Another idea is a low-cost outlier approach, where
17 the amount of profit a hospital could make on an individual
18 case would be capped at some threshold, and we could discuss
19 these ideas more on question.

20 So, another important issue is what type of
21 auditing would be needed with a short stay payment policy.
22 A short stay payment policy reduces the incentives for one-

1 day inpatient stays but increases the incentives for longer
2 stays. The two midnight rule, which focuses on auditing
3 one-day stays and generally exempts stays of at least two
4 days from auditing, is not consistent with the incentives of
5 a short stay policy. If a short stay payment policy were
6 adopted, it would be important to make the rule of the
7 auditors consistent with the incentives of the policy.

8 So, for example, under a one-day stay DRG
9 approach, two-day inpatient stays would, on average, be the
10 most profitable, so there would be a need for some auditing
11 to counterbalance the financial incentives to lengthen stays
12 from one to two days. This auditing could potentially be
13 limited in its scope, focusing on a subset of providers with
14 the most two-day inpatient stays, taking into account the
15 providers' overall inpatient and outpatient utilization.

16 With a graduated payment reduction, there would be
17 less incentive for two-day stays, potentially less --
18 meaning less need for auditing. But, there could also be
19 financial incentives for stays longer than two days. With
20 this approach, limited types of auditing may be warranted,
21 focus on providers with unusual length of stay patterns that
22 weren't consistent with their peers.

1 So, another question is whether any changes should
2 be considered to related policies. For example, the
3 Commission could consider whether observation time should be
4 included in the SNF three-day threshold. If there was
5 interest in pursuing such a policy, one issue that would
6 arise is how the cost associated with this potential policy
7 change might be financed. Because this policy change would
8 be expected to increase SNF use and Medicare payments to SNF
9 providers, it may make sense to consider policies in the SNF
10 sector that would offset these additional costs.

11 A second issue that could be considered is the
12 Medicare rebilling policy. As Zach mentioned, the RACs can
13 audit claims back as far as three years, but hospitals that
14 have claims denied for inpatient status can only rebill
15 those claims to receive payment for outpatient services
16 within one year of the date of service. A question that
17 could be considered is whether the rebilling timeline should
18 be consistent with the RAC review timeline.

19 So, to wrap up, as potential next steps, we have
20 work underway to build the capacity to empirically model
21 payment options in this area. In your discussion today, it
22 would be helpful to hear what policy ideas or directions you

1 think make sense to guide any further policy development or
2 modeling work we might do. We would also be glad to answer
3 any questions you have about the analysis.

4 MR. HACKBARTH: Okay. Thank you.

5 So, we'll do a round of clarifying questions
6 first, and let me ask one myself. Would you put up Slide 9,
7 please, and just give me -- I guess this is for you Zach --
8 give me an example of the last bullet.

9 MR. GAUMER: Kim is our expert here on Part D
10 drugs, so --

11 MR. HACKBARTH: Okay. Kim.

12 MS. NEUMAN: So, self-administered drugs are drugs
13 that are typically oral drugs that would be covered under
14 Part D. So, imagine someone who has a chronic heart
15 condition and they take a daily oral pill. If they're in
16 the hospital under hospital observation and they need that
17 pill and the hospital gives it to them, it is not covered
18 under Part B, and so in that situation, the hospital would
19 bill the beneficiary for that at the full charges. And,
20 then if the beneficiary had Part D, there's a possibility
21 Part D might pay for some of it, but the beneficiary could
22 wind up liable for all of that cost.

1 MR. HACKBARTH: So, I need to better understand
2 hospital policies here. Let's just say that the patient
3 brings his or her pills with them. It's general hospital
4 policy that you can't take your drugs that you bring in.
5 They have to administer the drugs. Is that the way it
6 works?

7 DR. COOMBS: We actually permit, and a doctor's
8 order will allow patients to take drugs from home.

9 MS. NEUMAN: And when --

10 DR. REDBERG: A lot of hospitals don't --

11 DR. MILLER: [Off microphone.] Yeah. I think --

12 MR. HACKBARTH: Okay.

13 MR. KUHN: Glenn, it's just a -- it's a liability
14 issue.

15 MR. HACKBARTH: Yes. Yes. Okay. So, that's the
16 clarification I needed.

17 Other clarifying questions. Cori.

18 MS. UCCELLO: So, I have a couple questions.
19 First, on Table 2 in the mailing materials shows the average
20 payment to cost ratio by different groups, and it shows that
21 the ratio is really quite high, especially high for the
22 discharged deceased group, and I don't know if you had any

1 insights into what's going on there.

2 MS. NEUMAN: So, the patients who have been
3 discharged deceased, they fall into DRGs that have very high
4 payment rates. A quarter of those patients have septicemia,
5 and the other high-frequency DRGs are things that are life-
6 threatening, complicated, high comorbidity DRGs. And, so,
7 because the payment rates are high for those DRGs, the one-
8 day stay patients tend to be profitable.

9 MS. UCCELLO: Thank you.

10 And, when you do these average payment to cost
11 ratios, the costs here include the fixed costs, so they're
12 not just the [inaudible] costs.

13 And, I think this is still round one, but I'm
14 happy to wait until round two. Some more background on the
15 SNF three-day rule, how that came to be, if there was a
16 rationale behind it.

17 MR. GAUMER: Yeah. So, the SNF three-day rule was
18 a part of the original Medicare law in 1965, and when it was
19 first set up, the best that we can understand, the rationale
20 behind it was that the Congress wanted to set up some
21 extended care for beneficiaries, but they did not want the
22 program to become a long-term care benefit. So, this little

1 policy was somewhat of a compromise to limit utilization of
2 post-acute care but also to, you know, enable folks to get
3 into the care they need, if they do, in fact, need it.

4 Just as an aside, I'll say that at the time, the
5 best that we know, observation care was not a big thing, and
6 one of the reasons I say is because we also know that in
7 1966, the average length of stay was something on the order
8 of 13 or 14 days. So, it was a completely different
9 situation.

10 MR. HACKBARTH: So, it's important to emphasize,
11 the three-day rule is in statute. It's not a regulation
12 that CMS can change on its own, although they have, under
13 certain demos and other programs, waived it to allow
14 organizations to not require three days, right?

15 MR. GAUMER: That's correct. And, just to give
16 three examples here, so under MA, MA plans can waive the
17 three-day rule. Ninety-five percent of MA plans do this.
18 And then, currently, there are two demonstrations that allow
19 participants, meaning either physician groups or hospitals,
20 to waive the three-day rule. And some -- I don't know
21 exactly how many of the participants do it, but the two
22 demonstrations are the ACO demo and also the bundled care

1 demonstration. One of the models under the bundled care
2 demonstration allows this.

3 MR. HACKBARTH: And, in the ACO, it's the Pioneer
4 model, where they bear downside risk.

5 MR. GAUMER: Exactly. And, actually, in both of
6 these demonstrations, there has to be some bearing of risk
7 in order to get this ability to waive the three-day
8 threshold.

9 MR. HACKBARTH: And, we have talked -- and, in
10 fact, I think it's actually included in our ACO letter --
11 that if another portion of the ACO program, the MSSP
12 program, moves towards two-sided risk, that the Secretary
13 should consider waiving certain rules, and I think we listed
14 this as an example, didn't we?

15 DR. MILLER: We did.

16 MR. HACKBARTH: Yeah.

17 DR. MILLER: And, the thing to keep in mind is
18 there is some evidence that if you were just to suspend the
19 rule entirely, that in the fee-for-service environment, that
20 there are assumptions that estimators will make that it
21 would increase spending.

22 MS. UCCELLO: Thank you. That was really helpful.

1 MR. HACKBARTH: Okay. I have Mary, Bill Hall,
2 Warner, Bill Gradison, Kathy. Clarifying questions still.

3 DR. NAYLOR: [Off microphone.] This is a very
4 important report. [Inaudible.]

5 Okay. That's what I've done. I'll sing it in
6 French now.

7 [Laughter.]

8 DR. NAYLOR: This is a very important report, and
9 I wondered if, as you looked at the top 15 diagnoses,
10 whether or not you had characteristics of the beneficiaries
11 that -- are there a common set of characteristics of the
12 beneficiaries that are most likely? So, I look at some of
13 these problems here, such as kidney, urinary tract
14 infections, septicemia, and they are more likely to come
15 from certain kinds of settings, and so how that factors into
16 the whole analysis. I know you're looking at, should we do
17 it across all DRG subsets? Now, it would be subsets of
18 subsets, and I know you don't want to do that, but I was
19 just wondering if we have a very good picture of the people
20 that are taking advantage.

21 The second piece that didn't come into this
22 conversation at all was a hospital readmission reduction

1 penalty, and, you know, you had around at least some of the
2 timing that your data is being presented where the
3 motivations were to move into observation days in order to
4 get to that first inpatient readmission and whether or not
5 the confluence of those factors affected what we're seeing
6 here.

7 MR. GAUMER: I'll answer the first one and maybe
8 Craig would do the second. In terms of beneficiary
9 characteristics, generally, folks that are in observation, I
10 think maybe the most telling example I've gotten from a
11 couple of medical directors at Max over the years, and also
12 some private plan medical directors, has been that the folks
13 -- a lot of the folks that are ending up in observation are
14 very frail and very elderly, and that bears out in some of
15 the other research that we've seen, and some of our own
16 research, and like you're talking about, some of the
17 conditions that they have speak to that. But, this is a
18 gray area of clinical practice and sometimes it's very hard
19 for people to tell -- for the clinical staff to know what to
20 do with these folks.

21 MR. LISK: Yeah. On the readmissions, it's always
22 -- it's actually always been a -- it has been a concern

1 about what is going to happen with the readmission penalty
2 and potential incentive actually to admit people -- I mean,
3 to put people in observation instead to avoid either
4 counting cases of initial admission or counting a case as a
5 readmission. Initial analyses that have been done hasn't
6 shown this to be much of a problem initially, but there's
7 been just limited research on that so far. But, the initial
8 analyses show it to be actually just a small factor, but
9 that's something we'll have to look into some more.

10 DR. MILLER: Also -- I might have misunderstood
11 the question, but also, the ramp-up in observation preceded
12 the penalty, right?

13 MR. LISK: That's correct, too.

14 DR. MILLER: Right. That would be --

15 MR. LISK: So, yes, the increase. So, it just is
16 observation is an issue with regard to the readmission --
17 can be an issue with regard to the readmission policy.

18 DR. HALL: So, I've had a chance to read a lot of
19 stuff in the medical literature about short stay. I would
20 say this is the best thing I've ever read. This is really,
21 really, really good. If the fine print didn't say, "Don't
22 share this document" --

1 [Laughter.]

2 DR. HALL: -- I'd be putting my name on it as the
3 author --

4 [Laughter.]

5 DR. HALL: -- and submitting it to Rita.

6 [Laughter.]

7 MR. HACKBARTH: Bill, as your lawyer, you'd have a
8 different problem.

9 [Laughter.]

10 DR. HALL: So, I wanted to understand the
11 mechanism for the RAC program for the review. In the white
12 material you presented to us, these are contractees who are
13 instructed to review records, but they're only paid if they
14 find something wrong, is that right? If they issue a
15 denial?

16 MR. LISK: Yes.

17 DR. HALL: And, there's no penalty for, how shall
18 we say this, over-diagnosis on their part. Is that a
19 routine Medicare approach to review an audit, or is this
20 kind of an exception?

21 MR. GAUMER: They are paid a contingency fee. It
22 ranges from about nine to 12.5 percent. There, to the best

1 of my knowledge, is not a penalty currently. I think that's
2 been talked about as potential policy in the future in the
3 circles that are making these types of regulations. And --
4 what am I missing here --

5 DR. MILLER: It was a shift in Medicare posture a
6 while back, and I think there was some sense of, you know,
7 the usual issues of can you create a motivation and how do
8 you finance it. So, I think the RAC was something of a
9 different approach when it was put in place a few years
10 back.

11 DR. HALL: Thank you.

12 MR. GRADISON: Two quick questions. I hope
13 they're quick. Do you have any estimates of the budgetary
14 impact overall in terms of increased cost to the Medicare
15 program from this issue? I appreciate it may vary from year
16 to year, but what's this cost overall?

17 MR. GAUMER: Do you mean the RAC piece or the --

18 MR. GRADISON: No, the -- a shift of patients into
19 a more profitable setting.

20 MR. GAUMER: I think the answer is that we don't
21 have a specific number to quote. I'm going to look to my
22 left and just verify that I think we -- when we considered

1 this a couple of years ago, where we came out was because
2 the outpatient payments are lower than the inpatient
3 payments, if we're getting a flood of people going from
4 inpatient to outpatient, the budgetary impact would mean
5 that there's savings as a result of this trend.

6 MR. GRADISON: Okay.

7 DR. MILLER: But, what's difficult is what do you
8 assume in the baseline --

9 MR. GAUMER: Yes.

10 DR. MILLER: -- would have happened just between
11 the outpatient and inpatient setting just because of, say,
12 technology. So, when you look at some of the high-frequency
13 conditions here, you do get a lot of the types of patients
14 that you and Mary were talking about, but you also have drug
15 eluting stents and that type of thing. So, there's some
16 shift that would happen in a secular way, and disentangling
17 that, I think, is what made us a bit -- felt it started like
18 we were getting into the deep end of the pool.

19 MR. GRADISON: Okay. That's helpful. And, the
20 other thing is my understanding from the presentation is
21 that there's significant variation among hospitals in the
22 frequency of these shifts into very profitable short

1 hospital stays, which kind of leads me to wonder how good
2 the data is. Very specific, when you consider your
3 alternatives, is there sufficient data that it might be
4 possible to craft a hospital-specific way of doing this, for
5 example, by setting some kind of a standard of what is a
6 reasonable proportion of short hospital stays, and for
7 hospitals to exceed it, to cut their DRGs across the board,
8 not just depending on the number of days, but just across
9 the board in order just to pull back, or claw back, what
10 appears to be an excess profit, but on an institution-
11 specific basis. So, my real question is, is there
12 sufficient data even to consider that rather than a uniform
13 policy that applies to everybody?

14 MR. HACKBARTH: You could target the audits
15 differently and have the audits focus exclusively on
16 institutions that have aberrant patterns in this area, which
17 may be easier than trying to modify the whole payment
18 system.

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

20 MR. HACKBARTH: Warner.

21 MR. THOMAS: A couple clarifying questions. On
22 Slide 8, you mentioned 15 of the most common observation

1 diagnoses account for 44 percent of stays. Have you looked
2 at what amount of DRGs do you have to get to to get to 80 or
3 90 percent of observation diagnoses?

4 MR. GAUMER: Yeah. I think if we looked at, I
5 think it was 100 DRGs captured about 70 percent of the
6 universe, is that correct?

7 MS. NEUMAN: A hundred DRGs account for over
8 three-quarters of the one-day inpatient stays. I don't know
9 if we have here for you that same number on the outpatient
10 side, but it's something we could go back and look at.

11 MR. THOMAS: And then it may be something to just
12 understand, because it's -- and, I guess, the other question
13 I would have is, how is this trending? I mean, my gut on
14 this is that you will continue to see continued shorter
15 lengths of stay, which means we'll probably see more folks
16 coming down into the one-day length of stay or observation.
17 So, I'm just curious of how that's trended over the past
18 several years. Has there been growth there? I know there's
19 been differences in -- or, growth in observation as people
20 have kind of moved from one day and tried to use the
21 observation status more, but I'm not sure if you've seen a
22 continued growth in one-day and observations in aggregate as

1 you've seen a continued shift in the shortening of length of
2 stay.

3 MR. GAUMER: So, we have seen some consistency on
4 the observation side in terms of consistent growth. The
5 same DRGs in each year seem to be the ones on the top 15
6 list. And, also, in terms of their length of stay, we've
7 seen longer and longer observation stays occurring. There
8 is the expectation that the two midnight rule itself is
9 going to start tamping down on the longest observation
10 stays, and I think that will probably bear out. But, there
11 is some similarity with the nature of observation from 2009
12 to 2012 in terms of their length, generally, their
13 diagnosis, so --

14 MR. THOMAS: Okay.

15 MR. GAUMER: -- it's the same types of cases.

16 MR. THOMAS: Okay. And then on Slide 6, on the
17 information on the RAC audits, you mentioned that the three-
18 year claim review window is out of sync with the one-year
19 window in which hospitals can rebill claims. Do you have
20 any idea on the claims that are looked at by RACs, or the
21 denials, I mean, how many kind of sit outside that one-year
22 window? Is it significant, or is there -- I have no idea.

1 MS. NEUMAN: I have seen one industry report,
2 which suggests that it is the majority, but we don't have
3 CMS data to be able to back that up.

4 MR. THOMAS: And that just may be helpful to
5 understand what that looks like to see how many of the
6 denials sit outside that one year, one-year window. I mean,
7 that may kind of give us more information to understand
8 whether there should be a correlation between those two time
9 periods.

10 Thank you.

11 MS. BUTO: Just a few qualifying questions or
12 clarifying questions. One was the Slide 5 where you have a
13 table showing average inpatient payment, and you mentioned
14 that it includes IME and DME. And I wondered if you had the
15 numbers taking IME and DME out, because I think then you
16 have a more comparable number between the two costs for
17 outpatient and inpatient, or is it too hard to do? Maybe
18 you can't disentangle it.

19 MS. NEUMAN: So we don't have it right now, but I
20 can tell you that in the aggregate in 2012, across all DRGs,
21 that IME and DSH increased the base rate by about 20
22 percent.

1 MS. BUTO: Okay.

2 MS. NEUMAN: Now, the world has changed a little
3 bit since 2012 --

4 MS. BUTO: Right.

5 MS. NEUMAN: -- because DHS is three-quarters
6 smaller. So that number would go down quite a bit today.

7 MS. BUTO: Right, right. Okay. That's helpful.

8 The other thing I wanted to know is whether since
9 this has been a trend -- well, I guess there are two things
10 going on. One is there has been a trend over time in one-
11 day stays increasing until the RACs came along, and now they
12 are decreasing, correct? And I guess when they were
13 decreasing over time, my question was whether the annual
14 recalibration picked up the change, because the whole notion
15 behind the DRG system was that even though there is a two-
16 year lag, the idea was that these costs differences were
17 supposed to catch up. And I'm wondering whether over time,
18 since it's been a trend, we've seen those DRGs go down as a
19 result of the one-day stays. Do you know?

20 MR. LISK: Yes. I mean, it would but with a
21 slight lag effect --

22 MS. BUTO: Right, right.

1 MR. LISK: -- because of the data, but, no, the
2 DRGs are recalibrated annually, and they reflect what the
3 next cases are within the set of DRGs and the short-stay
4 cases.

5 MS. BUTO: Right. I am just trying to get a sense
6 of what problem we're solving, in a way, and it sounds like
7 at least it has to do with the lag in data and maybe an
8 increasing trend, although now it's decreasing. So I'm not
9 sure --

10 MR. LISK: But you have to remember length of stay
11 has been going down, are always still short in lengths of
12 stay --

13 MS. BUTO: Right.

14 MR. LISK: -- and it's kind of like the natural
15 part of the whole system in terms of they decide to admit
16 the patient. You know, those decisions are made. So what's
17 changed is kind of the decision to admit patients. There's
18 been more of a decision to not admit and put them in
19 observation, is kind of what's gone on, rather than saying
20 just trying to gain the system to get at one-day stays, I
21 think.

22 MS. BUTO: Right. Okay. And then my last

1 clarifying question has to do with the readmission penalty,
2 slightly different angle, and that is, is there any
3 relationship between the penalty where it has been applied
4 to hospitals and these one-day stays? In other words, you
5 would think if the one-day stays were inappropriate -- in
6 other words, they were too short -- as opposed to they
7 really should have been observation days, that you'd start
8 seeing those data show up in the readmission penalties, that
9 these same DRGs would pop up as areas of vulnerability,
10 right, to the readmission penalty. And if the answer is we
11 don't see that, then it does seem to suggest more of the
12 issue is between the outpatient and the inpatient than it is
13 that the inpatient admission itself resulted in too hasty a
14 discharge. Do you know?

15 DR. MILLER: At least one part of that question is
16 the readmission penalty applies to a selected set of
17 conditions, and off the top of my head, I don't know whether
18 it's these.

19 MS. BUTO: I don't think these are on there.

20 DR. MILLER: Well, no. Off the top of my head, I
21 don't know.

22 So my first question would be, do any of you have

1 a sense of whether there is overlap, and if not, this one is
2 complicated enough that we might want to take it offline and
3 --

4 MR. LISK: I mean, it is heart failure and AMI are
5 the two cardiac-related DRGs here that are in the
6 readmission penalty.

7 DR. MILLER: So there is --

8 MR. LISK: Pneumonia is not one of the cases
9 that's in these short stays -- it's another one -- in terms
10 of the initial three. DRG. So I'm not sure in terms of our
11 list. I'll have to take a look at that. I don't think they
12 are in the top --

13 DR. MILLER: Let's come back on this.

14 I do want to --

15 DR. REDBERG: Heart failure is like .9 percent,
16 CHF unspecified, and the rest aren't.

17 DR. MILLER: I do want to just sharpen up
18 something. On the 20 percent rule of thumb, you were
19 saying, Kim, DSH goes down, but part of DSH goes back to the
20 hospitals through a different mechanism.

21 MS. NEUMAN: Yes, it does, and the only reason I
22 was pointing that out is that when we think about payment

1 differences between inpatient and outpatient, what creates
2 the difference is if it is a percentage add-on to the claim.
3 And the uncompensated care payments that are getting paid
4 instead of that DHS are flat payments on the claims, and
5 they actually get reconciled at the end of the year to some
6 raw number.

7 DR. MILLER: I see.

8 MS. NEUMAN: So no matter how many claims there
9 are, they are still going to hit the raw number at the end
10 of the year. So that was the reason for that being
11 meaningful.

12 DR. MILLER: Got it.

13 MR. HACKBARTH: Other clarifying questions?
14 Warner.

15 MR. THOMAS: Just to actually build on Kathy's
16 question, do we have any idea of within that 1-year window
17 of the RACs, if something is denied at an inpatient stay, if
18 there was a case denied as an inpatient stay, whether it
19 also would not meet any sort of observation status, so it
20 actually is somebody that should not have been admitted at
21 all? Do we have any idea or information on that? Because I
22 am trying to go on back to Kathy's point and get a handle of

1 is this an issue where people are trying to put folks in the
2 hospital that don't need to be there or is it really an
3 issue of categorization between observation and inpatient.

4 MR. GAUMER: So with the rebilling policy, it is
5 more an issue of which setting they are served in, not
6 whether or not they are treated in the hospital at all, and
7 the way this works is if you have a claim denied, an
8 inpatient claim denied, and you rebill it, you can recover
9 the ancillary part of the care, the outpatient care that was
10 actually provided. So if that inpatient claim had a bunch
11 of ancillary outpatient stuff on it and observation on it
12 that preceded the inpatient and it all got bundled together,
13 you can rebill for all of the outpatient stuff that actually
14 existed. However, if you have a separate claim where the
15 claim went from ER to inpatient and you try to rebill for
16 that, you can rebill for the ER, but you cannot replace the
17 inpatient care with observation care. That is not allowed,
18 and it is a contentious point in the hospital industry.

19 MR. HACKBARTH: So I want to just -- let me try to
20 get this out, Alice, or I'm going to lose it, so I
21 apologize.

22 I want to try and build on Kathy and Bill

1 Gradison's comments. Kathy, aided by Craig, pointed out
2 that there is a mechanism in the basic DRG system for
3 adjusting, at least with a lag, movement towards shorter
4 stays. So in the broad averaging mechanism that we used for
5 inpatient policy, if there is a big move toward short stays
6 over time, the weights for that DRG will come down, and the
7 hospitals will receive less payment.

8 Bill Gradison, I think, was trying to get a grip
9 on the scale of this particular problem, but also how
10 widespread it is. Is this a system-wide problem, or is it a
11 problem of certain institutions, aggressively, exploiting
12 these payment differentials?

13 If it is just a targeted problem, then maybe the
14 mechanism is very different than if it's a generalized
15 problem.

16 So I'll stop there and let you try to get me out
17 of this.

18 DR. NERENZ: Glenn, just so we can follow, could
19 you clarify why you used the word "problem" to describe what
20 you juts said? If stays are becoming shorter, is that a
21 problem? What exactly --

22 MR. HACKBARTH: No, no. Thanks, Dave.

1 I didn't mean to imply that general shortening of
2 stays was a problem. I'm saying if there is an issue where
3 patients are being moved and characterized as inpatient, not
4 for any good clinical reason, but simply to exploit the
5 higher level of payment, that is the whole premise of having
6 the RACs audited, that there are people out there doing bac
7 things that shouldn't be done. And I'm trying to get a
8 sense of whether that is a generalized issue or a problem
9 with a few institutions.

10 DR. MILLER: And if I could just -- so if could
11 answer this question, and we may have to come back on it,
12 what we might be able to bring on it is what does the
13 distribution look like for one-day stays, because we won't
14 know the clinical.

15 MR. HACKBARTH: Right.

16 DR. MILLER: That is obviously going to be very
17 hard for us to judge, but do we have any sense of whether
18 there -- when you look at the distribution of the data,
19 there is a lot of clustering of one-day stays in this set of
20 DRGs or more broadly in some hospitals versus others.

21 My sense in our hallway conversations is that this
22 is much more of a broad phenomenon.

1 MR. GAUMER: Yes. I think that's right.

2 We have more work to do on this subject, and we
3 can come back to you on that, but when we looked at the 2009
4 data a few years ago and just tried to look to see if this
5 was a state-specific thing, to see if it was related to the
6 RAC demonstrations, or if this was a hospital system thing,
7 there was wide variation. It was hospital-specific. Some
8 hospitals were using a lot of observation, some were not,
9 and I imagine that it's changed a little bit in the last
10 three years. But it was a broad problem with some
11 variation.

12 MR. LISK: I think the other thing is the RACs
13 were not actually for us targeting one-day stays. That
14 didn't start until 2011, so if you think that that, too, in
15 terms of the RACs.

16 MR. HACKBARTH: Alice?

17 DR. COOMBS: I'll wait for Round 2.

18 MR. HACKBARTH: Other clarifying questions? Rita.

19 DR. REDBERG: I just wanted to comment on what you
20 just said because it seems to me there's not actually often
21 a difference to the patient. You admit to inpatient or
22 admit to observation, but they are going to the same place

1 and getting the same services, so it's just that hospitals
2 or doctors will call it different things for different
3 reasons.

4 MR. HACKBARTH: And I understand that. That is
5 sort of the root of the issue, and the question is whether
6 some hospitals are much more aggressive as characterizing
7 those same patients as inpatient, because it means they get
8 higher payment.

9 DR. REDBERG: And some hospitals actually have
10 observation units, formally, and some just admit,
11 observation.

12 MR. HACKBARTH: I think we are ready to go to
13 Round 2, and we will use the process that we used yesterday.
14 Alice will kick off, and then we will see if people want to
15 build on her comments. Alice.

16 DR. COOMBS: So I just wanted to address page 42
17 of the chart, the Appendix 2, and a couple things came to
18 mind. I was looking at the diagnosis, and as Mary had
19 mentioned, UTIs. But some of the other diagnoses are
20 actually patients that may be coming from SNFs, which is
21 really a huge factor, because if you're coming from a SNF or
22 an IRF and you are being admitted with these diagnoses, what

1 I've found is that they may come to the unit with,
2 quote/unquote, urosepsis. We treat them with antibiotics.
3 They get better in 24 hours, and we are trying to get the
4 patient back to the unit for maintaining that bed, because
5 there are the different situations in which the bed is held
6 for X number of days. So I'm trying to actually get the
7 patient back to a place where they came from because of the
8 bed shortages in the various areas.

9 I think a key information point for me would be
10 what is the distribution of patients coming from SNFs and
11 IRFs and the likes, and I think that makes a difference in
12 terms of how you trigger your action plan of addressing the
13 observation status and the one day.

14 The other issue I have is that also looking at the
15 distribution of diagnosis on this Appendix 2, the number one
16 is chest pain. I'm not surprised, and to what extent chest
17 pain is going to be always a prevailing issue on both
18 observation status as well as the short stays is -- you
19 know, the incorporation of liability, the change in terms of
20 what you need to do to work up a chest pain, that may not
21 change, and historically, chest pain has always been at the
22 top of the list. So I think when we follow with the rest of

1 the diagnosis, I mean, there's some other things that we
2 think about in terms of better chronic care management and
3 issues around that.

4 In terms of the quality of care, we talk about the
5 observation and the one day, and one of the things I have in
6 the back of my head is that, first of all, the criteria for
7 admission, is this quality, could this patient possibly be a
8 non-admission and be taken care of in another -- you know, a
9 different setting.

10 I wonder if -- you know, you don't have pneumonia
11 on here or COPD exacerbation or any of the respiratory
12 illnesses, so I am just kind of interested in why that's not
13 the case. I know that in the wintertime in New England, we
14 see a lot of those diagnoses.

15 And then the gradient between the OBS and the one-
16 day rate for pay, if we could go back to the slide -- I
17 guess it's 15 -- for comparing current policy to graduated
18 policy. If you wanted to improve efficiency or send a
19 message that we applaud you for observation status, will you
20 get the patient in, take care of business, and get the
21 patient back to a state, a former state, it would seem that
22 you might do a smaller delta between the one day and the

1 observation status.

2 For me, clinically, what you are going to do in
3 the next 12 hours really is -- the big one, I think, is when
4 you get to -- past the two-day and the three-day in terms of
5 management of these cases, because you are saying that these
6 diagnoses, many of them, like syncope and collapse, if it is
7 dehydration, you are going to hydrate the person and send
8 them on their way, and hopefully, they will be in a better
9 state.

10 But I don't see that much difference between
11 observation in one day in terms of diagnosis. So I don't
12 think that the cliff, the ramping-up, necessarily has to be
13 symmetrical from bar to bar to bar, and just trying to
14 titrate the graduated policy with what you are trying to do
15 in the big picture, I think you can be more tailored in the
16 approach.

17 MR. HACKBARTH: Although, sort of in that context
18 in which these payment systems work, you need some
19 rationale, some data to support your approach for how
20 quickly to graduate. I suppose our hunch is that this one
21 should be different from that one, and so we would need to
22 develop some analytical foundation for that.

1 Okay. Anybody want to pick up on Alice's
2 comments? Jay.

3 DR. CROSSON: Yes. I think one of the things
4 Alice was saying was that we need that large a step between
5 the one-day and the two-day, for example, and it sort of
6 brings me back to the -- this is a transition statement. It
7 sort of brings me back to the potential solutions that we've
8 got on the list, and I wondered whether or not we could hear
9 a little bit about the site-neutral approach, because on the
10 face of it, this appears to be the sword that cuts the
11 Gordian Knot, but I'm sure it's not.

12 [Laughter.]

13 DR. CROSSON: If we could hear a little bit more
14 about the concept behind the site-neutral approach and then
15 what impact that might have -- of course, you just have the
16 question of how many days you are talking about -- what
17 impact that would have on the DRG curve of payment
18 profitability and whether or not, if you combine that with
19 the ordinary rebasing that Kathy was talking about, you'd
20 have something that would be relatively more simple than
21 some of the things we're talking about.

22 DR. MILLER: And the only thing I will say up

1 front before we start here is we always have to kind of work
2 through things a little bit at a time, and we have done more
3 work on the first two than on this one. I'm sure there's
4 some things that we can say, but we are probably not as deep
5 into that one as we've gotten into some of the other ones.
6 That's the only thing I'll say up front. So we can bring
7 more to this if we need to.

8 Do you want to run, or do you want me to start?

9 MS. NEUMAN: You can go ahead.

10 DR. MILLER: Oh, no. I definitely prefer you
11 start.

12 [Laughter.]

13 MS. NEUMAN: So, with a site-neutral kind of
14 approach, as I said, there's at least two concepts. There's
15 the one sort of school of thought, which is you cap the
16 payments for the higher cost setting at the payment amount
17 for the lower cost setting, and that is kind of what we have
18 done in some other work that the Commission has looked at
19 with site neutrality. And when the Commission did that kind
20 of thing, it was very careful to establish criteria to try
21 to get very like things in the two sectors to be able to
22 sort of apply the lower cost payment rate to the higher cost

1 service. So we'd have to think about whether we could --
2 that inpatient and outpatient would sort of meet that same
3 kind of criteria.

4 A second way to think about this is you're not
5 capping payments, but you're setting them jointly based on
6 combined data, so that the inpatient and outpatient are set
7 at a similar rate. The question becomes what are you going
8 to still compare between inpatient and outpatient, and then
9 let's just say you're like comparing inpatient and
10 outpatient of a certain length, around one day, and you're
11 going to pay them the same based on the same payment.
12 They're going to pay them the same payment amount. So that
13 gets rid of any incentive or any difference in payment that
14 exists between inpatient and outpatient for that length of
15 stay.

16 But then you're going to have a big jump in
17 payment between the inpatient and outpatient one-day stay
18 and an inpatient two-day stay, a bigger jump than we see
19 here, and so, again, there are tradeoffs that you'd have to
20 think through.

21 DR. CROSSON: So just to finish it -- so, exactly,
22 that would be the problem. But if you -- you could

1 theoretically carry it all the way up to three days, and
2 then you would get to a point where the fourth day -- as I
3 read the distribution of profitability, the fourth day is
4 hardly worth it, right? It's like one -- it's one-tenth of
5 the profitability of the second day. So the fourth day,
6 there would be very little motivation to try to go to the
7 fourth day. But by the time you get to the -- including
8 three days, you've kind of upended the whole DRG system,
9 right? It would have to be completely rebased.

10 MS. NEUMAN: And so the profitability that you're
11 seeing in that first chart that you're referring to for four
12 days is the profitability under the existing DRG system. If
13 you reduce the payments for one-day stays, increase the
14 payments for outpatient, and set it at some common rate, the
15 likelihood is that the longer stay payments on inpatient
16 would probably go up if you were doing this all budget
17 neutral. And so that four-day number wouldn't now --
18 wouldn't be the four-day number under the policy probably.

19 MR. HACKBARTH: Based on that, site neutral still
20 leaves you with the cliff problem and probably has to be
21 complemented with some sort of a graduated approach to the
22 patient payment to mitigate the cliffs. And so as opposed

1 to a completely separate option from graduated policy, it's
2 a way of calculating the initial payment.

3 MS. NEUMAN: Could be.

4 MR. HACKBARTH: It's sort of -- did that make
5 sense? Yeah.

6 DR. MILLER: Yeah, and it comes from Alice and
7 your comment, which is, well, if your first objective is to
8 try and neutralize the outpatient to inpatient incentive,
9 it's a different way of thinking about that.

10 MR. HACKBARTH: So let me go down my list. I
11 think Cori was next, and Cori I think was still building off
12 of Alice.

13 MS. UCCELLO: Yeah, and I was actually going to
14 say what Jay said, so what I'll -- I was going to say what
15 Jay said. But I think what also comes out of this is it's
16 difficult to go through the, you know, which DRGs question
17 and then how should the payments be structured in a step-
18 wise way when those questions, it seems like, have to be
19 determined together. You almost have to do the second one
20 first to figure out whether you can do all or whether you
21 need to target DRGs.

22 MR. HACKBARTH: Okay. So who wants to still work

1 on this thread?

2 MS. BUTO: Yeah, I think it's still this thread.
3 It's the graduated policy, and I'm having real difficulty
4 with this because it really feels like we're trying to go
5 back to some kind of cost-based reimbursement for hospitals.
6 And I almost wonder whether -- Bill, what you were trying to
7 get at earlier was really more like a medical loss ratio
8 kind of idea of if the hospital is able to manage under the
9 rules that are set in the DRG system and be very profitable,
10 whether there's some way that that should be plowed back
11 into services or something else, rather than trying to go
12 along and in a way confiscate profits wherever possible, you
13 know, in the DRG system, that does begin to undermine the
14 whole idea of there are going to be long stays, there are
15 going to be very difficult patients. You know, how do you
16 get at, I think, the concept, which is a good one, which is,
17 you know, is there a way to bring more of that benefit back
18 to the beneficiary or the Medicare program?

19 I don't know that going along and ratcheting down
20 payments for one-day stays, two-day stays, three-day stays -
21 - I sort of like the site-neutral idea, but it sounds like
22 it creates a whole series of issues as well.

1 MR. HACKBARTH: The best way to match payment to
2 cost is cost reimbursement, but that has other problems.

3 MS. BUTO: It has lots of problems.

4 [Laughter.]

5 MS. BUTO: Including incentives.

6 MR. HACKBARTH: Right.

7 DR. MILLER: And the only thing I would do is just
8 to go back to Glenn's comment to Bill's point and related to
9 this. You might approach this problem as saying is there
10 any recalibration in the payment system that ought to occur
11 for some general set of reasons, and you could have that
12 conversation or set it to the side, and then ask the
13 question of in that new context -- or in the current context
14 do you have a different auditing approach where you look at
15 aberrant patterns and go after it that way, which is the way
16 I think you took Bill's point.

17 MR. GRADISON: Maybe I could follow this by
18 commenting on Glenn's comment on Bill's comment, which is
19 briefly to request the staff in the next iteration -- maybe
20 we've already done this -- just take a look at whether there
21 are institution-specific approaches that are worth
22 considering. That's all. Thank you.

1 MR. HACKBARTH: I have Rita and Kate, who still
2 want to work in this same area. Are there people who want
3 to sort of go off in a fundamentally different direction?
4 So let me start that list, Herb and Bill and Dave and Craig,
5 okay -- and Jack. Okay. I'm tired. Yeah, right.

6 DR. REDBERG: It seems to me, before, we've
7 advocated the principle of paying the same for the same
8 services, no matter where they were, and that's what I kind
9 of think of when I think about this difference, because it's
10 a very artificial difference from my point of view between
11 observation and inpatient, because it is the same patient
12 getting the same service. You know, and I see a lot of
13 these chest pain patients, and I've gotten these e-mails
14 saying -- you know, I'm in a teaching hospital that I think
15 operates like a lot of teaching hospitals. So the resident
16 writes the admit orders for a chest pain patient. They
17 might write, "Admit inpatient." I see the patient. I think
18 they don't need to be here. We can do this as an
19 outpatient. That's better for them. And so I send them
20 home.

21 But then I get the e-mail -- because I have no
22 idea how the resident admitted that patient. I don't look

1 at those orders. I just see the patient and talk to them.
2 But then evidently the resident admitted them as inpatient,
3 but we sent them home, so we won't get paid for that
4 admission.

5 And then sometimes we have inpatients that, you
6 know, we send home from the emergency room, or they come
7 upstairs and they're observation. They're getting the same
8 -- so what is different about observation status? Because
9 it seems like it's the same care as inpatient status. And
10 why do we have differentials in this payment?

11 MR. HACKBARTH: I wish Jay were here. I think
12 that's what caused him to say, well, let's think about this
13 as just a site-neutral payment, i.e., the patients are the
14 same, receiving the same care, we shouldn't have inpatient
15 versus observation rates. Actually, that was the way I
16 first started to think about it, too. But that doesn't
17 solve all the problems. Then you've got the issues of
18 cliffs that still need to be resolved and the like.

19 DR. REDBERG: The last problem, I think -- and
20 people have referred to it -- is the RAC audits have been
21 incredibly aggressive, I think, and that has caused a lot of
22 bad feelings about -- and obviously it causes a huge backlog

1 and CMS is overwhelmed, I think, with the denying -- you
2 know, the appeals because people are really angry about the
3 RAC audits because they seem to be overly aggressive.

4 DR. BAICKER: I want to contribute to the general
5 discomfort with having separate payment rates for one-day
6 versus two-day versus three-day. We're unwinding the DRG
7 system that seems to have contributed to inpatient spending
8 rising more slowly than other components. So then the
9 question is: How do you deal with completely artificial
10 divide and the bucket of site-neutral payment? I'd rather
11 deal with those problems than deal with the problems of one,
12 two, three plus, or is it four plus, unwinding.

13 The challenge is if we just eliminate such a thing
14 as an observation stay and call it an inpatient stay,
15 suddenly you're paying for those as if they were an average
16 of 3.4 days or whatever the average inpatient stay is, and
17 that would be clearly an overpayment for a broad class of
18 patients. And what I'd love to understand is can we do a
19 DRG-based kind of thing that builds in the observation stay
20 in some way so that the average reimbursement isn't jumping
21 up because of this but we're not trying to draw lines.
22 We're worried about site-neutral payments. Now we're

1 carving up a site, a hospital, and doing different payments
2 for how the bed is labeled. So this seems -- the current
3 system seems at the bad extreme of non-site-neutral
4 payments, so I advocate for moving further in that
5 direction.

6 MR. HACKBARTH: I think we're ready to go in a
7 different direction here. I have Herb, Bill Hall, Dave, and
8 Jack, right? And Jay and Scott.

9 MR. KUHN: Okay. Thanks for this conversation
10 today and for this great paper. So let me talk first a
11 little bit about some of the policy options that you've all
12 put forward and give you kind of my reaction.

13 So one of the ones you put forward is a transfer
14 policy, and I'm not a huge fan of a transfer policy. It
15 does recognize that costs are not linear, that there are
16 some more upfront costs in the first day or two. But I
17 think there's great variation on that from what I have seen
18 in the past, and I just don't think that works well.

19 I do think there might be some merits in how we
20 can maybe go through either reweighting or refinements of
21 the MS-DRG system, because we know within the DRG system we
22 have three levels. We have those with no CC, or no

1 complication and comorbidity. We have those with ACC, and
2 then those with an MCC, or a major complication and
3 comorbidity. Is there any merit to thinking through could
4 we add a fourth category there that looks at short stay as a
5 possibility? Or do we take that bundle of those that are
6 already in place now and then add yet another category on
7 top of that? So instead of having four, you know, those
8 three and then a fourth one, or do you take those three, put
9 them together, and then you add yet another weight out there
10 that deals with short stays as a way to kind of refine, I
11 think, the DRG system?

12 What I keep thinking through here is we don't want
13 to overcomplicate this thing. I'd like to build it within
14 the existing system that's out there, and is there a way
15 with the weighting process, as Kathy mentioned earlier, that
16 you've got the two-year delay on the information, but you're
17 getting the weights sooner and quicker in there, and you
18 find a way to kind of manage that more effectively. I think
19 that might be one way to think about that, and it would be
20 something I would be interested in.

21 The second thing I would just mention is this
22 issue of the linkage to the other policy options you've

1 talked about, and one is the RACs. And I think we need to
2 explore the RACs just a little bit more, and here's my
3 point. You know, it is a different kind of auditing
4 function that we haven't seen, as I think Bill Hall raised
5 in terms of the conversation that's out there. Its error
6 rate is somewhere on the order of 40, 50, or 60 percent. I
7 don't think anybody would accept an error rate like that
8 when they're getting so many appeals overturned. You know,
9 most payment systems, if you have an error rate of 2 or 3
10 percent, everybody throws their arms up and says, "Oh, my
11 gosh." But these guys have huge error rates that are out
12 there.

13 As we all know, there's a settlement agreement on
14 the table from CMS to pay 68 percent of the pending claims
15 that are in appeal process right now. So to a degree, CMS
16 has -- they've thrown up their hands. We can't catch up
17 with all these appeals. We've got to clear the table.

18 But my concern is it's basically clearing the
19 table of a set of dirty dishes but resetting the table with
20 another set of dirty dishes. And if we don't get RAC reform
21 put in place, we've gone down this well-worn road before,
22 and we're going to go down it again three years from now.

1 So we've got to have some of the RAC reform that's part of
2 that.

3 So I like your notion that you've put out there,
4 the fact that maybe there is some targeting for outliers,
5 that the RACs are not throwing a net across everybody and
6 seeing what they catch as they come through, but more
7 targeted, more focused, where there's possible outliers as
8 part of it.

9 Another thing I'd like us to look at in this is
10 the fact that within the Medicare program, there are a bunch
11 of other audit functions out there. There's medical review
12 by the MACs. There's the ZPICs. There's all these other
13 functions that are auditing right now, and I'd really like
14 us to look at what they're doing right now, how much overlap
15 of those with the RACs, and is there -- you know, are the
16 RACs -- if we get the kind of reforms we're talking about in
17 the DRG system, are they really necessary with all the other
18 audit functions that are out there? Are we layering on is
19 what I'm worried about in terms of the auditing out there,
20 and I'd like us to kind of look at that to make sure that we
21 have good alignment in that.

22 The third area just to mention here is kind of the

1 rebilling issue. That, too, I'm glad that's been raised.
2 That needs to be part of the conversation.

3 The rebilling issue is like playing the lottery,
4 you know, if you're in a hospital right now. If you pick
5 Part A and the RAC says no, then you can't rebill at Part B
6 unless, you know, you're in that one-year window. And that
7 just -- you know, nobody says that there wasn't a need for
8 that care for that patient. So we've got to deal with that
9 rebilling issue as part of that.

10 And then I'm also glad that you brought forth the
11 three-day prior hospitalization. I'm not sure how to play
12 that one out, you know, whether you add observation days
13 into the three-day or some recommendations about that. But
14 I'd like to have kind of more information and discuss that a
15 little bit more as we go forward.

16 So just some thoughts on a lot of random things
17 there, but trying to react to some of the proposals you put
18 forward.

19 DR. HALL: Well, I've been straining to see if I
20 could say anything that hasn't already been said, and I
21 guess my fundamental sort of conclusion of this very
22 confusing topic is that much of it is predicated on a very

1 pernicious misconception of medical care, I think -- this is
2 a person opinion -- and that is that clinical medicine is a
3 precise science. It is not. So we can take a clean list of
4 the 15 most common one-day inpatient stays and say, well,
5 that chest pain wasn't handled correctly.

6 Remember, we're doing this retrospectively. No
7 patient comes in with a sign around their neck saying, "I am
8 MS-DRG 313." That's not how it works.

9 [Laughter.]

10 DR. HALL: I wish it were that way.

11 So we've perpetuated this misconception that we
12 are really, really good at what we're doing when, in fact,
13 we should be much more humble about this and say that when
14 older people get sick, what appears to be a diagnosis when
15 they come in often is not. For example, I would bet that a
16 lot of -- one of these high listing things here, the
17 esophagitis -- were probably labeled as chest pain when they
18 came in, and only afterwards do we shoehorn them into this
19 and then criticize people for not making the decisions that
20 are not even rationally possible when a lot of these
21 decisions are being made. And then we go to kind of
22 ridiculous things, as Rita has pointed out, of saying, well,

1 are you an obs unit or are you an admission, same doctors,
2 same nurses, same resources, same lights, same propensity
3 for human error. It really doesn't make any sense. And
4 then we hire people from the outside who are incentivized to
5 find things that are wrong.

6 Okay. So how would we -- if I think that's so
7 bad, what would I do about it? Well, I wonder if there
8 might be some way of going along the same lines that we have
9 done in measuring hospital-specific quality. For example,
10 we're now looking at readmissions. For years we looked at
11 mortalities, for infections. And we can say over a defined
12 period of time, your hospital did not perform as sort of the
13 -- what we like to think of as the golden mean of the way
14 hospitals should perform. You're misdiagnosing people,
15 you're keeping them too long, et cetera, et cetera.

16 And I think that since that seems to be the
17 pervasive way that we are evaluating quality in hospitals,
18 why can't this just be another set of metrics that we could
19 look at? So we wouldn't have to analyze excruciatingly
20 every single case three years after the fact. And I don't -
21 - I can't say more about that. I don't know how that would
22 work out. But I think one could find five or six sort of

1 hospital-specific parameters of how they handle
2 unpredictable people who come into emergency rooms and get a
3 much better system.

4 MR. HACKBARTH: I think this is a really important
5 point, Bill. Would you put up Slide 3?

6 So the last two bullets lay out the criteria for
7 inpatient admission and observation. They overlap, and both
8 lead with "relies on clinical judgment of the physician."
9 What that says to me is there is not a payment policy
10 solution to this problem. This isn't a matter of getting
11 relative payments right and then we'll get the right care at
12 the right place at the right time. I think that's a false
13 hope.

14 Now, that's not to say maybe we couldn't make some
15 payment adjustments that would make things a little bit
16 better. I'm still not sure about that. But I don't think
17 that jiggering relative payment rates is going to get us to
18 the right solution there.

19 Now, where I may -- just let me be a devil's
20 advocate, Bill. Clinical judgment and respect for clinical
21 judgment is really important. The pervasive problem we have
22 is that the incentives are wrong in fee-for-service. I am

1 really inclined to respect clinical judgment if there is
2 both financial and clinical accountability for the results.
3 So, you know, if hospitals don't like to be audited, get out
4 of fee-for-service. We're building new models where I'm
5 prepared to see that reduced. Become an ACO, go into
6 Medicare Advantage. But so long as you choose to stay in a
7 system where the incentives are sometimes perverse, part of
8 the deal is you're going to get people looking over your
9 shoulder. And so I think those two things go hand in hand.

10 What I'm sort of worried about in this equation is
11 the beneficiaries. We haven't talked about how this affects
12 the beneficiaries at all, and I'd like to get to that point
13 before we're done.

14 MR. KUHN: Can I react to that? One other thing
15 on the physician clinical judgment, and you're both right.
16 I mean, you know, part of this thing really does kind of
17 challenge the integrity of that through all the RAC process.
18 But, you know, it -- and the clinicians around the table can
19 talk to this more, but, you know, folks aren't just saying
20 this person ought to be admitted or this person should not
21 be. They're using a lot of decision support tools to help
22 them make those decisions. You know, there's InterQual,

1 there's Milliman, there's these other entities out there
2 that have these packages to help them do that. And maybe
3 that's something we could hear a little bit more about.
4 What are all the decision support tools that go into this?
5 It's not just a haphazard decision. There's some real
6 science behind -- or at least as much as they can put in
7 place to try to get to these decisions.

8 DR. HALL: Well, if I may, I don't have as much
9 confidence in the clinical decisionmaking as you think I
10 might have.

11 [Laughter.]

12 DR. HALL: In fact, it's quite the opposite. And,
13 remember, we're dealing with systems of care. It's not
14 whether I'm a greedy physician or what, but some of these
15 decisions are made in random sort of ways. Maybe the head
16 nurse in the ER is the one who makes all these decisions
17 where the triage goes. Maybe it's a quality officer
18 somewhere. Who knows?

19 So unless we take, as we've done with so many
20 other problems, and say when medical error occurs, it's
21 rarely just because of an errant individual. It's because
22 of a dysfunctional system that doesn't do review and learns.

1 And the only way that I can see of evaluating that is to
2 say, well, there are certain gold standard hospitals and
3 systems that do it right and let's judge everybody by them.

4 MR. HACKBARTH: And so I'm actually trying to pick
5 up on that, and let's not second-guess every individual
6 decision. That's the whole point that we've been discussing
7 about population level assessment of performance. And if
8 you have an ACO that has an accountable population, you can
9 look at the overall performance as opposed to every
10 individual decision and say, "How good are they doing?"

11 DR. HALL: So let the chips fall where they may
12 then in terms of the payment system.

13 DR. NERENZ: Again, as others have said,
14 absolutely great analysis. Thank you.

15 As we've had this discussion, I've been trying to
16 still get some clarity in my own mind about what exactly the
17 problem is here we're trying to solve, and let me just try
18 to parse out a little bit. And it started with my question
19 to you, Glenn.

20 It seems like there's at least four distinct
21 dynamics going on here, and only one of them strikes me as a
22 real problem.

1 If inpatient stays are shortening from two or
2 three days down to one day, that does not seem to me to be a
3 problem. And as Kathy pointed out, gradually, with a lag,
4 there's a DRG weighting solution to that. That doesn't
5 strike me as a problem.

6 If care is shifting from the inpatient to the
7 outpatient setting in a lot of these situations, that
8 doesn't strike me as a problem. Medicare pays less for
9 that. Patients can be happier. That doesn't seem to be a
10 problem.

11 If outpatient observation stays are getting
12 longer, particularly out into this 48-hour territory, from
13 the patient point of view, that kind of does seem like a
14 problem, but it seems like that, at least if I'm tracking
15 correctly, is driven very heavily by this RAC audit process,
16 because some of those might have legitimately been inpatient
17 stays, but they're continuing to linger in observation.
18 Maybe I'm interpreting that incorrectly. But if that's a
19 problem, it seems to be driven specifically by an earlier
20 policy change that perhaps should be changed.

21 So the only thing I've got left is -- again,
22 Glenn, what you -- is that things that should or could be

1 outpatient are inappropriately being inpatient, including
2 short stays. Now, it seems if that is the essence of the
3 problem, a couple of things other people have said are
4 perhaps the answer, and it's not really a complete redo of
5 the payment models. It's perhaps a much more sharply
6 focused audit process on truly aberrant patterns rather than
7 individual cases. You know, Herb I think was mentioning
8 that.

9 So I think I'm in line with some of the more
10 recent suggestions that have been made, and rather than a
11 more -- a large-scale overhaul of payment, which could -- as
12 others have said, we seem to be moving back to a per diem
13 model for hospital care. But it starts with trying to just
14 figure out what exactly is the clinical behavior problem or
15 organizational behavior problem that we're trying to solve.
16 And some of what's going on here just does not strike me as
17 a problem.

18 MR. HACKBARTH: Good points, Dave.

19 I want to -- we're running out of time, Kathy, and
20 we've got a number of people that haven't had a chance yet,
21 so I have Jack and Craig -- you had your hand up, Craig --
22 and then also Jay and Warner and Kathy. We'll try to get

1 you in if we can, but I want to make sure I get Craig and
2 Jack in first.

3 DR. HOADLEY: So, first, I just, like others, I
4 want to compliment this paper, because for those of us who
5 hadn't spent much time thinking about this issue, it's
6 obviously a hard one to think through, both the technical
7 details, but, as Dave said, sort of trying to think about
8 what the problem, and you certainly helped us make progress
9 on that, so that's great.

10 I want to focus specifically on the beneficiary
11 impact, and I know on Slide 9, you've got sort of the median
12 sort of financial impact of the \$1,100, \$1,200 versus \$300,
13 depending on which setting you're in on median. What I
14 guess I'd like to see is -- tease that out more. I was
15 thinking from Slide 5, for example, where you give examples
16 of some of the individual diagnoses, you know, how do those
17 beneficiary impacts vary, because you've got the 20 percent
18 going on on the one side.

19 And, then, as you work your way into options,
20 whatever it is we finally do, graduated options or whatever,
21 what would that do to the beneficiary cost? I mean, I say
22 all this recognizing that supplemental insurance means that

1 not necessarily everybody is facing that directly, but they
2 still may face it indirectly if it affects total cost faced
3 by supplemental and, therefore, affects premiums. But, I
4 think it's an important part of what we want to look at.

5 The other piece I wanted to say something -- and
6 this has come up already a little bit -- was the three-day
7 SNF requirement, and again, this is one of the places where
8 the beneficiary is most directly affected. And, I guess
9 one of the things I'm struck by, when you say this goes back
10 to the original statute when the average length of stay was,
11 whatever you said, 13 days or something, obviously, to
12 modify -- most of the ways we might modify the three-day
13 rule will have a budget cost, but, I think, what will be
14 important, depending on what else we're doing, is to think
15 through what those parameters are. I don't know what the
16 size of that budget cost if you switch three days to two
17 days, if you counted the observation days, you know, some of
18 the options that might be out there for rethinking that
19 three-day rule. What is the cost? Is there a way to do it
20 in a less costly way?

21 But, I think, if we're going to think through that
22 as part of this, I mean, part of it would be to think about

1 how has the effect of the three-day rule really changed over
2 the history of the program when the use of the hospital has
3 changed so much, and is that something that just doesn't
4 quite make sense structured that way. Is there a totally
5 different way to structure the SNF requirement? So, to the
6 extent that we're going to get into that as part of this,
7 some of those kinds of things, I think, would help us think
8 about it.

9 DR. SAMITT: I think I want to tag on mostly to
10 your comments, Glenn, that while I think that site
11 neutrality solutions have some promise to them, I think the
12 reality is, you don't need payment policy changes for site
13 neutrality when you've got accountable systems. Accountable
14 systems will naturally care for the patient in the
15 appropriate setting that's going to maximize outcome and
16 maximize quality. So, I'm inclined to say this is not an
17 area that we should influence. It's not clear that it's a
18 problem and it's not clear that our Commission has the
19 opportunity to solve that problem.

20 I'm more inclined to say, let's continue to
21 encourage movement toward ACOs and more accountable
22 solutions, or even bolster the readmission penalty process

1 going forward in the future. That will continue to motivate
2 people to care for patients from an inpatient/outpatient
3 setting in the more appropriate manner.

4 I also wanted to comment on the three-day SNF
5 requirement. That clearly is an area that, when you look at
6 more accountable solutions versus fee-for-service, that
7 there is a major disparity in terms of how the use of SNF as
8 it relates to three days is utilized. So, I think we should
9 take a fresh new look at that, not that we should waive the
10 requirement, but that we should alter the requirement so
11 that it doesn't increase inappropriate SNF utilization. I
12 think we need to change the requirement in an accountable
13 way, and we will likely need to think about alternatives to
14 do that.

15 MR. HACKBARTH: We're a little bit over, but I
16 think we can afford to spend, say, another 15 minutes on
17 this. So, I have Jay, Warner, and Kathy. Anybody else who
18 wants to get in on a final round here? Jay.

19 DR. CROSSON: Thank you. So, I certainly second
20 what Craig said and what you said, Glenn, about the fact
21 that moving to accountable systems and a prospective payment
22 system obviates some of these problems. However, in the

1 meantime, we have to -- I think we're charged with trying to
2 deal with the situation that we have without those systems
3 in place universally.

4 The core issue here -- and I think it was David
5 who said this -- the core issue is, is there some mechanism
6 which is simpler than what we're talking about here with the
7 RAC audits, or mucking around with the DRG system, is there
8 some counter-incentive to the fee-for-service incentive to
9 move patients from outpatient to inpatient or differentially
10 put patients in the hospital when they could be cared for
11 outpatient that would be possible and could potentially
12 obviate the need for the RAC audits, which have, as Herb
13 pointed out, a pretty high false positive rate.

14 So, one thought, and we could test it, would be
15 just simply to develop a list of the most likely DRGs that
16 are on this bubble between inpatient and outpatient -- we
17 have that already -- pick some cutoff point, 50, 20, 30,
18 whatever, and then say, essentially, for hospitals, develop
19 a ratio for those DRGs of patients who are treated inpatient
20 versus outpatient. It's a crude thing. It would obviously
21 be influenced by what hospitals have the capability to do
22 outpatient observation. But, if you, in fact, then created

1 an overall payment modifier based on that ratio, there would
2 be an incentive overall for hospitals to move towards
3 observation capability and to move towards a decision
4 process which favored that over putting the patients in the
5 hospital.

6 MR. HACKBARTH: Just say more what you mean by a
7 payment modifier --

8 DR. CROSSON: So, let's say we had a -- you know,
9 I'm making this up, of course -- but, let's say we had an
10 average ratio for this standard set of DRGs which are on
11 this bubble, could be inpatient, could be outpatient, and we
12 developed -- it should be possible to do that, I think, not
13 too difficult, establish a nationwide average ratio of how
14 many patients with these DRGs are cared for in the hospital,
15 how many are cared for in observation. It would change over
16 time.

17 But, if you as a hospital deviated significantly
18 from that, there would be a penalty imposed, and it could be
19 imposed quarterly, at the end of the year, whatever, to your
20 total payment. Or, you could receive a -- I mean, you could
21 do it double-ended or one-ended or whatever. But,
22 essentially, the purpose would be to create a mechanism in

1 the minds of the hospital administrators, you know, if I
2 over -- if I abuse this decision making process to favor
3 putting these patients in the hospital, then down the line,
4 I have to be concerned that at the end of the year, my ratio
5 is going to be too high and I'm going to get dinged.

6 MR. HACKBARTH: So, for example -- and I'm just
7 trying to make sure I understand -- so if your ratio is too
8 high, there could be a downward adjustment in your inpatient
9 DRG payments for the identified DRGs --

10 DR. CROSSON: Yes. Yes. I mean, the mechanism --
11 but, it's basically just building a counterweight which
12 would be relatively more simple than -- and potentially
13 could dispense with the RAC audits for this purpose.

14 DR. MILLER: I think that's what I hear there, is
15 it's kind of the aberrant pattern policy, but administered
16 outside of the RAC process.

17 MR. HACKBARTH: Yeah. And, so, we won't have time
18 to do it today, but the next time we take this up, I'd be
19 eager to hear, in particular hospital people, react to that.
20 Which do you prefer, this sort of formulaic adjustment based
21 on a ratio that, as you say, will inherently be a little bit
22 arbitrary, because hospitals have different circumstances

1 and capabilities, versus -- let's not call it a RAC program,
2 because that's become so pejorative and then so associated
3 with bounty hunters and all that -- but, a targeted audit
4 that actually looks at individual cases. I think each of
5 those approaches has merits and demerits and we'd want to
6 sort of talk through that.

7 DR. CROSSON: Just two more quick comments. So,
8 number one, I think if you did something of this nature and
9 you accomplished what we were trying to do, which is to push
10 more of these decisions to outpatient, then that would, I
11 think, suggest that we need to deal with the three-day non-
12 qualification for SNF status, right, because we'd be
13 increasing that problem, and that's a beneficiary issue and
14 an equity issue of some sort, so --

15 MR. HACKBARTH: [Off microphone.] Warner.

16 MR. THOMAS: Thanks for the opportunity. The
17 first thing is, you know, we keep talking about this from a
18 -- and I'm sure there's outliers from the hospital
19 perspective, but I think what's really happening when this
20 situation -- it's more driven by our physicians. Our
21 physicians are making the decisions whether this is an
22 observation or an inpatient. I think Rita's example that

1 she gave is a perfect example of an admission that occurred
2 in the ED, and she looked at it and said, no, that's
3 actually somebody that could be in observation. And, it's
4 not that there's a hospital sitting there and saying, you
5 know, should be admitted or not be admitted. I think
6 physicians just want to do the right thing. It's just that
7 the rules and the policies are so difficult to understand
8 and change that it's hard to get it right, and I think
9 that's really what drives a lot of this.

10 And, frankly, the current policy is not fair to
11 beneficiaries who end up getting a 20 percent bill if they
12 are in an observation status, and it's confusing them. They
13 really just do not understand this, including my own mom,
14 who actually was in a hospital, and she's, like, "Gee, I was
15 in a hospital and I got a bill for 20 percent." It's
16 because she's observation. So, people do not understand
17 this.

18 Just building on Herb's point, I think the idea of
19 having a category that is identified as short stay -- and
20 the reason that I think that makes some sense is because
21 this is not going to -- we're not just going to look at the
22 15 or so DRGs today, or even the top 50. I think this will

1 continue to be evolve. And, we'll be doing -- and there's
2 many places doing joint replacements on an outpatient or an
3 observation basis today, and I think that will continue to
4 basically grow. So, although I think the DRG program does
5 modify over time, I think having a category that deals with
6 folks that are in this area and really makes it clear would
7 be a lot easier for physicians, a lot easier for
8 beneficiaries, and a lot easier for hospitals.

9 The last point that I would make is around the
10 idea of ACOs and, once again, trying to have folks that are
11 going down that road. I mean, I agree. I mean, I think
12 there's a lot of organizations, that they can have all their
13 members in ACOs or have all their members in -- or their
14 patients in MA, I think they could do it. But, the reality
15 is, they can't. It's not their choice.

16 So, I think, we have to deal with this issue. I
17 mean, maybe there should be some consideration to the point
18 that if there are people that are in ACOs or taking up- and
19 downside risk, that maybe they're exempt from some of these
20 things. I don't know, and that would be something, I think,
21 that should be considered.

22 But, I do think Herb's point around having a

1 category that can make this clear for the patient, make this
2 clear for the physician, and make it clear for the industry
3 would be helpful.

4 And then, finally, I would just also dovetail on
5 Herb's comment, and then also, I think, yours, Glenn, that
6 if there are people that are outliers, I agree, there needs
7 to be some way to deal with people that really sit outside
8 of the parameters, the numbers and percentages of
9 observation. So, I do agree that that needs to be
10 addressed. But, I do think this idea of having the time
11 period of audits also align with the time period of being
12 able to rebuild -- because whether Rita's patient was
13 inpatient or observation, she took care of that patient.
14 That hospital took care of the patient, and they ought to
15 have the opportunity to get paid for what they did,
16 regardless of whether the resident wrote the right admit
17 documentation or whatever the situation was. That patient
18 was cared for and taken care of, and right now, we have
19 folks that come back a year or two later and say, what you
20 did wasn't right and, so, therefore, you are penalized.

21 So, just my two cents on it. Thank you.

22 MS. BUTO: So, I wanted to pick up on Jay's ratio

1 idea. That wasn't the original thought I had, but if you're
2 going to penalize hospitals, you better have really good
3 numbers, and that means if I have a tougher demographic,
4 more critical care patients, et cetera, you don't want to
5 penalize hospitals from taking those kinds of patients.

6 So, I would actually -- I like the idea of having
7 the ratio. I think there are several things that we ought
8 to explore, like just making the ratio public is one
9 possibility, because it's amazing what knowledge that
10 certain hospitals tend to admit versus do outpatient might
11 do. But, we could also --

12 MR. HACKBARTH: So, you're saying public without
13 any payment change initially --

14 MS. BUTO: Well, I'm saying --

15 MR. HACKBARTH: -- just publicize --

16 MS. BUTO: -- I think at one end of the spectrum
17 is Jay's idea of a penalty. I think that's going to be very
18 hard to stick because of, you know, there will be all kinds
19 of reasons. I'm thinking about hospital mortality data that
20 were so difficult to get out in the first go around. And,
21 then --

22 [Laughter.]

1 MS. BUTO: I don't think you were there.

2 But, the other idea would be, there are now a
3 number of quality measurement metrics that hospitals are
4 held to. Maybe this ought to be one that, you know, a
5 reasonable range is looked at, or the ratio in relation to
6 the regional average or whatever it is ought to be a
7 consideration.

8 So, there might be some other mechanisms, and
9 rather than just consider having the staff just look at
10 applying a penalty, maybe there are some other ways a ratio
11 like that could be very useful.

12 And, then, the last point is really picking up on,
13 I think, what was the staff work that's been done on this,
14 which is, at a minimum, we ought to be able to address the
15 one-year versus the three-year processes, you know, the
16 rebilling versus -- and, to me, the Part D versus the Part B
17 issue. That's kind of crazy, not being able to -- having to
18 charge the beneficiary for drugs and then having them, bill
19 the Part D carrier or their Medigap, whatever it is. We
20 ought to be able to say something about that. That seems
21 just dysfunctional.

22 MR. HACKBARTH: Okay. We've got a lot of work

1 still to do on this, but I think I hear some points of
2 consensus, and I'm going to try to identify what those might
3 be.

4 And, I would start with Bill Hall's comment about
5 the inherent complexity of these judgments and there not
6 being red lines and patients not having signs on them. And,
7 put up Slide 3 again. I think the crux of the problem is
8 that the criteria for what's appropriate for observation and
9 inpatient are overlapping, and appropriately so, and both
10 rest on clinical judgment. That's what is making this
11 challenging.

12 A second point, I think there's consensus that
13 while we may want to explore some payment adjustments, this
14 problem isn't going to be solved with a magical new payment
15 policy and there's still going to be some rough edges. A
16 related point where I think I heard consensus is let's not
17 undermine the DRG inpatient system that is working well in
18 pursuit of a payment approach to this problem.

19 Third is that I'm not sure there's consensus about
20 whether audits will continue to be necessary, but I think I
21 did hear that if they are part of the program, that it needs
22 to be reformed and the audits should be more targeted, and

1 certainly the rebilling problem needs to be addressed. And,
2 there may be issues about whether it's appropriate to use a
3 bounty sort of system, et cetera. But, if there are going
4 to be audits, it needs to be much better targeted than the
5 current system.

6 The fourth point where I think we may have some
7 consensus, although we didn't talk as much about it, is on
8 protecting the beneficiaries, and I'm not sure how to fix
9 the drug issue, but we can certainly explore that some more.

10 With regard to the eligibility for SNF coverage,
11 you know, set aside this issue. You know, the three-day
12 inpatient requirement is antiquated. It's archaic and it
13 doesn't make any sense for me on its own merits. And,
14 several years ago, we talked about redesign of the overall
15 Medicare benefit package, and one of our guiding principles
16 there was to rationalize in a way that did not increase or
17 reduce beneficiary cost sharing. And, personally, I'd like
18 to recommend that we do away with the arbitrary three-day
19 requirement as part of rationalizing of the Medicare benefit
20 package.

21 So, those are areas where I think we may have some
22 consensus. Obviously, there's still a lot of work to be

1 done within them, particularly on the payment piece. But, I
2 feel like we made a little headway today on a tough subject,
3 so thank you all. Great work on the presentation and the
4 analysis.

5 We will now turn to our final presentation on the
6 mandated report on home health, impact of home health
7 rebasing.

8 [Pause.]

9 MR. HACKBARTH: For those of you coming in and
10 leaving, could you do so quietly and quickly?

11 Okay, Evan. Whenever you're ready.

12 MR. CHRISTMAN: Good morning.

13 The PPACA includes a requirement for the
14 Commission to assess how payment reductions in the Act,
15 referred to as "rebasing," will affect agency supply, access
16 to care, and quality for home health care. The mandate
17 requires that we consider the impact for for-profit, non-
18 profit, urban, and rural agencies.

19 We presented this information to you at the April
20 meeting last spring. Today's presentation reviews the
21 material from the last meeting for new Commissioners,
22 responds to Commissioner comments, updates our analysis of

1 the financial impact of rebasing, and also provides updated
2 quality data.

3 I would also note that we have met with home
4 health industry numerous times on this issue, and I can
5 answer questions about their concerns, if you have them.

6 After reviewing the data again today, we plan to
7 prepare a final report for transmission to Congress, later
8 in the fall.

9 Today's presentation has three parts. I will
10 review the justification for and implementation of the PPACA
11 rebasing policy, the expected financial impact of rebasing,
12 and then we will look at how the experience of past-payment
13 changes can inform our analysis of how the PPACA changes
14 will affect the benefit.

15 Before we begin, I just want to remind you of some
16 of the issues with the home health benefit. Home health is
17 an important part of the continuum for serving frail
18 community-dwelling Medicare beneficiaries. Properly
19 targeted, it can be a tool for keeping beneficiaries out of
20 the hospital or other more costly sites of care. However,
21 eligibility for the benefit is broadly defined and does not
22 encourage efficient use.

1 The benefit also has an unfortunate history of
2 fraud and abuse, and there are many areas with aberrant
3 patterns of utilization. In addition, providers in this
4 sector also have a history of tailoring services to reflect
5 the financial incentives under Medicare payment.

6 The fact that home health can be a high-value
7 service does not justify the excessive overpayments that
8 have marked this service. As I will explain in a moment,
9 Medicare has overpaid for this service for over a decade,
10 and these overpayments do not benefit the beneficiary or the
11 taxpayer.

12 As another reminder, here is a brief overview of
13 home health. For the service to be covered, a patient must
14 be homebound and have a need for nursing or therapy,
15 commonly referred to as a "skilled need." Medicare spent
16 about \$18 billion on home health services in 2012, and there
17 were over 12,000 agencies, and we provided about 6.7 million
18 episodes to 3.4 million beneficiaries.

19 The rebasing policy in the PPACA made several
20 changes. We recommended a form of rebasing in 2010 for a
21 number of reasons. First, the margins for home health
22 agencies have been excessive since the PPS was established,

1 averaging greater than 17 percent through this period.
2 Obviously, there is variation around the margins, but I
3 would note that margins for the four categories of provider
4 in this study exceeded 12 percent in each year in 2001
5 through 2012.

6 In addition, home health margins could be higher
7 than reported. A recent audit of the home health cost
8 reports found that agencies overstated their cost by 8
9 percent. Margins in 2011 would have been over 20 percent if
10 we corrected for this error.

11 Second, in this period, there has been a rapid
12 growth in episodes, episode volume and supply, and it is not
13 clear that much of this growth has contributed to access.

14 Also, Medicare attempted to address high margins
15 with reductions to the market basket and other incremental
16 cuts, but despite these reductions, margins have remained
17 high. For these reasons, the Commission concluded that the
18 program needed to rebase the home health rates using current
19 information on episode costs and not rely on incremental
20 payment changes or other out-of-date assumptions that do not
21 reflect current agency costs.

22 One of the reasons Medicare margins have remained

1 so high is that past cuts to the home health base rate have
2 been offset by increases in the case mix reported by home
3 health agencies. In 11 of the last 12 years, Medicare has
4 implemented some form of reduction to the payment update,
5 and in 3 of those years, the reduction has been large enough
6 to lower the base rate. However, in most years, the
7 reported case mix has increased. Since the base rate is
8 multiplied by the case-mix value to compute the payment,
9 these higher reported case-mix values result in payment
10 increases. In years when the base rate has been reduced,
11 the growth in reported case mix has helped to offset these
12 cuts, and years when the base rate has increased, the rise
13 in reported case mix has compounded growth in average
14 payment per episode.

15 I would also note that CMS concluded that most of
16 the rise in case mix under PPS was attributable to changes
17 in agency coding practices and not increases in patient
18 severity.

19 Turning to the mandate, the PPACA included a
20 policy to rebase payments but followed a different approach
21 than the one the Commission recommended. First, the PPACA
22 phases the reduction in over four years. Our policy said no

1 more than two years. In addition, it set a limit on the
2 reduction that allows it to equal no more than \$81 a year,
3 and CMS set it at this maximum amount. Our policy did not
4 set a limit and would have permitted steeper reductions.

5 The PPACA includes a payment update that averages
6 about \$66 a year and offsets about 80 percent of the cut.
7 Our recommendation did not include the payment update and
8 would resume those after rebasing was concluded.

9 The net effect is that the episode base rate in
10 2017, the last year of rebasing, will be 2 percent less than
11 it was in 2013, and I would note that if the sequester were
12 in effect, payments in 2017 would be 4 percent lower.

13 Our mandate requires the Commission to consider
14 the impact of PPACA reductions on agency supply, access to
15 care, and quality. The report is due in January of 2015,
16 before data that will allow us to directly assess the
17 payment changes that will become available.

18 Consequently, for this report, we plan to examine
19 how payment changes in 2001 through 2012 affected these
20 parameters. In short, we are using past payment changes as
21 a corollary to assess how rebasing will affect supply,
22 access, and quality.

1 This chart shows how the average episode payment
2 has changed in this period. The periods colored in red
3 indicate years that the episode payment declined. The blue
4 years indicate years that experienced increases, and as you
5 can see, average episode payments decreased in 2003, 2011,
6 and 2012, and increased in all other years. The four
7 categories of provider each had similar trends for changes
8 in annual episode payment that you see here.

9 The second column shows the average margins, and
10 they give you a sense of how margins have remained high
11 throughout this period, regardless of how payment per
12 episode has changed.

13 We begin our look at the data for the mandated
14 report with a review of supply. This chart shows how agency
15 supply has changed in the period, and the years with a
16 decline in average payment per episode are shaded. All
17 other years experienced increases.

18 The overall supply of agencies doubled across this
19 period, driven by a rapid increase in for-profit and urban
20 agencies. The increase in for-profit and urban agencies
21 occurred, regardless of the direction of payment policy. It
22 increased in years that payments rose or fell. Preliminary

1 data for 2013 indicates that this entry has continued.

2 Non-profit and rural areas experienced a decline
3 in most years during this period. They declined in years
4 that payments increased or decreased.

5 These trends suggest that changes in supply are
6 not highly correlated with changes in the average episode
7 payment. For-profit and urban agencies increased each year,
8 regardless of the direction of payment policy. Non-profits
9 and rurals decreased. I would also note that many urban
10 agencies serve a mix of urban and rural areas, so even the
11 decline in rural agencies is at least partially offset.

12 With all of these changes in supply, it does not
13 appear that beneficiary access to care has changed
14 significantly. From 2004 and in each of the following
15 years, we have reported that 99 percent of beneficiaries
16 lived in a zip code served by home health. 84 percent in
17 2012 lived in an area served by five or more home health
18 agencies. And as I will show you in a moment, utilization
19 in urban and rural areas has remained comparable.

20 Next, we are going to take a look at how access,
21 as measured through utilization, has changed during this
22 period. As an overview, total episodes for home health have

1 more than doubled during this period. This breaks down to a
2 change in two ways. First, the share of beneficiaries using
3 home health has risen 50 percent, and the episodes that each
4 of those users received has increased 30 percent. I would
5 note that, again, most of this growth has been driven by an
6 increase in episodes provided by for-profit agencies, and
7 utilization in organ and rural areas has increased at about
8 the same rate.

9 This next slide shows that. It compares how the
10 number of home health episodes per 100 beneficiaries and
11 payments per episode have changed. The shaded area
12 indicates periods that average payment per episode declined.
13 The chart shows the change for urban and rural
14 beneficiaries, and as you can see, the two lines are almost
15 indistinguishable, emphasizing that the two areas have
16 exhibited similar rates of growth through this period.

17 The general trend for both areas is that
18 utilization increased on this measure through 2010,
19 regardless of the direction of episode payment, but it has
20 declined slightly in 2011 and 2012.

21 The declines in utilization for 2011 and 2012
22 coincide with years that average payment per episode

1 declined, but there are reasons to believe that other
2 factors influenced these trends.

3 First, the declines are small, less than 5 percent
4 from the peak in 2010. About 70 percent of this decline was
5 due to utilization falling in California, Florida,
6 Louisiana, Mississippi, and Texas, five states that
7 exhibited abnormally high rates of utilization in the prior
8 years. Without these states, utilization would have been
9 about 2 percent below its peak.

10 Second, changes were occurring economy-wide during
11 this period that likely affected the demand for home health.
12 Economy-wide the rate of growth in health care spending has
13 been slowing for all sectors, both private and public and
14 across multiple provider types, and this slowdown may have
15 affected the demand for home health.

16 In addition, I would note that a new requirement
17 for a face-to-face visit before ordering home health went
18 into effect during this period, and the Department of
19 Justice and other government agencies expanded their effort
20 to combat fraud, waste, and abuse.

21 The bulk of the volume growth has been for
22 episodes not preceded by a hospitalization. The number of

1 these episodes more than doubled during this period, and in
2 2012, the majority of episodes, over two-thirds, were for
3 community-admitted individuals.

4 To better understand this trend, we compared the
5 characteristics of home health patients that primarily used
6 home health for community-admitted episodes to home health
7 patients that used it primarily as a post-acute service.
8 Post-acute users generally had more chronic conditions and
9 shorter overall stays, while community-admitted users stayed
10 longer and were more likely to be Medicare/Medicaid dual
11 eligible beneficiaries.

12 To summarize, this data leads us to expect
13 rebasing to have a limited impact, if any, on access. The
14 small size of the reductions, less than six-tenths of a
15 percent a year, suggest that they should not significantly
16 change the financial incentives for utilization.

17 Access is very high right now, with the
18 utilization more than double what it was at the beginning of
19 PPS. The experience of recent years suggests that factors
20 other than payment can have a significant effect on
21 utilization. If policies to drive down fraud, waste, and
22 abuse continue to be implemented, utilization could drop.

1 If other trends such as the decline in health care spending
2 continue, this, too, could drive down utilization.

3 Next, we are going to look at quality on three
4 measures, hospitalization during the home health stay and
5 two functional measures.

6 Looking at hospitalization, we see that the rates
7 are mostly unchanged, even though payments increased
8 significantly. The rate was 27.5 percent in 2003. Average
9 payments in this period increased 18 percent, but the
10 hospitalization rate in 2012 was unchanged.

11 The steep increase in payments contrast with the
12 relatively flat rate of hospitalization and suggest that
13 there was not a relationship between payment and
14 hospitalization during this period.

15 The annual rates of improvement reported for
16 transferring and walking have increased on an annual period.
17 53 percent of patients reported improvement in walking in
18 2012, and 53 percent of patients reported improvement in
19 transferring in 2012. These rates increased in all years
20 throughout this period, regardless of the direction of
21 payment policy, and so they suggest overall that the changes
22 in the functional rates were not highly correlated with the

1 changes in payment. For example, the rates of improvement
2 increased in 2011 and 2012, even when payment fell.

3 In terms of the mandated report, the results for
4 all of our quality measures suggest little tie between
5 payment and quality. So, consequently, we would not expect
6 the reductions in PPACA to negatively affect quality.

7 To sum up, we expect rebasing to have a small
8 impact. The rebasing cut is small, as the cuts are
9 counteracted by the annual update. The sequester would
10 slightly increase the size of the reduction, but it would
11 still be smaller than reductions the industry has faced in
12 the past.

13 The supply of agencies has increased overall,
14 regardless of the direction of payment policy. Utilization
15 has increased an aggregate and on a per-beneficiary basis,
16 and though it has declined recently, factors other than
17 payment policy likely account for much of this decline. And
18 throughout this period, our quality indicators do not appear
19 to change in tandem with the direction of payment policy.

20 We would note that agencies have been able to
21 sustain their high margins in the face of past cuts to the
22 base rate by increasing case mixes, mentioned earlier, and

1 past history suggests that some or all of this cut will be
2 offset by case mix.

3 Agencies have also been effective at controlling
4 their costs. For example, when PPS was implemented, they
5 reduced the number of visits provided in an episode by one-
6 third. For these reasons, we expect the impact of rebasing
7 to be limited.

8 This completes my presentation, and I look forward
9 to your questions.

10 MR. HACKBARTH: Okay. Thank you, Evan.

11 So this is the final or nearly final step in a
12 process that actually has been going on for quite a while.
13 Here we are responding to a specific request from the
14 Congress for an assessment of the impact of rebasing, but
15 our discussions, our work on home health payment go back
16 many years.

17 Warner and Kathy, sorry, you're sort of coming in
18 at the very tale end of this. Jay has been with us before,
19 and so he participated in earlier phases of this journey.

20 Evan, thank you for the modifications that you
21 made in the draft report based on our last Commission
22 discussion.

1 For those of you in the audience who may not have
2 been her, among the requests that Commissioners made at the
3 last meeting was to emphasize again that we don't think that
4 home health is a problem. In fact, we think home health is
5 a critical component of a well-functioning program of
6 integrated care. The issue that we have is with the
7 particulars of the payment mechanism, and the fact that
8 often in traditional Medicare, it isn't well integrated with
9 other parts of the delivery system.

10 In that vein, we also asked Evan to provide some
11 information on how home health is managed in other contexts,
12 like integrated systems and by MA plans, and he has added
13 some discussion of that.

14 In the many years that we've worked on this issue,
15 among the points I've heard made by friends and colleagues
16 in the home health field is, well, we need this money, so
17 that we can invest in more staff, higher paid staff, new
18 information systems that will allow us to better care for
19 patients. And, of course, all of those things are steps
20 that we would support, but persistence of very high margins
21 mean that that reinvestment isn't happening. If the
22 reinvestment is happening, costs go up and the margins go

1 down. When the margins persist at double-digit levels, in
2 fact, the needed reinvestment is not occurring.

3 Another point that I've often heard over the years
4 is, well, we need these high margins for Medicare because
5 we're not paid well enough by other payers. And that's an
6 argument that we have not accepted for home health or any
7 other part of the Medicare payment system. Our
8 responsibility is appropriate Medicare rates for caring for
9 Medicare patients, not cross-subsidizing other payers.

10 So, with that preface, I don't think there's any
11 need for multiple rounds of conversation at this point, but
12 I will open the floor for any concluding comments on this.

13 DR. MILLER: May I add just one thing?

14 MR. HACKBARTH: Sure.

15 DR. MILLER: All right. This is merely a process
16 point, and it's to the public, our congressional people that
17 we report to, and the Commissioners and particularly the new
18 ones.

19 So this was a congressional mandate. The rebasing
20 was in PPACA. People were concerned. We did the best that
21 we could to assess this.

22 Keep in mind this is not the last time we'll look

1 at this. We'll look at it every year. That's a matter of
2 our mandate. As early as December we'll be back to looking
3 at all of the payment areas, including home health. So on
4 an annual basis, we'll look at that. So also for the new
5 folks, don't think this is it, we look at it and we're done.
6 This will be a continuous process. If something goes south,
7 we'll be back to this.

8 DR. COOMBS: First of all, Evan, I want to say you
9 did a great job, and I really like the fact that you hit
10 every note that previously I recorded, especially when you
11 added the comment on page 31 in the handout. And kudos to
12 you. I just think that everything was right on point, and I
13 agree with what you've placed here.

14 MR. ARMSTRONG: Yeah, I was really pleased to be
15 reminded that we will have the opportunity later in our rate
16 payment discussions to come back to home health and really
17 make some decisions about that.

18 But in the meantime, could you just remind me,
19 Evan? I mean, generally I think investing in home health
20 offers a tremendous return to our health system. I still
21 think we're paying these providers too much and the margins
22 are too high. But can you remind me, on the overall spend

1 for the Medicare program, how much is invested in home
2 health? And is that increasing as a percentage of the total
3 spend?

4 MR. CHRISTMAN: It's in the 3 to 4 percent range
5 as a percent of fee-for-service. And I would say prior to
6 2010 it was a rising share of Medicare payments. Because of
7 a number of initiatives, some of them targeted at fraud,
8 total payments have come down a tiny bit. So it's -- you
9 know, the rest of the program is probably growing a little
10 bit faster now, but before 2011 it was a growing share, but
11 a relative niche.

12 MR. HACKBARTH: Others?

13 DR. NAYLOR: I also want to congratulate you,
14 Evan, especially your responsiveness to a number of
15 questions that have arisen along the way. And so just I
16 guess my comments have most to do with major issues
17 unearthed during this report. You were given the
18 opportunity to say make some recommendations as you're
19 taking a look at this rebasing that we may want to be taking
20 a look at as a Commission. And I think the two things,
21 similar to the focus groups last evening, what stood out was
22 the work that was uncovered on the very substantial

1 differences between those cared for immediately post after
2 the hospital and those in the community. You have raised
3 it, and we see the difference in use and so on, and I'm
4 wondering if even in a summary we continue to encourage
5 ourselves and, therefore, members of Congress to really
6 recognize that this is different.

7 The second thing that came out in this report as
8 well, which you well documented, is the not-for-profit
9 declining and the rise of the for-profit. In one sentence,
10 it said something to the effect, well, you know, the for-
11 profits are kind of filling in the gaps. But in all of our
12 other conversations, yesterday anyway, we talked about the
13 for-profits and not-for-profits being different, both on a
14 willingness to serve the Medicare population.

15 Additionally I think the data that you present in
16 terms of quality performance on hospitalization rates and on
17 the functional improvement, especially mobility, really
18 reinforces the contributions of nonprofits in this world.

19 So it seems to me that you obviously are answering
20 the question around rebasing and answering that in the
21 context of that there is differences in the little data you
22 have available to suggest that these payments are adjusting.

1 But it seems to me that calling these two pieces out might
2 be helpful in a summary.

3 MR. HACKBARTH: Others?

4 DR. NERENZ: I'll just repeat an observation I
5 made in the past, and, again, thanks for the wonderful work
6 here. It's just on the issue of the hospital-based
7 agencies. You know, you noted in the report that the
8 margins in these agencies specifically are not only lower;
9 they are double-digit negative. And you point out that it's
10 because of higher cost per visit or per episode. And I
11 think when we discussed this in the past, we said that could
12 represent simply a cost allocation decision by the hospital
13 administrator and may not be particularly meaningful.

14 As this goes forward beyond this report, I guess
15 I'd just like to keep that on the radar screen, perhaps
16 something to look at in more detail. The reason I say that
17 is, at least in principle, a hospital-based agency can be an
18 integrator, a coordinator, a way of effectively linking the
19 care, the inpatient care, to the follow-up care. And I
20 guess before we just sort of dismiss that as sort of a
21 special issue of interest, I'd just like to know a little
22 more about what's going on and what that higher cost

1 reflects and if there's any offsetting good that comes from
2 it.

3 Now, if all that has been fully explored, we know
4 all that, you know, we can just let it go. But just to
5 follow on Mary's comment, I'm guessing the hospital-based
6 agencies are going to be a vanishing species here. To some
7 extent they already are.

8 MR. CHRISTMAN: I think the point I want to make
9 is that two things that have put -- one thing that has put
10 pressure on both the nonprofits and the hospital-based is
11 the explosion of the for-profits. And they will continue to
12 enter this market as long as they see it as highly
13 profitable.

14 I recognize that rebasing puts pressure on
15 hospital-based and nonprofits, but, you know, the graphs
16 I've shown you over the last 12 years, the pressure has been
17 the entry of the for-profits. And as long as that
18 continues, they're going to be under the same pressures that
19 you guys have remarked on.

20 DR. NAYLOR: And yet the performance value of for-
21 profit -- not-for-profits is much more positive.

22 MR. HACKBARTH: And so what we want to do is pay

1 at the level of the efficient provider and not focus on
2 whether they're hospital-based or freestanding, for-profit
3 or not-for-profit. As we've often discussed, that has two
4 basic elements. One, of course, is cost but the other is
5 the quality. Cost and quality combined make up value. And
6 so if, in fact, not-for-profit agencies or hospital-based
7 agencies are doing something better, conceptually what we'd
8 want to do is have, you know, quality bonuses in the system
9 that reward those improvements, not worry about how the
10 category is doing, not-for-profit or hospital-based, but are
11 we justly rewarding really high quality providers?

12 I don't think we're necessarily there in terms of
13 our quality measurement and bonus program, just to be clear,
14 but I think that's the path to address those issue as
15 opposed to vary payment based on category. And I think you
16 both agree with that?

17 DR. NERENZ: Yeah.

18 DR. NAYLOR: I just thought this might be a good
19 time to kind of set the case for continued conversation in
20 this report.

21 DR. COOMBS: I just want to comment. One other
22 issue was the dual eligibles in the two different entities,

1 that being the not-for-profits having a higher percentage,
2 and that was something that we'll keep our eye on.

3 DR. NERENZ: I'd respond to that. Basically I
4 think we agree. If there's not a shred of evidence that the
5 hospital-based agencies are doing anything differently or
6 more efficiently or with any net benefit, then if they have
7 higher costs, that's just too bad. So I think we're on the
8 same page there. Just it always strikes me odd, as I've
9 mentioned, that when we look at these other areas of
10 activity, the hospital-based always seem to be sort of
11 higher cost and lower margin, just seems strange.

12 MR. HACKBARTH: You know, I mentioned the
13 potential for quality-related payments. And the other issue
14 that we've had -- and we've discussed this in previous
15 meetings, Dave -- is that with regard to a SNF payment, as
16 we looked at that issue, what we found was part of what was
17 going on was the patient classification system, the money
18 wasn't being properly allocated, and as a result, hospital-
19 based SNFs were being underpaid because of their patient
20 mix. And we recommended changes in the payment system that
21 dealt with patient classification. And an ancillary effect
22 of that would be to improve payment to hospital-based

1 providers. But it was not, oh, we want to reduce the losses
2 for hospital-based providers. It was let's pay them fairly
3 based on their performance.

4 Okay. Other comments on this report to Congress?

5 [No response.]

6 MR. HACKBARTH: So we don't need any votes. We
7 have no recommendations. This is basically an analytic
8 report.

9 Okay. I think we are done except for the public
10 comment period, unless there is anything the Commissioners
11 want to add. Evan, thank you for your work on this. Well
12 done.

13 Any concluding comments on this or any other
14 subject by Commissioners?

15 [No response.]

16 MR. HACKBARTH: Seeing none, we'll have our public
17 comment period.

18 [No response.]

19 MR. HACKBARTH: Going once? Twice? We're done.
20 Thank you very much.

21 [Whereupon, at 10:50 a.m., the meeting was
22 adjourned.]