MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 16, 2014
9:43 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHS
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WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
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MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP
AGENDA

Assessing payment adequacy and updating payments: hospital inpatient and outpatient services, and reforming Medicare’s prospective payment system for long-term care hospitals
-- Jeff Stensland, Dan Zabinski, Dana Kelley, and Julian Pettengill

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The Medicare Advantage program: status report, and employer group plan and hospice policies
- Scott Harrison, Carlos Zarabozo, and Kim Neuman

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MR. HACKBARTH: Okay. Would you take your seats, please?

Before we begin our presentations and going through the issues one by one, I just want to do a little bit of stage setting for the audience.

First, sort of an overview of what we'll be doing the next couple days. As those of you who follow our work know, this is the meeting at which we complete work on our recommendations on update factors that will go into our March 2014 report.

Today we will have votes on a package for acute-care hospitals and long-term-care hospitals, two recommendations relative to Medicare Advantage, a dialysis recommendation, and a couple recommendations related to post-acute-care services.

On Friday, tomorrow morning, we will have votes on ambulatory surgery centers, long-term-care hospital updates, IRF updates, and hospice. We will not have our usual extended staff presentation and Commissioner discussion on those issues tomorrow morning. Based on our discussion in December about the draft recommendations, it seemed that
there were few outstanding issues, and we decided to
truncate the time allotted to those issues so that we can
make room for some other topics, including ACOs, the Part D
landscape chapter, and discussion of recommendations on the
Medicare savings programs.

So we are trying to not use up all of our time at
this meeting on updates where there's no controversy among
Commissioners and reallocate it to some other topics.

We will not be discussing at all at this meeting,
either today or tomorrow, physicians, skilled nursing
facility, and home health agency payment. As we discussed
in December, in each of those cases we have a multi-year
recommendation that has been in place. In December,
Commissioners did not express any concerns about those
recommendations, and so we will be including, of course,
chapters in the March report, but we are not going to be re-
discussing those issues today or tomorrow.

Because of that, I want to emphasize here at the
outset that, on physicians, repeal of the SGR system for
physicians continues to be one of our top priorities. I
sort of scanned the press accounts of our meetings, and
after the December meeting, somebody inferred from something
I said about physicians that maybe we had backed away from our position on repeal of the SGR. Nothing could be further from the truth on that.

What I did say and tried to convey is that we are glad that the Congress, the relevant committees of the Congress are working actively on SGR repeal. We are encouraged by the progress that they have made and the general direction that they are headed and hope that they will complete that work in an expeditious way. At this point I just don't think MedPAC spending more on the issue, while it's under active deliberation in Congress, I don't think we have more to say on the topic. We are not, however, backing away from our more than a decade long position in favor of repeal of SGR.

So that's sort of an overview of the meeting.

The next thing I want to do is talk about the sequester and how our recommendations work and the implications for the sequester. The sequester, which, as people know, reduces payments to Medicare providers and suppliers by 2 percent, has recently been extended so that it will be in effect, barring a future change by the Congress, change via legislation, the sequester will be in
effect from April 2013 until March 2024. It was extended 2
years in the Bipartisan Budget Act of 2013.

Next slide.

This illustrates how the sequester works. The
yellow line in this graph is the base payment amount under
the Medicare payment system. Each of the Medicare payment
systems for hospitals and skilled nursing facilities and
long-term-care hospitals, et cetera, each of them has a base
rate that is then multiplied by various factors -- wage
indexes, case-mix indexes, et cetera -- to get the payment
rate for a particular service.

The updates that we recommend are updates to that
base rate. So the yellow line here illustrates the increase
in the base rate for a provider group that under current law
is to get a 2 percent update each year. So that yellow line
moves up in 2 percent increments each year.

The sequester is depicted by the green line. The
sequester is actually not part of the Medicare law. It is a
different statute altogether. And what the sequester does
is say that we're going to reduce the payment rate below the
yellow line by 2 percent at the beginning of the year; then
at the end of the year, the rate pops back up to the base
rate provided for in current law. The sequester is temporary. The sequester is not cumulative. The sequester does not change the base rate.

Next slide.

So MedPAC's approach on making updates is that we make recommendations on the base payment amount, the rate established in the Medicare statute, Title 18 of the Social Security Act. We make recommendations on the yellow line.

The Commission opposes the sequester, and I want to be crystal clear on this. The sequester is a way of reducing payments below that yellow line to hit budgetary targets established by the Congress.

Our approach is to recommend changes in the base rate, the yellow line, and to make other recommendations for changing the trajectory of Medicare expenditures. We don't think that reducing the base rates for hospitals, for physicians, for skilled nursing facilities by 2 percent using the sequester as the mechanism is the best way to find savings in the Medicare program. Each year we produce many recommendations, some of them for update factors, some of them for other policy changes, that will reduce Medicare spending. There are better, more targeted ways to reduce
Medicare spending than arbitrary 2 percent cuts executed through the sequester.

We don't ignore the sequester. We say there is a better way to reduce Medicare spending. And we make recommendations about Medicare payment rates that affect the yellow line, the base rate. When the sequester reduces the payment rate going to providers below our recommended yellow line, MedPAC opposes that. We're not ignoring the sequester. I want to be crystal clear. We oppose the sequester when it reduces rates below our recommended yellow line.

Now, we're not the decisionmakers. The Congress makes the decisions. But where the sequester reduces that rate below our recommended rate, we're opposed to it. In fact, as I said a minute ago, as a matter of principle we don't think this is a good way to reduce Medicare spending. There are more targeted ways to go about that task.

Move to the next.

And so this is a real simple example to illustrate what I'm saying. For this provider group, in fiscal year 2014, or it can be calendar year for a payment system, for 2014 the base payment amount, let's just say for the sake of
discussion, is $100. Now, the amount that providers are
actually getting because of the sequester is not the $100
but the $98, the sequester amount at the bottom of that
column.

Now, we have assumed in this example that the
current law update for this group of providers is 2 percent.
So as you move from 2014 to 2015, the current law update
would be to go from $100 to $102 in the base rate.

For the sake of illustration, let's say that the
MedPAC recommendation is not for the current law 2 percent
increase in the base rather but, rather, 1 percent. That
gives you the circled $101 base rate in 2015.

Under the sequester, if Congress doesn't enact our
recommendation, the current law provides for $102, and the
sequester would reduce that to $100. Since 100 is less than
101, it's clear that we oppose the application of the
sequester to this group.

Now, sometimes, in fact, even after the sequester,
the rates paid to providers may be higher than MedPAC
recommends. Sometimes it's lower, sometimes higher. But
rather than confusing things by saying, "Well, sometimes we
like the sequester, sometimes we don't," I want to be real
clear. We don't like the sequester at all. We don't think as a matter of principle this is the way to reduce Medicare spending. A much more targeted approach is the way to go. I am not ignoring the sequester, as has been frequently reported. This is what we're doing. So hopefully that makes it clear.

I think that's all I have for the introductory session. Any suggestions from Commissioners for clarifications on that?

[No response.]

MR. HACKBARTH: Okay. Let's do the first presentation, which is on hospital services and LTCHs. While the group is getting in place, I recognize that the sequester and how it plays into all of this can be confusing for people, and so next year, when we go through this process again of formulating update recommendations, we will consider changes in how we package our recommendations, how we report projected margins, things like that. Given that the sequester now seems to be if not permanent, at least semi-permanent, permanent for the next decade or so, it's going to be with us, and we need to think about how we can most clearly communicate our message.
So as I say, there may be some changes in packaging and presentation on the fundamental substantive point, though don't expect any change. We're going to work from the Medicare law, the base rates in the Medicare law. That's what we're charged with making recommendations on. And that will continue to be our approach.

Okay. So who has the lead?

DR. STENSLAND: Good morning. This session is going to discuss Medicare payments for hospitals. First, I'll review the adequacy of Medicare payment rates. Because we've already discussed this in November and December, I will go quickly through that part of the presentation.

Second, Dan will recap aligning hospital outpatient rates with physician office rates.

Third, Dana will discuss aligning LTCH and acute care hospital inpatient rates.

The common theme throughout the presentation is to create incentives to improve the efficiency of care while maintaining an adequate level of aggregate payments.

As we discussed in December, in general, most payment adequacy indicators are positive. Access to care is good, with excess capacity in most markets. Access to
capital is adequate, as measured by access to debt markets, access to equity markets, and hospital construction spending. Quality is generally improving, as measured by 30-day mortality rates and hospital readmission rates. However, as we discussed before, Medicare margins remain negative for the average hospital and are expected to remain negative in 2014. The projected margin would be six percent if the sequester is repealed, and that could go to almost eight percent, or two percent lower, if the sequester remains in place.

As we discussed in December, while average margins are negative, there is a group of hospitals that have been able to generate a small profit treating Medicare patients while having relatively good quality metrics. This group of relatively efficient providers has 13 percent lower mortality, lower readmissions, and costs that are about ten percent below the average hospital. The point of this slide is to show that it is possible to produce good outcomes while controlling costs.

Now, I just showed you the most recent data we have, which is for 2012, and gave projected margins up to 2014, with and without the sequester. However, today,
you'll be voting on a recommendation for 2015 payment rates. Under current law, we would expect payment rate to decline by 1.3 percent in 2015 due to the changes in payment policy that we discussed last month. If payment rates declined by 1.3 percent next year, we would expect Medicare margins of the relatively efficient hospitals to fall below zero.

Now, next, we're going to shift to discussing aligning payment rates across sectors, and after that discussion is complete, I'll come back to you with the draft recommendation for 2015.

A key problem in the Medicare payment system is that Medicare hospital payment rates encourage care to be shifted to higher-cost sites. This can increase provider costs of care, increase Medicare program costs, and increase beneficiary cost sharing without any evidence that care is improved. We discuss aligning payment rates for similar cases across silos in order to eliminate this distortion in Medicare prices which can create inefficiency.

First, Dan is going to discuss eliminating the adverse incentives in the outpatient payment system.

Second, Dana will explain how to correct the incentives that currently encourage certain inefficient practices in the
delivery of LTCH care.

Now, I'll turn it over to dan.

DR. ZABINSKI: Efficiency in ambulatory settings

is becoming a larger concern because it does appear that the
billing of services is shifting from the lower-cost hospital
office setting to the higher-cost OPD setting. For example,
in this slide, we show that the volume of E&M office visits,
echocardiograms, and nuclear cardiology services that are
provided in freestanding offices all decreased in 2011 and
2012 while the volume increased in OPDs for the same
services.

Also, there has been widespread attention to this
issue in the press concerning the private sector. Stories
describe increased costs on insurers and patients in the
private sector due to shifts in billing from offices to
OPDs.

In the Medicare program, this shift in billing
from offices to OPDs increases program spending and
beneficiary cost sharing without any significant change in
patient care or quality.

We estimate that Medicare and beneficiaries are
paying about $2.1 billion more for E&M visits and other
services than they would if OPD rates were more closely aligned with lower physician office rates, with program costs being about $1.7 billion higher and beneficiary cost sharing being nearly $400 million higher. And if the shift in the site of service continues, the costs to Medicare and beneficiaries will increase further.

The Commission has recommended equal payment rates for E&M office visits, whether they are provided in freestanding offices or OPDs and has had several discussions about eliminating or narrowing the differences in payment rates between freestanding offices and OPDs for other services. We do want to emphasize, though, that it is not appropriate to pay equally across these two settings for all services, and we have identified five criteria that services should meet in order for payments to be equal in offices and OPDs and we have discussed these five criteria in detail in previous meetings and the June 2013 report, so we won't cover them here.

We have identified some APCs in the outpatient PPS that meet these five criteria and are viable candidates for equal payments across settings, where APCs are the system for classifying services in the payment units and the
outpatient PPS. We call these APCs Group 1.

We have also identified some APCs that meet four of the five criteria, but they have greater packaging of ancillary items under the outpatient PPS and in the Physician Fee Schedule. For these APCs, payment rate differences between settings could be narrowed, but should remain higher in OPDs than in freestanding offices by the costs of the additional packaging in the outpatient PPS. We call these APCs Group 2.

And using 2010 data, we find 24 APCs that meet the criteria for Group 1 and 42 that meet the criteria for being in Group 2.

Making these payment rate adjustments in these 66 APCs would reduce hospital program spending and beneficiary cost sharing by about $1.1 billion per year, and this translates to lower overall Medicare revenue for hospitals of about 0.6 percent and lower Medicare OPD revenue of 2.7 percent. Most hospital categories would be affected by about the same amount as the overall average of 0.6 percent, except that rural hospitals and hospitals that have 100 or fewer beds would be affected more.

And a concern that many have expressed about these
lower OPD rates is that access to ambulatory services for low-income patients may be adversely affected, so in response, we have developed an illustrative example of how losses to hospitals that serve low-income patients could be mitigated.

And now, Dana will talk about payment reform and LTCHs.

Ms. KELLEY: The Commission has developed a draft recommendation for the LTCH prospective payment system that would reduce incentives to admit patients who are not appropriate candidates for LTCH services. This recommendation would maintain a separate LTCH payment system, but higher LTCH level payments would be made only for LTCH patients that were chronically critically ill, or CCI. All other LTCH cases, the non-CCI cases, would be paid IPPS-based rates. All LTCH cases, whether CCI or non-CCI, would be eligible for LTCH outlier payments. The outlier pool would remain set at eight percent of total LTCH payments.

Under this recommendation, LTCHs would be required to maintain an average length of stay of more than 25 days only for their CCI cases. Savings from these changes would
be transferred to the IPPS outlier pool and used to increase outlier payments for chronically critically ill patients in the IPPS.

As we've discussed, under this recommendation, CCI cases would include those that spent eight or more days in an ICU during an immediately preceding acute care hospital stay. In addition, we've expanded our CCI definition to include those patients who received prolonged ventilator services during an immediately preceding acute care hospital stay. This was in response to Commissioner concerns that the threshold of eight days in the ICU could prevent some prolonged ventilator patients from receiving specialized weaning services in LTCHs. Our analysis found that most prolonged ventilator cases in LTCHs had had long ICU stays during their preceding hospital stay and, therefore, would meet the eight-day threshold. However, we've expanded our definition of CCI to include all of these cases to maintain access for these patients. We estimate that about 41 percent of current LTCH cases would qualify as CCI under this definition.

Some have questioned why the Commission has focused on ICU as a definition of CCI. The definition
arises from both the research literature and the industry itself. Researchers are consistent in describing chronically critically ill patients as having long acute care hospital stays with heavy use of ICU services. In addition, in CMS technical advisory panels and in site visits conducted by RTI under contract to CMS, LTCH representatives and acute care hospital critical care clinicians agreed that the appropriate candidates for LTCH care are medically stable post-ICU patients.

Findings from the PAC reform demonstration strengthen the case for using ICU length of stay. In the demonstration, it was found that ICU length of stay was the most important factor explaining variation in LTCH routine resource intensity. Our resource has found that ICU length of stay can be used to identify the CCI patients who may be appropriate candidates for LTCH care and who have resource needs that are likely to be aligned with higher LTCH payments.

Another question that has come up is why eight days. There is no magic number, but ICU days, as I said, are positively associated with case complexity. As the ICU length of stay threshold is reduced, the average complexity
and resource needs of patients fall. If the threshold is set too low, less-complex cases will be designated as CCI and CMS will continue to pay too much for cases that could be cared for appropriately in other settings at a lower cost to the Medicare program.

Our recommendation is to implement LTCH payment reform over a three-year period. This slide shows the impact on payments to LTCHs and IPPS hospitals assuming no behavioral change. As you can see on the left, when fully implemented, total payments to LTCHs would decline by about $2 billion. As I mentioned, 41 percent of cases would receive the high LTCH payment rates. Fifty-nine percent would be paid IPPS-based rates. On average, assuming no behavioral change, an LTCH's total Medicare payments would decline 36.5 percent by year three. The impact will be greater for for-profit LTCHs and LTCHs in LTCH-saturated markets, as well as for any LTCHs with relatively low CCI shares.

On the right, we show the impact for IPPS hospitals. Under our recommendation, savings from LTCH payment reform would be used to increase outlier payments for CCI cases in acute care hospitals. When fully
implemented, total outlier payments to IPPS hospitals would increase by $2 billion. About six percent of current IPPS cases would be eligible for higher outlier payments. There would be no reduction in payments for any IPPS hospital. On average, an IPPS hospital's total Medicare payments would increase by 1.8 percent. It is not shown on the slide, but the aggregate average increase for CCI cases would be 10.8 percent. IPPS hospitals that care for more CCI cases will benefit more under our recommended policy. These include major teaching hospitals, low-margin hospitals, and hospitals in areas with fewer LTCHs. These impacts assume no behavioral change for LTCHs. However, we do expect significant changes in behavior, so let's talk about what we anticipate will happen.

This slide shows the relationship between an LTCH's margin and its CCI share of cases. As you can see from this scatterplot, there is no relationship. An LTCH's margin is not associated with its CCI share. This is important because it means that LTCHs do not systematically make their margins on their less-complex non-CCI cases. LTCHs can focus on caring for CCI cases and still maintain
positive margins.

Historically, LTCHs have been very responsive to payment incentives. Under our policy, we expect that LTCHs will admit fewer non-CCI cases and be more selective in choosing which non-CCI cases they do admit. We also anticipate that LTCHs will alter their delivery of care so as to reduce their costs for the non-CCI cases they do admit.

As this hypothetical example shows, LTCH lengths of stay for non-CCI cases will likely fall. In the first year of the transition to the new policy, an LTCH could reduce the length of stay for a non-CCI case by five days and still maintain a positive margin under the new payment rate.

To be fair, the LTCH would have to continue to reduce lengths of stay for non-CCI cases if they want to continue caring for non-CCI patients. There are a number of ways they can do this. For example, they could admit non-CCI cases later in their course of illness, after they have spent a few more days in the acute care hospital, or they could discharge cases earlier to lower levels of care.

Now, Jeff will review the draft recommendation and
DR. STENSLAND: So, that brings us to the joint draft recommendation. It states, the Congress should direct the Secretary of Health and Human Services to reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected APCs, set LTCH base payment rates for non-CCI cases equal to those of acute care hospitals, and redistribute the savings to create additional inpatient outlier payments for CCI cases in IPPS hospitals. The change should be phased in over a three-year period from 2015 to 2017.

Increase payment rates for acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

And the rationale for this recommendation is, first, that there's a need to reduce incentives to shift care to higher-cost sites, and this would accomplish that in three different ways. First, aligning selected APCs with physician office rates would reduce unnecessary costs
associated with the shift of services from physician offices
to being billed as hospital outpatient services.

Second, equalizing the LTCH and acute care
hospital rates for non-CCI cases would eliminate the problem
of LTCHs keeping low-severity patients longer than truly
needed in order to increase their LTCH payments.

Third, increasing acute care hospital CCI payments
through the additional outlier payments Dana just discussed
would bring greater equity between markets with and without
LTCHs.

In addition, the draft recommendation is designed
to provide adequate payments. After considering
beneficiaries' strong access to care, the potential for
decreasing margins given changes in current law I just
discussed, and the two draft policy changes, an update above
current law is warranted.

This graphic shows you how acute care hospital
payments would change under the draft recommendation. The
first column shows acute care hospital payments in 2015
under current law, and we already talked about this. This
is the 1.3 percent expected decline.

The second column shows the impact of the
recommendations in 2015. If you look down the second column, you see that the outpatient site neutral recommendation would reduce hospital payments by about 0.6 percent, as Dan mentioned. The LTCH reform part of the recommendation would increase PPS hospitals' payments by 0.4 percent, due to those outlier payments being phased in one-third in 2015. Then the update in that last line is 1.05 percent higher than in current law. The net result is that payments would be higher in 2015 than current law, but payment growth would still be a negative-0.5 percent.

The last column shows what would happen when the recommendation is fully phased in. The impact of the LTCH reform now increase to 1.2 percent because the full reduction in the LTCH payments is taking place and that full amount of money is now available for IPPS hospitals as extra outlier payments.

In the end, there is a 0.3 percent increase in acute care hospital payments relative to 2014, which is 1.6 percent above the current law estimate of negative-1.3 percent.

Now, we talk about the implications of this recommendation in terms of spending and for beneficiaries
The draft recommendation increases Medicare spending because we're recommending a higher update than current law and because we recommend that savings from LTCH reform be redistributed to hospitals as new outlier payments. Now, our recommendation differs from current LTCH reform that was passed recently in that we recommend equalizing rates for more LTCH cases, because we're going to eight days and current law is three days. This generates bigger savings than current law. We also differ from current law in that we're recommending the savings be transferred to acute care hospitals in the form of higher outlier payments. The net result is that our recommendation would increase Medicare spending by between $250 and $750 million over one year, and by between $1 and $5 billion over five years.

Now, in terms of beneficiaries and providers, the recommendation may slow or stop the shift of services from freestanding practices to OPDs. This will reduce beneficiary cost sharing. It will also reduce payments to LTCHs, but those reductions will be used to assist IPPS hospitals that care for the most difficult CCI cases in an
acute care setting.

And now, we'll open it up for discussion.

MR. HACKBARTH: Clarifying questions first. Any

strictly clarifying questions on the presentation? I have

Bill, Herb -- anybody else? Bill?

MR. GRADISON: I do have one.

MR. HACKBARTH: A clarifying question?

MR. GRADISON: Yes. On the 20 -- perhaps I didn't

hear you correctly. I thought you said that the savings

over five years would be $1 to $5 billion, and the document

up here says $5 to $10 --

DR. STENSLAND: Yes, and I misspoke. It's five to

ten.

MR. GRADISON: Thank you.

DR. STENSLAND: Five to ten is the right number.

MR. GRADISON: Thank you.

DR. HALL: Perhaps this is more of a semantic

point, but I think it could be important. On Slide 6 of the

current packet -- could I just put that up there -- and I'm

particularly concerned about how we talk about the

adjustment of payments between the two outpatient sites of

seeing patients. Let's see. Under "Solutions." Okay. So,
if you look under "Solutions," there, halfway down the slide, and we say, pay hospital rates that are comparable to physician office rates for services that can be provided, that's very clear to me. There's no equivocation.

In many of our previous statements in the material we received at home, we actually use a different phrase at least five or six different times, and the phrase is "reduce or eliminate differences in payment rates between outpatient departments and physician offices." Someone reading that for the first time could reasonably say, well, I think what they're trying to say is that we ought to pay the ambulatory sites the same rates that we're paying the hospital, and that's not what we're doing. It's just the opposite of that.

So, I like the nomenclature in the slide here. Pay hospital rates that are comparable to physician office rates for services, et cetera. that is very, very clear. Otherwise, I think we're going to confuse a lot of people in what is a very good policy recommendation.

MR. HACKBARTH: Okay. Got that?

Herb.

MR. KUHN: Thank you. On page 15, where you look
at the LTCH margins, and just to be sure, that's all LTCHs together. That doesn't differentiate between freestanding versus hospital in-hospital, is that correct?

MS. KELLEY: No, that's all LTCHs.

MR. KUHN: Okay. If we did differentiate between the two, do we think we would see much difference between freestanding versus hospital in-hospital?

MS. KELLEY: No, I don't. No, I don't believe so.

MR. KUHN: Okay. Thank you.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: Okay. Since we went over this in December, I think we'll just do one round here and each Commissioner will have their opportunity to comment on the proposed recommendation, beginning with Peter.

MR. BUTLER: Okay. So, this may take a little longer than two minutes, but not too long. I'll try to be efficient.

I like to remind Commissioners every year that this is the most important vote we take because it's the biggest amount of money. It's somewhere, I think, between 25 and 30 percent of the budget sits with this vote. And if
you look at the chapter, we spent $166 million last year, in 2012, $163 the year before, which is only about a two percent increase, I think, by my math, and it is actually a reduction in per capita spending for this component of the Medicare program, which says from a fiscal standpoint -- and we don't like to take things in isolation, but it's done pretty well on the cost side of things. As shown, the access, the quality, and -- not bad. And while the value-based purchasing and other tools that we're trying to implement are not perfect, this is a sector where we've got some traction, particularly with things like HCAHPS that seem to be a positive development.

I'd also point to the Health Affairs blog that, Glenn, you sent my way, and maybe to some others, that Kaufman, Hall looked at the Chicago market, and the title is "Where Have All the Inpatients Gone?" -- "Where Have All the Patients Gone?" And it was an interesting portrayal of the reductions being not really due to a lag in the economy, but due to systematic changes in care. And it's just one example that I think things are really -- are happening. And, also, it highlighted that the switch to observation stays and things, also, was not an explanatory variable.
So, maybe some good permanent things are occurring.

I think all this is occurring, too, at a time when hospitals have invested in IT, are adapting with ICD-10, are investing in ACOs at probably higher numbers than we expected, and all costs money at the same time this sector is showing it's not really increasing very rapidly, if at all, on a per capita basis.

So, four things I like about the recommendations here, and I support the recommendations. The first is the treatment of the sequester, which applies to, really, all the sectors, but I think the public shouldn't underestimate the amount of sensitivity and attention Commissioners, staff, Glenn, himself, has paid to wanting to get this right. The fact is that the sequester is not Medicare law. It is law, but it is not Medicare law, and we are opining on Medicare law and there is a difference.

Glenn, I thought for a minute you were going to be Jack Nicholson when you were saying, "Am I clear as crystal?" --

[Laughter.]

MR. BUTLER: -- because you said it many times, and we're trying to be very clear about sequestration as the
wrong tool and really outside our domain, anyway, in terms
of a specific recommendation. So, I like the sequester.

I also like how we're handling the pricing issues,
where we said repeatedly, some pricing is just -- not only
does not make sense, it's leading to behaviors, or enabling
behaviors like maybe employment in cases where it really
shouldn't occur and increase ultimately in Medicare spending
and we need to put a stop to that.

I like this particular recommendation because
while I have previously supported the E&M codes, I think the
APCs is a better starting point because it also deals with
the test and procedure issues as opposed to the office
visits. And I also like it because I think it's a better
place to start, and I do want to be clear that I think that
if you were to put E&M and APC on the table at once, I
couldn't support -- the whole recommendation doesn't hang
together. So, I'm supportive of the APCs, although I
realize there are some technical issues in terms of the
current list of APCs that would have to be worked out to
make this work.

The third thing I like is the fact that this
crosses payment silos, and that's kind of precedent setting
for us, where we're trying to price things in a way that
puts patients in the right place, at the right time, at the
right price, and I think that that is an important thing for
us to do and I think this does this.

And, finally, I think this meets the test of
paying providers -- efficient providers -- at a level that
is acceptable. It's the 3.25 percent, as people will be
quickly to translate means 5.25 percent if you did not have
the sequester, which is we're opposing the sequester, is a
significant update over what is occurring now. And I think
it's an important message as over the next three months we,
once again, find -- try to find dollars to support SGR
repeal. It says that maybe this isn't the sector that is
the well you want to go to too aggressively to achieve those
kinds of offsets.

MS. UCCELLO: Yes. I support the recommendation,
as well, and agree with pretty much everything Peter said.
I especially like, as Peter did, the alignment of payments
across silos. We really need to stop providing incentives
to provide care at higher cost settings when lower cost
settings are available, and I think the way that we've
approached this is appropriate.
DR. BAICKER: I would echo Cori's sentiment about enthusiasm for the equilibration of payments and also reiterate your initial comments that what we're recommending is the payment rate that we think should be in effect, and if the sequester does something different from that, that's not what we think the right answer is. This is what we think the right answer is, and I support the recommendations.

DR. HOADLEY: I also support the recommendations, and I really think we've got a nice package here, you know, addresses the site-of-care differentials, addressing the LTCH issues, as has been described, both cases where we're trying to get the payment right and not attached to just the sector where, you know, a particular thing came from, but to overcome sort of our underlying rules and make adjustments to try to put things in a better place. And I think the update, you know, there are plenty of arguments for high updates; you know, we want to make sure people are paid adequately and access is protected. There are a lot of arguments out there for, you know, keeping updates low for budgetary reasons. And I think we've really tried to hit a sweet spot that kind of balances the things in the ways that
have already been described, sort of pay attention to where
the margin issues are, pay attention to access, pay
attention to budgetary considerations, not go crazy with
unnecessarily large update but really try to hit it right.
And I think we're in a good place on this.

DR. HALL: I would echo what others have said, and
I'm in support of the recommendations. And I think what I
really like about this is the tremendous amount of research
and analysis that has gone on by MedPAC staff on this.
There's nothing like this anywhere in the literature. I
think you've really gotten it right. And it is a marvelous
way of saying that we don't just cut rates irrationally, but
what we try to do is redistribute rates in a way that
incentivizes where we think the health system should go to
improve the quality and efficiency of care to older adults.
So I think this is a wonderful recommendation.

DR. COOMBS: First of all, I want to say I support
all three recommendations. I would agree with the APCs
selected. As I go through them, I think they're the most
appropriate ones that have been selected for this phase of
our advancement. And the other thing is I'm glad that, you
know, we -- we struggle with this whole issue of getting
around non-CCI versus CCI and criteria. I think this does exactly what we want in terms of no matter what setting the patient's in, is to treat them and to reimburse it according to whatever setting they're in based on their status, so that if they're non-CCI, whether they're in the hospital, or whether they're in the LTCH, I think this gets around that. So job well done. Thank you.

DR. CHERNEW: I also support the recommendation, and I guess I want to say three quick things. The first one is in support of what other people said that we have to recognize that our task is not simply to get a certain amount of money into a sector, but to try and make sure that the prices are set correctly to give the right incentives. And I think this is an example of where we're beginning to move in that direction, and I strongly support that.

The second thing is -- and Peter mentioned about silos; I'll say it more explicitly -- we focus here in ways on types of patients in terms of site of care in the sense that we look at CCI, non-CCI patients. And the more -- so I think it's basically a patient-centered approach, which I think is important, and that is why it ends up being working
across silos. And the third thing is something I've said before, which is I do believe margins are an important criteria, but they're not a definitive criteria about what we do. There's a range of other criteria: access, quality, things of that nature. And so I think it's important to understand that when thinking about what the right update is, at least in my mind, you don't simply look at the margin, you look at all the other things going on and try and make a determination. And I think that we've done a reasonably good job, as Jack said, in hitting a balance.

DR. REDBERG: I support all of the recommendations and for all of the reasons that my fellow Commissioners have already outlined. I think it really represents a very thoughtful process to maintain our principles to access to care, maintaining quality of care, and neutralizing site-specific payments, and that we oppose the sequester.

MR. KUHN: It's a good body of work, and I appreciate the comments Glenn made this morning and the conversation you had in the presentation about the sequester. It's real clear that the Commission, like everybody else, doesn't have a tin ear on this issue, and we
have a good sense of self-awareness of what the sequester
means, its impact. And I really appreciated when you put up
the margin information, indicated that those margins would
be 2 percent less if the sequester was in place. And I look
forward to the drafters' reports to also reflect that as
well as we continue not only this year but in future years
as we go forward.

The other thing I would just say is I continue to
be concerned about those margin issues, and I understand
exactly what Mike is saying, and there's other factors in
there. But I think the critical point to continue to come
back to here is that 302 hospitals that we've identified
that are relatively efficient right now on a current
trajectory of negative margins in 2015, that is a cause of
concern, and that says something that we need to continue to
monitor closely as we go forward.

DR. SAMITT:  I wholeheartedly support the
recommendations. I think Peter described all the positive
elements eloquently. And the one point that I'd underscore
is even beyond the notion that this recommendation spans
silos, I would go one step further, which is I envision that
it actually really will drive a greater collaboration
between these various parts of the system because now this
will encourage LTCHs, hospitals, and physicians to truly
identify what is the right care in the right place with the
right provider at the right price. It will really encourage
those various silos to come together to evaluate the care
for a population, the care for the beneficiaries, which is
what is so critical here.

MR. GEORGE MILLER: Yes, I also echo what my
colleagues have said about this process and the tremendous
amount of work, and particularly that across settings, with
the right incentives, that we can put the patient in the
right location, not worry about what's the most cost-
effective method but the best site of care. And I
wholeheartedly support the recommendations as my colleagues,
but in the reading I've got a couple of things that I'd just
like to get clarity on.

One is on the hospital outpatient department. As
I understand it, on the hospital side we collapsed ten codes
into one, so we've got one code. But on the physician side,
physician fee service side, there's still ten. So we've got
ten E&M codes and ten different payments, but on the
hospital side there's just one. So my question is: How
would the caps work under that scenario since we're dealing
with ten versus one? How do you envision the caps working?

DR. ZABINSKI: I can picture a situation of, say,
on physician claims, they report site of service. So you
know when these E&M codes, which of the ten was provided in
an OPD, and you can use that information then to do an
average, you know, use the volume that you have in each of
those ten codes to create a single payment rate for that
single -- you know, that APC that now has only one code.
I'm not sure if that's being clear or not, but --

MR. GEORGE MILLER: No, but I can follow up later.

[Laughter.]

MR. GEORGE MILLER: Because I don't know how you
compare the two. On the hospital side now it's just one
code, but if that patient goes to a physician, that
physician can code that 1 through 4, and it's still ten
separate E&M codes.

DR. ZABINSKI: Well, let's simplify it a little
bit. Suppose you only had two E&M codes --

MR. GEORGE MILLER: Well, that would be helpful.

DR. ZABINSKI: -- instead of ten on the physician
side and one on --
MR. GEORGE MILLER: That would be very helpful.

DR. ZABINSKI: Well, just suppose, you know.

MR. GEORGE MILLER: Yeah, suppose.

DR. ZABINSKI: Being an economist here and just, you know, assuming.

MR. GEORGE MILLER: I don't know how to do that.

[Laughter.]

DR. ZABINSKI: You still have one on the hospital side, and you know that the -- and suppose that the payment rate for one on the physician side was $10 and the other was $20, and half of the E&M codes were in -- you know, it was divided equally, you know, half was in one E&M code, the other half of the volume was in the other. So an average of that is 15, okay? And that's what you'd -- you can picture that's what you're going to then apply to the single --

MR. GEORGE MILLER: Cap.

DR. ZABINSKI: -- hospital outpatient code.

Something like that.

MR. GEORGE MILLER: Something like that, okay.

All right. We can come back to that later offline.

DR. MARK MILLER: And just to tack back to a point that Peter was making, this is a discussion of the E&M
codes, and it's a fair question, and I hope you're getting close to an answer. But just to remind people we're on the other 66 codes for the purposes of this recommendation. But your question still stands.

MR. GEORGE MILLER: Yes, right.

DR. MARK MILLER: I just don't want anybody to misunderstand us here.

MR. GEORGE MILLER: Well, I'm going to ask about the APCs also. As I understand it, the final OPPS rules pack this into five different areas, which recategorize all the APCs. So how do we differentiate between the OPPS and the physician fee-for-service? Did they recalibrate when you came with the 66 after the package in the five different categories?

DR. ZABINSKI: I think I know what you're driving at.

MR. GEORGE MILLER: Okay.

DR. ZABINSKI: This year there was an increase in the packaging -- you know, for the --

MR. GEORGE MILLER: Yeah.

DR. ZABINSKI: Okay. Well, what's going to happen there is any of the -- you're going to have some APCs in our
Group 1 where, you know, in Group 1 --

MR. GEORGE MILLER: You have two groups.

DR. ZABINSKI: The idea is to have APCs that have minimal levels of packaging, our definition less than 5 percent.

MR. GEORGE MILLER: Right, right.

DR. ZABINSKI: Under the new packaging rules, the packaging of those -- the amount of packaging in those items is going to -- for some of them it's going to increase, and that might push them to Group 2, but they'll still be in the analysis. And, you know, any savings that you get from lower OPD rates is going to be the same, whether they're in Group 1 or Group 2, because we make the adjustment for that additional packaging.

For example, suppose you have -- making more assumptions, suppose you have an APC that's in Group 1 where the outpatient payment rate is $100, and if we equalize the payment across the two settings, that would drop the payment rate to $50. All right? And suppose that, you know, under the old system it had nothing packaged with it, okay, so it's in Group 1. Now suppose under the new system with greater packaging in the system, the packaging cost is $20.
That would raise the outpatient PPS rate to $120.

MR. GEORGE MILLER: Right.

DR. ZABINSKI: But we would say to equalize the payment you'd raise the -- you'd drop the payment rate to $70. So it was $50 when it had no packaging, and now it's 70.

MR. GEORGE MILLER: 70. Okay.

DR. ZABINSKI: The change in the payment rate pre- and post-expanded packaging is still $50, so --

MR. GEORGE MILLER: Okay, so you've taken --

DR. ZABINSKI: So it washes out.

MR. GEORGE MILLER: Okay, got it. Thank you. I support the recommendation -- even after those explanations.

DR. NAYLOR: I want to echo everyone else's comments about the extraordinary quality of this work and the analytics -- quality of evidence, the analytics, and the efforts to really look at intended and unintended consequences with a real strong Medicare beneficiary focus, both from the standpoint of access and quality and also on implications for cost sharing. So I support the recommendations.

If I had one other recommendation that really
honestly flows from this work, it is to make very explicit in the chapter that the goal here is to really get people with the right set of services given the challenges that they need. So on Slide 16 you talk about behavior changes expected in LTCHs. We want to also think about behavior changes expected in acute-care hospitals, and ultimately we're interested in making sure that chronically critically ill and non-chronically critically ill people are in the right context. And it might not be either of these when they're in the right point in their trajectory.

So I would really want to make sure that we continue to monitor seeing how patients are directed as a result of these, and I think that that's just part of the evolution that you've stimulated with this whole analysis saying we can move to the next step, but we have to continue to do so. So thank you very much.

DR. NERENZ: Yeah, I will vote in support of the recommendation, and I repeat what others have said about the excellent quality of the analysis.

Just two comments looking forward to issues of implementation and back to our future agenda, one on behavioral response. If you could go to Slide 20? We talk
about this may slow the shift of services. I think actually
what I anticipate happening is much stronger than that, and
I think we actually may sort of assume that in our
discussion, that we might actually expect a reversal, a
shift back. In fact, it seems almost essential. Unless
hospitals are willing to just sit back and absorb these
cuts, it would seem that some of the services currently
provided in the HOPD settings are going to have to be
provided elsewhere, in lower-cost settings. It would seem
that without explicitly saying so, that's what we think
might or should happen. Or perhaps as a variant, hospitals
may create settings that currently do not exist that are, in
fact, lower cost. They're not subject to the cost-driving
functions of the hospital.

So with that assumption essentially in mind, I
just would observe that there are probably some settings and
some hospitals in which that shift in the other direction
cannot occur. There is not a network of private practice
offices in which care can be provided. Medically
underserved settings as a class are probably one way to
think about that.

So now if we could flip to Slide 10, bottom
bullet, we talk about mitigation. I realize this is not formally part of the recommendation, but I would just suggest that as this moves to implementation that there be good consideration of other possible mitigating either situations or strategies, meaning if there are hospitals currently providing services and being paid on the provider-based rates, where the services simply cannot be provided elsewhere -- the office settings don't exist -- that there be some consideration about some mitigating strategy. I'm not proposing a specific one, but I realize the DSH-based strategy here is one example, but there may be others. And, again, that doesn't undercut the basic recommendation, but it says there may be some cases where the expected behavioral response perhaps cannot occur.

Okay. Second comment. I have appreciated and accepted the general idea we've had when we talk about site-neutral payment that the payment stream should be as cleanly as possible directed to where the costs truly reside, and that we should generally not have payments that effectively cross-subsidize one body of work with payment to another that then end up sending inappropriate signals. I think Mike, among others, has been quite eloquent about that. I
agree with that.

When we think about what hospitals must do in areas like standby ER capacity, I just hope that we are then open in the future that if a cut in this particular -- in the HOPD payment actually produces some difficulty, that then we can be open to some discussion about adequacy of that payment under a model that actually pays for that activity in a more direct way. Now, again, that may or may not arise because we've also made this recommendation about 3.2 percent overall, but just hoping that we can at least consider that if it arises in the future.

DR. MARK MILLER: I'm sorry. The only comment on that, because I just want to remind the Commissioners how this particular set of site-neutral APCs varies from when we talked about the E&M stuff. When we talk -- and we didn't go into it in detail because we had been through it. We talked about the mitigating strategies. We pivoted off of whether they were serving significant proportions of poor folks, and so that access would become an issue.

In this particular instance, you can set up a mitigating factor -- a mitigating, you know, policy. It doesn't have a lot of impact because the people who are
benefitting from these APCs don't serve the poor in large numbers. And, in fact, a lot of them are specialty hospitals. But your point stands, and in particular, when people are talking about E&M, this was a much bigger deal.

MR. GRADISON: I support the recommendation. I've been trying to come to a better understanding in my own mind about this increase in the number of physicians that are employed by hospitals. From the physician's point of view, there are two factors that seem to me, as I've thought about it, to be particularly important. One is newly minted physicians, I can see a lot of advantages now, rather than striking out fresh, to begin a practice, certainly solo practices. That isn't happening very much anymore, or even very, very small groups.

The second thing is the perhaps unintended consequence of the EHR. It's extremely expensive. I went into one of my doctors in an office building just a few blocks from here recently and was surprised to see a sign out front with the name of one of the prominent local hospitals. And I asked my physician what was that all about, and she said, "Well, we have four of us here in our specialty. Our analysis is that we'd have to add one full-
time tech person in order to make this work. And it just
didn't make sense financially for us to do that." In other
words, there are reasons apart from an inappropriate
reimbursement system to justify this.

What I'm kind of curious about and will be
watching over time from the hospital's point of view is what
this means if we continue to have a decline in inpatient
admissions, and particularly if that decline is not somewhat
balanced by the increase they've been experiencing in
outpatient revenue. And the reason I say that is simply
that, you know, depending on the contract, the kind of
contract that the hospital has with the physicians, the
hospital's fixed costs could be increased very substantially
through this kind of change, which raises some interesting
strategic and financial questions if we are in an
environment where their revenues are under pressure. I
won't say any more. It's just something we need to keep an
eye on.

Thank you.

DR. CHRISTIANSON: I support the recommendation.

Maybe we could go back to the recommendation slide? And I'm
particularly enthusiastic about the first bullet point
there. I know it has been the Commission's policy for some
time to try to eliminate differences in payment rates
whenever that's feasible, and I support that. I think it's
actually simply fiscally irresponsible not to do that. So
I'm a very strong supporter of that. But I also think it
would be irresponsible of the Commission not to do it in a
thoughtful way. So I want to commend the staff, as many of
you have done, for recognizing situations where there might
be differential payments that would be appropriate and
situations where there wouldn't be. And I was glad to hear
Alice's comment that she thinks they've got it right in
terms of what they've identified.

I also support David's comments, that I think
continuing to investigate possible mitigating policies would
be useful. Even though I hear you say, Mark, that the
impact might be on relatively few facilities, I think it's
still important to look at that.

And then switching courses a little bit, I was one
of the Commissioners, I think, that was a little bit
cconcerned about relying too heavily on the 8-day ICU
criteria. And I again want to thank the Commission staff
for putting some thought into that and modifying that.
That's all I have to say -- oh, one more thing.

If there's any time left in this session, maybe we could call on Glenn to tell us what he really thinks about the sequester.

MR. HACKBARTH: We need to save time for that.

[Laughter.]

MR. ARMSTRONG: First, I also support the recommendations and won't reiterate many of the points made about them. I would just add to comments a few other Commissioners made about I think within the constraints of rate setting within silos, we've done really a valiant and elegant job of trying to advance the improvement of our health care systems' incentives for moving patient care to the right place given their needs.

I would, though, acknowledge, you know, $160-some billion, this is a significant area of spending for the Medicare program, and I think we're being very responsible about setting rates for how that money gets spent. But despite, you know, busting through silos through this recommendation, we still aren't really dealing with the fact that there's huge percentages of hospital admissions and ER visits and other services that we're spending through this
part of the program that are preventable and that just shouldn't be spent at all. And we just need to keep that in mind as we turn to some of the other payment policy opportunities we have outside of our current rate-setting process, which I know we'll pick up next month and the next couple of months.

MR. HACKBARTH: Okay. Thank you. Let me just say a real quick word, not about the sequester but about -- actually, my favorite Jack Nicholson quote is, "You need people like me on the wall." Remember that?

DR. CHERNEW: Keep going.

[Laughter.]

MR. HACKBARTH: Okay. So I think it's really important that Medicare pay hospitals adequately for the services they uniquely provide and that we all depend on hospitals for, not just Medicare beneficiaries but all of us, notably inpatient care. And given the trends on efficient provider margins, I'm worried that Medicare is slipping towards paying inadequately, recognizing that there are considerations other than just the margin in the analysis.

On the other hand, I don't think it is feasible,
desirable in the long run to pay hospitals much higher rates for services that can be more efficiently provided at a lower cost in other settings. Not only is that a big issue for Medicare spending and the taxpayers, it also is a big issue for Medicare beneficiaries, and also a big issue, judging by the press, for many private payers as well.

And so what I look about this package is it tries to strike that balance. Let's make sure we're paying adequately for those services that we really depend on hospitals for, but let's also move towards neutrality on services that can be provided at a much lower cost just as safely and effectively for Medicare beneficiaries. And, you know, I hope we struck a reasonable balance towards that goal.

So it's time to vote at this point. All in favor of the recommendation, which is on the screen, please raise your hand.

[Show of hands.]

MR. HACKBARTH: Okay. Opposed?

[No response.]

MR. HACKBARTH: Abstentions?

[Mr. Kuhn abstains.]
MR. HACKBARTH: Okay. Thank you very much. Well done.

[Pause.]

MR. HACKBARTH: So we're now turning to Medicare Advantage plans, and we'll have two recommendations -- one related to employer-sponsored plans and the other to hospice patients.

So who's going first? Scott.

DR. HARRISON: Good morning. I'm going to present a one-slide summary of the MA landscape that we presented in detail last month. Then Kim and I will reiterate the material to set up your discussion and votes on the two draft recommendations, which we have discussed in November and December. Of course, we will also take questions and comments on the draft MA chapter in your material.

Two thousand thirteen saw the highest enrollment in MA in terms of both the 14.6 million enrollees and the 28 percent share of all Medicare beneficiaries. Enrollment grew about 9 percent over the year. Plans project continued enrollment growth for 2014 though at a lower rate.

Plans continue to be available to virtually all Medicare beneficiaries. Only 0.4 percent have no plans
available -- the same as in 2013. There is some decrease in
the number of plans available due primarily to private fee-
for-service plans cutting back as was expected from previous
legislation.

The bids for 2014 show that the average
benchmarks, bids and payments are 112 percent, 98 percent
and 106 percent of fee-for-service respectively.

And the plan quality indicators are mostly stable
with some showing improvement.

Last time a few of you had questions about plan
margins. According to the 2014 plan bids, the average plan
will spend 84 percent of its total costs on medical care, 11
percent on administrative functions and maintain a 5 percent
margin.

A GAO report based on the 2010 bids got similar
results although past GAO work found that margins may be
higher when actual, rather than projected, spending is
analyzed.

On to the recommendations.

Recall that we laid out over the past few meetings
how the bidding dynamic is different for the employer plans
compared with the nonemployer plans.
Nonemployer plans try to bid well below the benchmark so they will have rebate dollars to provide extra benefits to attract enrollees. Nonemployer plans compete for enrollees through their bids.

However, employer group plans do not compete for enrollment through the bids they submit to CMS. Instead, the closer the bid is to the benchmark the better it is for the plan and the employers because a higher bid brings in more revenue for Medicare, potentially subsidizing expenses that would have required a larger contribution from employers.

Evidence of the strength of the employer plan incentive lies in the fact that the median bid of employer plans is 99 percent of the benchmark.

Because the employer plan bids do not reflect competitive market incentives, we looked to an alternate payment policy that would set payments to employer plans, using the market-based bids of the nonemployer plans. Such a policy is used for setting Medicare Part D payments.

So here, unchanged from last month, is the draft recommendation which reads: The Congress should direct the Secretary to determine payments for employer group Medicare
Advantage plans in a manner more consistent with the
determination of payment for comparable nonemployer plans.
The wording of this draft recommendation would allow the Secretary to use a range of policy options.
However, over the last several months, we have discussed several specific options.

Our initial discussion centered around using the national bid-to-benchmark ratio for nonemployer plans, which we have calculated as 0.86 for 2014, and using it to set the employer plan bids. If you've forgotten how that would work, I'll go into it in a little more detail on the next slide.

Then we discussed an industry suggestion to use separate ratios for HMOs and PPOs. However, that raised some concerns.

First, this would set a precedent of paying differently by plan type. The Commission has always stressed that all plans should be on a financially neutral basis.

Such a policy would produce less market pressure for beneficiaries to choose the most efficient plans.

And, if PPOs were paid more, then HMOs would be
disadvantaged in the market.

So the option we are stressing would set each employer plan's bid at its individual benchmark times the national bid-to-benchmark ratio for nonemployer plans, which, from the last slide, is 0.86. That formulation would treat all employer plans the same, would accommodate the different benchmarks that the plans may face in local areas and would incorporate the quality bonuses in the plans' benchmarks.

The total Medicare payment to the plan would then be its resulting bid plus the rebate dollars which are also based on the plan's quality rating.

So, for implications, we expect that the draft recommendation would reduce Medicare spending by between $250 million and $750 million in the first full year, and between $1 billion and $5 billion over 5 years.

Most employer group plans would be paid less by Medicare because of the lower Medicare subsidies. Thus, plans would either charge employers more, make lower profits or lower their costs.

Some employer group plan enrollees might choose plans in the nonemployer market or move to fee-for-service
Medicare if employers dropped plans or increased charges to plan enrollees.

And now Kim will present the draft recommendation on hospice and MA.

MS. NEUMAN: As we've discussed in past meetings, the Medicare hospice benefit is carved out of the Medicare Advantage benefits package. This carve-out has a number of effects that seem inconsistent with the goals of Medicare Advantage.

When a beneficiary in Medicare Advantage elects hospice, financial responsibility for that beneficiary's care becomes split between Medicare fee-for-service and the MA plan. Fee-for-service pays the hospice provider for care related to the terminal condition and pays other fee-for-service providers for any Part A or B services unrelated to the terminal condition. The MAPD plan pays for any unrelated Part D drugs and supplemental benefits such as reduced cost-sharing under certain circumstances.

In terms of care coordination responsibilities, the hospice provider is responsible for coordinating the care that the hospice furnishes and is expected to share information with and coordinate with unrelated providers.
However, no one entity, neither the hospice nor the MA plan nor any other provider, has overall financial responsibility and accountability for all care received by an MA beneficiary enrolled in hospice, and this contrasts with the situation prior to the patient's hospice enrollment when the MA plan is responsible for all the patient's Medicare services.

Another issue with the carve-out is that it results in complex coverage rules that can be confusing for beneficiaries who have been used to having all their care provided through Medicare Advantage.

In addition, the hospice carve-out makes an MA plan's responsibility for end-of-life care uneven across its enrollees. The MA plan has full financial responsibility for end-of-life care for some of its enrollees but not others, depending on whether they elect hospice.

In contrast to Medicare Advantage, ACOs are accountable for hospice costs through their benchmarks, and most private insurers include hospice in their benefits package.

If the purpose of Medicare Advantage is to give
plans financial responsibility and accountability for managing the care of their enrollees in an integrated and coordinated manner, it would make sense for plans to have responsibility for the full continuum of care, including hospice.

Another potential benefit of including hospice within Medicare Advantage is that MA plans could offer concurrent hospice and conventional care as a supplemental benefit if they wish to do so.

So the Commission is considering a draft recommendation to include the hospice benefit in the MA benefits package.

Here are the operational details of the proposed policy:

First, the full hospice benefit would be included in the MA benefits package. That would mean the plan would be responsible for the full hospice benefit as outlined in the Social Security Act. The plan could not pick or choose what services within the scope of the hospice benefit it would cover. And we expect that this could be monitored through the MA encounter data that plans submit to CMS.

The second aspect of this policy is that the
government base capitation rate for MA plans would need to increase for all MA enrollees to reflect plans' responsibility for a broader set of services than they are currently responsible for. Different from the current system, the capitation for an individual MA enrollee would not change if that beneficiary elected hospice.

The MA risk scores would also need to be recalculated so that they predict the relative risk of total Medicare expenditures including hospice.

So this brings us to the draft recommendation, and it reads: The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package, beginning 2016.

As you'll recall, at the December meeting, there was a lot of discussion among commissioners about wanting to move more quickly on the proposed policy. So the time frame in the draft recommendation has been revised from 2017 to 2016.

In terms of the effects of the draft recommendation, we expect the impact on Medicare program spending to be negligible, meaning close to zero. We always report spending impacts using standard budget categories.
So this policy would fall in the smallest category which is 
a cost or savings of less than $50 million over 1 year and 
less than $1 billion over 5 years. But, as I said, we 
expect the effect will actually be close to zero. 
In terms of beneficiaries, we expect no adverse 
impact on beneficiary access to hospice care. Like other 
Medicare Advantage services, choice of providers may be more 
limited than fee-for-service. Some beneficiaries might 
obtain access to concurrent care as plans would have the 
option to offer it as a supplemental benefit. Plans also 
would have the option to charge cost-sharing. 
As far as the implications for plans and hospice 
providers, there would be administrative costs for plans and 
hospices related to contracting. Plans, though, would be 
better positioned to manage and coordinate end-of-life care 
than they currently are. And this may give hospices 
opportunities to work with plans, to participate in new 
models of care delivery. 
In terms of quality and delivery system reform, 
this would promote integrated, coordinated care and would be 
a step toward synchronizing policy across Medicare systems. 
So that concludes our presentation, and we turn it
over to the Chairman.

MR. HACKBARTH: Thank you very much.

Clarifying questions?

I have Alice and then Jack and Dave and Mary.

DR. COOMBS: Thank you very much for the presentation.

So, if I can just drill down a little bit on this notion of the capitation in terms of the rate that you would try to monetize this within the system of the MA, are you saying that the exchange from what we do with the fee-for-service carve-out now is essentially the same even when you consider the administrative costs -- the administration costs -- on either side of the fee-for-service for the carve-out versus putting it all under one umbrella?

MS. NEUMAN: What I was saying is that the Medicare Advantage capitation base rate would be increased to take the average spending in fee-for-service on hospice and put that in for Medicare Advantage so that now the Medicare Advantage capitation covered the full range of services.

Is that helpful?

DR. COOMBS: Yeah. And maybe if I could ask you,
Mark, wouldn't you expect some savings based on now the
coordination and using just the scale margin in terms of
being able to better address this 28 percent of Medicare
beneficiaries?

DR. MARK MILLER: Okay. So let me just track
through your question.

What you're hypothesizing is that if the managed
care organization is better at coordination, shouldn't some
small savings occur?

And I think what Kim is saying, consistent with
the way MA rate methodology is in general, is if that occurs
those savings would accrue to the MA plan because the
capitation rate would be set on the base of fee-for-service,
unless you have a different idea. But --

DR. COOMBS: No, no.

DR. MARK MILLER: Right. [Inaudible comment.]

MR. ZARABOZO: No, you did not screw it up.

MR. HACKBARTH: I was a little leery when Carlos
hit the light. I thought it was going the other way for
you.

DR. MARK MILLER: For the record, with Carlos, it
usually does. Okay.
MR. HACKBARTH: Jack, clarifying.

DR. HOADLEY: Yeah, I had a clarifying question on one thing you have in the chapter that wasn't in the presentation, on the medical loss ratio requirement that goes into 2014 and with premium refunds if it's not met. What's the timeliness of that determination, and what happens to a beneficiary who's paying zero premium? Do they still get a refund?

Do we know these? Has CMS set those policies?

DR. HARRISON: If they have set them yet, I don't know. I kind of think they're still under discussion, but it's supposed to happen quickly.

So if there's -- there are similar requirements in Medigap, but those take three years to actually have money returned, and you have to miss them for three years.

I believe that the MLR intention is that if you miss it for one year you're supposed to get money back, and I don't know whether the money goes back to Medicare or to beneficiaries.

MS. UCCELLO: I might not be right on this, but I looked up some of this with Part D, and if they're run the same way, it looks like the refund goes back to the
government but doesn't get refunded to the bene, from what I could tell. I could be wrong on that.

DR. MARK MILLER: We'll look into this.

MR. GRADISON: I want to make sure if this is correct. Let me just, to save time, say it as factual. And please tell me if I'm wrong.

What I jotted down here is: Most MA plans are run by organizations which already offer non-Medicare plans, for example, to employers, which cover hospice care.

In other words, most MA plans at some part of their organization already have experienced doing this sort of thing. Do you think that's correct or not?

MS. NEUMAN: As far as we know, that's correct.

MR. GRADISON: Thank you.

DR. NERENZ: Slide 6, please.

Okay. Just to clarify, the quotation marks around the word, bid, are meant to imply that this is not really a bid in the usual sense in this model, right, that it's simply a calculation where the plan has no discretion over what that amount turns out to be. That's what that means, right?

DR. HARRISON: Correct.
DR. NERYN:  Thanks.

DR. NAYLOR:  My question is really from the chapter related to the first recommendation.

So, page 19, you describe employers that may drop out from offering these plans. And you probably have done this in earlier chapters, but I didn't go back. Have you done modeling in terms of what that might be and how it might affect?

I mean, I know now we have almost 100 percent access of beneficiaries to the plans. But, if employers drop out, do you have modeling about what impact it might have on access to plans?

DR. HARRISON:  We do not include employer plans in our access numbers.

However, right now, you do have employer access even in remote areas of Alaska or, you know, everywhere. There are some employer plans that have bid for the entire country. They may not actually have anybody there, but --

DR. MARK MILLER:  The answer to her question is even if an employer decided to step back, by making your nonemployer point, you're saying that beneficiary still has access to a plan. Is that your point?
DR. HARRISON: Correct. And it might even be that the employer decides to help subsidize that choice also.

DR. NAYLOR: And, two questions related to the hospice recommendation.

The industry response, meaning what you've also articulated earlier, can you just summarize that very briefly?

MS. NEUMAN: The hospice industry, the MA industry or both?

DR. NAYLOR: MA industry to the plan to the proposed recommendation.

MS. NEUMAN: Okay. The health plans that we've talked to have generally been supportive of the idea of including hospice within Medicare Advantage. We heard from them that they felt that would better position them to manage and coordinate end-of-life care, and it would simplify things for the beneficiary.

The hospice community -- the response has been less favorable. There's concern about the administrative burden of contracting with the private plans. There is some of that that goes on now --

DR. NAYLOR: Right.
MS. NEUMAN: -- but that's a much smaller population than the Medicare population is. And so it would increase the amount of those activities.

There's also concern from both the hospice community and, to some extent, from the plans about what the rates will be and whether -- you know, the hospices, whether they will view the rates as too low or the MA plans will view the rates as too high.

So there are those issues that we've heard, and I would say those are probably the biggest.

I guess one last thing I would note is on the hospice side they've been worried about prior authorization kinds of requirements that sometimes they see from commercial plans.

You know, we think if this was expanded -- hospice was expanded to the MA population -- that that size of that population is so large, that prior authorization would not be a viable approach for plans and they would have to take more expeditious routes to ensuring care is appropriate.

DR. NAYLOR: Great. And, one last comment.

When you describe the hospice benefits integration into the MA plans, you stress the possibilities here of
concurrent palliative care and hospice services. So it implies that the eligibility criteria currently used would not be integrated in, too.

MS. NEUMAN: So the eligibility criteria for hospice would be integrated -- would be included in the Medicare Advantage benefits package. So that would be the base.

And so it would be the same benefit, the same eligibility criteria and so forth, but MA plans have the ability to offer supplemental benefits which are broader, that are not covered by Medicare traditionally. So it would be within the ability of an MA plan to offer concurrent care as a supplemental benefit.

So they wouldn't have to, but they would have that option, just like they have the option to offer home health visits to beneficiaries who aren't homebound, let's say, if they find that to be valuable in certain circumstances. It's the same kind of thing. They have more flexibility than we do in the fee-for-service program.

MR. HACKBARTH: George, clarifying questions?

MR. GEORGE MILLER: Yes, on slide 2.

And I think, Scott, as you were going through
this, you mentioned the percentage or breakdown of costs, that 84 percent -- I think you quoted 84 percent goes to the beneficiaries, 11 percent for administrative, 5 percent for margin. Is that codified in law, what that ratio has to be? Do we monitor that? Is 5 percent appropriate? 

DR. HARRISON: Before the actual MLR provisions go into effect, it has not been regulated. Now the other -- and so the MLR requirements are going to be that 85 percent is spent on benefits. 

MR. GEORGE MILLER: Right. 

DR. HARRISON: I am not sure that what is reported in the bids -- the spending -- is categorized the same way as what would occur under the MLR situation. So I don't know that it's completely analogous. We're going to check into that more also.

MR. GEORGE MILLER: Okay. All right. Thank you.

DR. HARRISON: I don't know if Cori has any --

MS. UCCELLO: [Inaudible comment.]

DR. HARRISON: Okay.

MR. GEORGE MILLER: You think that's right, okay.

DR. SAMITT: On slide 8, I have a question about
ACOs and their -- the experience with hospice thus far. We may not have enough experience to study this, but I'm wondering if this can foreshadow the implications on hospice, given that now ACO is the only sector in Medicare that has financial accountability for hospice today. Have we looked at whether we've seen any change in hospice utilization or relationship in the ACO world yet?

MS. NEUMAN: We have not looked at data on ACOs' experience with hospice care, but anecdotally, you know, we've asked about, you know, how ACOs view hospice. And, in general, it seems to be favorable, good for the beneficiary, good for the program. And so that is something that we can look at in the longer run.

It would seem that the ACO model would sort of get the interests of the patient and the interests of the program in line with regard to hospice.

MR. HACKBARTH: So when will we have access to patterns of care in ACOs -- you know, a large claims base -- that we can begin to explore that? Does anybody know the answer?

DR. STENSLAND: You can do it.

MR. HACKBARTH: Okay. That's a bold statement. I
like that.

DR. MARK MILLER: One I'm going to want to explore.

[Laughter.]

DR. MARK MILLER: I'm not sure I would have said that quite as strongly, but I think we're sort of starting to get to that point now that there's been enough experience. Is that just a little different way of saying it?

DR. SAMITT: And when would we get that same thing for Medicaid?

DR. MARK MILLER: Yeah, I hear you.

And the thing I wanted to emphasize on this point is we have done a survey of ACOs and kind of what kinds of experiences that they've had, and we've had a lot of one-on-one session of people in. And David and Jeff have handled this a lot more than I've been able to be in the room although I have tried to be in there.

And there has been some pretty explicit discussions about, you know, trying to get a better handle on what happens at end of life and that some of the ACOs are seeing that as -- you know.
You talk to them, and they all have slightly different orientations -- I'm going after this; I'm approaching things this way.

But this came up more than once. So they seem to be paying attention, and what Kim said describes the experience.

DR. CHERNEW: This is about slide 6. I just want to make sure that the slide is meant to be understood as an illustration of something the Secretary might do but is actually not part of the recommendation.

So words like calculate one national bid -- that's not part of the recommendation that came right before; that's just an illustration of how it might play out.

DR. HARRISON: Correct.

DR. MARK MILLER: I mean, the only thing I would add is there's the one slide -- I can't remember what number it was, Scott, where we --

DR. HARRISON: Right before that, I think.

DR. MARK MILLER: Exactly. There was a discussion of it, and some problems did surface there.

MR. HACKBARTH: Any other clarifying questions?

[Pause.]
MR. HACKBARTH: See none, let's go to round two.

This will be our final round and followed by the vote.

Scott, do you want to kick it off?

MR. ARMSTRONG: Thanks, Glenn.

So let me begin by saying that I support both sets of recommendations and plan to vote in support of them, but let me comment briefly on each one, beginning first with the employer group issues.

Initially, I did have some concerns with this, but ultimately, equalizing the Medicare program's contributions to these two different categories of MA plans is good policy, and I support that policy.

The issue was really in some of the implications of the initial approach that we were describing for setting -- you know, equalizing -- those payments. And I just want to commend the MedPAC staff for great work you've done.

I think there's still work to figure out exactly how that unfolds, as these last couple of comments implied, but the direction that you're heading in there after, you know, some of those first ideas is a direction I do support, and I appreciate your work on that.

One other point on this I would make is that I am
a little concerned about the implications for current Medicare Advantage beneficiaries through these employer-based plans who potentially, as our analysis suggests, could see a diminishment in the value of their benefits and/or lose benefits and be forced to move elsewhere.

And I think we just need to pay attention to whether that's really an implication of some of these changes or not, particularly since it's inconsistent with the broad goal that we have for moving -- if we have a goal to move patients between fee-for-service and Medicare Advantage, it's to move them from fee-for-service into Medicare Advantage and not the other way around. I just think we need to pay attention to that.

With respect to the hospice benefits, this, I strongly endorse.

I work for an organization that covers Medicare patients through an MA plan, and the minute we admit them to a hospice program we need to -- even though it's our own hospice program, run by our own staff -- bill Medicare directly for those hospice services. And it's an administrative hassle. It's a nightmare.

We're able to overwhelm kind of the care
consistency through that transition, but the industry itself -- I just think this is a big issue and this is a nice way of resolving it.

You made several other arguments for why this is a good policy to advance, and I support them all.

I would just say that you've mentioned some of the operational implications of this. We do need to pay attention.

I'm particularly concerned about a topic we've spent time on before, and that is the risk adjustment and the way in which, particularly for patients who are incurring a lot of expenses at end of life, that risk adjustment is made to the payment in the year after the patient dies. And that's just one example that -- you probably have many others.

I really do think paying attention to how this assures that the payments are appropriate and adequate will be an important piece of work for ourselves.

So I do support both sets of recommendations and think it's great work.

Thanks.

DR. CHRISTIANSON: Yeah, I also support both
recommendations and I think it's been -- I think we should commend the staff for educating us on these. I think one of the reactions of the Commissioners early on was we were not maybe as well informed about these particular aspects of the law as we might have been, and I think you've done a great job on educating us about that.

So, I think they're both really compelling, the logical things to do. I think we have to do, as Scott suggested, pay attention to the details as we move forward and how it plays out, but I certainly support the recommendations.

Kim, I'm not sure I understood one thing correctly about what you were saying about prior authorization, but we can talk about that later. I mean, I totally agree with that.

MR. GRADISON: I support both recommendations.

DR. NERENZ: A question about, again, behavioral response, and this will tie loosely to Slide 7. If an employer-based plan currently is national in scope, or let's just say multi-region in scope, and let's imagine that the method of a national benchmark and that a ratio of bid-to-benchmark were implemented, is it possible, then, that an
employer-based plan in that environment could shut down some
regions but not others? Is that either plausible or likely?
And then if that happened, what would be the net effect on
program spending? Would we -- because, presumably, they
would continue to operate in those places where they thought
it was financially attractive, but not in others. The first
question is, would that even be possible? And then, if so,
should we worry about that?

DR. HARRISON: So, if there were going to be a
problem, it probably wouldn't be the national plans because
they're submitting one bid right now and, you know, they're
not differentiating between regions. Now, you may get some
issues for a plan that's more local and there's an unusual
bidding situation. You know, the non-employer plans have a
different behavior there. Then, you might have an issue.
But, again, they could move to an exchange, right, and offer
plans, just offer other local plans and not offer through
the employer.

DR. MARK MILLER: If the exchange in that were --
in the exchange that you just had, the exchange you're
referring to is more --

DR. HARRISON: A private Medicare exchange.
DR. MARK MILLER: -- a kiosk of access to Medicare, individual-level, non-employer plans, and Scott said this earlier in response to Mary's question. The employer might subsidize that person making a choice, because the other part of your question is, isn't there a cost here. To the extent that a person walks away from MA into fee-for-service, then, actually, it's a savings until we hit around 2016, 2017, given the transition.

I would have said -- and, Scott, I'd like to know whether you agree -- I know Carlos will tell me I'm wrong -- that the likely, most likely scenario is if somebody pulled out, the person would walk to a different MA plan. That would be my guess. That is not --

DR. HARRISON: That would be my guess, also.

DR. MARK MILLER: That is not based on a model.

DR. HARRISON: I think that there's very few employers that are offering only MA options. They're probably also offering wrap policies.

DR. NAYLOR: I support the recommendations and just think, of course, we need to track what happens here as a result of the employer recommendation.

And the chapter, in terms of the recommendation
about integration of hospice into the MA plans, I would maybe encourage using this as an opportunity -- because only those that choose to offer this as supplemental, the curative, do that, and you've made that explicit. But I would use this as an opportunity to encourage the kind of experimentation, because MA plans are in such a great position to do this, to do some of the things we've talked about in prior years of earlier access to palliative care, concurrent therapies, and so on. So, maybe encouraging as part of the recommendation that kind of demonstration or experimentation.

MR. GEORGE MILLER: Yes, I support the recommendations, as well, especially on number two, and Mary just hit the nail on the head for me, and that is this is an opportunity and I'm just wondering if we shouldn't be -- at least express more that we'd look for that experimentation. I think the comments that Rita has made about end-of-life care is a perfect opportunity to use this as a springboard for us to be very, very prescriptive instead of using heroic efforts at end of life, but look at this as an alternative and try to push this. If we truly want to make savings in the Medicare program nationwide, this is, I think, an
excellent opportunity to start walking down that path and having those discussions and we should use this opportunity to encourage more experimentation with this, the hospice and end-of-life care, palliative care, versus heroic efforts.

DR. SAMITT: I support both recommendations, as well. I do want to make a couple supplemental comments, specifically about the hospice benefit. You know, I think, to tag onto Mary's comments, that we should track what happens not just with the employer plans, but with the hospice experience, as well.

In prior meetings, we've talked about, really, an imperative to begin to measure differences between quality, service, cost for the fee-for-service population from the ACO from MA, and now this is an example where a benefit that was historically always treated the same will now be treated a bit differently between MA and fee-for-service, and I would be very interested to track the patient experience with end-of-life care now in those two models when this benefit changes. And I think we would look at quality, we would look at service experience, we would look at appropriate utilization of hospice services in those various settings.
Assuming we can get at that information, I think we have an opportunity to measure before and after, and I would be interested in subsequent years to really analyze this, because it may, again, begin to tell us, are there differences in quality, service, and cost between the various Medicare programs and what does that tell us about what we should seek to incent and spread to other markets.

MR. KUHN: I support both recommendations for all of the reasons that everybody has cited before. And particularly on number two, the one on hospice, I think it's important that we create enough transition time here, and I think creating the date of 2016 does that, so it's a good -- more worked and compliments to the staff for thoughtful work on this and thinking through all those elements as we go forward.

DR. REDBERG: I also support both recommendations. In particular with regard to the hospice plan, I mean, certainly, there wasn't any particular, I think, justification for having the carve-out in the first place. It just kind of happened as a historical quirk, it seemed. And that it is an opportunity, as Mary and others noted, to think about expanding -- you recommended full coverage
benefits, but expanding and trying other things like concurrent care.

I think it's encouraging that more Medicare [indiscernible] have used hospice over the last few years, but it's still pretty much less than half, and I think we could consider incentivizing or making a benefit -- even in the "Welcome to Medicare" package, I think, a discussion about what your preferences are at end of life. Obviously, people aren't at end of life at that time, but it's always good to have the discussion before you're in the acute, you know, life-threatening or terminal illness, so -- and then to have it again, because I think it is an opportunity for better care, higher quality care at lower cost, but mostly because patients, I think, prefer, if given the choice, not to get care that is not going to extend their life and actually often is a decrement on quality of life, keeps them in the hospital with lots of tubes and lines and unpleasant side effects when they could be home spending the last few months with family and loved ones.

So, I would support the recommendations and also support trying to expand conversations about shared decision making, patient preferences, and incentivizing use of
DR. CHERNEW: So, I support both recommendations and want to make two general comments. The first one is that I think the high payment rates and benchmarks and associated payment rates that we've had in Medicare Advantage were a patch for, in some ways, incomplete coverage in the general basic Medicare benefit program, and so although I might become typecast in every comment as talking about the consistency about parts of the program, I do believe that paying in one sector to solve that problem is inconsistent if you don't do it in the other sectors. So, this notion of, we've talked about before, level playing field, and, frankly, that masks some of the problems of the Medicare benefit, in general. And, of course, we've done other work on Medicare benefit design, which I think is important work and we're going to have to continue. I think that as we move forward, in general, we're going to have to monitor the impact of these changes in Medicare on the beneficiaries as the concerns with the underlying Medicare benefit package become more transparent when the payment generosity drops. And, frankly, I'm worried that employers are going to drop. So, as I've said
for years, we are going to have a potential problem in the future. We have a lot of beneficiaries with much less generous supplemental coverage, either in MA or not, and that has important ramifications that are going to have to be monitored generally. But, I like the idea of comparability across the fee-for-service and the Medicare program as a general rule.

The other point that I want to make relates to the one versus two ratio discussion and this issue of consistency. So, all the critiques on Slide 5, I think, are correct. I believe all of them. In fact, I think there's a few other considerations, as well, that would probably push towards one ratio.

But I would just point out two things. One is, these are not part of the recommendations, so the Secretary could do what she wants, or whomever, whenever the Secretary or whichever Secretary has to do it. But, nevertheless, the broader point is, all of those disadvantages, I think, generally exist in the non-employer sector. In other words, I think the non-employer sector also pays differently by plan type and also reduces the pressure to move to the most efficient plan, and also disadvantages some plan types...
relative in the market. So, I think that there are
legitimate concerns up here, all of which I agree with, but
those same concerns, I think, exist in the non-employer
market, as well, so there's a question about consistency
across the markets versus getting the most efficient design
in one.

DR. HARRISON: So, in the non-employer market,
generally, the PPOs bid higher than the HMOs do. But what
happens is the HMO benefit packages are then richer so that
they're more able to attract the beneficiaries, because
they're using the rebate dollars from the lower bids. And
so if you -- that's how they compete.

DR. MARK MILLER: Yeah. The way I would say it is
differently. They're not treated differently under the
payment system. They have chosen to offer, or to submit
higher bids and skinnier benefits.

MR. HACKBARTH: And they also may selectively
choose markets where benchmarks are higher and then that
goes into the calculation.

DR. CHERNEW: So, we can have a longer discussion
of this. My only point -- because I -- we can have a longer
discussion of this, but I think if you work through the
math, I think it's a little more complicated one way or another. My broader point is not the merits of one versus the other as much as the recommendation is silent and so it's going to take some more work to sort through the implications of different approaches.

MR. HACKBARTH: Yeah, and I understand that point, Mike. But just for the record, the non-employer side does not pay differently by plan type. Now, it can result in different payment levels, again, based on choice of geography and things like that. But it doesn't say, oh, we pay PPOs this way and we pay HMOs that way.

DR. COOMBS: I support both recommendations, and Kim, you said something about the industry in terms of some reluctance in the industry. Before when we discussed this, I was concerned that what the fee-for-service patients look like in terms of the demographics and their comorbid disease versus the MA that have the carve-outs, and from the information that you provided in the chapter, it's excellent in that it supports that there's great similarity between the two groups, with the exception of the neurologic diseases being a little bit more prevalent in the fee-for-service. I think it's really important for us to understand
if industry is reluctant to support it, is it because that
the patient groups look differently. But that's not the
case, and it's not supported by the information in the
chart. And also, in terms of the results of the dissidence
in terms of how likely is it that someone is actually being
discharged from hospice, because it has a lot to do with the
criteria for admission to hospice.

So, my whole concern initially was that if the
groups looked very different in terms of how their outcomes
would wind up, I think that that may be a reluctance for
industry to support it, and so I just wanted to know from
you if that was a prevailing concern.

MS. NEUMAN: We didn't hear much about concerns
about differences in the patient populations between MA
hospice enrollees and fee-for-service hospice enrollees.
That was not one of the areas that was a big focus.

DR. COOMBS: So, when I discussed the
administration issue in terms of what the amended cost is,
it would seem like the MA plans would be much more efficient
and would have a lot more in terms of support and
infrastructure, so, therefore, this would be something that
might be very attractive to do the comprehensive coordinated
care piece.

DR. MARK MILLER: I think that that's true from the MA plans' point of view. I think if you followed Kim's comments earlier, I think the MA plans' view of the hospice change is they're fine. They're interested in it. I thought just now you were talking about the hospices' reaction to it, and to the extent my --

DR. COOMBS: [Off microphone.] Earlier, yes.

DR. MARK MILLER: Yes. I've been in the room, too, and I don't -- I think you said "less favorable." I don't think they like the idea. But most of the comments come down to comments that you would hear from almost any provider. They'll say, this means I have to negotiate with the MA plans, and what if they don't put me in their network? Of course, the MA plans are required to have comparable -- I mean, to have network requirements, but that might not mean that they take each and every hospice in every market. And I've got to say, there's probably some markets where even the hospice industry would agree that that might be a good idea.

Then they're upset that, you know, well, what if the rates aren't as high as Medicare rates, and again,
that's a negotiation.

There were comments of, well, are they going to be required to give the entire benefit, and we clearly have stated, and just like it works in the rest of AEB, they are required to do the benefit. And then you had this entire conversation from several of you, could they even go beyond that, and they are.

So, that was kind of the nature of the hospices' reaction. I don't recall this patient thing coming up.

MR. HACKBARTH: Another one, I think, that was in the letter I read was, well, this infringes on patients' freedom of choice of hospices. Again, that -- it's a choice to enroll in an MA, and if the beneficiary chooses to enroll in MA, that may have implications for the providers that they can see.

DR. MARK MILLER: That's true.

MR. HACKBARTH: And they may not be able, as Mark says, to go to any hospice. But that's not -- this isn't unique to hospices. This is true of physicians and hospitals and every other type of provider.

DR. MARK MILLER: If you enroll in MA --

MR. HACKBARTH: If you enroll in MA, yes.
DR. HALL: Am I up? I'm in favor of both recommendations.

And just a comment, also, about hospice, which I think is something we're all thinking about here. You know, Medicare as an insurance product is unique in many ways, but one way that it is truly unique is that it's the only insurance product if you're marketing to say, if you take Medicare, there's a 100 percent probability you'll die. It's a life form of health insurance. It's a major component of the benefit structure.

So, hospice has come in and has made enormous progress over the last, I don't know, 25, 35 years, and it's not surprising that there are some inconsistencies, that why does Medicare Advantage have a carve-out on this? It is historic, but it wasn't really by design.

Curiously, also, end-of-life care is one area where we've talked a lot about shared decision making, where we're doing a pretty bad job overall across the country, even in terms of advance directives, pain control, and family engagement. Where you think it would be at the very top of our priorities, it isn't.

Medicare Advantage, so far, seems to have been a
product that has been able to develop innovation, and I would predict that one of the positive outcomes of this may be that Medicare Advantage plans may be able to even enhance this field more than we have up until the present time. So it's a -- and the timing couldn't be better right now in terms of the degree of expertise and medical knowledge that's there.

DR. HOADLEY: I'm also in favor of both of the recommendations here, and I won't add to the discussion on the hospice one.

On the employer plan one, the only thing I would do is note, sort of like David mentioned earlier, some of the potential geographic issues, and I think I brought that up in another meeting. But our recommendation has the flexibility, and if the Secretary sees that that could be an issue for more regionally-based employers, that perhaps there's a policy tweak in that direction that the Secretary could use.

My other comment, really, is that, you know, these recommendations are part of a broader chapter. I really do appreciate all the stuff that's in this chapter in terms of landscape material and the ongoing Commission analysis of
the payment rates compared to fee-for-service and sort of
the documentation that we're still -- have payments that are
higher than fee-for-service and we're not through the
transitions to some new policies there, and I think that's
just an important part of the chapter.

And I guess my one other thing is, and partly
triggered by this discussion of the network inclusion
relative to hospice, is that maybe the network adequacy
standards in general are something we should think at
looking at over the next year. You know, there have been
some issues, somewhat anecdotally, this year about plans
that have cut back substantially on their MA provider
networks or their physician networks, and I must say, in
thinking about this, I'm not too aware of -- I know what the
standards are, generally, in Medicare Advantage, but sort of
the degree of enforcement and the degree of monitoring that
CMS is doing, and maybe that's something we could take a
little bit of a look at over the next year.

MR. HACKBARTH: Could I just pick up on Jack's
last issue? There is intertwined here several different
issues. You know, there's the traditional notion in an MA
of having an adequate network. Then there's also the issue,
which I think has arisen in these recent cases, of giving
beneficiaries adequate notice of what the network is so
there isn't a bait-and-switch, where they think they're
buying this physician network and, in fact, they're getting
a very different one. And those are different sorts of
issues.

Kate.

DR. BAICKER: I support the recommendation and I
share my concern that the devil is in the details with how
you do the change to the employer-based MA plans, but they
are different from the other plans in the way that they're
working now and some update clearly is in order, and the way
the recommendation is framed, to me, seems like a great
start down that path.

MS. UCCELLO: I also support the recommendations,
and in terms of the employer MA plan, thank you for this
additional discussion about the plan type stuff. I think
this was really helpful to think this through.

And in terms of the impact on employer decisions
to offer MA plans to their retirees and the impact on
retirees' access to MA plans, I think it is completely
appropriate for us to consider what those impacts will be.
But I also think we have to remind ourselves that these plans are getting paid in excess of fee-for-service, so it's other people who are helping subsidize, in effect, those payments, and I think we need to keep that in mind, as well, when we consider what the impact on these retirees is.

MR. BUTLER: So, I support both recommendations. I don't want to say that one is more important than the other, but I'm more sensitive to unintended consequences in recommendation two. What tips me over is the fact that the private plans now have it in their benefit package and I don't hear any outcries about how it's working, including in those plans that are fairly tight in their networks now.

And the second reason is it does bring another example of the silos coming together. And as hard as we've worked on the U-shaped pricing, my guess, but I don't know and we don't know, that bringing this together is likely to actually accelerate the end-of-life -- entry into true end-of-life care sooner and maybe have an additional oversight on the over-utilization where inappropriate in a way that the fee-for-service pricing may not or has struggled to do. So, I think we're going to align things and I think overall hospice care is still going to go up under this model. I
think there's just some fear about change and about being left out as a hospice in a narrow network, but I think we'll get through it.

MR. HACKBARTH: Just one other thought on this issue of network adequacy, Jack. I have read that at the State level, there is a movement, at least in some States, to impose, reconsider, "any willing provider" laws, and this whole issue has been given new life by the relatively narrow networks in many of the exchange plans under the Affordable Care Act. This is very reminiscent of the 1990s. If you want to kill private plans' ability to manage care and cost, there's no faster way to do it than "any willing provider" laws.

So, my own personal view, and obviously this isn't a MedPAC view, is that, yeah, we need to assure there are adequate networks. We need to assure that there's not bait-and-switch with beneficiaries on enrollment. On the other hand, we've got to preserve the ability of plans to make decisions about who's in the network and who's not. That's their contribution to trying to make the system better. That's how they can help us. Traditional Medicare finds it basically impossible to steer beneficiaries to higher
performers, and so it's through Medicare Advantage that we have at least the potential of some parties trying to steer volume to the more efficient providers. We cannot kill that off.

Okay. We're ready to vote on this, so let's put recommendation one up here. So, all in favor of recommendation one, please raise your hand.

[Show of hands.]

MR. HACKBARTH: Okay. And number two. All in favor.

[Show of hands.]

MR. HACKBARTH: Opposed.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay. Nice work.

Before we turn to the public comment period, I want to just go back to the hospital LTCH recommendation for a second. I'm operating at less than peak performance today, and there was something else that I wanted to say at the very end, and that is that we view that recommendation as a package, not sort of a menu of possible things to do.
And I know that was very important from the perspective of some individual Commissioners, that it is a package and so I wanted to make that clear to the audience, and, of course, we will make that clear in the text.

Okay. We'll now have our public comment period.

[No response.]

MR. HACKBARTH: Seeing none, we will adjourn for lunch and reconvene at 12:30. Excuse me, I got that wrong — 1:30, yes. I told you, I'm operating at less than peak performance.

[Whereupon, at 11:52 a.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]
AFTERNOON SESSION [1:30 p.m.]

MR. HACKBARTH: Okay. It is time for us to begin. This afternoon we have three sessions scheduled, the first on ACO policy, which does not have anything to do with updates; rather, we are preparing to offer suggestions to CMS as it moves forward with the ACO program.

Then we have two sessions, one on dialysis and one on post-acute care, where we will be voting on recommendations.

So I am feeling a little bit under the weather. I'm not sure I'll make it all the way to the end today. If I do leave early, it's not because I don't care about dialysis or post-acute care or something else. I just don't think it's very becoming for the Chair to flop over and put his head down on the table. Better to hand it to Mike.

DR. CHERNEW: [off microphone].

MR. HACKBARTH: I didn't mean that the way it came out, Mike.

DR. CHERNEW: No, you said exactly what I [off microphone].

MR. HACKBARTH: Okay. Before we turn to the three afternoon sessions, I did want to quickly talk about the
effect of the sequester on our update recommendations for those of you in the audience who were not here this morning.

Let's see. Actually, can we skip to the next slide, David? So I'm not going to go through everything that I went through this morning. I just want to highlight a few points.

So what this graph illustrates is on the yellow line is an illustrative increase in the base payment amount for one of the provider sectors, say hospitals. And the yellow line has steps up that are 2 percent in magnitude. That signifies that under current law they are scheduled to get a 2 percent update.

The green line below represents the sequester effect, and which you can see is that at the beginning of each year, the sequester takes the base amount down by 2 percent, and then at the end of the year it goes back up.

A couple points are really significant here. First of all is that the sequester adjustment is temporary and non-cumulative. It does not permanently affect the base amount. Indeed, the sequester is a separate statute from Medicare, and so what we are focused on, what we are making our recommendations to the Congress, is the shape of that
yellow line. How should the Medicare law's base payment rates change from one year to the next?

We recognize that the sequester can in any given year work to reduce the flow of dollars to, in this case, hospitals. Our recommendations, however, are focused on the Medicare law's base payment amount.

So let's go ahead to the final table there. The next one. This is a real simple numeric example. So in the year 2014, let's assume that the base amount for this type of provider is $100. The sequester takes 2 percent of that away from each of the checks, and you can see that in the bottom row, the sequestered amount of 98. We are making recommendations for 2015 this year. The first row under 2015, 102, that signifies what the current law update would be in this sector, which we assume to have a current law update of 2 percent in the base amount.

What we are focused on is the next row. What is the Commission's recommendation for the base amount under the Medicare law? And in this hypothetical example, we've said 101.

Now, let's assume for the sake of argument that Congress does not take our recommendation, current law stays
in place, and so the base amount becomes 102. But the
sequester takes away 2 percent, so the checks written to the
provider fall to 100. We have recommended 101. What we are
saying is a number higher than the actual flow of dollars.
We do not support the sequester in this case because it
results in payments less than we've recommended to this
provider group.

In fact, I'd even go one step further to say that
although in some cases even after the sequester the payment
amount might be higher than MedPAC's recommendation for the
base amount, we don't like the sequester in those cases
either. Using this sort of across-the-board reduction in
payment is not the best way to achieve an appropriate level
of Medicare spending. We believe the best way to do that is
to have very targeted changes in payment, whether we're
talking about changes in the base amount or restructuring
payments systems or restructuring the benefit package. If
we need to get savings in Medicare, that's the way to do it,
not through 2 percent across-the-board reductions operating
through a law outside of the Medicare program.

So, in principle, we do not support the sequester,
and its application in particular cases, we don't support
the sequester. We are asked by Congress to recommend what
the right amount is. That's the 101 that's circled in this
illustration.

So that's the process. After the last meeting,
there were some articles written and statements made that,
well, MedPAC ignores the sequester. That's not the case.
All we can do is recommend to the Congress what we think is
the proper rate. They are the decisionmakers, and they
decide the actual flow of dollars.

So I will stop there, and I hope that is a little
bit clearer to people. We will for next year look at
whether there are some ways that we can clarify our approach
given that the sequester now seems destined to be with us in
the long run. It has gone from temporary to something
that's written into current law for the next 10 years. So
we will look at issues like how we frame our projected
margins, where that is part of our analysis, or how we frame
the wording of our recommendations to try to make all of
this a little bit clearer to people. But we are not
ignoring the sequester.

Okay. So let's now turn to ACOs. David, are you
leading off?
MR. GLASS: [off microphone].

MR. HACKBARTH: Oh, right. Sorry about that.

MR. GLASS: Good afternoon. We discussed some issues related to ACOs in November. Based on that discussion, today we’ll bring you some policy options you may want to consider further.

Just as background, there are two ACO program in Medicare serving over 5 million beneficiaries now.

The first is the Pioneer demonstration, and there are now 23 ACOs starting their third year in that demonstration.

The second is the Medicare Shared Savings Program. There are 220 ACOs that started in 2012 or 2013, and 123 more ACOs started this month, and they include some ex-Pioneer ACOs and a mix of physician-led and hospital-based ACOs. Of these 343 ACOs, five are in the two-sided risk model.

In 2015, the next phase of the program starts. That is, the second round of three-year contracts in the MSSP. Coming up, we anticipate some information on the first year of performance later this month with new quality reporting to follow.
There are several opportunities for policy refinements coming up. For Pioneer ACOs, CMMI issued a request for information called "The Evolution of ACO Initiatives at CMS." They're interested in comments on a second round of applications for the current Pioneer ACO model and ideas on new ACO models to encourage greater care integration and financial accountability such as full capitation, including Part D, and integrating with Medicaid. Comments are requested by March 1st.

For the Medicare Shared Savings Program, we anticipate a proposed rule for the MSSP in the next few months. As the second phase of the program begins in 2015, comments in the summer of 2014 could be a good opportunity to weigh in on issues the Commission considers important. If the Commission is interested in refinements that include changes to statute, recommendations could be included in a future report to the Congress.

We'll talk about four areas for refinement today. We have the beneficiary attribution to ACOs, benchmark calculations, one-sided versus two-sided risk models, ACOs sharing savings with beneficiaries. So first let's consider beneficiary attribution.
Currently beneficiaries are attributed to ACOs based on the plurality of primary care claims over the past three years. Primary care claims are defined as qualified E&M visits, and they essentially exclude inpatient hospital visits.

In the MSSP program, direct attribution to mid-level practitioners such as nurse practitioners or physician assistants is not allowed. This is because of how the statute is written. In response to comments, CMS created an indirect method for attribution but it's somewhat complicated. This issue is a problem in general and in particular for rural health clinics and FQHCs where use of NPs and PAs is common.

In Pioneer and MSSP, if there are few or no visits to primary care, there is a second stage of attribution to specialists. This could make sense if, for example, a cardiologist was in effect someone's primary care provider. So in our comments we favored that approach.

Finally, although MSSP ACOs are given a preliminary list of beneficiaries that is determined prospectively, final attribution in MSSP is retrospective, which means that savings and loss calculations are made
after the fact based on patients who used the ACO in the course of the performance year. This is sometimes referred to as prospective attribution with retrospective reconciliation.

As the programs have unfolded, we have heard some concerns from ACOs. The basic issue is that they are not getting the beneficiaries they expected. On the one hand, patients who the ACOs think of as their patients were not attributed. This could result from the mid-level issue we just talked about.

On the other hand, some beneficiaries were attributed that they did not expect, for example, beneficiaries who were not primary care patients who might have been attributed from visits to a specialty practice. Also in the MSSP they were not sure which patients they would be accountable for at the end of the year because of retrospective attribution.

Specialty practices have voiced concerns as well. The first is that specialists can only be a member of one ACO if they can be used for attribution. This is referred to as being exclusive to one ACO. The way the algorithm works is the ACOs have to submit a list of physicians in the
ACO, and then CMS associates all claims for beneficiaries with those physicians to the ACO. If a physician were in two ACOs, the algorithm would not know which ACO to align the claim with. So physician assignment must be exclusive to one ACO for the algorithm to work.

In MSSP physicians are identified at the practice level, not at the individual physician level. The problem is that the entire practice can be made exclusive to an ACO if one physician can be used for attribution. One faculty practice reportedly became exclusive to an ACO that way, and it was not the ACO the university hospital was in, and that caused a problem.

A physician organization brought the exclusivity issue to our attention because they were concerned that primary care providers in other ACOs would not refer patients to them if they were exclusive to one ACO and that might mean they would lose business.

In light of these issues we have rethought attribution and come up with a few ways to simplify it and make it more predictable.

First, allow direct attribution of mid-level practitioners. The text box in your mailing materials shows
how the statute could be modified to do that, and this might attribute more of the expected beneficiaries to ACOs, particularly ACOs with FQHCs or rural health clinics as members.

Second, identify the providers individually in the MSSP program. Although it may be difficult operationally, this would take care of the issue of an entire practice being assigned to an ACO because of one physician.

Third, have ACOs designate their primary care providers which could include physicians, mid-levels, and possibly specialists who provide primary care. Everyone who was designated by the ACO would have to be exclusive to the ACO because they would be used for attribution. This would result in fewer unexpected beneficiaries being attributed. Often those beneficiaries are not closely tied to the ACO primary care providers, and thus, their care management is difficult.

Fourth, second stage attribution based on specialists would no longer be necessary if the above steps were taken. The second stage attribution seemed like a good idea, but it is apparently not accounting for many beneficiaries in the Pioneers, and it adds complication and
unintended consequences such as the exclusivity issue.

These changes would allow specialists to share savings with more than one ACO.

Finally, make attribution fully prospective. This would allow MSSP ACOs to know who they would be accountable for in advance as we discuss on the next slide.

Prospective attribution means the ACOs know who they are accountable for at the beginning of the year and they remain accountable for exactly that list of beneficiaries. This is the case for Pioneer ACOs now.

However, the current MSSP model has preliminary prospective attribution but retrospective reconciliation, which means the ACO knows who may be attributed but that list of beneficiaries can change over the year based on actual use of services, and the final accounting is toted up on beneficiaries who it turns out were actually touched by the ACO during the year.

Under prospective attribution, because the ACOs know that they will be accountable for those beneficiaries no matter what, they have the incentive to make the investment to educate the beneficiaries and manage their care, furthering beneficiary engagement. It removes the
incentive to send potentially expensive beneficiaries elsewhere for care, that is, engage in selection. For example, if a patient is known to need an expensive procedure such as a knee replacement that would not be indicated by their risk score, an ACO might want to refer the patient to some other provider rather than be on the hook for the cost of that treatment.

In addition, prospective attribution is compatible with prospective benchmarks, the next issue, which we will discuss on this slide.

There are two issues concerning the benchmark for ACOs:

First, the final benchmark is not known in advance. This makes planning difficult because the ACO does not know what target to shoot for. It also makes it difficult to make mid-course corrections as spending becomes known in the course of the year.

The other basic issue is whether improvement over one's own baseline is sustainable over time. The benchmark is calculated based on the historical expenditures of the ACO's beneficiaries. For the second cycle, the benchmark is rebased and will be those beneficiaries' experience in the
ACO for the three previous years. If the ACO has done a
good job of controlling spending, that means the benchmark
will be low. This has already been raised as an issue by
those ACOs who feel that they were already efficient before
the first cycle started.

Improving the benchmark calculation takes a few
steps.

First, it could be made fully prospective so that
the target is known in advance and the ACO can make mid-
course corrections. To do so, CMS would have to forecast
fee-for-service growth rates, but it already does that for
MA plans. ACOs would have to live with poor forecasts which
may or may not be to their advantage. But those forecast
errors would not compound; they get corrected year to year.

The benchmark should also take into account ACO-
specific mortality rates and input prices. Mortality rates
are an issue for benchmarks in the Pioneer demo because the
only beneficiaries in the baseline are alive at the
beginning of the period. That means their historical
spending does not include any end-of-life costs. End-of-
life costs need to be added in to compute a realistic
benchmark because some beneficiaries will die in the course
of the year. It's important that mortality rates be ACO specific because the rates can differ among the ACOs.

Input prices are important to take into account as well. Currently a nationwide absolute dollar amount is calculated and applied to all ACOs. ACOs in high-input-cost areas, such as San Francisco, get the same as ACOs in low-input-cost areas and are, thus, put at a comparative disadvantage. This can be corrected by accounting for input prices in the absolute dollar amount.

The other improvement would be to not rebase benchmarks for relatively efficient ACOs. "Relatively efficient" would be defined as ACOs whose use rates are below the national average. ACOs that remained high use would be rebased. This is a matter of equity and of making the model sustainable over time.

The next issue is which risk model to use.

We have discussed one-sided versus two-sided risk sharing before, so we'll go over this very briefly.

The advantage of one-sided risk -- that is, a model with no shared losses only shared gains -- is that it could draw in more ACOs to participate in the initial phase of the program, even those that were not sure of achieving
any savings. And, in fact, almost all of the MSSP ACOs have chosen to be one-sided.

The advantage of the two-sided risk model, where the ACOs share in savings and losses, is that it gives much stronger incentives for efficiency. The incentive is greater for two reasons. First, any improvement in efficiency will pay off for the ACO either in more shared savings or lower shared losses. In the one-sided model, only if there are shared savings will efficiency be rewarded. There is, therefore, greater incentive to invest in care management and less incentive to invest in growing volume as we'll illustrate in a moment. Second, the savings threshold can be lower because random variation will balance out over time in a two-sided model. The program does not need the protection against random variation that it does in the one-sided model.

So in this illustrative example, we examine how an ACO bonus structure could reduce a practice's incentive to purchase or lease an MRI machine. And, remember, all the values here are hypothetical and just for illustration. So absent any ACO incentive, which is the case in current fee-for-service, the profit for the practice from leasing and
operating the machine would be $100,000 in this example, and
that's calculated as shown, revenues minus costs.

Now, we assume for this example that Medicare
patients account for 40 percent of the revenue, or $200,000,
and that spending for the ACO's beneficiaries is increased
by that amount.

The rest of the calculation proceeds from that
$200,000. The key difference is in the next row. We assume
that in the one-sided model there's only a 60 percent chance
that the ACO will get a bonus and that the increased
spending will offset that bonus. In the two-sided model,
the $200,000 is guaranteed to either offset the bonus or
result in a larger loss. Working through the calculations,
the one-sided model results in an incentive of $16,000 to
lease the machine. In the two-sided model, the loss is
$140,000, and there is a negative incentive to lease the
machine and, therefore, they wouldn't do it.

Thus, the two-sided model has a stronger incentive
to avoid cost-increasing investments. Because ACOs were
invented to control unnecessary utilization, that's an
important result.

With that in mind, how should we think about the
issue of one-sided versus two-sided risk sharing?

The Commission commented on the MSSP proposed rule that the two-sided risk should eventually be the only option. Pioneer ACOs now all have two-sided risk, although they did allow some ACOs to be one-sided in the first year.

As you discussed in November, there seemed to be a consensus for allowing one-sided risk in the first agreement period, but requiring MSSP ACOs to move to two-sided risk in the second agreement period and subsequent agreement periods. And that is the current regulation as well, so no change is needed there.

I would also note that two-sided risk does not mean full risk. There could be caps on losses, or reinsurance, or other limitations. Now there are limits or caps on the maximum loss allowed. These ranged from 5 to 15 percent for the Pioneers in the first years, and in the MSSP, for those under two-sided risk, from 5 percent in the first year to 10 percent in the third year. One complication is that 5 percent of total Medicare spend for an integrated provider that gets all the revenue may be pretty manageable, but for a primary care practice that forms an ACO and only gets a small share of the revenue, it
could be a pretty big deal. So they are in some sense leveraged on the downside as well as on the upside.

So to the next issue, as the Commission has noted in the past, the beneficiary does not now share in any savings if the ACO succeeds. One could argue that the beneficiary is getting better care coordination and higher-quality care, but those benefits may not be obvious to the beneficiary. This could raise the issue of a consumer backlash if beneficiaries think the ACO and Medicare gets savings and they get nothing.

The ACOs are aware of this problem, but restrictions on beneficiary engagement are unclear to them.

Communication is an issue; in particular, the notification letter for the beneficiary is confusing. Beneficiaries seem to think it is giving their doctor permission to share information with the government not vice versa. One ACO we spoke with did not send it out for fear of alienating the beneficiary, which meant the ACO could not get any claims data from CMS until the beneficiary came into the office on an office visit and said it was okay.

Another issue is limitations on offering additional benefits. Regulations derived from fee-for-
service may be overly restrictive. It is important to note that incentives are different than they are in fee-for-service. In fee-for-service, inducement of services is a big issue; therefore, much regulation is devoted to prohibiting volume-inducing actions. In ACOs, inducement for more services is not as much of an issue because the ACO is accountable for all spending and has an incentive to reduce it. So regulations need to recognize the difference.

So here are a few ideas to make it possible for ACOs to share success with their beneficiaries. First is to clarify marketing and communication guidelines that prevent ACOs from readily communicating. It's important that beneficiaries have privacy and other protections; however, it is also important that ACOs be able to engage their beneficiaries. For example, one approach might be to have regulations crafted in consultation with the ACOs that guarantee rapid turnaround for communication reviews and a one-stop shop rather than regional review.

Second, improve the notification letter. It should be short and clear and not subject to the current misunderstanding.

Third, clarify regulations on inducements.
particular, explicitly allow the ACO to waive cost sharing for primary care visits with ACO providers. We see this as having several benefits.

First, it might enable the ACO to get the beneficiary to use ACO providers exclusively for primary care, which would build identification with the ACO system. This might help the ACO to decrease leakage and control utilization better.

Second, it might make beneficiaries more likely to buy Medigap plans without first dollar coverage, which has been shown to be beneficial to Medicare.

Finally, clarify that ACOs can recommend high-quality post-acute-care providers. A number of ACOs that we have spoken with are recognizing that post-acute care costs can be considerable and are often much higher for ACO beneficiaries than they are for beneficiaries in the same practice in MA plans. Part of the explanation is that certain PAC providers are better than others in terms of cost and quality. ACOs are working to develop networks of efficient PAC providers, and they should have the capability to recommend them to their beneficiaries.

I will leave you with these issues for discussion:
changes to attribution, improving benchmark calculations,
moving to two-sided risk in the second cycle, and allowing
ACOs to share savings with beneficiaries.

As Glenn pointed out in November, these issues are all linked, and Scott suggested a general principle that the goal is to create accountability for outcomes in a care delivery system. Thinking about the issues related to that goal leads, I think, in the direction of prospective attribution and benchmarks to promote accountability for a clearly defined population, and two-sided risk, and some way to better involve the beneficiary.

We would be happy to try to answer any questions on the presentation or paper you may have.

MR. HACKBARTH: Okay. Thank you.

I envision doing three rounds here -- round one, clarifying, then round two, and then I would like to be able to get to round three where we can focus on a few specific issues where I would really like to get your input.

Starting with round one, I've got a couple of round one clarifying questions.

David, could you put up slide 12?

[Pause.]
MR. HACKBARTH: So, in this illustration, could you talk about the row, Probability of a Decreased Bonus or Increased Penalty, the 60 percent and 100 percent? Where does the 60 and the 100 come from?

MR. GLASS: Okay. Well, the 100 percent is easy.

They're sure to be either penalized or rewarded --

MR. HACKBARTH: Yeah.

MR. GLASS: -- for the extra spending.

MR. HACKBARTH: In a two-sided --

MR. GLASS: In the two-sided model.

MR. HACKBARTH: Where does the 60 come from?

MR. GLASS: The 60 -- we just made that up and said there's not a -- you know, what is the chance that they will get a bonus?

So it's not a 100 percent chance they'll get a bonus; it's something less. For this illustration, we said 60 percent.

MR. HACKBARTH: And just as a reminder to people, the reason it's less than 100 is because there's this threshold that you have to get more savings than X --

MR. GLASS: Right.

MR. HACKBARTH: -- based on the size of the
organization so that --

MR. GLASS: And there's also the chance that

they'll just, you know, have a loss instead of a savings.

MR. HACKBARTH: Yeah, yeah.

DR. MARK MILLER: Well, there's variability in

that experience.

MR. GLASS: Yeah. So we said, well, let's use 60

percent. Then people can do the arithmetic easily.

MR. HACKBARTH: Okay. Then put up slide 15.

[Pause.]

MR. HACKBARTH: So the third bullet -- explicitly

allow waiving cost-sharing for primary care.

So, as I understand it, the Stark rules prohibit

this in other contexts. It's considered an inappropriate

inducement for beneficiaries to use services. Is that

correct?

MR. GLASS: I think that's right.

MR. HACKBARTH: Yeah. And so what we're talking

about is waiving one type of regulation in the ACO context.

Now, if you do this in the context of a two-sided

model, where the ACO bears downside risk as well as upside,

you become less concerned about the Stark issue of
inducement to use more services.

MR. GLASS: Right. And I don't think you'd want to do it in a one-sided, yeah.

MR. HACKBARTH: And so that was just going to make that clear. This is the sort of thing that you would do in the context of a two-sided model.

Okay. Other clarifying questions?

[Pause.]

MR. HACKBARTH: Peter, Cori, Rita, Herb, George.

MR. BUTLER: On this slide, but a narrow question. They recently announced a number of new ACOs. So remind me; we went from like 250 or something to how many, and how many million do we estimate are now covered by ACOs?

MR. GLASS: There were 220 in the MSSP program. They added 123 this month.

And what was the next question?

MR. BUTLER: How many millions of the 40-plus million do you think are in ACOs?

MR. GLASS: Oh, I think the number is something like 5.1 million in all forms of ACOs in Medicare.

MS. UCCELLO: So, in terms of improving the benchmark calculation, there were a couple different options
for the efficient ACOs. There was the don't-adjust-the-
benchmarks-downward, and there was also this use-a-national-
standard-amount. And I just wasn't clear on whether these
were competing options or whether they could both be done.

MR. GLASS: I think that we could do them all,
yeah.

MS. UCCELLO: Okay. I just wanted to make sure.

DR. REDBERG: Yeah, I wanted to understand a
little better the secondary -- second stage attribution
because -- for example, I'm a cardiologist, and I practice
in a faculty practice. And so for some of my patients I am
their only doctor; they're relatively uncomplicated. Some
of them clearly have a primary care physician. Some have
multiple cardiologists and primary care physicians.

So I have two questions.

How do I know when I'm being considered the
primary care physician in an ACO?

And then the other question was it says a few
visits for a Pioneer; and what are a few, and what is the
time period?

Those are two separate questions.

MR. GLASS: Let's see. How does this work?
So I think the Pioneer was if they're 10 -- what
was it?

If under 10 percent of the visits were with a primary care person, then you could consider a specialist.

DR. REDBERG: Last year?

MR. GLASS: Last three, I think.

DR. REDBERG: Last three.

MR. GLASS: In the MSSP, it was if there were no visits with a primary care provider. So that's how that works.

I'm sorry. And the --

DR. REDBERG: For the varying types of patients, would I be an ACO provider for some but not for others if they had --

MR. GLASS: Well, say you're in the MSSP -- and you're exactly who they were thinking of when they said the secondary stage attribution -- and you have a patient with no primary care visits in the prior three years but who had qualified E&M visits with you, then you would -- that patient would be attributed through you to the ACO, assuming you were in a practice whose taxpayer identifier number was registered with that ACO as an ACO member.
So, as long as you're -- the practice's TIN is part of that ACO, then you would be in that. Your patients would get attributed to that ACO, and you and all your practice would be exclusive to that ACO.

MR. HACKBARTH: Rita couldn't be unwittingly connected to another ACO because her practice in that TIN is associated with only one ACO.

DR. MARK MILLER: But, if I understand this, if somebody else in her tax ID gets attributed to an ACO, she goes with it.

MR. GLASS: If the TIN somehow gets --

DR. MARK MILLER: Right.

MR. GLASS: -- is signed up as a member with another ACO, then the whole TIN has to go that way.

DR. MARK MILLER: That's some of what the concern is, and so a different way to -- sorry.

A different way to understand all this problem is just to look at what we're trying to say to solve it, you know, because there's a lot of moving parts and, you know, MSSP and Pioneer and all the rest of it.

I do want you guys to understand this; it may be hard at any given moment to understand exactly how it works
now, but what we're trying to say is identify the practitioner as opposed to the TIN, let the ACO or A -- what are these things we're talking about?

[Laughter.]

DR. MARK MILLER: I'm sorry. Which is the one?

Medicare, okay. All right.

So let the ACO -- and probably within some range of specialties, but you guys need to discuss that -- identify that, you know, Rita can act as a primary care provider, you know, because there are certain patients where their cardiologist serves as a primary care provider. Then you become an attribution node through that designation.

So we're trying to clear away all the underbrush of it could happen this way, it could happen that way, and just say the ACO has actively looked at you and said this is one of my specialists who acts as a primary care provider.

That's sort of what we're saying, right, David?

MR. GLASS: Correct.

Yeah, and the point is then you'd have one stage of attribution and add up all the primary care visits with the ACO. And some of them would be yours. Maybe some would be someone -- a primary care person's, but you'd add them
all up for that ACO.

And we think that that would attribute

beneficiaries who actually go there for their care a little

better than having the second stage attribution.

DR. CHERNEW: On this point, I just wanted to make

sure I'm clear from this exchange.

The provider gets to choose whether they're part

of an ACO or not. So Rita never has to worry that something

is going to happen and she's accidentally in some other ACO.

The issue is in the current model all the

providers in the same TIN have to basically make the same

choice, and in the model that's on the table we would allow

providers in the same TIN to make different choices.

But the key point is the providers are always

making their choice, and they could choose no ACO.

But, if they do make a choice to be in an ACO,

then their visits count towards attributing patients to the

ACO that the provider has chosen to be part of.

And, if they don't -- if the provider doesn't make

a choice, or the ACO hasn't recruited you, or however that

works, then there's no issue here about what happens.

So I think the issue is whether or not Rita and
her colleagues make different choices if they want to or
not. That's the way I interpret this.

DR. REDBERG: I think that's true and the
clarification -- what you suggested about individual
attribution -- makes sense.

It's just at teaching hospitals the primary care
practice is huge.

DR. MARK MILLER: That's the key point.

DR. REDBERG: The faculty -- the specialist
practice is huge, and so it's very hard to keep track of all
the ACOs.

DR. CHERNEW: Right.

DR. MARK MILLER: So I think I need help here. It
could very well be that this TIN has made a decision, but
you could end up having practices so large that somebody
like Rita could be surprised that she's in an ACO.

DR. REDBERG: My primary people could have an ACO,
and they did it on their own, but then I happen to be the
primary care doctor for those designated beneficiaries.

DR. STENSLAND: The only thing I would add is I
think it's a point of discussion of whether you want to let
each individual provider opt in or out because there could
be some selection issues there.

Or, do you want to say: Okay, we're taking all primary care providers. So all your family practitioners, your general practitioners, your internal medicine doctors under this TIN are in, but you tell us which of your specialists actually provide primary care?

Maybe this cardiologist is really just doing interventions and he's really not doing primary care, or this endocrinologist does some primary care and this one doesn't. But we would let them decide that for those certain specialties.

And you might not want to let all specialties in either. You're not going to say your radiologists can declare themselves as primary care physicians -- that kind of thing.

DR. MARK MILLER: That's what I was trying to say. The rules we were describing pertain to the specialists. So I was trying to say that, but I didn't say it precisely.

MR. KUHN: On the benchmark calculations, it talked about the end-of-life costs and how we can kind of bring that in there, but in the advance reading material we also talked a little bit about SES, or socioeconomic
factors, as part of that activity.

About a year ago, we spent a lot of time on risk adjustment and talked a lot about SES at the time. Are these some of the same things that we talked about before, or are we introducing new kinds of ways to calculate end of life?

I'm just trying to understand what kind of information we would be using to help that or what would CMS be using to help make those determinations for the benchmarks.

DR. STENSLAND: There is kind of -- I would call it -- the base SES characteristics. You know, the income and their socioeconomic status.

And because the spending is based on your historical spending, that SES effect on your kind of expected annual spending is already built into your baseline.

But there may be some differences in SES in your life expectancy, like we might find out that life expectancy is lower in rural Louisiana than it is in Honolulu. And so there's going to be a bigger portion of your people are going to have end-of-life expenditures in rural Louisiana.
than they do in Honolulu. So you might want to make an
adjustment for that.

But I think the SES really only flows, as far as I
can think of -- maybe I'm missing something, but it only
really flows through that expected mortality rate we have
for your population because the rest of it is built into the
baseline.

MR. KUHN: Okay. That's helpful to get a bit of
clarification on that.

And then the second issue -- in terms of benchmark
calculation, just for a point of reference for me on this,
in addition to MA and outliers, are any prospective
benchmarks used elsewhere in the program right now?

MR. GLASS: I'd have to think about that. I don't
know.

Mark, do you have anything?

DR. MARK MILLER: Yeah, I'm thinking about it, but
I'm not --

MR. KUHN: And the reason I'm -- because, I mean,
CMS has had pretty good experience with that. But, as I
think you all well pointed out, if CMS overestimates versus
underestimates, you know, there's some juggling there.
So I'm just looking at, you know, experience that they've had, their ability on their predictive modeling and things like that.

And so that is the only two areas, I think, in the program they use now, but I just wanted to see if there were any others.

MR. GLASS: Part D? Is that -- I'm just not familiar enough. Possibly.

MR. KUHN: Okay. Thanks.

DR. HOADLEY: There are payments that are made prospectively, but that's really just a cash flow.

DR. MARK MILLER: We'll think -- [inaudible comment.]

MR. GEORGE MILLER: On slide 2, please, I believe in the presentation you mentioned out of all of the new ACOs that there currently are a total of 5. So are any of them the new two-sided risk models, or were they in the previous group that started in 2012-2013? Where are these?

MR. GLASS: I'm not sure, but I think they were in the previous group.

MR. GEORGE MILLER: Previous.

MR. GLASS: Yeah.
MR. GEORGE MILLER: Of the 120, no one?

MR. GLASS: We'll have to check that, but I think that may be correct.

MR. GEORGE MILLER: I think that would be interesting, at least for me, to know.

Thank you.

MR. ARMSTRONG: Back to the issues of attribution, so given the direction we're going in, if a patient doesn't have any primary care visits, they will never be attributed to any ACO; is that correct?

I mean, the ideal ACO --

MR. GLASS: Under the patient that they get paid for but never shows up for a visit, and what we're saying is that that can't happen under this methodology.

DR. STENSLAND: There's the three baseline years. So we're saying we look at 9, 10 and 11 and decide which ACO you're assigned to.

MR. ARMSTRONG: Over the course of the full three years.

DR. STENSLAND: The full three years.

MR. ARMSTRONG: Oh, okay.

DR. STENSLAND: And if you saw no one over those
full three years, then we have no idea who to assign you to. So you wouldn't be prospectively assigned.

But you could have seen somebody in 2010, and then you're just healthy as can be, and you don't see somebody in '11 or '12. But you're still assigned to that doctor for '12 even though you never saw them because historically that was your primary care doctor, as best we can tell.

MR. ARMSTRONG: That answers it.

MR. HACKBARTH: Okay. Any others?

[Pause.]

MR. HACKBARTH: So moving to round two, let me just ask a question here.

So I'm trying to imagine what it looks like to lead an ACO, and let's set aside the Pioneers who are unique in their organizations that have more structure and experience with this.

So I'm thinking about a newly created ACO, and I'm very ambitious and idealist, and I want to improve medical care for beneficiaries and hopefully get some benefits to my organization as a result. What tools do I have at my disposal?

Now, as I understand how all this works, the
dollars continue to flow on a fee-for-service basis.

And so let's assume that this isn't an integrated group practice and you got people on a bunch of different practices and legal structures that we're trying to meld into an ACO. So all of them are continuing to get their checks from Medicare.

I, as the idealistic, ambitious leader of this new ACO, am not getting any checks. Unless we beat the target and there's a savings to be had, I assume that goes to the ACO corporate structure. Is that --

MR. GLASS: But it shows up, you know, a year and a half later.

MR. HACKBARTH: Right, right. So --

MR. GLASS: There's no -- except for something called advance payment, which a few of them are in.

MR. HACKBARTH: Yeah.

MR. GLASS: So there's basically no money up front.

MR. HACKBARTH: Yeah. So the tools that I have at my disposal

MR. GLASS: But

MR. HACKBARTH: Yeah, yeah. So the tools to
influence practice inside this new ACO are pretty limited. Hopefully, I'm an inspirational leader and speaker because I don't have any money that I could offer people; I don't have any new money, no money from Medicare other than the advance payment model that I can invest in programs.

If I want to change, you know, the structure of physician payment, I can't do that. The flow of dollars to specialists versus primary care is still driven by the Medicare fee schedule.

MR. GLASS: So, essentially, even in the one-sided, you're at risk for whatever initial investment.

MR. HACKBARTH: Exactly, exactly.

And so if I wanted to do something, you know, basic, like say: Well, you know, I want to not require patients to come in for face-to-face visits all the time. I think I can really improve the efficiency of this operation if we have more email and phone appointments and really use our face-to-face appointments for the patients who need to see the physician face to face. And that's how I'm going to streamline our practice, improve access to care for sick patients, et cetera.

I really don't have any tools to do that because
under the Medicare payment rules Medicare doesn't pay for the email and Medicare doesn't pay for the phone calls, and so I've got to exhort my physicians to do these things that they're not getting any compensation for. Right?

MR. GLASS: Correct. There are no fee-for-service payments coming in for anything that they wouldn't come in for to begin with.

MR. HACKBARTH: So we've often talked about the one-sided model being a weak model, and David's illustration, the table on slide 12, is a numeric illustration of why it's a weak model.

This is another sense in which it's a weak model. The flow of money through the organization is still driven by the Medicare fee-for-service structure, I think.

DR. BAICKER: I have a clarifying question about your question. Medicare wouldn't pay the ACO for the phone call. But, couldn't the organization -- couldn't the physician group -- say we think we're going to reap savings from this in this model, so we're going to pay our physicians to make those phone calls?

That's not precluded.

MR. HACKBARTH: They could, but they wouldn't have
any new money to do that. They'd have to reach into their pockets and say we're going to take a chance and do that.

DR. BAICKER: They'd be taking a chance on the savings that they thought that they would accrue, but it's not precluded.

MR. HACKBARTH: Yeah, whereas in Scott's model, where he's getting a global capitation, he can reprogram the dollars, you know, subject to the constraints on winning consensus within his organization and say, I don't have to ask my physicians to reach into their personal bank accounts to finance this; you know, we'll try to build a consensus that the dollars need to flow a different way.

MR. ARMSTRONG: And just to build on your clarifying question, so the hypothetical ACO leaders that were putting this together -- really, you are describing two different levels at which they have to invest in certain capabilities. One is just around payment policy and that they don't have the funds to set up the kind of incentives within the system that you're talking, but there's a whole other set of functions and capabilities that simply don't exist.

I mean, the first thing I'd do is call my regional
Medicare Advantage plan and see what they could do to help me build some of those capabilities. It still doesn't answer, though, that funding point.

But it's both. It's really both of those things. DR. SAMITT: Can I pile onto that clarifying as well?

I mean, correct me if I'm wrong, but there was also an advance payment option for ACOs that wanted access to resources to invest in ACOs. So it wasn't as much of a cash flow issue.

But I think what most organizations do is they would estimate to what degree could they influence savings even though the ultimate reward for that is a year and a half later, and the cost of achieving those savings is invested as part of the organization's budget with the premise that it would produce savings downstream. So I think that's how several ACOs have been thinking about it to date.

MR. HACKBARTH: The advance payment model -- is that limited to certain types of ACOs?

MR. GLASS: That was limited to, essentially, small ACOs. I think there was an emphasis on rural
physicians.

MR. HACKBARTH: Yeah.

Alice?

DR. COOMBS: Glenn, this is so round three, but I have to say this is one of the hurdles for the onesie-twosie groups. What you have highlighted that is really important is this big hurdle of getting over infrastructure development to be able to progress to an ACO.

And we saw this in Massachusetts when we were in the process of that whole payment reform.

And I know with the AQCs that they actually earmark and they look at certain doctors in certain regions and say, okay, we have information.

But a piece of it is the providers actually knowing what their panel looks like, and that's all IT and infrastructure in terms of being able to have an EMR with the bells and whistles.

The other piece of it is actually having the regionalization of onesie-twosie doctors coming together and being able to say this is what our patient profile looks like in this area.

And I think that's really important going forward,
to get over that initial hurdle, to say that I can do this.
The I-can-do-this is built and predicated on the resources
that are available to those docs, but you have highlighted
an essential issue with the buy-in to get the next level of
providers together and to move forward.
If we don't get over this hurdle, I think it's
going to be one of those things that we need to address
before we can see that real swing in terms of the number of
ACO development.

MR. GLASS: I would point out, though, that there
are entities out there, private sector entities out there,
that are making -- that are essentially providing the up-
front capital and information, you know, the IT capabilities
and all the back office stuff --

MR. HACKBARTH: Right.

MR. GLASS: -- to groups of practices.
So they'll find some practice and say I want to
set up an ACO, and they'll provide all that.

MR. HACKBARTH: Yeah.

MR. GLASS: So that is happening.

MR. HACKBARTH: Yeah. So the reason I raised this
whole line is that it is something I'm considering for round
three.

You know, we talk about strengthening the model, as being from -- moving from one-sided to two-sided, but I'm trying to raise the possibility of another dimension of strengthening the model, which is to move at least some of the payments away from fee-for-service so that they flow on a different basis and provide leverage to really transform practice.

So, John, do you want to pick up round two?

DR. CHRISTIANSON: Okay. Just to clarify, so the idea is our thoughts on these policy issues and their relative importance?

MR. HACKBARTH: You can frame it as questions or comments, whichever way you want.

DR. CHRISTIANSON: Well, I will focus on the benchmark issues, and I'll do that because I think without resolving the benchmark and how to set an appropriate benchmark the ACO program will fail in its objectives.

And I know that -- I actually took this down: ACOs were invented to control unnecessary utilization.

I hope more than that. I hope that their goal is to actually reduce the rate of increase in Medicare costs
through better coordination of care.

And, if you rewind to the early 1980s -- which I hate to do, but -- the language is exactly the same for the MA program. Somehow we were going to capitate MA plans, and utilization would be controlled, and Medicare would save money.

That's the problem with that link. There's nothing about utilization being controlled that necessarily results in Medicare saving money. It all depends on how you set the benchmark.

So now we have savings plans here, which say keep 7 percent. Well, 7 percent of an appropriately set benchmark is a savings. Seven percent of a benchmark that somehow is 150 percent of what reasonable costs are lets Medicare say, oh, we saved 7 percent, but in fact it cost Medicare a lot more money.

To me, this is the critical issue.

And I'm not actually reassured by the experience we've had with the MA program, starting with the AAPCC back in the mid-1980s and on. It seems like we're continually changing the way we're reimbursing MA plans. We end up paying MA plans, as the data that the staff has generated
over the years suggests, more than the cost of providing the
care in traditional Medicare. And the politics of changing
that is pretty intense.

I don't see any reason why ACOs won't go down that
same path.

And so, to me, the number one issue in terms of
whether this turns out in retrospect to be a good move, in
terms of restructuring the Medicare program, is how you
establish and maintain a benchmark that reflects something
resembling reasonable costs plus a margin that's acceptable
to us and to the industry. So I would think a lot of
attention should be given to that.

And the presentation talks about, you know, some
of the sort of more technical issues in setting the
benchmark.

I think we have a bigger issue in setting the
benchmark -- what's our policy as a Commission going forward
in terms of setting the benchmark? And, if we don't get
that right, we don't get the program right.

MR. HACKBARTH: Of course, that links into the
conversation we had in October, was it, about a level
playing field and how you define what the playing field is?
DR. MARK MILLER: It wasn't in October.

DR. CHRISTIANSON: One more comment, I guess, before -- the other thing -- this is just a suggestion for the staff, which is there are examples now where organizations designated as ACOs are now offered as options within Medicare Advantage plans.

So I haven't thought through what the implications of that are, if there are any implications.

They're going to be offered at a particular price to beneficiaries. There is some market information there relative to the benchmark except there's also likely to be some selection because they're in a narrower network plan. They may get healthier beneficiaries. So it may not be appropriate to assume that the price at which they're offered in an MA plan anywhere reflects what the benchmark should be for a more random selection of Medicare beneficiaries.

But I think it would be worthwhile for the staff to try to monitor whether this is occurring in any more than a handful of instances. And, if it is, does it (a) help us, or does it (b) raise any issues in terms of how we want to think about ACOs going forward?
In the private sector, the people I talk to who manage networks now tell me, you know, total cost of care contracts -- they refer to this as a transition arrangement. They don't see this as something which is going to be maintainable in the long run, and it has a lot to do with the issues that you folks have raised in terms of if you continue to base it on historical costs, how long -- you know, how much savings can you continue to crank out of that?

So it comes back to the whole benchmark issue.

MR. GLASS: Yeah, this ACO within an MA plan -- we'll have to follow up on.

But, if it's within an MA plan, then I guess there's some lock-in involved, which would, you know, torque things around quite a bit.

MR. HACKBARTH: Just for the record and the people in the audience, the discussion we had about the level playing field was November, not October. October was the government shutdown. So we didn't meet.

So, if you want to look up the transcript, it's November that you should look at.

DR. MARK MILLER: Yeah. And even then, was it
November, or was it September? I know it wasn't --

MR. HACKBARTH: Just for the record and people in
the audience, the discussion we had about the level playing
field was November, not October. October, there was the
government shutdown, so we didn't meet. So, if you want to
look up the transcript, it's November that you should look
at.

DR. MARK MILLER: Yeah, and even that, was it
November or September? I know it wasn't October. I was
here, but everyone else --

[Laughter.]

DR. MARK MILLER: Nobody else was in the room, but
I was here.

DR. REDBERG: [Off microphone.] Did you talk
about it?

DR. MARK MILLER: I did.

DR. STENSLAND: November.

DR. MARK MILLER: November, all right.

MR. HACKBARTH: Okay. Bill.

MR. GRADISON: Thank you. I've been troubled, as
many have, about the attribution question from the time ACOs
first came up. At times, I say to myself that I'm like the
economists who are very troubled by something that works in practice but doesn't work in theory, and in this instance, I don't really know how bad it is. That is to say, I'm not sure that the definitions exactly -- that we've used are clear, at least, not to me.

We say this is retrospective, and I understand that. But my understanding is that the potential patient, beneficiary, is notified and has a chance to opt out and about five percent of them opt out. So, in that sense, it is a choice. It's a negative choice, but somebody who doesn't want to be under this can get out from under it --

MR. GLASS: Well, their --

MR. GRADISON: -- but they can't say, I want to be under one. It has to start from the other end, from the provider end. Is that sort of correct?

MR. GLASS: Well, the ACO is given a list at the beginning -- and we're talking MSSP -- at the beginning of the period, they're given a list of who seems likely to be in their ACO, and yes, for those people, those people are then given the opportunity to opt out of data collection. Now -- to opt out of their data being shared from CMS to the ACO. But their spending will still be counted if, at the
end of the year, it turns out that, retrospectively, they were, indeed, in the ACO. So, in other words, their spending is counted. It's just their -- CMS can't send their data to the ACO.

DR. MARK MILLER: Or, to put it differently, I wouldn't say -- I wouldn't characterize it as five percent of the people opt out.

MR. GRADISON: Oh, that's what I want to understand.

DR. MARK MILLER: I wouldn't put that --

MR. GRADISON: How would you -- help me. I'm really just trying to --

MR. GLASS: They opt out of data sharing.

DR. MARK MILLER: Five percent of the people don't --

MR. GRADISON: Oh, they opt out of data sharing.

Okay. Well, then that raises an interesting question, whether there should be a clearer opt-out opportunity if they want to opt out, that's all. I mean, the attribution strikes me as so weak that, looking down the row, as I say, at least theoretically, I don't see how it works over time, but I may be wrong about that and we'll find out soon enough
from so many different organizations that are trying to do
this right now.

The other thing I want to just simply mention, and
please don't throw anything at me about this, but when we
talk about providing incentives or trying to share savings
with beneficiaries, whether it's under MA or in the
discussion here, we've left out -- we haven't left out, but
left out of the discussion almost always is a sharing of
something called cash. I mean, the assumption is that we're
going to have some additional benefits or some lower cost
sharing or something like that, but there are things in life
which lead me to believe that cash can also be a powerful
incentive and that savings along that line really ought to
be thought about. I know it's a radical -- seriously, I
know it's a radical idea, but I really hope at some point we
can give a little thought to that across some of these
programs.

That's all I really have. All I'm trying to do is
reflect a lot of uncertainty and the fact that I found this
discussion and your presentation excellent and I know I've
got to give a lot more thought to it to know where I'm going
to end up.
DR. NAYLOR: So, let me just echo that last point. I also found this work and your presentation just really important. It seems to me that we're in an experiment to try to figure out what we can learn. We have three years with 23 and two years with 220 and just starting others.

The set of recommendations that you've described to get us from the set of challenges around attribution or beneficiary rules or benchmarks seem quite reasonable to me if looked at as a set. You know, I would be concerned if we begin to take things apart and don't see this as a planned opportunity to really tackle what seem to be challenges on different fronts.

I hope we will really use the opportunity, as we think about ACOs and the emphasis on primary care, on shared accountability, on accountability, that we really do think about it from the insurers' and clinicians' and beneficiaries' perspectives, and it seems that this set of recommendations has done that.

I also think that access has been a kind of golden rule around the Commission and I think it's very important that we not just tackle regulatory adjustments, but where
there are needs for statutory adjustments, such as thinking about all of those people who access, are trying to access accountable care through ACOS, through NPs and at PAs, that we really begin to see this as part of the set of primary care services that we should be promoting access to and holding accountability for.

So, I think that this is a really excellent plan looked at holistically, from multiple lenses, and really based on our learning, and I think that's what the Commission is supposed to be doing.

MR. GEORGE MILLER: Yes. I'll echo what many of my colleagues said about this being excellent work. But something Mary just said struck a chord with me and I was going to address that, and that is if we -- first of all, my statement would be, what have we learned from this, from the ACO model and where we are today, and then if we were able to restart this over again, what would we do differently? And more importantly, at least, more importantly from my perspective, as the Medicare beneficiary, would this be valuable to me, what we have now, or how could we make that better? And it's a two-sided risk model. While it may be better for the Medicare program to have risk, shared risk
and savings, but would that get the outcome we want for the
patient, to improve quality of care, lessen the spend, and
is there another way to do that?

So, I don't know the answer to those two
questions, but certainly -- and as Bill said, this has got
us all thinking. It certainly raised the question in my
mind, how to look at this so that the Medicare beneficiaries
improve and we have some increased quality and certainly
lower the cost spend. So, the question in my mind, does
this do that and can we take this opportunity now to tweak
this to move in that direction.

And if we make it too complicated, the discussion
about if a physician doesn't know which ACO she's in or not
in, or he is or is not in, how do we fix that issue, and
does the patient have the free opportunity to decide they
don't want their information shared with anybody, and if
that is the case, then how does that impact the goals that
we're trying to get at. So, those are just some of my
thoughts.

DR. SAMITT: So, before I share my remarks, I
guess I should admit my inherent bias that I'm a big fan of
the ACO movement because I do believe that it helps us
overcome the inertia of the fragmented fee-for-service system. And while it may be an experiment, I think it is progressively moving us in the direction of alternative payment models that we really need to encourage, with the presumption being that these alternative models, we believe that they have promise to deliver better care at a lower cost. I would imagine that what we want is to ensure that a greater number of providers are incented to move in this direction and a great number of beneficiaries are incented to move in this direction.

And so I would say of the four proposed changes, I am actually a big fan of all four, but I want to dig deep on two in particular, the benchmarks and the sharing of benefits with the beneficiaries.

So, I completely echo John's comments that the benchmarking and getting that right is going to be probably the most significant element in making this work. My greatest concern is if we're dealing with inaccurate benchmarks and at the same time we're encouraging the current one-side to move into two-side, this becomes exceedingly problematic, and it's most problematic, I would argue, for the most efficient providers.
And so working for one previously and now one currently that's on the efficient side of things, if you're in the one-sided space and the benchmarks are a bit imperfect, you probably can live in that world because there isn't risk. There's up-side, but you can still effectively survive there.

But as you move into two-side, and if the benchmarks are inaccurate, and, in fact, it's based on historical performance and so every time you improve, in a two-sided model, you're actually facing increasing amounts of risk, not increasing amounts of gain, then I would be concerned that the efficient providers would not stay in a two-sided model and would seek to either move all the way to Medicare Advantage or go back to fee-for-service. And I'm not so sure that's the type of movement we'd want.

So, I completely echo the notion that we need to continue to create incentives, even for the most efficient providers, to find new opportunities as opposed to find great risk.

On the benefit sharing with beneficiaries, I'm a big fan of that, too, because we don't want to have a party that no one comes to, that if all the providers say, you
know, we envision that we want to be in the ACO space but
there isn't a similar recognition of the benefits to the
beneficiary, then I think we have a disconnect.

So, I would say that I would even encourage us to
go further in identifying how we can share with the
beneficiaries, and what I mean by that is I would even make
the sharing much more significant. I would encourage us to
even say an ACO is not an ACO is not an ACO, that the ACOs
that are either the most efficient or demonstrate the
highest quality have the even greatest degrees of freedom to
provide benefits to beneficiaries because it encourages them
to be even more efficient and higher quality and creates
even greater incentives for beneficiaries to seek them out
as the best providers.

So, I think there is great merit in the concept of
beneficiary benefit sharing and we just will need to figure
out how to effectively do that.

MR. KUHN: I'm a lot like Craig. I am a big fan
of the ACO model, as well, but when I look at all that we've
got up here today, it reminds me of a fingerpainting from my
niece that we have on our refrigerator right now. There's a
lot going on in that picture, I'm just not sure what it all
MR. KUHN: And that's kind of what I think about when I look at these kind of four areas that we're looking at right now.

But, three things I'd like to just kind of focus on. One, David, we were talking a little bit about the types of ACOs out there and these one model that's coming forward with these outside consultants coming in, perhaps no capital requirements by the ACO itself. It's the other group putting it up. I don't know whether it's a good or bad thing. It reminds me a little bit of a model we saw a decade or a decade-and-a-half ago with some of the physician-owned specialty hospitals and some of the development of those. What kind of -- are these becoming pretty widespread out there, or what's kind of the take-up rate of this particular model of ACO? Do we have much information on it yet?

MR. GLASS: Well, there's one big group of these, and they had over 30 and they have some additional ones in the 123 that just came in, so that would be, I don't know, 35 or something.
MR. KUHN: Okay. I don't know whether it's a good thing, bad thing, just curious about that.

MR. GLASS: Yes.

MR. KUHN: It's just an interesting kind of phenomena here and we'll see how it works out.

The second thing, I, too, am interested in the sharing success with beneficiaries, and I like all the things that we're kind of enumerating as we go forward. I will just say that a couple ACOs I know I'm familiar with, the one I'm really interested in is the recommending post-acute care providers, among all of them. I'm interested in all of them, but that one. And the reason I raised that one is I'm seeing more ACOs actually taking their staff from their organization and putting them, say, in a long-term care facility or other kind of post-acute care provider in order to improve the quality so they don't get bounce-backs from readmissions or whatever the case may be. They could alleviate that problem if they could just recommend certain high-quality providers out there, and it's a strange work-around to make it work, but I think there's we can help that through these set of recommendations, so I'm interested in that.
And then, finally, what I'm interested in here, too, is that since this continues to have its roots in the fee-for-service world, unless Glenn has his way and thinks about different other payments here, but I'm just wondering if there are any program integrity issues that we need to think about here as we go through these set of recommendations. I don't know what those would be. I don't think we've raised those. But are there any additional program safeguards that we need to think about as we go through the set of recommendations, and just something -- I wanted to just make sure we fully vet those.

MR. HACKBARTH: On that last issue, Herb, I agree with that, and one concept that we've introduced is that if we were to move towards two-sided risk, then that would allow potentially clearing away some of the regulatory underbrush that is directed at cost increasing behavior, for example, Stark rules.

Rita.

DR. REDBERG: Thanks for an excellent discussion, and I also like the concept of ACOs but think the devil is in the details and a lot of the changes that you've suggested, I think, would improve the ACOs. I particularly
think it's important to focus on the beneficiary engagement, because right now, and particularly -- maybe we could talk about Medigap a little more, because we have before, but particularly beneficiaries who have Medigap and don't pay anything, there's not a lot in it for the beneficiary to be in an ACO because they mostly have unlimited care whether they need it or not. For whatever reasons, beneficiaries currently think the more care they get, the better it is, which isn't necessarily true, but that's a lot of the -- and so the ACO doesn't have that kind of culture. But right now, the way it's structured, there isn't a lot in it for the beneficiaries.

So, I think the cost savings, the elimination of cost sharing, getting away from and making it more favorable for beneficiaries to participate, and, I think, additional things besides just leaving the cost sharing, additional perks for the program, things that beneficiaries clearly want, you know, facilitated communication, ease of access to their providers. I mean, I think those are things that beneficiaries really value and are becoming harder and harder to get and that would make ACOs -- give them a better status in the marketplace compared to standard fee-for-
service plans, because otherwise, I fear there's just too much leakage and there's no incentive. I mean, the provider signed up. The beneficiary is going to get a letter from the government saying, you're in this, and they have nothing invested. So, I think those changes and more, as Craig and others have said, would be a good -- a really important step for the success of ACOs.

DR. CHERNEW: So, a few quick points. First, I agree very much with John's comment that getting the benchmark right is key. And, actually, in the chapter, it alludes to the fact that we'll try and bite that off separately, and I think that's probably right. There's a lot of issues with how to do that. One is how to coordinate with Medicare Advantage in a level playing field kind of way.

Another one is when the system captures the savings, on one hand, we want to capture the savings as the ACOs become more efficient. On the other hand, you can't be afraid of profits. They have to have an incentive to be more efficient. And so, working through that requires some thought.

I'm a little wary of sort of halfway tweaks to the
benchmark, in other words, don't rebase after two years for
those that are relatively efficient, because you're setting
up this whole other set of things. So, I'd rather wait,
bite it off as a big thing and figure how we want it to go
forward strategically as opposed to a few small things, and
I think the chapter actually notes that we'll try and do
that.

A few other things. I very much agree with these
points that have been made about administrative costs. In
general, I think we often ask organizations to spend less,
but then we impose a lot of administrative costs or other
restrictions that make it hard to do that, not just in ACOs,
incidentally. If we would have had more time in the
hospital sector, I would have said the same thing. We put a
lot of pressure on hospitals. We have to make sure that we
don't add a lot of costs to them at the same time in a bunch
of ways. So, I think, generically, that's a theme.

The one thing that's clear from your presentation,
and I would appreciate it if -- I very much appreciate it,
although it's depressing in some ways, is the aspects of
 attribution is just a mess, and there's a lot of tweaks we
talk about, and thinking about how to work around that is
going to be very important. I think, despite a very
thorough and thoughtful presentation, in many ways, I feel
like we've just scratched the surface on how to get the
attribution right.

In response to Bill's point, we actually have a
paper that's under review now on how well the attribution is
working or not, and there's different types of people that
are getting misattribution -- I don't know, "mis" isn't the
right word, but you have problems with. One is you have
basically healthy people that don't go very much and so
their care patterns bounce around because there are just not
that many visits, and maybe that's not a big deal if you get
it wrong.

Then you have people that have serious events.
Something bad happens to them and they end up in a nursing
home and with rehab and they end up somewhere, or a lot of
different things, and those are people we really do care
about and there's issues with how that attribution goes,
too. It's sort of a version of the mortality story,
although it's not exactly that.

And so I really think it's important to think
about attribution, and honestly, my preference would be to
get away from some attribution thing, but there's all kinds of other barriers, which we've talked about, about doing that. I do worry a lot about it.

The last thing I'll say is I think some thought about the role of a one-sided risk model is important, and so let me say, I agree with where we've been collectively, and I've said this, that I prefer a two-sided model for all the reasons that have been said. So, I don't think it's a huge question that the two-sided model in many ways is better. The question is, that might not be for everybody. So, it's not clear who the other folks are.

But then the question is, is there anything for those other folks, and let me say, just in general, it's not our job as a Commission, and I don't think it would be advisable if we interpreted our job as to come up with models that support the existing practice configurations and infrastructures. You know, having them change in various ways, I think, is fine. So, I don't think we should look at a small practice and say it's really good and you always have to be small and our job is to give you enough money so you can stay small. Maybe that would be good, but inherently, I don't think we have to support it.
On the other hand, we can't ignore the existing infrastructure and just assume that everyone can transform to some other configuration that we may or may not think eventually could be better or not. And so I think there is a struggle we have to come with about is there a role for something in the transition or not, for organizations or areas that won't fit well into a two-sided model if we think those exist. And I have to admit, for many of the issues that you raise in the chapter and some that I've commented on, I am on the fence about how far to go and how it ultimately plays out.

And I think, as I said in another meeting, the one thing that is clear to me is finding some way to move away from the fee-for-service -- you know, however bad this looks, it looks more promising to me than where I think the trajectory of fee-for-service would go for a whole variety of reasons. So, I think it's crucial that we get this right, but these are very hard issues that I don't have necessarily strong opinions on yet.

DR. COOMBS: So, I think the benchmark is important. I think the attribution is even more important, because unless you get the assignment right, then you don't
know the baseline and you don't understand who is caring for what in terms of -- not just in terms of cost, but in terms of quality, and the quality piece is as important. And that, combined with the risk adjustment, that was our language with payment reform.

And another benchmark that I think is important is the progression along the way, and the Secretary will be able to assess how well we are doing in terms of ACOs, newly adopted ACOs, over what period of time, so that there should be a benchmark. In 2009, with the Payment Reform Commission, we looked. It was 21 percent global payment and it would progress to 40 percent and so forth within the next time period. That's probably as important, because what it tells you is that culture is changing in terms of providers feeling like they have the support and going to the next level.

And so I want to remind myself more than anything else is that there's two things occurring at the same time. There's health care delivery reform and then there's payment reform. They should go together. They should be married. And that's the piece that sometimes we talk about it as though they're two different things. But the global payment
was a really important piece of where we went for health care delivery reform.

I think the infrastructure, as mentioned before, is really important for providers to see that they can do it, and unless you address that, because of the percentage of onesie, twosie providers, whether it's physicians or nurse practitioners, you have to be able to have a heal that is reachable. I mean, it has to be something that's attainable, and it has to be perceived as fair, and it has to be something that actually looks at the overhead for providers in terms of being able to reasonably do something in terms of this whole hurdle of understanding what your patient panel looks like, what the risk adjustments look like, and whether or not this is something that's attainable. I think those are the important things going forward.

And I have to say that I was pleasantly surprised at the progression in Massachusetts in terms of where we've gone from capitation in terms of percentage benchmark per year, how many of the providers have transitioned. But one key feature is that it's almost like a continuous pilot study, where you're looking at issues that arise and you
have to be willing to deal with mid-course corrections along the way. But you can't have just health care delivery reform in the absence of payment reform. They go together. They're married.

DR. HALL: I'll try not to repeat too much what others have said. I think that the work we've done here is terrific. I feel much better informed by this than anything else that I've read about in terms of ACOs.

But, I think our discussion is pointing out that we would all agree that the construct of the ideal ACO, or constructs of ACOs, has yet to be determined, that there are still some very basic integers that need to be filled in here. For example, the whole issue of attribution that everybody has mentioned here, whether it's retrospective or prospective, we're now looking for labels to do attribution. So, we're saying, well, anybody can be the designated primary care provider to define membership in an ACO. That has nothing to do with the definition of primary care, not even the definition we used when we were trying to find ways for paying for the sequestration. We were very, very specific about who was a primary care provider.

So, it's kind of trying to monkey wrench names
into entities that we don't really know much about yet at
the present time. That says to me that this is such a work
in progress that we can make suggestions, but I think we
need to follow this much more closely.

And, in particular, I don't think any of this is
going to work unless both providers and patients have
confidence in these systems. It's not enough to just say
you're an ACO in a community. You may be an ACO in a highly
competitive urban community and your real purpose is to
steal market share from your competitors. Others may
really, truly want to embrace an entire State and say, we
can make this the best possible "X" that there is in the
world. But we need to urge people to take a look at some of
those factors, as well.

Do we know anything, really, about consumer
reaction? Do we know anything about what so-called primary
care providers feel about this? Unless we look at that, I
don't care -- we can come up with arguments that might be
more like how many angels dance on the head of a pin until
we really have some idea of what is the real human effect of
these things.

So, I think we should keep going, but I would be
very cautious for us to think that we have the answers here and that we can make one suggestion on some of these alternatives that come forward.

MR. HACKBARTH: Let me just pick up on Bill's comment. Earlier, we talked about when data would be available on the MSSP program, and Jeff boldly said, we have it now.

[Laughter.]

DR. MARK MILLER: Just for the record, Jeff will now clarify. We talked at lunch.

DR. STENSLAND: We have data on about 600,000 to 700,000 people in the MSSP, so we can --

DR. MARK MILLER: Pioneer.

DR. STENSLAND: In Pioneer, excuse me. So we can track those Pioneer individuals.

MR. HACKBARTH: Just Pioneer.

DR. STENSLAND: Just the Pioneer. We don't have the data yet, and we haven't got that all squared away on the MSSP people. But to the extent that -- that's still a pretty big sample of people that you could look at some things and say, you know, what is the hospice use for the people in the Pioneer and the year they were in the Pioneer
compared to other people in their same community. You could
do that kind of analysis with the stuff that we have. We
don't have the full five million.

MR. HACKBARTH: For this discussion, I'm actually
less interested in the Pioneer because they have, you know,
a more advance payment model, or "advanced" being defined as
one that I like.

[Laughter.]

MR. HACKBARTH: You know, I think Bill is right.
In a sense we're operating in sort of a vacuum and trying to
make decisions about these policy variables, and we don't
know much about what has, in fact, happened with the MSSP
program. And I think that is really critical.

My own hunch is that the MSSP program is so weak
that it's not a very effective tool for promoting the
delivery system reform that Alice seeks, and I agree, that's
the ultimate goal. But that's just my hunch. Maybe the
data prove me wrong. And so I would like to see how quickly
we can get a look at some of the MSSP data.

MR. GLASS: So we're hoping to at least hear about
MSSP performance in the next month or two. You know, but
that would be --
MR. HACKBARTH: Top-line numbers.

MR. GLASS: Yeah, top-line, did they make money, lose money, you know, savings lost sort of thing.

DR. MARK MILLER: And in those types of analysis, that won't be stuff that we'll have looked at independently. It will be reported out. And if I could just get two other clarifications here, the data that we have for Pioneer has come by recently, like the last 48 hours. Is it claims level data or blocks of expenditures, you know, like sort of the rolled-up summary level stuff?

DR. STENSLAND: We have the beneficiary identifying numbers, so we can link the --

DR. MARK MILLER: So it's more individual.

DR. STENSLAND: -- identification to the actual claims and look at the individual claims of individual people.

DR. MARK MILLER: Okay, and that's much ore powerful. And then for Mike, you just described what you guys had done, which is under review?

DR. CHERNEW: Just the stability issue, right, but we [off microphone] --

DR. MARK MILLER: Sorry, I caught you --
DR. CHERNEW: No, I was hoping you would. We've been looking at how many people stay in an ACO when, you know, if you're assigned in one year, are you still in them the next year? We weren't looking at them in the actual ACOs because of the lag. We were looking in those types of groups. So in big groups, how much movement is there across those groups.

DR. MARK MILLER: Okay, that's what I wanted to know [off microphone].

DR. CHERNEW: So that could all change when the ACOs are keeping people in, but the underlying notion of the basic care patterns are pretty noisy in a variety of ways.

DR. MARK MILLER: Right, and the thing I'm just trying to clarify here and I need you guys to make sure I'm asking the right question, you're not saying I have beneficiary IDs assigned to this ACO; you're sort of looking at how attached a beneficiary stays to a group?

DR. CHERNEW: In groups that are defined as ACOs, but that's a longer discussion.

DR. MARK MILLER: Okay.

DR. HOADLEY: So I will echo what a number have said. I think the research here you guys have done has
really been helpful in sort of setting us up. Having said that, this is still a lot of hard questions, as, again, many of us have said.

Thinking about the four topics that are up here, I'm very convinced by a lot of comments here that the attribution issues are really important. I'm also fairly convinced that I don't have anything to add to that discussion, so I won't try -- at least today.

I'm also convinced by Jon's and others' comments that the benchmark is really important, and I totally get that sort of comparison back to the early days of Medicare Advantage. I don't think I have anything else that I feel a need to add on that.

I have some thoughts on the two-sided risk, and I partly was intrigued, Glenn, by your initial question, trying to sort of say, well, how would your answer to that question be different if you were under two-sided risk? I mean, you're that same entrepreneur. There's still nobody putting money in your hands.

MR. HACKBARTH: Actually that's the question I meant to raise. We sort of simplified it as, oh, two-sided is better than one-sided. But if it still all flows fee-
for-service, from the perspective of the fledgling ACO, it may be worse.

DR. HOADLEY: Right.

MR. HACKBARTH: Because I don't have any more tools, any more means to redistribute the dollars, but now I've got downside risk. So that's the question I --

DR. HOADLEY: Yeah, and that's exactly the way I thought about it. And then as I go deeper into the sort of notion of two-sided risk, I started to try to think about -- and I don't know if there's experience at this point in the Pioneers that have done this on sort of how the money -- you know, what sort of happens with money, you know, if there's a loss. You know, is this all a matter of what the contract relationships are amongst the various players? Is there any concern -- I mean, it's not like the beneficiaries are at risk. You don't have sort of the insurance issues that you might have on a provider-sponsored MA, you know, issues we dealt with a few years back. But I am interested in sort of what's the ability to put that money back in to cover that and how all that plays out, and potentially more so when you sort of think about the variety of kinds and some of those smaller kinds of ACOs, ones that don't have a hospital
involved because the hospital has potentially deeper pockets
to sort of work with, both in terms of putting money up
front but also uncovering a loss. If you've got a
relatively small let alone not even the ones and twos, but
even a modest six physician practice trying to head up an
ACO, you know, what are the protections either for the
individual providers or for the entity as a whole in terms
of that downside risk? And how is that being played? I
know there were some references to reinsurance and some
other things in that.

So those are things that I think, you know, as we
think through the two-sided, I think it's really important
to think about and whether we're learning anything from the
relatively few groups, and maybe they're so atypical of the
rest of this universe that it doesn't help.

And then, last, on the beneficiary side, you know,
I've made points in other meetings about sort of the general
notion of how is it that a beneficiary is ever going to
understand what this is when we're having trouble explaining
them and understanding and thinking about attributions and
who's even attributed to be with let alone sort of with.

And I think, you know, these notions of improving
notification letters are very important but not necessarily easy. How do you write a letter that has all the right legal statements in it that sort of passes muster the way CMS tends to want those letters to look, and yet ends up saying something that's clear to a beneficiary reading it. Marketing guidelines, same thing. We've seen lots of problems with marketing in the Medicare Advantage world and other worlds, and sort of, you know, yeah, we ought to be able to figure out a way to do it, but we got to stay clear of some of the problems.

And I'm very interested in some of the other possibilities of waiving cost sharing and sort of thinking about, you know, what are the rules that you need to do, and even in the example used about recommending high-quality PAC providers, I guess my question there is: Is there something in the rules today that prevents them from doing that? I mean, any doctor is going to make a recommendation to their patient of here's the specialist or here's the home health agency, or a hospital's going to say we're recommending this home health agency, is there any further limit today in their ability to do that? I mean, what would we be changing if we somehow made that easier? So that's a very specific
1 question.

2 MR. GLASS: I'm a little unclear, but there seems
3 to be some rule that you have to say here are the five home
4 health agencies in the area, we kind of recommend this one,
5 but you can't say you really should go to this one. But I'm
6 not sure -- maybe Herb knows what exactly the rules are.

7 DR. HOADLEY: I mean, I think it would be useful
8 then, if we're sort of going to get into these things, I
9 mean, the cost-sharing one is clear because there are Stark
10 rules and some things that sit there. But, I mean, I think
11 for any of the various kinds of things which seem advisory
12 on the one hand, you know, are there any limitations? Or is
13 this just something they should be doing? And then when
14 there's some money issues, like waiving cost sharing, we
15 should get to the point where we know exactly what rules are
16 in the way, what would need to be waived, and then we can
17 see whether it makes sense to sort of take some of those on
18 -- again, within whatever context of only in the two-sided
19 model or whatever it might be.

20 DR. MARK MILLER: I guess the only thing I would
21 say is -- and we're up against time, so I want to -- there
22 are several things to say here, but I'll take this all
offline. We should look harder at this, because I think some of what you said depends on whether you might be in Pioneer versus MSSP. And I think it's more -- it might be even more rigid than what you've said, depending on which one you're talking about. And we keep jumping back and forth in all these conversations, and I suspect people might end up being confused. So we'll come back to you on that.

DR. BAICKER: So despite some of the gratuitous potshots at economists -- which need to stop.

[Laughter.]

DR. BAICKER: -- I did want to follow up on --

DR. CHERNEW: Get more original [off microphone].

DR. BAICKER: Yes.

[Laughter.]

DR. BAICKER: That's really very much appreciated. I wanted to follow up on the question -- that we may not have the data now to answer -- of how often this retrospective truing up is really a problem in practice, not just in theory. I wonder if this doesn't actually happen very often; or if you don't have the data to answer that question, in practice you could see if this rule were in placed based on beneficiary patterns, what's our best guess
at how often there would be -- how many people would move based on prospective versus retrospective? And it may be that it's particularly the problematic patients, very expensive, hard-to-manage ones, so we care about who it is, not just how many. But it would be helpful to have a sense of how big that is.

That said, I do think that the prospective assignment has a lot of attractive features, one of which is giving providers a responsibility for those patients no matter what, but also discouraging selective movement of patients, where movement, I'm picturing a shove not a walk out the door, and that suggests that you don't want providers to have an incentive to say, "Wouldn't you be better off across the street, Mrs. Very Expensive Patient?"

That concern goes over then to thinking about beneficiary choices in moving. I wonder how often beneficiaries who opt out would be doing so truly volitionally versus some subtle encouragement of expensive beneficiaries to opt out, not just -- I worry about that less with data sharing than I would with actual --

MR. GLASS: They can't opt out now. They can't opt out of the ACO now. They can only opt out of data
sharing.

DR. BAICKER: Exactly. So I worry if they could opt out of their data being counted towards the reimbursement, not just their data being shared. Clearly, we want beneficiaries to have options, but we also want to make sure that providers don't have an individual to have those options selectively exercised. And that could be done through some ex post risk adjustment if that's adequate. But that's something that I would think that we'd want to keep an eye on for sure.

For the other two questions that came up, I still like the two-sided risk better than the one-sided, although I'm sympathetic to a transition period. But I think there are all sorts of properties of the two-sided in terms of continuity of incentives that are worth capturing, and I think it's a great idea to give providers opportunities to do things like waive cost sharing for, you know, certain types of services for certain patients, seeing certain post-acute care, better information about that. All of those tools seem really good.

MS. UCCELLO: So as the actuary who is more typically the target of --
DR. BAICKER: I know. What's --

[Laughter.]

MS. UCCELLO: -- the potshots, I'm happy to share.

So a lot of great comments have already been made, so what I'll do instead is share an anecdote about the notification letter.

So I was home for Christmas. My mother received notification that she was now part of an ACO. And my mom, I want to say for the record, is a smart lady. Get that in the transcript.

[Laughter.]

MS. UCCELLO: She did not understand at all what this letter was telling her. She was getting nervous as she was reading it. And so I took the letter and I read it, and I go, "Oh, I know what this is. I know what this is. It's okay. It's okay." And I explained to her, to the best of my ability, what, you know, this all meant. And so, you know, she was a lot more comfortable with it.

But I think what was still confusing after all this is that we could not figure out how she got attributed to this ACO. We got on the website and looked at the list of providers, and she didn't really recognize any of the
names. And so it was just confusing -- it's still confusing.

So I don't know if this is practical, but if these letters could be a little bit more personalized to say how it is what providers that they've been to that are in this ACO I think would help. And I asked her if that would help, and she said, "Oh, yes, it would." So she also said if you need to call her for any information, she'd be happy to a focus group of one.

[Laughter.]

MS. UCCELLO: On the other hand, you don't necessarily want providers now to be listed on this that are going to have to take all these calls from patients getting these letters, but it might just make someone feel more comfortable that they're just not out of the blue being assigned to something that they have no idea what it is.

MR. GLASS: Well, some of the ACOs actually send the letter out through the primary care provider so that people know who they're being attributed on more or less.

MS. UCCELLO: That makes sense. Yeah, not my mom's.

MR. GLASS: But that requires a lot of work to do
MS. UCCELLO: Yes.

MR. BUTLER: So did you hear about the one where the actuary and the economist go under the bar?

[Laughter.]

MR. BUTLER: You had your say. I do feel like Herb's niece's painting is getting bigger and very expensive for what might be a transition or interim model. So why are these people all -- these five million kind of -- how has this happened in the absence of tools and significant investment is a good question. I used to think it was, you know, maybe you were going to lose your patient, therefore get your primary care physician in there and don't lost your patients. And then I said, "And physician groups, it's easy and one-sided. They're not cannibalizing their own revenue. It's somebody else's." But I think it is more now, frankly, a lot of health systems want to learn, and you do hear that common theme. They're learning a lot.

And I wouldn't discount the synergies with other activities. Readmission rates, understanding medical spending per beneficiary, palliative care -- a lot of things that we're doing, they'd said, gee, we're doing those
things, they would help. And if there's some one-sided savings, why not? And there are other payers it's working for, too, so most states have moved or are moving toward Medicaid managed care, so we look, for example, at frequent flyers in the emergency department and what are their characteristics and where are they going on their discharges. Again, all of this kind of feeds into and is really consistent with an ACO theme, and it just becomes -- you know, it does help. And the absence of other tools, you still are working on these things.

Okay. So with respect to the discussion items, I'm actually more of a one-sided guy, unlike a lot of you, because I believe that if you are efficient, you will get -- you will opt to the Medicare Advantage plan. If, as Jon says, the rates are set right, why wouldn't you just go into Medicare Advantage as the option? And so I don't mind keeping one-sided going. It has gotten 5.1 million people in now learning a whole lot and not a big expense. Don't be so quick to just kind of flip it to two-sided where there would be all kinds of gaming and other things that get introduced when you really want to go to Medicare Advantage if you're efficient anyway.
On the sharing with the beneficiaries, you know, I'm with Bill a little bit. Cash is real. I mean, maybe this wouldn't work, but the ACA requires you to rebate money above -- below 85 percent of the MLR. Is there some way to take your end savings simply and rebate back? Maybe that's way beyond what we can do, but that would get people's attention, I think.

And, finally, on our lessons kind of learned research piece, my calculation is that about 14,000 on average in the 366 ACOs. Remember, we had the threshold we wanted at 10,000, and they settled for 5,000. So the random variation would be a good thing to understand under the MSSP and whether that's a factor or not.

MR. ARMSTRONG: So there is a benefit and a downside to being the last person in the round. I'm sitting here feeling a little overwhelmed -- more than a little -- and kind of discouraged and trying to remind myself why the ACO idea is actually a very exciting and powerful thing, you know, that many of us have worked for a long time to try to advance. And Peter started saying this. I do think it's an experiment. You know, it's this space between a pure fee-for-service payment structure and prepaid MA or something
like that. And it's a messy process, and it's not alone. There's a lot of other things that are moving us forward, and so I feel better having said that, and I just did that for my --

[Laughter.]

MR. HACKBARTH: [off microphone].

MR. ARMSTRONG: I am reading a book called "The Happiness Advantage," and I'm just really trying to apply it.

With respect to the specific issues here, I think it's a nice inventory of the issues we should be putting on the table, and then I would really support moving our agenda forward. I would just add a couple of comments. One, I work for an organization with 80,000, 85,000 Medicare Advantage plan members. I know who they are. They enroll every year. I have all the information on their care and their claims payment and so forth. And I still engage in endless debates about our attribution methodology. So it's a hard thing. There are organizations, though, that are experts at this and who have been spending years trying to figure it out. It will never be perfect, and so, I mean, I think maybe we just need to
acknowledge that. I won't comment -- I agree with the point about getting the benchmarking right, and not surprisingly, a real advocate for the two-sided risk dynamic. I just think that's the kind of incentive we're trying to create. With respect to the beneficiaries and their relationship to all this, I think we've actually understated the importance of that, and that whether it's just, you know, being in a relationship that's not scary or confusing, like Cori's mother's relationship, and owning --

MS. UCCELLO: That was [off microphone].

MR. ARMSTRONG: I'm sorry. Cori's mother's relationship. Sorry. But these ACOs need to be in a relationship with the beneficiaries that are part of the ACOs that not only gives them an incentive to but allows them to actually be in a trusting relationship and engage in a dialogue that recognizes their ability to meet the benchmarks is, in fact, to a high degree a function of what kind of behavioral changes can they make in those patients when they're not actually sitting in the exam room or in the hospital bed. And the way we built this is really impairing our ability to do that.
Just one anecdote. I would say within the MA program we now have accounts where beneficiaries had a very poor record of having a relationship with primary care providers or filling out Health Risk Assessment tools and so forth. We have the flexibility -- we paid those beneficiaries $25 cash if they showed up in the primary care office in the first three months of being a member of this plan. We pay them cash if they fill out the Health Risk Assessment tool online and have a conversation with their primary care provider about it.

You know, I just think ACOs are so impaired in their ability by so many of these issues that are in the design to actually fulfill our desire for this experiment to teach us things that we just have to pay attention to it. And in the end, and at the risk of sounding like, you know, an insurance salesman, I think the Medicare Advantage program solves these problems. And at the very least -- and I remember we had this at some point. We should be asking, as we line up all these issues, that we want to inform and advise on with respect to helping the ACO experiment move us forward. Line them up against the solutions that we've seen in Medicare Advantage and just ask, Why is it so bad to make
sure MA really does what we want and fill in that space,
particularly, you know, MA plans that are provider focused
and, you know, engaged in care delivery and so forth? What
really is the hurdle that keeps us -- or what's the issue
that keeps us from filling the space between this ACO
experiment and really going for MA as a solution to some of
this stuff?

I'm sure that there's political answers and all
sorts of other reasons, but my hope is we can objectify some
of those differences in the analysis that we do going
forward.

MR. HACKBARTH: Okay. I had promised a Round 3,
but there will be no Round 3. I was thinking that we should
have a Round 3 because I thought that we might be close
enough to consensus on some issues that I wanted a Round 3
to crystallize that. I think actually we've moved away from
consensus compared to our last conversation. For example,
on the issue of two-sided risk, I think there's less
agreement this time than when we discussed this issue last
time.

Now, that's a healthy sign that people are really
wrestling with what's a complicated question, so I don't
have a problem with that, although we do have a fixed time
allotment to sort of come up with a view for the MSSP
proposed rule, which will come out sometime in the next
couple months, I think David said. So we've got some work
to do.

One last thought about this. I think there were
some really articulate comments about how you might want to
be careful about moving to two-sided risk prematurely
because the participation might fall off dramatically, and I
think that's probably a reasonable assumption. And so the
question that I'm starting to wrestle with, which is better
from the perspective of the Medicare program: to have a
much smaller program that involves providers that are
further along in terms of delivery system organization and
integration, or to have one that includes a lot of people
that are in a much earlier state of evolution? And hope is
-- I think Peter and some others described that in time, you
know, we'll get benefits, even though the incentives are not
all that strong, it's getting people to think about some of
the proper questions. And there's some intuitive appeal to
me in that, but I do think we need to take care to focus on
layering on complexity to the Medicare program for -- if we
1 don't think there's going to be a really big benefit,
2 because this one in particular, the more it expands, the
3 more beneficiaries we're going to have like Cori's mother,
4 "What in the world is this? I don't understand it." It's
5 such a, you know, sort of like a test tube idea that people
6 like us think up that a lot of Medicare beneficiaries find
7 it very, very difficult to relate to.
8 So there are costs to having a really big sort of
9 low-success program, a lot of regulatory costs and confusion
10 costs for beneficiaries, and we need to figure out how to
11 weigh that versus a much smaller, perhaps much more powerful
12 program.
13 I do think that having some data on how successful
14 MSSP is in changing behavior and getting people to start
15 doing things differently could be decisive in thinking this
16 through. So Jeff has promised us that we're going to have
17 data next week, and we'll look forward to --
18 [Laughter.]
19 MR. GRADISON: Glenn, may I make a brief comment?
20 Once before -- and I can't recall on which silo -- we
21 suggested that CMS had gone too far with the demonstration
22 in terms of how many people they brought into it. I think
we ought to give some thought to that in this instance as to whether with all the things that aren't known and all the variations as to whether there ought to be a moratorium on new entries at some point in order to gain a little bit more experience -- five million is a pretty good sample.

And the only other thing I want to say while I have the floor is to apologize to Kate for what was meant to be a self-effacing comment and to promise her I'll work on some new material for next month -- for the next two months.

MR. HACKBARTH: Last word.

DR. CHRISTIANSON: Last word. All right. So most of you are way too young to ever remember when Johnny Carson was the King of Late Night TV, I'm sure, but he used to have a bit called "Carnac the Magnificent," and he would take an answer, and he would divine the question. So here's the answer: "No Medicare-specific shared savings parameters."

So the answer to that is: "What are ACOs going to look like in the future?" And we already see it in total cost of care contracts now. The health plans are providing back-room support to the provider systems. They also sell reinsurance. It's much more efficient for ACOs to buy reinsurance from health plans for their combination of their...
total cost of care and ACO contracts than to engage in this 
shared savings plus 7 percent minus 2 percent, all of this 
stuff we're worrying a lot about. The larger ACOs are going 
to want to do that very quickly, and so my point is: Where 
does Medicare point to for its savings at that point? It 
all depends on where you set the benchmark. It all depends 
on where you set the benchmark at that point.

MR. HACKBARTH: Okay. Thank you, David and Jeff.
We'll now move on to dialysis.

[Pause.]

MR. HACKBARTH: Okay. Before -- where did 
everybody go?

DR. CHERNEW: It's the after-lunch rush-out.

MR. HACKBARTH: Yeah, right. Well, once some 
other Commissioners come back, I'm going to leave.

[Laughter.]

MR. HACKBARTH: I really am feeling crummy, and so 
I'm about at the end of my battery for today. So I'm going 
to turn the chair over to Mike. I apologize to people in 
the audience. As I said earlier, this does not mean that 
I'm not interested in dialysis or post-acute care, but I had 
some food poisoning last night, and I'm just sort of totally
out of energy at this point. I didn't sleep much. So please accept my apologies. But I will stay until we get some more butts in the chairs.

Go ahead, Nancy, whenever you're ready.

MS. RAY: Good afternoon. Today's presentation on assessing the payment adequacy of outpatient dialysis services consists of four sections. First, I'm going to answer some questions raised during the December meeting. Then I will summarize the indicators of payment adequacy and present the draft update recommendation for your consideration. Lastly, I will discuss improvements to the new Prospective Payment System that we discussed during the December meeting and present a draft recommendation for your consideration.

As background, in 2012, there were about 370,000 dialysis fee-for-service beneficiaries who were treated at roughly 5,800 dialysis facilities. Total Medicare spending for outpatient dialysis services was $10.7 billion in 2012. So now I'm going to move to answer some of the questions raised during the December meeting.

Alice and George asked questions about kidney transplantation, and in response we have added a discussion
regarding access to kidney transplantation in the draft chapter.

George asked about mortality differences by ESRD modality. The adjusted rates are highest for hemodialysis patients, second highest for peritoneal dialysis patients, and lowest for transplant patients.

Alice raised the issue about bundling transportation services into the payment bundle. In last year's report, we discussed one approach for facilities to provide transportation services to their dialysis beneficiaries, but that it would require exceptions to the anti-kickback statute. It could be an option that providers could take if they deem it essential.

George also asked about facility ownership by the two largest dialysis organizations in rural areas. We call out in the chapter that these organizations comprise the majority of facilities in rural areas as well as in urban areas.

Now I will summarize our payment adequacy analysis.

The indicators assessing payment adequacy for outpatient dialysis services are generally positive, and you
have seen most of this material in December.

Regarding providers' capacity, the growth in the number of dialysis treatment stations has kept pace with the growth in the number of dialysis patients.

Regarding access, there are few facility closures in 2011. Our claims analysis suggests that the few beneficiaries who were affected continued to receive care at other facilities.

Looking at volume of services, between 2010 and 2012, growth in dialysis treatment stations and facilities matched beneficiary growth.

Looking at volume changes, we also look at volume changes by measuring growth in the volume of dialysis drugs furnished. Now that dialysis drugs are in the payment bundle, providers' incentive to furnish them has changed.

Recall that under the prior payment method, these drugs were separately billable. I'd like to highlight two findings that we discussed last month: between 2007 and 2012, use of the leading 12 dialysis drugs declined by 39 percent, and that ESAs, erythropoietin-stimulating agents, that manage patients' anemia declined by 45 percent.

There are quality implications concerning the
decline in the ESA per treatment use. The reduction is good for clinical reasons. Between 2010 and June 2013, the cumulative proportion of beneficiaries experiencing negative cardiovascular outcomes associated with ESA use has generally declined. As expected, lower ESA use is associated with a decline in hemoglobin levels. Of concern is the modest increase in the percent of dialysis beneficiaries receiving a blood transfusion from a monthly average of 2.7 percent in 2010 to 3.3 percent in 2013. This contrasts with the relatively constant rate of the blood transfusion rate over the last decade. I'll come back to address this issue at the end of the presentation.

Other measures of quality that I'd like to highlight: hospital admissions have declined between 2010 and June 2013, and there has been an increase in the use of home dialysis, which has been associated with improved patient satisfaction.

Regarding access to capital, indicators suggest it is adequate, as suggested by the increasing number of facilities that are for-profit and freestanding. The aggregate Medicare margin for freestanding dialysis facilities is 3.9 percent for 2012.
The Medicare margin in 2012 is higher for the two largest dialysis organizations than other freestanding facilities. The Medicare margin is higher for high-volume facilities compared to low-volume facilities. That is, the margin increases as total treatments increase. The lower Medicare margin for rural facilities is related to treatment volume. Rural facilities are on average smaller than urban facilities.

The 2014 projected Medicare margin is 2.9 percent. This margin reflects statutory updates in 2013 and in 2014. It includes policy changes implemented by CMS that increase payments in both of those years. It includes the 3.3 percent rebase of the base payment rate in 2014. Recall that the law requires the Secretary to rebase the dialysis base payment rate by the reduction in per patient drug use between 2007 and 2012. CMS is phasing in the rebasing over a three- to four-year period. For 2014 and 2015, CMS intends to offset the rebasing amount with the payment update and other positive impacts so the overall impact will be 0 percent compared to the total spending in the prior year.

This projection also includes the estimated small
reduction in total payments due to the ESRD QIP. And, finally, the margin would be about 2 percentage points lower if sequester cuts continue. This leads us to our draft update recommendation. The Congress should not increase the outpatient dialysis payment rate for calendar year 2015. Spending implications. This recommendation would not change spending relative to current law over one year and five years. We anticipate no adverse impact on beneficiaries. We anticipate increased financial pressure on some providers, but overall a minimal effect on providers' willingness and ability to care for Medicare beneficiaries is expected. So now I'd like to begin the last part of this presentation. In December, we discussed three issues concerning the new Prospective Payment System. I will summarize each issue for you and present a draft recommendation for your consideration. The first issue concerns the change in anemia management. As I previously said, the new Prospective Payment System resulted in a reduction in the use of ESAs.
We are concerned about the incentive to undermanage anemia under the new Prospective Payment System. Beginning in 2013, the ESRD Quality Incentive Program, the QIP, does not assess anemia undermanagement. The Secretary has the authority to include such a measure in the ESRD QIP. We do not specify the measure, but envision that such as measure could assess treatment outcomes such as rates of increasing blood transfusions or rates of admission.

The second issue concerns the design of the low-volume adjustment. For existing facilities -- those in business in 2010 -- CMS does not factor the distance to the next facility for determining the adjustment. In 2012, nearly half of all low-volume facilities were within 5 miles of another facility.

Cori, in December you asked about rural facilities, and they are disproportionately paid under the -- they disproportionately receive the low-volume adjuster, and we have called that out in the chapter.

A low-volume adjustment should focus on protecting facilities critical to beneficiary access. The Secretary has the authority to redesign this adjustment by developing a distance requirement that applies to all facilities.
The last issue concerns the accuracy of dialysis facilities' cost reports. This sector has experienced a major change. The accuracy of cost reports under the new Prospective Payment System has not been examined. The last audit was conducted more than 10 years ago. Prior ESRD audits have found that facilities have overstated allowable costs from 4 to 10 percent. If providers' costs are overstated, then the Medicare margin would be understated. It would be good fiscal management to assess the accuracy of the cost reports.

So this brings me to Draft Recommendation 2. It reads that the Congress should instruct the Secretary to: include a measure in the ESRD Quality Incentive Program that assesses anemia undertreatment; redesign the low-volume adjustment to consider a facility's distance to the nearest facility; and audit dialysis facilities' cost reports.

We expect that the spending implications of this recommendation will be budget neutral.

Concerning implications for beneficiaries and providers, we anticipate that this recommendation should improve the quality of anemia management and help ensure that beneficiaries' access is maintained at isolated, low-
volume facilities; that it would have a minimal effect on providers' willingness or ability to serve beneficiaries; and that it would decrease payments for facilities that receive the low-volume payment adjustment but are in close proximity to other facilities and would increase payments for isolated low-volume facilities that do not receive this payment adjustment.

That concludes my presentation. Thank you.

DR. CHERNEW: [Presiding.] Wonderful, Nancy.

Thank you.

So we're a tad behind schedule, so I'd just ask you to keep that in mind as we go for clarifying questions, and that said, are there any clarifying questions?

DR. HALL: In the slides we just looked at in terms of assessing anemia, you used the term "anemia undertreatment." In the narrative we were provided before, the emphasis seems to be on transfusion being done excessively, and I wonder if you could equate those two. I think it's -- it makes a big difference.

MS. RAY: Right. The narrative was not intended to give the impression that blood transfusions are being provided too much. What we are trying to raise is that
there has been a trend under the new PPS and there's a small
trend for a modest increase in the rate of blood
transfusion.

DR. HALL: So that would be anemia overtreatment.

I guess I'm not making myself clear.

DR. REDBERG: I was confused by the same thing. I

think that they're calling it "anemia undertreatment"
because they're saying there's more transfusions because
hemoglobin levels are dropping. But my clarifying questions
are related to that issue.

DR. HALL: In Round 2 we can have a few more

points.

MR. GRADISON: I guess it's a similar subject.

Can't they get more frequent or do they get more frequent
readings, at least from the big companies that probably have
the data anyway with regard to, let's say, monthly figures
on transfusions or something of that kind rather than
waiting to do it once a year? I mean, I assume these
companies probably have it every week internally.

MS. RAY: Well, generally dialysis patients don't
receive transfusions in the dialysis facility. At least
historically they did not.
MR. GRADISON: Right.

MS. RAY: They received them in outpatient hospitals. So that probably -- so the ability of the facility and the nephrologist -- well, the ability of the facility to know about the transfusion is probably going to vary to the extent to which the facility and the nephrologist are able to keep track of that information, gather that information.

MR. GRADISON: Not to drive this into the ground, but the nephrologists are usually the ones who say you need a transfusion.

MS. RAY: Yes, that's correct. Well, if -- yes, if it is ESRD related. But just to be clear, not all transfusions are ES -- there are other reasons that a dialysis patient may require a transfusion, is what I'm trying to say.

DR. MARK MILLER: I might have heard the question a little bit differently, Bill, so let me just ask. The way we're looking at this, this comes out of the claims data.

MS. RAY: Yes [off microphone].

DR. MARK MILLER: And so at least our line of sight on it is to know that a patient got a blood
transfusion and that patient is a dialysis-eligible patient. That's how we have line of sight.

It may be that the dialysis organizations and facilities have some other line of sight on this, and if you want to tease that out in subsequent rounds, let's do it. But for us, what we have line of sight on is claims.

MR. GRADISON: [off microphone] the annual?

DR. MARK MILLER: Well, I mean, the other way I could have taken your question is: Is it possible to get it any more frequently? Potentially we could get dumps of claims more frequently, but, yes, we'll tend to be coming back to you on an annual basis and saying this thing's moving up or down.

The one thing I would say -- and I do want to move this along -- this is such a rare event that it's a pretty noisy measure, and getting it more frequently is even rarer. I mean, you'll have even smaller N on a quarterly basis than you will on an annual.

MR. GRADISON: Thank you.

MR. KUHN: Nancy, just a quick question or help me get a clarification on the Draft Recommendation 2 where we talk about the spending implications being budget neutral.
And one of the recommendations is to do more audits of cost reports. From my time at CMS, there were a lot of things I wanted to audit, but we just didn't have the administrative dollars to do it. It does take a lot of money to do these audits. So I'm just trying to understand where the offsets are from the audits to make this budget neutral. This is administrative dollars or are talking trust fund dollars, is what I'm trying --

DR. MARK MILLER: Trust fund [off microphone].

MR. KUHN: Okay. So if it's trust fund, I understand. Got it. Thank you.

DR. REDBERG: So back to the anemia undertreatment, I was very troubled, you know, reading on page 2, it says, "Hemoglobin levels have decreased from 11.4 to 10.6." And that's good because we were overtreating. And the guidelines now are hemoglobin levels 9 to 11. So we're still on the high side of those hemoglobin levels. And then the next line says, "While blood transfusions increased from 2.7 to 3.3 percent," which as I say that, that was where I was guessing you were getting the anemia undertreatment. But, first of all, as you said, that's a very small increase, and there are a lot of reasons why
people get transfusions that have nothing to do with -- you
know, they come into the hospital acutely, and their
hemoglobin drops, or there's a lot of variability in
transfusion practice. And maybe we can get back to this in
Round 2, but I'm just wondering if there was any more basis
for this, because I have a lot of concern. You know, we've
spent billions of dollars trying to get people's hemoglobins
very high with very little benefit on outcomes -- no
quality-of-life benefits, no mortality benefits, very
little. And now, you know, we've seen tremendous drops in
strokes and heart attacks because we've kind of brought the
hemoglobin targets down. But I would be very careful about
trying to ramp it up again without having really good data
that there was some harm coming from this very tiny change
in transfusion when hemoglobin levels really are still on
target.

MS. RAY: Right. And it is not our intention to
ramp up hemoglobin levels again. Over the prior decade,
according to U.S. Renal Data System's data, rates of blood
transfusions were relatively constant. The new Prospective
Payment System has changed providers' incentives with ESAs
now in the bundle. We have seen, beginning in 2010 to 2011,
'12, and now for the first six months of 2013, you know, this small increase in blood transfusions. So including a measure in the Quality Incentive Program -- now, keep in mind, I mean, there are already other measures that Medicare holds providers accountable for: dialysis adequacy, another measure is anemia. There is already an anemia measure in the Quality Incentive Plan that holds providers accountable for the proportion of patients with hemoglobin levels over 12. So this would just be another measure to counteract any possible incentive that there could be under the new PPS regarding anemia management.

DR. REDBERG: I guess I'm not clear. How are you defining "anemia undertreatment."

MS. RAY: We are not specifying a measure. This would be up for the Secretary to develop a measure. Such a measure could be by looking at rates of hospital admissions. And the Secretary discussed this in the regulatory process a couple of years ago, saying that lower hemoglobin levels could lead to higher rates of blood transfusions, higher rates of hospital admissions, and those could potentially be two measures that the Secretary -- and this is the Secretary saying that she would look into down the road.
DR. CHERNEW: So my take on this is that there's a number of pieces of evidence that just -- you know, in the chapter, but the main point is when the bundle was expanded and we saw the practice patterns change the way that you document in your slide, there's always some concern that you're going to go too far. And I take the spirit of -- I think you're talking about the first point in the second draft recommendation, that's the one under discussion, and just again to clarify, I take that as saying with a lot of flexibility to encourage the Secretary to try and make sure that we don't go under. But the evidence that we provide in the chapter isn't intended to specify what that type of measure should be or what the thresholds are. It's just -- and I don't know if that's --

DR. REDBERG: I'm still not even clear of the reason for the measure. We can get back to it.

DR. MARK MILLER: And maybe we are rolling into Round 2, but just to add one other sentence to what he was saying, nothing is intended to say we think we're observing undertreatment. The trend was a concern to make sure that we don't get there. And just to, you know, put a little bit of a different tone on this, the last time we had this
conversation, there were several concerns expressed on this, and we kind of crafted this in response to the concerns that were expressed.

But, again, it's to his point, we aren't asserting that undermanagement of anemia is occurring. It's a concern over a possible direction.

DR. CHERNEW: And nor are we asserting that the types of evidence presented, the number of transfusions, should be in any way related to the measure that ultimately is developed. It's more of a potential concern as you see a dramatic reduction in the use of a service that I believe we felt was overused to start with. You take a service you believe is overused, you see it dropping, and for all the reasons that were said in the presentation, there's a lot of good things that seem to have happened because of that. The question is: As you see things begin to drop, making sure that they don't drop too much, because I would defer clinically that I don't even know what that means. I can't pronounce "dialysis." But my clinical knowledge is basically limited to that. But I think the issue was because there was some concern, we would encourage some attention to it, but not that we think that we are either
observing it now or that we necessarily will observe it in
the future, or that we think that we should increase back to
where we were in any way.

DR. REDBERG: Just we saw a lot of good things. I
didn't see any data in here for bad things, so that's why
I'm confused about why we have this recommendation.

DR. BAICKER: I interpreted that to mean guard
against stinting.

DR. CHERNEW: Yes [off microphone].

DR. BAICKER: So we think levels were too high,
this is movement in the right direction, but we're cognizant
of the fact that that doesn't mean lower, lower, lower is
always better. There should be measures included to make
sure that there is not stinting as the flip side of the
overuse that we might have observed.

DR. CHERNEW: Yes, in a very non-prescriptive way
about how we would do that.

I'm going to go around now for Round 2 since we're
basically in Round 2, and I don't want Glenn to read the
transcript and see I failed.

[Laughter.]
since, Alice, your hand was up, why don't we start with
Alice, and we'll come around and end with Rita.

DR. COOMBS: I support the draft recommendations
with one caveat, because I had the same problem, being in
the ICU, our threshold for transfusion is 26. So, you know,
those are critically ill patients, and we have a lower
benchmark than what's described.

I think that what would make this easier is to
take out the word "undertreatment" and just put "anemia
treatment," because it presupposes that -- a whole bunch of
other implications. If you just put "anemia treatment,"
then that actually has a better approach so that it talks
about inappropriate transfusions versus indicated. And the
Secretary can get into the rest of it.

DR. CHERNEW: My understanding is there's already
an anemia treatment measure, and so the particular concern
here, in the spirit of what Kate said, was that because the
new incentives that were put in place include a potential
incentive to undertreat -- we're not claiming that's
necessarily going on, but so we particularly want to worry
about undertreatment. But it might be that as the measure
gets put in place, there's a whole other process of what
that measure would be. So I think my personal opinion is --
and, again, this is why it's Round 2 and we'll go around --
I think that calling out the concern that there might be --
that we have to guard against stinting in that way I think
is relevant. As the measure gets developed, the exact
measure would be -- I thought about in more detail as to
what it is. But in any case, sorry, I've got to learn to
talk less now.

DR. HALL: So I also think the chapter was
terrific and incredibly informative. Look, even though the
intention was not to say that we got to catch clinicians
doing something wrong, the perception, at least those of us
here who do this on a day-to-day basis, is that, in fact,
that's exactly what is being said here. So rather than make
these judgments about under- or overtreatment, we could just
say that we ought to be -- they ought to be monitoring
transfusion use, period, and not try to get so clinical at
this point. I don't know the necessity for that.

DR. HOADLEY: So I generally thought that this was
a really good analysis, and I support the direction of the
recommendations.

I also had reacted in reading this to the same
point about this provision on the anemia treatment.  
And I guess -- Nancy, is there an existing measure on treatment other than -- you had talked about the one that was 2012 that they stopped using.

MS. RAY:  Okay.  Right, but in --

DR. HOADLEY:  What's the state of play?

MS. RAY:  In the quality incentive program right now there's an anemia -- there are two anemia-related measures.

The first one is designed to assess the proportion of beneficiaries with hemoglobin levels that are considered too high. And so that would be a bad outcome, and facilities could potentially lose under the QIP. And that hemoglobin level would be greater than 12.

The second measure is an anemia reporting measure that requires facilities to report epo dose and, I believe, hemoglobin levels.

DR. CHERNEW:  I'm sorry. Am I correct in assuming that first measure for an economist is a measure of over-
treatment?

MS. RAY:  Yes, yes, yes.

DR. CHERNEW:  So there exists a measure of over-
treatment essentially in there.

MS. RAY: Yes.

DR. HOADLEY: So, you know, I'm in this same sort of dilemma of what's the right statement, and maybe part of the answer -- again, no more -- as a political scientist, I'm not more a clinician than the economist, and I hate to try to practice medicine. So I won't try.

But maybe one part of the answer is let's just be clear in the text around this that some of the points that are made here are: We're not observing an existing problem of under-treatment. We are concerned about the possibility of stenting. And, thus, the measure should be -- you know, if we stick with the recommendation, that the measure -- the recommendation is there because of this concern and blah, blah, whatever.

But I think if we can surround it with text that puts some of these other concerns and put it in context, then I think it might be a place where people can be comfortable.

DR. CHERNEW: Right. So part of the issue is the wording, which I actually view as relatively weak, and the other is the tone.
And so the tone is clearly one that I think was not intended.

DR. HOADLEY: Right.

DR. CHERNEW: And we will have to go back. I would defer to Nancy and the staff to worry about the tone. And then -- well, we'll come around for the recommendation.

Kate.

DR. BAICKER: So that's the difference between political scientists and economists. We totally don't mind overstepping our disciplinary bounds.

So I actually thought that it was helpful that the recommendation calls out under-treatment rather than just monitoring treatment in general. I think it builds into all of this that we're monitoring what's going on.

But I thought it was helpful to acknowledge that in a world where you're trying to discourage over-use you must also be cognizant of potentially generating under-use. So guarding against stenting in particular seems like a helpful counterbalance to me given that we are pushing in one direction. We just want to acknowledge being aware that you can push too far in that direction without saying you've
actually observed anything like that.

So I thought the suggestion potentially to modify
the text to make it more clear that that's what we're
talking about would be really helpful, but I thought it
might actually unhelpful to take out the under-treatment
component of the recommendation.

MS. UCCELLO: Yeah, I agree with Kate.

I support the recommendations, and I do see the
need to protect against this potential stenting. You know,
the way the incentives are now could lend themselves to
under-treatment rather than over-treatment, which both are
not outcomes we want.

So, if the solution to this just making sure the
text surrounding the recommendation maybe needs to change in
tone and just clarify what we're trying to get at, but I do
agree that highlighting the under-treatment in this is
appropriate.

DR. CHERNEW: Peter.

MR. BUTLER: I was a psychology major and am
prepared to provide therapy to all of you struggling with
your identities.

[Laughter.]
MR. BUTLER: You could look towards the number 1 recommendation.

Well, you missed us, Mark.

DR. MARK MILLER: But when I came back into the show --

MR. BUTLER: Well, put on recommendation 1, please.

So this is a small point, but it kind of goes to Glenn Hackbarth not here on sequestration.

We might -- we talked earlier in executive session about changing the wording in the recommendations, and we backed off of that. But here, where you say spending, no change in spending relative to current law, you might say Medicare law because someone would say -- you know.

So, when you look at these spending implications, it's another opportunity to maybe clarify because I think what this says is that actually it's 2 percent more than would be in place if sequestration continues.

DR. CHERNEW: You're correct.

DR. MARK MILLER: That's right.

MR. BUTLER: Just a suggestion. We don't have to vote on it.
MR. ARMSTRONG: First, I'm very happy with who I am. 

[Laughter.]

DR. REDBERG: [Inaudible comment.]

MR. ARMSTRONG: So I don't need Peter's help. I support both draft recommendations number 1 and 2 as they've been written and won't repeat points other commissioners have made.

DR. CHRISTIANSON: I also support both recommendations, and I'm comfortable with Alice's suggested change in wording or with the recommendation as is, either way.

MR. GRADISON: I support both of them. I'm just trying to figure out what I should try to do when I finally grow up.

DR. NERENZ: Not much to add here. I think I just might suggest in terms of some of the surrounding wording around the second recommendation, since we do not have overt evidence of a crisis in terms of under-treatment -- we have hints; we have possibilities -- that maybe the text of the recommendation can be as is, but some of the narrative around it might also say something about whatever measure is
developed ought to be light in terms of data collection burden and analytic burden, that sort of thing, because measures can come in many different flavors.

And I think the burden of a measure should be proportional to the severity and health impact and just mathematical size of the problem, and maybe some words about that could be added.

DR. NAYLOR: I really support the way in which this has evolved to include current Medical law, to adjust the text, and I support the recommendation.

MR. GEORGE MILLER: Michael, when Glenn reads this transcript, you're in trouble.

DR. CHERNEW: Already figured that out. I've already figured that out.

MR. GEORGE MILLER: In principle, I support both of the recommendations.

And I certainly want to commend the staff on the thoroughness of this chapter and particularly dealing with the issue that I've raised several times, and they've done an excellent job talking about race, demographics and disparities.

What I'm a little, just slightly, concerned about
-- and we've brought this issue up, and I've brought it up before. I'm really concerned about the lack of transplants particularly among all ethnic groups, but particularly among the African American population. And it is stark, and it is a huge difference.

There is some explanation in the writing and the literature about some of the reasons why that takes place, but it doesn't explain all of it. And, while we've dealt with other equality issues, I would encourage us to consider addressing this, maybe not in a recommendation but in a text box, to deal with the issue, to see in the chapter and to talk about ways we can improve that.

The differences are stark, and Afro-Americans are disproportionate users of these services, significantly different than the population and dramatically different in getting transplants.

So these providers are paid a lot of dollars, and I'm wondering how we can incentivize or encourage a resolution to this, in my mind, very glaring problem.

DR. CHERNEW: Craig.

DR. SAMITT: So I want to point out to everyone that Scott said he's happy who he is and then about an hour
ago he said he was reading The Happiness Project. So I think we all need to read what Scott is reading. I support all of the recommendations.

MR. KUHN: I support both recommendations.

DR. CHERNEW: Rita.

DR. REDBERG: I support the first draft recommendation and the second draft recommendation with the proviso that I do think I would like to perhaps change the wording to clarify as Alice had suggested.

I think it's important we look at instead of anemia under-treatment, which I don't think is what we are really trying to get at, but to have a more outcome-related measure. Perhaps it's anemia-related hospitalizations we're concerned, or something that looks at quality of life related to end-stage renal dialysis treatment. But the wording on calling it anemia under-treatment I don't think captures what we were trying to get at.

DR. CHERNEW: So let me just ask a few other questions or at least maybe ask in general of Nancy. I don't perceive the recommendation or the text as advocating any specific type of measure, including a process measure. So I think everything that you say could fit into the
category of anemia under-treatment.

So the question I would ask to the clinicians mostly is in the last time we met, I was under the impression -- I think Glenn was and maybe the staff was -- that there was concern in the room broadly about the potential, not the actuality, that people would be under-treated for anemia.

That may not be happening. I don't know if there is concern, but I think the feeling was that -- and again, I may -- please correct me if I'm misreading the room, that when the incentive changed there was concern that this might happen and that some attention to worry about stenting, since we already had a measure of over-treatment, would sort of balance the scales, you know, in sort of an even-handed way.

But a measure, for example, of under-treatment that would focus on any of the things that you just mentioned -- quality of life, hospitalization. I don't know enough clinically to know what the right indicator would be.

I certainly wouldn't interpret either the recommendation -- and I think we could clarify the surrounding text to make sure that it's clear that we don't
intend to mean there has to be a particular process measure related to you have to treat more for anemia because I think your concern would be that if we put in such a measure we would go back in the wrong direction.

And I think that's a legitimate concern, and at least my read of the chapter is that is not our intent, but maybe there are challenges there.

Craig.

DR. SAMITT: That's my understanding as well.

It may just require language. I mean, if we're going to tweak the language, you know, we really want a program that monitors the risk of anemia under-treatment. We're not essentially saying there's anemia under-treatment today, but what we've observed is a red flag that we want to just pay attention to, that we're not seeing a continuous decline or worsening of anemia, that we're monitoring for the potential.

DR. CHERNEW: Right.

DR. REDBERG: What is the red flag?

DR. SAMITT: Well, just the -- you know, the increased frequency of transfusions. And it may not be statistically significant, but, in essence, it may enough to
say let's watch this.

DR. REDBERG: But we don't even know what levels of hemoglobin those transfusions were occurring at because the levels clearly are nowhere in the anemia range.

I mean, you know, transfusion is a very squishy outcome, and that's why I don't think we can make a lot of clinical conclusions based on a very small change in transfusion rate. There are a lot of things that -- as I said.

DR. CHERNEW: Right.

DR. REDBERG: And that's right I think it would be good to clarify.

DR. CHERNEW: Okay, Alice.

DR. COOMBS: So I just want to say something. The problem is the example that's given in the text of the narrative of the chapter actually is consistent with over-treatment, whether you use epo or whether you use transfusion. Those chits are relatively robust.

And so, if a clinician -- and we were talking if a nephrologist saw that there was this resolution to look at under-treatment, based on the narrative in the text, they would say: Under-treatment? You ought to be thinking more
along the lines of, as a clinician, over-treatment.

DR. CHERNEW: Right.

DR. COOMBS: So that's part of the issue.

DR. REDBERG: Right. And I did talk to my nephrologist colleagues after this, and that was what they reflected. They said the only thing that they could suggest that possibly -- is that he told me sometimes insurance coverage -- and he wasn't talking Medicare -- for epo lapse is because you need prior authorization; so hemoglobin could drift down.

But there wasn't, based on this, concerns about under-treatment.

DR. CHERNEW: Since I can only say epo, I can't say the full name of it, and I'm not completely sure.

DR. REDBERG: Erythropoietin.

DR. CHERNEW: Exactly. That will be for an extra study session.

The broader question I have is -- so there are several options on the table. One of them is -- and I hear from a number of people -- the concern that the text in one way or another has to be clarified to resolve this issue.

And I would encourage -- so that's sort of at a
minimum issue.

Then the next question is we could take that first point in the draft recommendation and either modify it or strike it one way or another. I think the concern that it was meant to address --

DR. REDBERG: Right.

DR. CHERNEW: -- was the concern, regardless of the evidence in the chapter, that when we've given an incentive to use less of certain types of things we've actually seen a dramatic reduction in those things. Although, by and large, we think so far it's been fine for a number of reasons, there is a concern that it could go overboard.

And so I think there is a general sense that we have a measure of hemoglobin -- of over-treatment for anemia. We don't have the corresponding under-treatment measure in an era where that would be the concern.

So I am fine, in all honesty. I am not tremendously wedded to that first point, and if people -- I've heard different things around the table of people's views to that.

So I'm trying to figure out for those that feel
the most strongly and know the most clinically, how strongly
they feel about the first bullet point on recommendation 2.

If the solution is we want to strike it completely, I'm mildly uncomfortable with that in part because Glenn is not here, but in part I actually substantively believe that there's a concern about under-treatment -- that we would want to be sure we, at a minimum, monitor it per what Craig said.

There might be a wording change, or it might be in the text.

So, for those, I think Alice and Bill and Rita feel the most strongly.

So we're in round four now.

Bill.

DR. HALL: You know, I'd hate us to not pass this resolution or this -- I mean the recommendation. I think it's important and time's a wasting.

DR. CHERNEW: Passing a good recommendation is more important than passing a recommendation.

DR. HALL: I'll just speak for myself. I think we will lose credibility as a Commission among physicians and other health care providers who are very intimately involved
in analysis if we put this kind of value judgment in.

That's all.

I think --

DR. MARK MILLER: So, to that point, you've talked about striking it. Does striking the one word change the nature?

DR. COOMBS: Yeah, it does.

DR. HALL: I think it gets it a long way. I would be happy with that.

DR. COOMBS: Yeah, treatment.

DR. CHERNEW: The word, under, is what --

DR. REDBERG: I think that we should focus more on outcomes -- what is it we're worried about -- because anemia -- we don't even have any signals, and anemia is a lab value.

I mean, I really think we need to be thinking about what are we worried about.

DR. CHERNEW: So I will just say my view of a measure looking at anemia treatment could actually be a measure that looks at outcomes.

So, for example, if I said we need a measure of cholesterol treatment, that could be a measure of, you know,
either the cholesterol or some bad thing you think happened if cholesterol wasn't managed well.

So it doesn't have to be --

DR. REDBERG: Well, that's why I said do you want to say anemia-related hospitalizations -- because, to me --

DR. CHERNEW: My personal view is I am more wary for a number of reasons of, at this stage, making a change in the recommendation that is more prescriptive about the type of measure that's included. So I would be less comfortable picking something like hospitalizations or any of the other things that would happen. I actually would be more comfortable personally, if that were the case, of just striking one.

I don't mind removing the word, under -- this is a personal comment -- because that's -- you know, although I do think that's the concern that I personally have. And others expressed it, it seems, last time.

But I'm also cognizant of the concerns that the folks have raised, and I certainly wouldn't want to, you know, be the one to say Glenn left; so the Commission could lose credibility on my watch.

But, no, I understand. I do take the point
seriously, and so of those people that are more familiar with this area I'm happy to, you know, figure out what your view is.

DR. MARK MILLER: The only other thing I would add is that at least as it went around the room there were a lot of people who were relatively comfortable with the concept, if not the words.

And then we have a group here -- the clinicians who, on this one, carry a lot of weight.

DR. REDBERG: [Inaudible comment.]

[Laughter.]

DR. MARK MILLER: Yeah.

DR. REDBERG: I have to clarify.

DR. MARK MILLER: I didn't want to finish the sentence with that, but as long as you finished it that way, yeah, okay. Fine.

I mean, here's one other take on it. There is still striking -- is on the table. Okay.

But, if I listened to the last exchange, what if it read as follows: Include a measure in the ESRD QIP program measuring poor outcomes related to anemia?

Then I leave the measure open. I get to your
outcome. We're still --

DR. REDBERG: That sounds great.

DR. HALL: [Inaudible comment.]

DR. COOMBS: [Inaudible comment.]

DR. CHERNEW: Done.

In that spirit of eloquence of Mark, it is now time to vote, and we will start on recommendation 1 if we could have recommendation -- we have recommendation 1 up.

For recommendation 1, all those in favor?

[Show of hands.]

DR. CHERNEW: Opposed?

[No response.]

DR. CHERNEW: Abstains?

[No response.]

DR. CHERNEW: And now we'll go to recommendation 2 with the modified bullet 1 to read --

DR. MARK MILLER: As follows.

DR. CHERNEW: As follows.

DR. MARK MILLER: Include a measure in the ESRD Quality Incentive Program related to poor outcomes -- oh, sorry.

DR. CHERNEW: It was so eloquent before.
DR. MARK MILLER: I know.

DR. REDBERG: You wish you could read it back.

DR. MARK MILLER: Okay. Include a measure related to poor outcomes -- oh, God, I don't think I can do this now.

DR. REDBERG: It says poor outcomes related --

[inaudible comment].

DR. MARK MILLER: Measure that assesses --

DR. CHERNEW: Poor outcomes related to anemia.

DR. MARK MILLER: Yeah. Include a measure that assesses poor outcomes related to anemia in the ESRD Quality Incentive Program -- that's the language.

DR. CHERNEW: Are we -- well, we're going to find if we're okay with that actually.

So all those in favor?

[Show of hands.]

DR. CHERNEW: Opposed?

[No response.]

DR. CHERNEW: Abstains?

[No response.]

DR. CHERNEW: Thank you very much and thank you, Nancy.
And so now we will move, Carol and Evan, to PAC payment reforms.

DR. REDBERG: Great job, Michael.

[Pause.]

DR. CHERNEW: Whenever you're ready.

MR. CHRISTMAN: We're starting this presentation with a discussion of payment adequacy and rehospitalization policy for home health agencies, and then Carol will discuss the draft recommendation to gather common assessment information across PAC settings.

The home health presentation will cover two areas. I will deliver a brief review of the payment adequacy framework we reviewed from last month and remind you of the recommendations we have previously made for home health. Recall that since we are reiterating our prior recommendations, we will not be voting on payment recommendations this year.

Our second item will follow up on a new topic we introduced last month, a draft recommendation for an incentive to reduce hospital readmissions for beneficiaries in home health. As a reminder, Medicare spent about $18 billion on home health services in 2012. There were over
12,000 agencies and the program provided about 6.7 million episodes to 3.4 million beneficiaries.

Last month, we reviewed and discussed the payment adequacy indicators in detail, and you have more detail in the papers. As a reminder, here is a summary.

Beneficiaries have good access to care. The number of agencies continues to increase, reaching over 12,300 agencies in 2012. The number of episodes and rate of use declined slightly, but after several years of rapid increases. Quality shows improvement on most measures.

Access to capital is adequate. And the margins for 2014 are projected to equal 12.6 percent. Margins would be two percentage points lower if we included the sequester. I recognize this is just an overview, and if there are any areas that need clarification, please feel welcome to ask during the Q and A session.

Since our indicators for 2014 are mostly unchanged, the Chairman has proposed that we rerun our payment recommendations from earlier years. As a reminder, we recommended a more robust form of rebasing that would address the historically high margins of home health agencies. Our recommendation also addresses an incentive in
the payment system that may encourage more therapy. We recommended that CMS eliminate the use of the number of therapy visits provided in an episode as a payment factor in the PPS. This change is budget neutral, but it would lower payments for agencies that did more therapy, which typically have had higher profits, and increase payments for agencies that do less therapy, which have typically had lower than average Medicare margins.

We have also advocated that CMS fully use its authority to address fraud and abuse in the home health benefit. There are many areas of aberrant utilization that suggest investigation and enforcement efforts are needed. Finally, we have also recommended that Medicare establish a copayment for episodes not preceded by a hospitalization or PAC stay.

Next, we turn to a new topic introduced last month, establishing an incentive for home health agencies to lower their rate of readmissions. As a reminder, there are several reasons it would be appropriate for the Medicare program to do this. First, reducing readmissions is a major goal of many of the new models of payment in Medicare, such as the Hospital Readmissions Reduction Program and others,
such as ACOs and medical homes. Many of the beneficiaries in these new models will be served by home health. Home health agencies are not usually holding financial risk in these new models, so adding an incentive in fee-for-service for agencies would align their incentives with those of other providers seeking to reduce readmissions.

Second, extending an incentive for home health agencies to lower readmissions might be appropriate because home health is the most common site of post-acute care. Under pure fee-for-service, agencies do not have a direct incentive to reduce readmissions.

Finally, adding an incentive is also important because readmission is a relatively common occurrence in home health. About 29 percent of post-hospital home health stays ended in a readmission in 2010.

The broad regional and provider-level variation in readmissions rates suggests there may be substantial opportunity for improvement. For example, the providers in the top quartile of readmissions had a rate of 58 percent while the rest of the agencies had an average of about 26 percent. Across the States, readmissions were highest in four States that also had very high rates of home health
utilization. Providers in Texas, Louisiana, Oklahoma, and Mississippi averaged a readmissions rate of 38 percent. If providers in regions with higher than average rates were able to lower their readmissions rates closer to those achieved by better performing agencies, beneficiaries would experience fewer readmissions and Medicare spending would fall.

A home health readmissions policy would have several parts to it. I would note that the elements I propose here are based on the Commission’s review of the Hospital Readmissions Reduction Program that we included in our 2013 June report. Under this policy, Medicare would establish a fixed target based on performance in a prior year, say, the rate of readmissions for the agency at the 40th percentile in a selected base year. Using the value from a prior year would let agencies know in advance the value they must be below to avoid penalties. Establishing a targeted value like the 40th percentile would encourage most agencies to improve. The rate would be risk adjusted and computed at the agency level. Agencies with readmissions rates in excess of the target would be subject to the penalty.
The penalty could take several forms, but at a minimum, it could be equal to the amount Medicare paid for the home health services provided to the stays that resulted in excess readmissions. The penalty would be collected through a reduction to the agency's base rate. The key part of this incentive is that the target readmissions rate an agency has to be below is set in advance and does not change. Agencies would presumably know how their performance in prior years compared to the benchmark, and those with higher rates could avoid the penalty by lowering their readmissions rate. In the future, Medicare could raise or update the target as necessary as performance changes.

The policy should also include several safeguards. Agencies that serve more dual eligibles generally had higher readmissions rates, so it would be appropriate to compare agencies to a peer group of providers that served a similar share of low-income beneficiaries. This would lessen an incentive to avoid these patients to improve performance.

The time period of the measure should include the entire home health stay plus 30 days after discharge. Including a post-discharge period would be appropriate, given that a successful return to the community is the
typical goal in home health. I would note that our measure includes post-hospital stays of home health only, which is about 40 percent of all home health stays.

Finally, the measure should focus on readmissions it would be reasonable to hold providers accountable for and exclude those readmissions that are not necessarily attributable to home health. In the hospital setting, we have referred to these as potentially avoidable readmissions.

To get a better sense of how this policy might work in practice, we modeled its impact using 2010 data. For this exercise, we identified agencies that were above the 40th percentile on readmissions rates compared to other agencies that serve similar shares of low-income beneficiaries. We only had one year's worth of readmissions rates to work with, so what we will show you is how many agencies cross that 40th percentile benchmark based on 2010 data. Keep in mind that if the policy were in effect, those above the target would likely work to lower readmissions, so fewer agencies could be subject to the penalty.

Overall, 60 percent of agencies would be at risk, a result of setting the target at the 40th percentile. The
shares would vary by group, but they broadly track the
trends in readmissions rates by agency characteristics.
More for-profit agencies would be above the target and under
pressure to change, while government and nonprofit would
have relatively fewer above the target. Freestanding
agencies would have more above the target compared to
facility-based. The rate for urban and rural was about
equal. Most strikingly, 74 percent of agencies in the four
States with the highest rates would be above the target,
indicating that pressure for improvement would be
particularly acute in these areas with the highest rates.
This slide provides a sense of the net financial
impact. Again, for simplicity, we have assumed no agency
lowered its readmissions rate to avoid the penalty. For
each year, Medicare would compute the number of hospital
readmissions an agency had over the target rate. For each
of these readmissions, Medicare would assess a penalty,
which in this example we have assumed would equal the
payments for the home health service preceding the
readmission. Medicare would reduce payments to an agency to
recover the total penalty amount. In practice, this
reduction could be implemented as a reduction to the base
rate for the agency in the following year. The policy would likely want to include a stop loss provision so that agencies would not incur unsustainably high penalties.

With these parameters, the table shows that the total penalties incurred would be about $90 million a year. Keep in mind that the primary goal of this policy is to reduce readmissions, not collect penalties from agencies. If agencies reduce the number of readmissions by ten percent, the savings could lower inpatient hospital spending by $300 million a year.

In sum, adding a home health readmissions reduction policy would align agency incentives with those of other providers seeking to reduce readmissions. It would encourage providers with the highest rates to improve, and it would recognize that avoiding readmissions is a primary goal for post-hospital users of home health.

With these considerations in mind, we reviewed a draft recommendation for your consideration. The recommendation reads, the Congress should direct the Secretary to reduce the payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.
The spending implications are that this policy would lower Medicare spending by $50 million to $250 million in 2015 and less than $1 billion over five years. Beneficiaries may experience fewer readmissions. The recommendation should not adversely affect beneficiary access or affect providers' willingness or ability to care for Medicare beneficiaries.

This completes my portion of the presentation, and now Carol will take you through a recommendation on post-acute care data collection.

DR. CARTER: In December, we reviewed the current status of the patient assessment information and the need for common information across settings. Medicare requires home health agencies, SNFs, and IRFs to use different patient assessment tools, and LTCHs are not required to submit patient assessment data. Each tool uses different definitions, measurement scales, time periods, and methods of assessment.

In 2011, CMS successfully completed a demonstration that developed, validated, and tested a common assessment tool but has not established a timetable for implementing it across settings.
We also reviewed the benefits of having common assessment items. Common assessment items would help us compare patients treated in different settings, their costs and outcomes. This comparative information would be valuable for beneficiaries, discharge planners, and physicians when selecting PAC providers. And having common items would also facilitate narrowing the prices Medicare pays for similar services to similar patients across settings and, in the longer term, to develop and implement a consolidated PPS that spans PAC settings.

Given the comments that several Commissioners made about the urgency of this recommendation, the draft language was modified to implement individual items rather than an entire tool. A set of assessment items would be more feasible to implement in the near term compared to an entire tool.

The draft recommendation now reads, the Congress should direct the Secretary to implement common assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term care hospitals by 2016.

Let me walk through one possible implementation
timetable which is discussed in the text under the recommendation in the paper. In 2016, CMS could start adding common assessment items as a supplement to existing tools, beginning with items most important to understanding differences in costs and outcomes, such as those measuring functional and cognitive status. We're thinking a select number of items in a couple of domains. For LTCHs, these items would comprise their new reporting requirements. Though diagnoses and comorbidities are also key, this information is available on claims data.

During 2017, CMS would verify that these common new elements could be successfully used in each PAC PPS. The existing tools would remain in place for each setting.

In 2018, CMS could replace the items in the original assessment tools with the new common items. The existing tools would remain in place for each setting. CMS may elect to add or to refine common item sets over time, just as it revises existing patient assessments over time.

The implications of this recommendation are: The recommendation does not directly raise program spending. There will be administrative costs in the short term as Medicare adds the new common assessment items to existing
tools and tests whether the new items can be used in existing PPSs. For beneficiaries and their families, they will have better comparative information that they can use in selecting providers. And providers will have better data to assist patients in making their PAC decisions and to compare their costs and outcomes with other providers.

In the short term, providers will incur modest additional costs to administer common items and to train their staff on the new assessment items. In the longer term, if assessment information shapes patient and provider decision making, the mix of patients treated in different PAC settings could shift.

And with that, we're going to put up this recommendation to start your discussion.

DR. CHERNEW: Thank you, Carol and Evan.

Before we go around to do clarifying questions, I want to do a little housekeeping from before.

Craig was out of the room during our vote on the first recommendation, so I want to give him the opportunity to vote. All in favor.

[Show of hands.]

DR. CHERNEW: Any abstentions?
[No response.]

DR. CHERNEW: Opposed.

[No response.]

DR. CHERNEW: So, Craig is on record as supporting the first recommendation for the dialysis session.

And so with that, let's move to clarifying questions. We'll start with David and we'll go around on the post-acute reforms.

DR. NERENZ: Slide 14, please. I have two quick questions, and I'm interested in the link between this slide and the next slide. There's no -- there are no numbers here on 14, no percent, no model, no calculation. And then in 15, we estimate a certain financial amount of change in spending, and I think that was true in the chapter we got, as well. Can you just tell me, what's the basis for, then, the number estimates on 15?

MR. CHRISTMAN: It's basically this model here that I ran on this slide. This slide shows that in the first year, if no agencies change their behavior and lower their readmissions rates, Medicare would collect about $86, $87 million in penalties. And so we have this arrangement with CBO where we put our -- we score our proposals in what
we call buckets, and because that one is about $90 million a
year or roughly $450 million a year, it falls into this
bucket, the $50 to $250 million in the first year and the
less than $1 billion over five.

DR. NERENZ: Okay. So, maybe I'm just obtuse and
it's late in the afternoon. Maybe we need to go to 12.

What is the penalty? What's the formula?

MR. CHRISTMAN: The penalty is, in this model, every -- an agency would be on the hook to basically repay
the costs of the home health service for each readmission
that occurred in excess of the benchmark that was
established.

DR. NERENZ: I'm sorry. I -- all right. I just
missed it on the slides.

MR. CHRISTMAN: Sure.

DR. NERENZ: Okay. I get that.

And then very quickly on Slide 7, there are two
words or phrases here, worst quartile of agencies, lower
performing providers, and this question may, in part, be to
Mary. Is there actually evidence that some one or more
process measures of quality of care in home health are, in
fact, associated with ending up in a higher quartile of
readmission? Do we have that information?

MR. CHRISTMAN: So, you're asking sort of how are these correlated with process measures?

DR. NERENZ: No, we're just -- we're using words that are quite loaded. We're saying, you're a bad performer, and I'm just curious, do we know independently that these entities are bad performers by some process measure?

MR. CHRISTMAN: I guess I have not looked at that specifically. I mean, these are risk-adjusted rates, so they are adjusted for differences in patient acuity across the settings. These are areas where they do have some --

DR. MARK MILLER: This may be a more complicated question and I just don't understand it. What -- all this slide is saying is when you look at the quartiles of readmission rates, these are the worst end of that distribution. We're not making judgments about the rest of their operation, right?

DR. NERENZ: Well, and that's actually another way of saying what I'm saying. The language here is that you are a low-performing provider. You performed badly. It doesn't say, you are in the lowest quartile of end result,
and I think that -- to me, in my mind, that's an important
distinction. And I'm just curious, what do those words
really mean and what's the underlying evidence?

MR. CHRISTMAN: I guess we could easily -- I think
you could say the highest quartile of agencies and the
highest rate of readmissions, you know, that's who that
group is in the context of this project. We haven't looked
at them on other measures.

DR. CHERNEW: We're still going to start with you
for round two, so why don't you ask your clarifying question
and then we'll go to round two.

DR. NAYLOR: Surely. Slide 15, please. So, I
just wanted to -- Evan, if you could remind us of the
remodeling that was done, which you presented a number of
times, that talks about the intersection between the
Hospital Readmission Reduction Policy and the proposed --
this recommendation, particularly in those first 30 days,
since there would be, under the Hospital Reduction
Readmission Program, penalties assigned to hospitals and
then to the home health. So, I just wanted to make sure we
talked about that.

And in that same vein, in the modeling, how we
came to an understanding that this would not affect beneficiaries' access to home health agencies, meaning would home health agencies want to shy away from people who have high readmission rates.

MR. CHRISTMAN: I mean, I think there's -- on your first point, about the overlap between this and the Hospital Readmission Reductions Program, you know, for those readmissions that occur within 30 days and are considered potentially avoidable by the definitions used in both the Hospital Readmissions Reduction Program and the home health program, both entities would be on the hook for a penalty, different penalties. The hospital would be on the hook for the cost of the readmission and the home health agency would be, you know, in the model we've shown here, just on the hook for the cost of the home health services.

The important thing to keep in mind is when we've talked about this policy in the past, we've talked about it as sort of an all condition applying to all home health cases. Right now, the Hospital Readmissions Reduction Program is only looking at six conditions, so unless the -- the Commission has leaned towards expanding the Hospital Readmissions Reduction Program to all conditions. So,
eventually, this disconnect may disappear, but under current policy, there might be some readmissions that the home health agency would be on the hook for that the hospital wouldn't, but it would be because of that difference in definition.

And, I'm sorry, you had a second question --

DR. NAYLOR: Well, it just had to do with just, you know, in terms of the implications that this would not adversely affect home health agencies' willingness to accept high-risk patients.

MR. CHRISTMAN: So, I think there's three pieces to that, and one, of course, is we would want this to be risk adjusted.

The second piece of this is that we've, again, used a safeguard you guys talked about with the Hospital Readmissions Reduction Program, where you're comparing facilities to sort of peer facilities in terms of the numbers of low-income patients they take. So the effect of SES is kind of diluted by that in the sense that they're just being compared to their peers, and if somebody has a much better mix of more affluent patients, they're not going to be penalized for that.
And then the third piece of this is we have talked about having a stop loss policy, and that would put a limit on how much agencies could lose. And I think all of those things would combine to counterbalance some of the financial risks that agencies would face in this model.

DR. NAYLOR: So, in terms of response, do you want me to --

DR. CHERNEW: And now we are in round two. Notice the difference in tone. Or, we can respond to round one.

DR. NAYLOR: So, I support the notion of the home health readmission policy. It is very much in keeping with the notion of alignment of these policies to promote a continuum of services and shared accountability. Easier said than done, but for what I just described about who's going to be accountable for this. But, nonetheless, I think that this is the direction that says all parts -- all silos are responsible for what happens to Mr. Smith or Mrs. Jones as they're going through an acute episode of illness.

One thing in terms of the text, or as we're thinking about this, even, is to realize when the Hospital Readmissions Reduction Program went into place, it went into place along with programs that helped to position hospitals
to better get to community-based care transitions and so on, so to think about this in the context of making sure we're positioning home health agencies to be able to affect this change is really important in recognition in the text.

In terms of the elements, I totally support a common set of elements, so that would be the next recommendation, that -- and the only question I'd have is whether or not we should be more explicit in the recommendation itself. Even though the text is very explicit about the predictors of readmission, and you mentioned them, function and cognition and so on, but whether or not we should refer to -- as we're talking and thinking about a common set of elements, it's to really incorporate those domains that we know from evidence are predictors of -- will help us to understand what can be done to prevent poor outcomes, to promote positive outcomes.

And the second point on that, which is the notion of you're going to have in the short term agencies collecting -- some sectors collecting multiple measures of functional status or cognition, and the notion that the public beneficiary that gets to better information, I think we need to really think that through in the conversation in
the text because it means the public might be confused, having access to information about multiple measures of something for the short term as we get to a final. So, if there is any thinking that could be done to say, we totally want to make this publicly available and here's what we're doing, public, that would be very helpful, if, especially, we want to use it to increase their understanding of performance of the post-acute sector.

DR. CHERNEW: Thank you.

George.

MR. GEORGE MILLER: I have just one technical question on Slide 15. Evan, did I understand you to say that the buckets that are scored are -- the range is between $50 million and $250 million? That is one bucket?

MR. CHRISTMAN: Yes. These buckets are --

MR. GEORGE MILLER: Huge.

MR. CHRISTMAN: Well, they're negotiated with CBO about how much -- how wide a range they want to give us. I don't really have too much of the history behind them. It's part of how we sort of separate between our duties to make recommendations and their duties to provide scoring.

MR. GEORGE MILLER: All right. Thank you.
DR. SAMITT: I support both of the recommendations. I do have a question about the readmission penalty. I'd be curious to hear your perspective on whether there's any risk of screening out patients that could potentially have a greater risk of readmission. So, as home health agencies evaluate whether to accept patients to provide care, would we envision that we will see agencies that are concerned about the risk of readmission and, therefore, don't accept care for those patients, and is that a potential side effect of this readmission policy?

MR. CHRISTMAN: I suppose that it is. I think we're kind of in the conundrum, also, that -- you know, this is paired with Carol's recommendation for a reason, in that we don't always know where people belong. So, when somebody who is a higher readmission risk is moved to a, hopefully, more intensive setting where, hopefully, their risk of readmission will be lower, that is potentially what you want to have happen. Now, it also may reflect those inpatient PAC settings are more expensive and that's something you have to deal with, but it -- when a patient who is higher risk goes to a higher level of care, I can't always say that that's the -- that might be what we want to have happen.
MR. KUHN: I support both recommendations. On the readmission policy, we recommended here a year, a year-and-a-half ago on long-term care, now to have one in the home health area. So, we're capturing a greater part of the post-acute care area, is critical and important, so I'm glad this recommendation is moving forward.

In terms of the common assessment items for post-acute care, these are going to be very helpful and, I think, a useful movement forward.

Just to make sure that it gives us a stronger platform to deal with post-acute care payment reform as we go forward, if we can get these elements in place, it just makes it easier to drive these future payment areas for site-neutral payment systems in the future. So, I think both of these are very important and strong movements forward.

DR. REDBERG: I support both recommendations. Hopefully, the risk adjustment would address some of the issue Craig raised about the readmission, always a concern, about avoid people with high risk of readmission. And, again, I just wanted to reiterate that I think the common assessment tool is really important and am very supportive.
DR. COOMBS: So, I support both recommendations, and this was an excellent chapter. I really enjoyed reading it.

One of the issues with this stop loss, is there a way to carve out those agencies that are taking care of more vulnerable populations, and I don't know if you could tailor it so that those agencies would not be as adversely affected in terms of their ability. I know that the margins, there's some variability as to the margins in different regions and different counties. I think I saw something about counties and what it looks like. There's a chart in Table 6 that actually goes through the rates of use for beneficiaries and they used counties on that.

And so I was just concerned that with stop loss, if the stop loss is too high for small functioning home health agencies, they may be adversely affected.

And I think it's really good to now have the LTCHs have a benchmark, because this is where the rubber meets the road in terms of being able to say that we do either a better job or we do the same job. Thanks again.

DR. CHERNEW: Thanks, Alice.

Bill.
DR. HALL: I'm strongly in favor of both recommendations.

DR. HOADLEY: I'm also in favor of both recommendations. The only point I wanted to bring up was almost more of from a clarifying thing, but the context of the readmissions policy, and you said it at one point, this applies to just those home health stays that are post-hospital, and I think in the chapter, that point -- the first time I read through, it kind of got lost, and I think to make that very clear at the front, including the quantification. I think you mentioned a figure of 40 percent of all home health episodes were post-hospital, but I also saw, I think, in a table in the chapter, there was a number that said 34 percent were preceded by a hospital or another PAC stay.

So, I mean, you can deal with the numbers, but, I mean, putting that right in the context of the recommendation will just kind of help remind everybody of the context and that this isn't all home health stays we're talking about, it's this particular set. I mean, you could have a policy for ones not preceded by a hospitalization, about how many of those end up in a hospitalization, but
that's obviously not rehospitalizations and that's not the area we're in.

DR. CHERNEW: Thank you.

Kate.

DR. BAICKER: I support the recommendations and I echo Mary's enthusiasm for the creation of an arc of responsibility over the whole course of treatment.

DR. CHERNEW: Cori.

MS. UCCELLO: I support both recommendations, and I just want to highlight again the finding in the chapter, how striking the variations in readmissions are across these different agencies. I mean, it really shows that there's a lot of area for improvement, that something needs to be done here. And I also want to thank you for including the little couple sentences about the QIOs.

DR. CHERNEW: Peter.

MR. BUTLER: So, could you put up Slide 14. I don't want to be difficult here. So, 60 percent of the agencies would be subjected to the penalty if they didn't lower their readmission rates, right?

MR. CHRISTMAN: Right. We're showing that as the -- perhaps I should have used these words. I mean, that's
the illustrative policy that we showed, yes.

MR. BUTLER: Right. So, what I'm struggling with is this says, should direct the Secretary to reduce payments to home health agencies with relatively high risk adjusted rates. You could be better than average and you're subjected to the example that you show. So, I wonder whether it's not more accurate to say, the Congress should direct the Secretary to reduce payments to home health agencies based on high risk adjusted rates of hospital readmission, so you're not -- if you follow me. I just don't like the adjective, "relatively high risk," because that says, well, it may be 20 percent of the institutions are impacted, when we're really kind of showing an example of where it's 60 percent. Or, if we just drop the words and said, to reduce payments to home health agencies based on risk adjusted rates of hospital admission.

DR. BAICKER: I wouldn't interpret --

MR. BUTLER: I don't feel -- okay. You don't interpret it --

DR. BAICKER: I was interpreting that to mean based on having high rates, where relative was meant to be broadly cast. It doesn't mean above average. It doesn't
mean above the median. It just means the payments would apply based on having rates that are too high where we're not taking a stand on what too high is.

DR. CHERNEW: Yeah --

DR. BAICKER: Is that -- that was my interpretation.

MR. BUTLER: Well, I'm just giving you my interpretation. It looks like not that many are going to be impacted. That's how I read that.

DR. CHERNEW: That wasn't how I read it, but I think if you get rid of the word "relatively" or just put it "based," then it just seems like based on -- it strikes me as harder to read if it just says with high risk adjusted rates, because you have to end up defining high. So, we're defining high sort of relative to some other group, and I -- I don't mean to be defensive in the recommendation, so I'll let Mark and Evan jump in. I think where the threshold gets drawn, whether it's 40 percent, whether it's 60 percent, or where it is, is something to, you know, not specify it in the exact recommendation, and so we used that illustratively. I must admit, I'm a little --

MR. BUTLER: Well, I'll vote for it as is. I just
think -- I read that to impact a small percentage of the home health agencies when our example impacts 60 percent.

DR. CHERNEW: Right. No, I understand, and I think that's a -- right. That's a valid point, so we'll -- my view is we would deal with that in the text, about what that word means, but in any case, if it's okay, I'll go to Scott.

MR. ARMSTRONG: I'm prepared to vote in favor of these recommendations. I don't have anything more to add.

DR. CHERNEW: Well, let me just -- because I still have to go around to get back, so I have Jon.

DR. CHRISTIANSON: Okay. I also support the recommendations, but I share some of Craig's concerns about hospital discharges not randomly distributed to home health agencies. Discharge planners work with different home health agencies and I think they tend to try to put patients with agencies that do a particularly good job with certain types of patients, and so risk adjustment is critical and I am not somebody who has a great deal of belief in the ability of risk adjustment to deal with these types of issues.

DR. CHERNEW: Bill.
MR. GRADISON: I support both recommendations. I want to say with regard to the common risk assessment tools, that my best understanding is that we have a much better reason to be confident in them than we did when we adopted the DRGs, which had been tested, if that's the right word, in a slightly different form in just one State and did have to be modified from time to time to improve them. So, I'm very comfortable with that.

With regard to -- and I will support both recommendations. But the question that I would like somebody to help me answer in case it gets asked, if we believe that there can be steps taken in PAC settings to reduce hospital readmissions, then why don't we apply this simultaneously to all PAC settings rather than just picking this one out?

DR. CHERNEW: I'll leave that -- Evan, do you want to take that not quite clarifying question, and thank you for saving that for round two.

MR. CHRISTMAN: I mean, we have recommended it for skilled nursing facilities, and I believe it's something we're thinking about with the IRF. I think we -- I think it's -- coming up with a common policy -- right now, these
silos are administered separately. That may not be a completely correct answer to your question, but I think that that's definitely -- I think the one area where we haven't recommended it yet, technically, is IRFs, and I think that's something we're working towards.

DR. CHERNEW: I read that as we're moving in that direction.

DR. NERENZ: If I could just speak for a minute on this issue of disincentives for caring for low-income beneficiaries and the related text on page 33, the text is quite accurate in describing the current NQF and CMF policy suggesting against including variables like race and income in adjustment. I would say that the actual text of where that is currently in writing does not identify specifically race and income. It describes the broader category of SES variables, and if you talk about race, you're actually talking about an even broader set that we'd call socio-demographic.

The NQF, as I think you know, has established quite recently an expert panel to help it think through this position, and although the report of that group is not out until June of this year, the meetings are open to the
public. The transcript is a matter of public record. And I think the signals indicate that the NQF position will probably change to a more positive, more affirmative statement about including socio-demographic variables in risk adjustment models, and that certainly would be applicable here.

So, with that in mind, when we look at 14, we may just have in our minds, without changing any of the wording, that a future risk adjusted model may include some SES or socio-demographic variables that would not currently be put in on the basis of current NQF policy. That's -- so, we may choose to have some special position about that, but just -- it's kind of the background of what that phrase might mean in the future.

The other thing is that we do specifically mention on page 33 one approach that does not actually adjust the measure, but it does take income into account when applying a penalty. I would ask us that, as this moves to final form, we use text that says, this is one approach, it is an example, but it is not necessarily a suggested or recommended approach in the sense that we collectively have considered ten or 12 different alternatives and selected
this one as the best. Could we do it that way, because I --

DR. MARK MILLER: The only reason I'm going to hesitate here, and you and I had some of this conversation this morning, is the Commission did come to this posture for dealing with the SES issues as it related to the hospital correction, or penalty. And what we've basically said in both the SNF and in now building out to the home health is we're saying that's our reference point for what the methodology is.

And I think, philosophically, you're opening a much -- while you're saying this is just something to change in text, philosophically, you're sort of taking the Commission back to a point where you could be opening the door on saying the basic measure should be adjusted for SES, and the Commission kind of hassled through that for a couple months to get where it was on the readmission penalty. In some ways, I do think it's bigger than just an editorial point.

Now, what I would be willing to say, to try and reach, is to say, you know, in the environment, there are people who are thinking of different definitions, and sort of put it that way. But saying that it's the Commission's
position that you could just do it this hundred different ways, I would feel that we may have moved off of a position.

DR. NERENZ: Okay. Let me just try to clarify it.

Ninety percent of what I just said is just describing changes in the environment that I think we should be aware of. I am not asking the Commission --

DR. MARK MILLER: No --

DR. NERENZ: I am not asking the Commission to revisit its basic policy. Two years from now, we may choose that. But I'm just saying, this is a change that is in the environment that may affect this.

Still, though, on the issue of this specific approach, I would just say, for example, I don't know, at least not at the level of the full Commission discussion, that we have seen data suggest that income is the most important variable that should be included in a model of this type, which is not specifically an adjustment model. It's a payment application, or a penalty application model. Now, have we actually done that?

DR. MARK MILLER: We have, when we went through the hospital --

DR. NERENZ: No, no, no, but here, because what's
good for the hospital is not necessarily best for here.

DR. MARK MILLER: I understand what you're saying, although I'd be willing to bet you your paycheck that it probably is, but --

[Laughter.]

DR. NERENZ: I might take that deal, Mark. I might --

[Laughter.]

DR. MARK MILLER: I just wanted to run it past you and see if it happened.

No, I do see what you're saying. It could be that suddenly in home health, the strength of income relative to some other variable is suddenly very different than what you find in hospital, although, in all seriousness, I'd tend to bet against it.

But what the Commission has been doing through -- and this is why I think this is something of a bigger change -- through hospital, SNF, and home health, is sort of said, that's the approach that we saw the most evidence for and that's what we built our house on. I understand what you're saying. Maybe that's different here. But I think that the Commission has had a position up to this point that income
is the most dominant factor when you get into these areas.

DR. NERENZ: Well, and I guess, again, this is not in the wording of the recommendation. It will not affect my vote on the recommendation. But, I guess, then, I would like to see the data that led to that, and maybe this preceded my time on the Commission. I'm not convinced, based on what I do know, that income necessarily matters most here because it matters most in hospital. Maybe it does. I'm happy to be convinced.

DR. MARK MILLER: I'll have the -- at least immediately have the link sent to you for the June 13, 2013 chapter that went through that analysis for hospital.

DR. NERENZ: I've read it ten times over in the last week. That, I've got. It's okay. For hospital.

DR. MARK MILLER: Okay. Well, that's the basis of it.

DR. NERENZ: Well, but -- okay. I understand.

We're not talking hospital here.

DR. CHERNEW: Right. So, we can continue to sort and discuss through that, but I think I get the point, and I think the general view which I've heard is there is concern about some issues related to making sure that people aren't
avoiding high-risk folks, and I think, as in all our recommendations, monitoring how that is playing out and how it's affecting these agencies as we go forward will continue to be an important thing, and I think that's part of the normal course of business, is that we follow what happens. And so none of the recommendations we ever make are always set in stone as we go through. And monitoring for quality effects, et cetera, I do think are important.

Mary, did you have something to say before we vote?

DR. NAYLOR: No.

DR. CHERNEW: Really?

DR. NAYLOR: Really.

DR. CHERNEW: Okay. So, if we can have recommendation one. So, it is, in fact, time to vote. How many in favor of recommendation one.

[Show of hands.]

DR. CHERNEW: Opposed.

[No response.]

DR. CHERNEW: Abstentions.

[No response.]

DR. CHERNEW: And -- okay. And so, recommendation
two, the common assessment items. All right. All those in favor.

[Show of hands.]

DR. CHERNEW: The votes are getting up before the question is called.

Opposed.

[No response.]

DR. CHERNEW: Abstentions.

[No response.]

DR. CHERNEW: All right. That passes, as well.

Thank you both very much. It's an important area.

That brings us now -- notice that not only are we on time, we're a little ahead of schedule. I take all credit.

[Laughter.]

DR. CHERNEW: No, seriously, thank you all. Those actually were very important discussions on both of those chapters and so I appreciate that.

It is time now for public comment, and let me just say, as I try and channel Glenn, I will try and keep track of two minutes, but you should know, this is certainly not your only opportunity to make remarks or even your best
opportunity to make remarks, and I encourage anyone who has comments to contact the staff and Mark, but I'm waiting to see. There were no comments this morning, either.

[No response.]

DR. CHERNEW: Seeing none, we are adjourned.

Thank you all.

[Whereupon, at 5:04 p.m., the meeting was adjourned, to reconvene at 8:00 a.m. on Friday, January 17, 2014.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 17, 2014
8:02 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP
AGENDA

Assessing payment adequacy and updating payments: Ambulatory surgical centers, hospice, inpatient rehabilitation facilities, and long-term care hospitals
  - Ariel Winter, Kim Neuman, Sara Sadownik, and Dana Kelley

Status report on Part D
  - Shinobu Suzuki

Financial assistance for low-income Medicare beneficiaries
  - Christine Aguiar, Julie Lee

Public comment
MR. HACKBARTH: Okay. It's time to get started.

We begin this morning with a series of votes with brief presentations. This is a new thing that we're doing this time around. These are all issues on which there was no controversy when we discussed the draft recommendations in December, and in order to save time for other work, we decided to take this approach of very brief presentations, followed by votes.

Okay. It didn't sound like it was on. Is this on? The people in the back can't hear me.

There we go. Now we're live. Okay. Starting again, we're going to have a series of votes on recommendations preceded by brief presentations. This is a new procedure that we're doing this time on these issues on which there was no controversy when we discussed them in December.

We're using this approach to save some time for other issues. You'll recall that we missed a meeting in October this year because of the shutdown, and so our scarce resources, our face-to-face time together, and we needed to
make some adjustments in order to make the best possible use
of our group time.

Before we turn to those votes, I want to say just
a little bit about the sequester, and I apologize to people
in the audience who were here yesterday for having to listen
to this again, but there has been much discussion about how
the sequester affects MedPAC's decisions or does not affect
them, and so I want to just quickly walk through our
approach.

Could you go to the next slide?

So this slide depicts the world as we see it. The
yellow line represents the increase in the base rate paid to
providers under one of the many payment systems within
Medicare, and for sake of illustration, this graph assumes a
current law update of 2 percent per year, so the yellow line
goes up in 2 percent increments each year.

The green line signifies the effect of the
sequester. The sequester at the beginning of each of those
years reduces the base rate by 2 percent; then at the end of
that same year, the rate pops back up again. The important
point here is that the sequester is a temporary adjustment
and it is not cumulative. In fact, the sequester law is not
part of the Medicare law. It's a completely separate issue. And so what we do -- and could you go forward to the table? So what we do is focus our recommendations on what the change should be in the Medicare base rate, focused on the Medicare law, and this table provides a simple illustration of that.

So in 2014, the base rate for this particular provider type is $100, and because of the sequester the amount the providers are paid falls to $98 at the bottom of that column. In 2015, if we assume that this is a category that has a current law update of 2 percent, all other things held constant, the base rate would go from $100 to $102 in 2015.

Let's say MedPAC does its analysis of payment adequacy, looks at access to care, access to capital, quality of care, margins where that data is available, and we conclude that the appropriate base rate is a 1 percent increase, so that's the 101 circled in red. The sequester amount -- and for this example, let's just assume that Congress doesn't accept our recommendation; they leave the current law in place, which provides for a $102 base rate. The sequester would then take that down to $100. Because
$100 is less than the $101 that we recommended, we disagree with the sequester. We are focused on what the base rate change should be. We're not ignoring the sequester. What we are doing is recommending what we think the Medicare law should say, which is our responsibility. So that's how it works.

Now, there are cases where our recommendation might actually be high -- or lower, rather, than what providers would be paid even after the sequester. And so you might say that, well, in some instances we like the sequester, in some instances we don't. That's not the way we look at it. We're focused on what the right rate should be under the Medicare law and think that there are better ways to achieve Medicare savings than an arbitrary, across-the-board 2 percent cut in everybody's payment rate. We are in principle opposed to the sequester as a way to achieve Medicare policy goals.

It isn't our call though. The Congress obviously is the decisionmaker on this. All we can do is recommend what we think the appropriate rate should be in the Medicare law, which is our responsibility.

So that's how it works. We will take a look at
ways that we can reframe our recommendations or present margin information to take into account the fact that the sequester now has been extended through 2024. And so it seems a more or less permanent part of our lives now, and we will try to make some adjustments or consider some adjustments in how we present -- package what we do. But the substance of it is going to stay the same.

So with that, let's turn to our presentations, and we're beginning with ambulatory surgery centers, I think.

MR. WINTER: Good morning. So with regards to the ASC update, the questions that you asked us at the December meeting, we have tried to address them in the draft chapter that we mailed to you.

Just to review a couple of key facts, in 2012, Medicare payments to ASCs totaled $3.6 billion. There were over 5,300 ASCs that treated 3.4 million Medicare beneficiaries.

To summarize our measures of payment adequacy for ASCs, access to ASC services continues to increase, as shown by growth in the number of beneficiaries treated, volume per beneficiary, and the number of ASCs. There has been strong growth in Medicare payments per beneficiary. And, in
addition, growth in number of ASCs suggests that access to capital has been adequate. However, our analysis is limited because we lack cost and quality data.

CMS began collecting data on five quality measures in October of 2012, but they have not yet released the data that ASCs have submitted. In addition, the Commission has recommended several times that ASCs be required to submit cost information. But CMS does not collect cost data and has not announced plans to do so.

So the draft recommendation reads: The Congress should eliminate the update to the payment rates for ASCs for calendar year 2015. The Congress should also require ASCs to submit cost data.

In terms of the implications, under current law, ASCs are projected to receive an update in 2015 of 1.4 percent. Therefore, relative to this statutory update, this draft recommendation would produce small savings.

We estimate savings of less than $50 million in the first year and less than $1 billion over five years. Our smallest savings category for five years is $1 billion; the savings would actually be substantially less than that.

Because of growth in the number of ASCs and the
volume of services, we do not anticipate that this draft recommendation would diminish beneficiaries' access to ASC care or providers' willingness or ability to furnish services. ASCs would incur some administrative costs to submit cost data.

And with that, I'll turn the discussion back over to Glenn.

MR. HACKBARTH: Okay. Thank you.

Any questions about the recommendation before we proceed to vote?

[No response.]

MR. HACKBARTH: Okay. All in favor of the recommendation?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]

MR. HACKBARTH: Abstentions

[No response.]

MR. HACKBARTH: Okay. Thank you.

So next is?

MS. KELLEY: Long-term care.

MR. HACKBARTH: Okay.
MS. KELLEY: Good morning. The Commission made a recommendation yesterday that would significantly change Medicare's payments for LTCH services. Today I'm going to ask you to switch gears and focus on the payment update for LTCHs in 2015 in the current policy environment. Our update recommendation is relevant if Congress does not mandate LTCH reform for fiscal year 2015, and it will be relevant for payment for CCI cases if Congress did mandate our recommended policy change. Also I'd like you to note that the pathway for SGR reform does mandate changes to LTCH payment policy, but those changes do not begin until fiscal year 2016.

Last month we presented the findings from our update analysis for LTCHs. Those findings are summarized here. Our indicators of payment adequacy are generally positive.

We looked first at access to LTCH services. Remember that many beneficiaries live in areas without LTCHs and so receive similar services in other settings with few apparent differences in quality or outcomes. Remember too that from 2008 through 2012, Congress imposed a moratorium on new LTCHs and LTCH beds. Not surprisingly, given this
moratorium, we saw little growth in supply in 2012. The number of facilities and beds remained stable, and there was little change in volume.

We considered changes in quality. We lack patient assessment data in this area, and there are no available quality measures as yet, so we're forced to rely on aggregate mortality and readmission rates. Those have been stable.

We then considered access to capital. The current availability of capital for LTCHs says more about uncertainty regarding possible policy changes than it does about Medicare payment rates. Both the industry and the financial markets have been taking a wait-and-see approach to growth and expansion.

Finally, the 2012 margin was 7.1 percent. Our projected margin for 2014 is 6.5 percent. This decrease is due to a couple of factors: the PPACA-mandated adjustments to payment updates in 2013 and 2014, and CMS' budget neutrality adjustment corrects for an underestimate of how much LTCH spending would increase in the first year of the LTCH PPS. We also expect aggregate payments in 2014 to be reduced by changes in CMS' short-stay
outlier payment policy. Overall, we expect cost growth to continue to be below market basket levels, but we do think it will be somewhat higher than payment growth. If the sequester remains in effect, the estimated aggregate margin would be two points lower.

We make our recommendation to the Secretary because there is no legislated update to the LTCH PPS. The draft recommendation reads: The Secretary should eliminate the update to the payment rates for long-term-care hospitals for rate year 2015.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2015 will produce savings relative to the expected regulatory update, even assuming PPACA-mandated reductions. Savings are estimated to be between $50 and $250 million in 2015 and less than $1 billion over five years. Medicare patients will continue to be profitable in 2015, so we don't anticipate that eliminating the update will have adverse impact on beneficiaries or on providers' willingness or ability to care for patients.

And now I'll turn the discussion over to Glenn.
MR. HACKBARTH: Okay. Any questions about the recommendation?

MR. BUTLER: One comment. I know that yesterday we voted on the change in the payment here. We probably haven't done a lot of modeling on who might get impacted in terms of the changes in payment. Or maybe you have, because it's so significant and it won't fall equally across these institutions. But do we know much about where the impact's going to fall?

MS. KELLEY: Well, as you would expect, the impact depends mostly on the LTCH's share of CCI cases. We expect overall, when the policy was fully implemented, for payments to drop 36 percent, and we found in our modeling that proprietary LTCHs and LTCHs in LTCH-saturated markets would have relatively greater impacts.

MR. HACKBARTH: Any others?

[No response.]

MR. HACKBARTH: Okay. Ready to vote. All in favor of the recommendation?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]
MR. HACKBARTH: Abstentions?

[No response.]

MR. HACKBARTH: Okay. Thank you.

MS. SADOWNIK: Good morning. I will discuss the adequacy of Medicare payments to inpatient rehabilitation facilities, or IRFs. Questions from the December meeting have been addressed either through direct communication or as indicated on the cover letter to the mailing materials.

In summary, in 2012, 1,166 IRFs treated 373,000 fee-for-service cases totaling over $6.7 billion in spending. Our indicators of Medicare payment adequacy for IRFs are positive. Beneficiaries generally maintained access to IRF services in 2012, with the number of cases increasingly slightly, by half a percent. In terms of provider supply and capacity, the number of facilities was almost unchanged from 2011 to 2012, a shift from declines in previous years. Occupancy rates decreased slightly to 62.8 percent. Occupancy rates have been stable in recent years, changing by less than one percentage point overall from 2008 to 2012. Together, these measures suggest that capacity remains adequate to meet demand.

In terms of access to capital, one major
freestanding chain has very good access. We are not able to determine the ability to raise capital of other freestanding facilities. The parent institutions of hospital-based IRF units have maintained reasonable access to capital.

Quality of care has continued to improve in recent years on measures of functional outcomes, discharge to the community, and rates of readmission to an acute-care hospital. Due to changes in our cost growth assumptions, we revised the projected 2014 margin from the one we presented in December. Aggregate margins averaged 11.1 percent in 2012, and we project margins will grow to 11.8 percent in 2014. If the sequester is in effect for the full year of 2014, the projected margin would be about two percentage points lower.

The draft recommendation for your review is: The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2015.

Future work will include addressing trends in financial performance among sectors of the IRF industry. Recall from the discussion in December the differences in financial performance between hospital-based and
freestanding IRFs. While 2012 margins in hospital-based facilities averaged 0.8 percent, margins averaged 24 percent among freestanding facilities, which provide care for 45 percent of all IRF discharges. With very high margins among providers for almost half of Medicare discharges, payments may no longer accurately reflect providers' costs. In future work, we plan to consider options for rebasing IRF payments.

On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the current payment rate. We estimate that this recommendation will decrease federal program spending relative to current law. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries.

This recommendation may increase the financial pressure on providers, but overall we expect a minimal effect on providers' willingness and ability to care for Medicare beneficiaries.

This concludes the presentation, and I will now turn discussion over to the Chairman.

MR. HACKBARTH: Any questions?
MR. HACKBARTH: Ready to vote? Okay. All in favor of the recommendation?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]

MR. HACKBARTH: Abstentions?

[No response.]


MS. NEUMAN: I'm going to talk about hospice and summarize indicators of hospice payment adequacy that we discussed in December and that are described in detail in your mailing materials.

In 2012, more than 1.2 million Medicare beneficiaries received hospice care furnished by more than 3,700 hospice providers, and Medicare paid those hospices about $15 billion.

Our indicators of access to care for hospice are favorable. The supply of hospice providers continues to grow, increasing nearly 4 percent in 2012. For-profit providers account almost entirely for this growth.

Hospice use has also increased. About 46.7
percent of Medicare decedents used hospice in 2012, an increase of 1.5 percentage points over the prior year. Average length of stay among decedents also increased -- from 86 days in 2011 to 88 days in 2012. Median length of stay has been fairly steady at 18 days in 2012 and 17 or 18 days since 2000. Different from most other sectors, we do not have publicly available quality data to examine for hospice providers currently. In terms of access to capital, the continued growth in the number of providers suggests capital is accessible. So that brings us to margins. As you'll recall, our margin estimates assume cap overpayments are fully returned to the government and exclude non-reimbursable bereavement and volunteer costs. For 2011, we estimate an aggregate Medicare margin of 8.7 percent. For 2014, we project a margin of 7.8 percent. That projection is before the sequester. The margin would be roughly two percentage points lower after the sequester. So that brings us to the draft recommendation. It reads: The Congress should eliminate the update to the
hospice payment rates for fiscal year 2015.

The implications of this draft recommendation are a decrease in spending relative to the statutory update of between $250 million and $750 million over one year, and between $1 to $5 billion over five years.

Since we expect that hospices would be able to cover their costs in 2015 without an update to the payment rates, we would not expect the draft recommendation to have an adverse on beneficiary access, nor would we expect it to affect providers' willingness or ability to care for Medicare beneficiaries.

So that concludes the presentation, and I turn it back to the Chairman.

MR. HACKBARTH: Thank you.

Any questions?

[No response.]

MR. HACKBARTH: Okay. All in favor of the recommendation?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]

MR. HACKBARTH: Abstentions?
MR. HACKBARTH: Okay. Thank you very much.

So now we move on to status report on Part D.

[Pause.]

MS. SUZUKI: Good morning. In this presentation, I'm going to give you a status update on Part D with a focus on program costs and the driver of the growth in spending.

Here's a quick overview of the Part D program.

Spending totaled about $62.5 billion in 2012, up 4.4 percent from 2011. About $59 billion of that was for payments to Part D plans, and a little over $3 billion was for the retiree drug subsidy. The rest of the presentation will focus on the $59 billion.

In 2013, over 35 million, or nearly 70 percent of Medicare beneficiaries, were enrolled in Part D. For 2014, the base beneficiary premium increased by four percent to a little over $32. This reflects the plan's expectations about the costs per beneficiary rather than the actual premiums paid by enrollees. Enrollees filled, on average, four prescriptions at $240 per month in 2011. Surveys indicate that Part D enrollees are generally satisfied.

First, I'll provide a quick summary of Part D
enrollment and plan offerings for 2014. Then, we'll look at costs of the program, with a focus on understanding the drivers of the growth in spending, including how changes made by PPACA to close the coverage gap has affected program spending. Finally, I'll summarize key evidence from program spending on insurance risk and plan incentives and discuss our ongoing and future work related to the topics we discuss today.

There hasn't been a dramatic shift in Part D enrollment patterns from year to year. In 2013, about 64 percent of Part D enrollees were in stand-alone PDPs and the rest were in MA-PD plans. As in previous years, most LIS enrollees continue to enroll in PDPs.

In 2014, we're seeing a modest increase in PDP offerings, with over 1,100 plans available, up from a little over 1,000 plans in 2013. There are between 28 and 39 PDPs, depending on the region, and the typical county has between three and ten MA-PDs.

In 2014, fewer PDPs are offering coverage in the gap. The phase-out of the coverage gap may have affected plans' decision to provide coverage in the gap.

Now, I'm going to talk about trends in program
spending. This chart shows Medicare's payments to Part D plans. Between 2007 and 2012, payments grew from $43 billion to $59 billion, a 38 percent increase over this period. Part D enrollment grew by 29 percent during this period, which is nine percentage points lower than spending growth.

I want to call your attention to two figures in this chart. First, payment for LIS for the low-income subsidy continued to be the largest component, accounting for 38 percent of payments to plans. Most of the spending is used to help LIS beneficiaries with their cost sharing. In Part D, plans set their own cost sharing amounts. For example, a plan may charge $40 for preferred brands and $90 for non-preferred brands. For LIS beneficiaries, their cost sharing is set by law. In 2014, for the majority of them, it is a little over one dollar for generics and $3.60 for brands. The difference between the plans' cost sharing amount and the amount set by law is picked up by Medicare, and plans are not at risk for this spending.

Second, payments for individual reinsurance continue to grow rapidly, growing by 95 percent between 2007 and 2012. As you know, a typical Part D plan benefit has
three distinct phases: Initial coverage, where plans cover, on average, 75 percent of the cost; gap phase, where, until recently, there were no coverage unless you were in enhanced plans with some gap coverage; and the catastrophic phase, where plans cover 15 percent of the cost, enrollees pay five percent in cost sharing, and the remaining 80 percent is paid for by Medicare's reinsurance. So, plans have some risk in the catastrophic phase, but a limited risk, and spending for reinsurance may continue to grow rapidly as the coverage gap is phased out, and we'll come back to this issue in a few minutes.

The three key things to keep in mind as we go through the next few slides are that Part D spending has been growing faster than enrollment. Payments for the low-income subsidy continue to be the largest component. And payments for individual reinsurance continue to grow much faster than other components.

To understand the sources of this growth, we looked at various data and aspects of the program, including per capita spending, prices of drugs, trends in plan formularies, and, finally, the effects of closing of the coverage gap.
Since not all growth in program spending can be explained by enrollment growth, we looked at per capita spending and use. This is total spending that includes enrollees' out-of-pocket. We found that per capita spending for LIS enrollees grew faster than for non-LIS enrollees, growing by 4.8 percent annually between 2007 and 2011, compared with 1.8 percent for non-LIS enrollees. The growth in number of prescriptions filled was comparable between LIS and non-LIS enrollees, indicating that growth in prices per prescription account for the difference. Average price per prescription filled by LIS enrollees grew by ten percent between 2007 and 2011, while the average prices decreased for non-LIS enrollees.

The mix of drugs can have significant effects on the cost of medications, as we'll see in the next slide. Some of the difference is likely due to the structure of the cost sharing subsidy that limits plans' ability to encourage generic use among LIS enrollees. Moreover, because of subsidies not part of the benefit, plans have no incentive to manage that part of the spending.

Overall, Part D drug prices based on individual drug products rose 29 percent between January 2006 and
December of 2011, and that's the gray line, solid gray line. However, when generic substitution is taken into account -- that's the dotted line in gray -- prices rose by only three percent. Here, the shift in volume from brand name drugs to generic alternatives have resulted in a dramatic difference in prices.

Another way to see how the use of generics has kept prices low is to look at brand and generic prices separately. The red line at the top shows that the prices of single-source brand name drugs grew by 66 percent, while the blue line shows that the prices of generic drugs decreased to about 40 percent of the average prices in 2006. So, encouraging enrollees to use generic drugs when appropriate can slow the spending growth by keeping prices low.

The use of generic drugs has increased over time, from 61 percent in 2007 to 77 percent in 2011. However, the rate of generic drug use varies across beneficiaries. For example, generic use has been consistently higher among MA-PD enrollees compared to PDP enrollees and higher among non-LIS enrollees compared to LIS enrollees. The difference between LIS and non-LIS enrollees have grown from two
percentage points to five percentage points between 2007 and 2011.

As we just saw, the prices for brands are growing rapidly while the prices of generic drugs have, on average, decreased. So, that difference in generic use rate has a significant effect on the average prices of drugs covered by Part D and a significant effect on Medicare spending for Part D.

Spending on the low-income subsidy may also be affected by the structure of formularies' plans' use. In recent years, an increasing number of plans have added a non-preferred generic tier, in some cases with a substantially higher cost sharing relative to the preferred tier. In 2014, on average, about 75 percent of all formulary generic drugs are placed on non-preferred tiers and the share is even higher if weighted by enrollment. But, as we just discussed, cost sharing amounts for LIS enrollees are set by law and that amount is the same for all generics. So, the higher cost sharing required for drugs placed on non-preferred tiers are paid for by Medicare. From beneficiaries' perspective, their cost sharing is the same whether they take medications on preferred or non-
preferred generic tier. We're also seeing an increasing use of tiered network pharmacies that further stratifies cost sharing so that the amounts are lower if one filled medications at a pharmacy that is designated as preferred. We are concerned that some enrollees may not have access to preferred pharmacies. We are also concerned that while the costs may be lower at preferred pharmacies, if LIS beneficiaries do not use those lower-cost pharmacies, it could increase Medicare spending for the low-income subsidy.

Finally, as we saw earlier, reinsurance has been the fastest growing component, growing by 95 percent between 2007 and 2012. Growth was particularly high between 2010 and 2011. This is when the phase-out of the coverage gap began, which was accomplished partly by manufacturers' offer of a 50 percent discount for non-LIS enrollees while they were in the gap phase. That discount is treated as beneficiary out-of-pocket for the purpose of determining when an individual has met their annual out-of-pocket threshold and enter the catastrophic phase. That is, if a drug costs $100 and a beneficiary paid $50 and the manufacturer discount paid the other $50, the beneficiary...
still got a credit for $100 as their out-of-pocket spending. Because non-LIS enrollees who filled brand name drugs now had to spend less in out-of-pocket to meet the threshold, it was expected that more people would reach the catastrophic phase, further increasing spending for reinsurance. From beneficiaries' perspective, it may make financial sense to choose brand name medications if they think they'll have high enough expenses, and the limited cost sharing required in the catastrophic phase may not provide strong enough incentive for them to use generic drugs.

Our analysis of the Part D data for 2010 and 2011 shows that the number of non-LIS enrollees who reached the catastrophic phase of the benefit increased by 28 percent and spending for these high-spending enrollees increased by 38 percent. In the past, number of non-LIS enrollees who reached the catastrophic phase of the benefit remained stable, at around 400,000. If discount did not count towards the out-of-pocket threshold, most likely would not have reached the catastrophic phase as quickly, and some likely would not have entered the catastrophic phase at all and spending for reinsurance would have grown more slowly.
This is different from saying that these people would not have reached the catastrophic phase without the discount. Many of them likely would have, but given that now we have a discount that reduces their out-of-pocket by half during the gap phase, if the discounts were not treated as their out-of-pocket, it would take them longer and possibly many more prescriptions before they can meet the out-of-pocket threshold. That also means that if the discounts did not count towards the out-of-pocket threshold, many would have likely incurred a much higher out-of-pocket cost.

So, one issue we'll be focused on is how this manufacturer discount should be treated. Should it continue to be treated as beneficiary out-of-pocket when determining whether one met the out-of-pocket threshold?

So, to summarize, program enrollment and plan offerings remain stable, with generally high satisfaction among enrollees. Spending is growing faster than enrollment. Higher use of brand name drugs used by LIS enrollees is contributing to higher growth in spending. Use of non-preferred tiers and tiered pharmacy networks may increase Medicare's costs. And closing of the coverage gap
is accelerating the growth in Medicare spending for reinsurance.

In 2012, the Commission recommended changes to the low-income subsidy cost sharing structure to encourage the use of generic drugs. If implemented, this policy could lower Medicare spending for Part D because the average prices would be lower, the spending for LIS would be lower, and some LIS enrollees may not reach the catastrophic phase of the benefit or have lower spending in the catastrophic phase because more of their medications would be for generic drugs.

We have also reported on the preliminary findings from our analysis of the relationship between Parts A and B and Part D spending. If spending for Part D continued to grow, we'd need a better understanding of the relationship and whether there are drug classes or conditions for which Part D provides higher or lower value.

Our focus on cost is because we need to ensure that the program is sustainable. Medicare spending for prescription drugs accounts for over a quarter of total national spending on prescription drugs and it has been growing faster than overall spending, partly due to
enrollment, but also because of other factors, like more people reaching the catastrophic phase.

We are also concerned about fraudulent or abusive prescribing as well as overuse of medications that could be harmful. CMS has announced in the recent proposed rule that they are considering changes to allow them to more easily identify fraud and exclude prescribers who engage in fraud or abusive prescribing. We'll monitor this issue and we'll come back to you if we think more needs to be done.

We'll also continue to monitor changes in plan formularies and their effects on program spending and we'll revisit them, if necessary.

In the future, we plan to focus on the effects of the manufacturer discount on program spending and we'll come back to you with policy options.

We'll also be looking at the effects of insurance risk on plan incentives and consider ways to strengthen plan incentives to manage costs.

Finally, we plan to come back to you with an updated analysis of the relationship between Parts A, B, and D spending later this spring.

And that concludes my presentation.
MR. HACKBARTH: Okay. Thank you.

So, this status report on Part D will be included in our March report, and as Shinobu indicated, in the future, we may consider some specific recommendations.

What I'm thinking is that we ought to go for three rounds here: Round one clarifying questions. Round two monitored by the light -- give everybody two minutes. Don't feel obliged to use the full two minutes if you don't need to. And then a third round that we focus in on some particular issues.

So, round one clarifying questions. I have Dave and then George and Rita and Scott.

DR. NERENZ: Okay. Slide 8, please. Just a question of how we interpret the top red line. Is this the same market basket of drugs from 2006 to 2011, or does it include the new entry of drugs during that period?

MS. SUZUKI: It actually is chain weighted, so it does evolve over this period. But if you look at time period that's closer to each other, it has a lot of overlapping drugs.

DR. NERENZ: So for those who are not technical term oriented, chain weighted means --
MS. SUZUKI: Chain -- umm --

DR. MARK MILLER: One way to -- if you kind of understand a Paasche and Laspeyres, this is like blending two of those.

[Laughter.]

DR. NERENZ: That didn't get better.

[Laughter.]

DR. CHERNEW: I think the answer is, it's more analogous to the same drugs' prices going up than it is to more expensive drugs coming into the market, because in any given period, they keep the drugs the same and get inflation between that period. Then they do the next period with a new basket and they connect them. But the way to think about it is -- I believe -- is that it's the same drugs' prices rising as opposed to more expensive drugs coming in, driving up the average price.

DR. NERENZ: That was exactly the distinction I was after, yes.

DR. CHERNEW: I am not sure I'm right, but I think of those two choices, that's the one I think is probably closest.

DR. MARK MILLER: [Off microphone.] But it does
allow for substitution over time. It's just -- it's not all
-- like, a Paasche and Laspeyres is either all one set at
the beginning -- and this is kind of takes both of the
change in the price and substitutes drug change over time.
That's what chaining does.

DR. SOKOLOVSKY: For those who aren't more
technically oriented, it is a Fisher index. But the key
thing is that before something is added for the next period,
it has to be in the previous period. There has to be a
certain amount of use in the previous period before it gets
included in the next period.

MR. GEORGE MILLER: I'm not sure if I should
follow that with a question.

[Laughter.]

MR. GEORGE MILLER: I've got a different question
on Slide 13, and in the chapter -- and it was just
fascinating reading -- I'm struck by the notion that if we
do better education, we can help drive the cost down,
particularly around generic drugs. My question may not have
an answer to it, but I wonder how much is being spent on
education, and I contrast that on every TV station there's
some advertising for some kind of drug to make your hair
grow and your warts go away and you become more beautiful
and all of that stuff.

[Laughter.]

MR. GEORGE MILLER: I mean, it's just the barrage
of drugs versus the amount of money we're spending on
education. That just struck me as a parallel. I mean, are
we in the -- by referencing, that would help drive costs
down, are we spending -- I'm not sure I'm framing this right
-- are we going to spend enough money to make education
overcome the amount of money the drug manufacturers are
spending in advertising? I don't know if that's a good
question, but it just struck --

MR. HACKBARTH: That's a great question, but more
a round two question than a round one.

DR. MARK MILLER: [Off microphone.]

MR. HACKBARTH: Right. Bill.

MR. GRADISON: Maybe I need another cup of coffee,
but could you explain to me why the use of tiered pharmacy
network is pushing prices up? I have a little trouble
understanding that.

MS. SUZUKI: So, one way we were thinking about
this is -- so, non-preferred pharmacies typically have cost
sharing that are higher than at preferred pharmacies, and
all of that difference is going to be picked up by
Medicare's low-income subsidy for LIS beneficiaries. And so
if low-income subsidy enrollees don't have access to
preferred pharmacies or don't know that there are different
types of pharmacies and continue to use the non-preferred,
that may result in higher spending for the program.

MR. GRADISON: So, the increase in the cost is
through the use of the non-preferred rather than the
preferred.

MS. SUZUKI: Right.

MR. GRADISON: Thank you.

MR. ARMSTRONG: On Slide 6 -- oh, I'm sorry.

[Off microphone discussion.]

DR. REDBERG: -- having an identity crisis.

[Laughter.]

[Off microphone discussion.]

DR. REDBERG: That was yesterday.

[Laughter.]

DR. REDBERG: Shinobu, that was an excellent
presentation. My question is about what percentage of
enrollees use mail-in pharmacies and does that differ by LIS
and non-LIS.

MS. SUZUKI: So, we have not recently looked at the mail order pharmacy use, but my understanding is that it continues to be low. The last time we looked at it, I believe, was in 2007, when it was less than ten percent of the prescriptions were through mail order, and it could have been much lower than ten percent.

DR. MARK MILLER: And the other part of her question was LIS and non-LIS, and what I remember, and it is a number of years ago, we kind of looked at it urban and rural, but I don't remember that --

MS. SUZUKI: I don't think we have that.

DR. MARK MILLER: Okay.

DR. SOKOLOVSKY: We did look at it urban and rural, and rural actually used it a little bit less than urban. But it was ten versus nine and it wasn't growing.

DR. REDBERG: Because, I mean, it just seems like an opportunity for people that don't have access to preferred pharmacies that everyone has access to mail order. My other question is can you estimate what percentage of Part D spending is for biologics versus other drugs?
MS. SUZUKI: I can get back to you on the overall share, but for the people who reach the catastrophic, it's less than ten percent.

MR. ARMSTRONG: So, I'm looking at Slide 6, but I think there are references to the trends in Part D prices in several places. What I don't really understand is that I think the way you describe the increase in prices, it's really a function of the relative use of generics versus non-generics. It's kind of the net price. But what do we know about the trends in the price per pill, or price per unit of service that underlies that? Is that a different number than the way in which you're using this term, trends in Part D prices?

MS. SUZUKI: So, the one place where I do talk about prescription prices is where I compare the LIS and non-LIS enrollees and said that between 2007 and 2011, price per prescription for LIS enrollees grew by ten percent while the prices for non-LIS enrollees actually decreased by about two percent.

MR. ARMSTRONG: But my understanding is the difference is largely a difference in the percentage of generic drugs that the non-LIS versus LIS patients are
using. It really has no -- there's no impact of the underlying price per drug. It's just really the ratio of low-cost to high-cost drugs --

DR. BAICKER: Doesn't Slide 8 show us what's going on with branded drugs versus generic drugs that's not affected by the mix of branded and generic that people are taking? This is about the prices of a basket of drugs, where the basket is evolving over time in a chain weighted kind of way to let new drugs enter, but it's -- from period to period, it's showing for a basket of drugs, how did the price for that basket change. So, I thought that spoke to that question.

DR. CHERNEW: It's sort of analogous to a case mix kind of question, and I believe the right way to look at the slide that Kate's talking about is that it is case mix adjusted, although I would defer to them, but I think that's the question that --

DR. BAICKER: But the initial question was branded versus generic and the mix of that, and these lines separate that out. So, it's not adjusted. So, this shows you what's happening to the price of branded drugs. The basket of the branded drugs that you are pricing is evolving over time
based on utilization. So, as new drugs enter, if they're more expensive, that would, over time, make this move up, although from period to period, you're saying, what's the CPI for this basket of drugs.

MS. SUZUKI: But the utilization is reflected in the dotted line.

DR. MARK MILLER: But the solid line right above the dotted line, that's net across all drugs and it's a price measure that doesn't take into account the generic substitution.

MS. SUZUKI: Right.

DR. MARK MILLER: Does not. Right. That's what I'm trying to say. So, to Scott, what I think I would be saying is if you wanted to look at a price effect across the entire program, if that was your question, which I've in some ways lost a little bit of sense of --

MR. ARMSTRONG: Yeah.

DR. MARK MILLER: -- I think it's the solid white line. Are you guys okay there?

DR. SOKOLOVSKY: The solid red line is what happened to the price of the branded drugs.

DR. MARK MILLER: Well, that's single source, and
if he is asking branded, then I would push him up to the red line. But the white line is across everything, right?

MS. SUZUKI: Mm-hmm.

MR. ARMSTRONG: Okay. So, then, my related question is, I'm not exactly sure -- I probably should know this, but how is the price per drug determined? Are those negotiated by the plans with bulk purchasing organizations, or does MedPAC set those prices, and then how does that -- like we do for so many other services, but --

[Laughter.]

MR. ARMSTRONG: -- and then later -- anyway, I'll stop there.

MS. SUZUKI: So, the prices are negotiated between the plans and the pharmacies. So, we have that side of the payment. Plans also negotiate rebates. That's not reflected in the prices we're measuring for using the claims data.

MR. ARMSTRONG: Okay. And so CMS has no role in setting those prices?

MS. SUZUKI: No.

MR. ARMSTRONG: Okay.

MR. HACKBARTH: Any other clarifying questions?
Jon.

DR. CHRISTIANSON: So we don't actually -- if I understand what you just said, we don't actually know what the plans paid for the drugs because we don't know the rebates.

MS. SUZUKI: Correct. Well --

DR. MARK MILLER: And just to be clear, it is known; it's not known by us.

DR. CHRISTIANSON: We don't know.

DR. MARK MILLER: We don't know. MedPAC does not know.

And I guess I would ask for one other clarification.

To the extent that CMS or whoever knows, do they know drug by drug, or do they just know this is the spend and these are the rebates?

MS. SUZUKI: The trustees' report puts out an aggregate rebate amount, and I can't remember the percent.

I believe it is by drug. Or, manufacturer?

DR. SOKOLOVSKY: I think it's by manufacturer.

MR. SUZUKI: It may be by manufacturer.

DR. BAICKER: So while we're on this chart, which
I found really helpful, is this just standalone Part D, or is it MAPD plus?

MS. SUZUKI: It's both.

DR. BAICKER: It's both. So it would be interesting to see how those -- how the chart looks different for each of those in that we think there might be different management tools available in the MAPD.

I think it would also be -- and I don't know if you know the answer to that offhand.

It would also be interesting to know how the bundle used by Medicare Part D enrollees overall compares to other populations, ideally, you know, somewhat similar commercially insured populations, but I know they're never going to be quite the same and that you're not going to have the claims data.

But it would be interesting to know how the program is influencing the bundle overall compared to not the program as well as the MAPD versus the standalone.

DR. SAMITT: So, while we're also on this graph, I'm curious again to get clarification on the difference between the solid white line and the dotted white line. I assume the solid line represents reality whereas the dotted
line represents what the incremental cost would be, assuming full generic substitution had been applied where all opportunities for that existed. No?

MS. SUZUKI: So the dotted line is the closest to reality. We're taking the actual weights of brand versus generic and coming up with a price index.

The white line is showing that if you just measure the growth in drug prices over time but not considering that some people would switch from Lipitor to a generic statin, then what would the price growth be?

DR. CHRISTIANSON: So, I mean, I always think of price as what we pay for things, and this really isn't what is being paid for things.

How much are we to take away from this graph? The line -- what's actually being paid for stuff may look different, quite a bit different than that, right?

I mean, I'm just trying to get some clarification on this.

DR. SOKOLOVSKY: It's what beneficiaries are paying in the coverage gap. It's what Medicare is paying for, say, LIS and what they're paying in catastrophic. It's not the net price for the plan.
DR. MARK MILLER: Well, you're absolutely right because then there's this discount, or rebate transaction, that occurs all behind this.

And you're right; it is what a person faces at a counter, you know, when they're standing at the counter.

I suppose over time, to the extent that rebates drive down the cost of the plan, the plan might reflect that in a premium, but again, that's a different signal than the price signal here.

But you're absolutely right; it's in some ways not the actual net price when all is said and done.

MR. HACKBARTH: We're going to be really clear after this round what we --

[Laughter]

DR. REDBERG: Your presentation was very clear.

It's just an additional question on table 13 in the mailing material.

I'm assuming I'm looking at the average number of prescriptions per enrollee. I'm assuming this is just for the Part D enrollee; so it doesn't include beneficiaries who are not part of Part D.

MS. SUZUKI: Right, this is just for Part D
enrollees.

DR. REDBERG: And then do you have any data now or later on median and range? I'm just interested.

These are average, I assume, but I'm assuming some people have very low and some people might have very high use.

Thank you.

MR. HACKBARTH: Any other round one questions?

[Pause.]

MR. HACKBARTH: I'm going to kick off round two with sort of a rhetorical question. I don't expect an answer to this, but -- during Shinobu's presentation about the gap and interaction with the reinsurance, I couldn't help but wonder how the approach to Part D compares to what we do with Part A in terms of plans assuming risk. And since yesterday we were talking about ACOs assuming risk, that's still another model.

And it seems to me that there ought to be some logical reason if we differ our approach to risk-bearing across different elements of the program. There ought to be some rationale for why we do it differently in Part D versus MA versus ACOs.
And I don't think that people have looked at it that way across the different elements of the program. So that may be just a way to think about some of these issues. My impression is Part D plans assume a lot less risk than MA plans, and I recognize that there may have been a reason for that initially -- that this was a new type of insurance. As Tom Scully famously said, this is a type of product that doesn't exist in nature.

But now we're pretty well into this. And, does it make sense to have dramatically different approaches to risk-bearing across the different parts of the program?

So that's a rhetorical question for maybe future consideration.

Jack, do you want to take us from here?

DR. HOADLEY: Sure. And I really want to thank Shinobu for a great analysis. There's all kinds of good data points.

And I've talked to her separately about some technical questions that I have and don't want to take the Commission's time on those.

I would observe, sort of as a starting point, that, as she pointed out, there's about $60 billion worth of
spending in Part D. And, if you think about the 4 sectors we talked about this morning and the 2 we talked about yesterday afternoon, they actually add up to about $60 billion. So what we're talking about today is a piece of the program as big as the last six sectors that we talked about.

Now it's a little apples and oranges because here we're counting subsidies to low-income beneficiaries as well as the direct coverage. So, I mean, you can quibble about whether it's a direct comparison, but I just thought it's helpful to think of it.

And because we don't have -- we don't work on the prices, to Scott's question. You know, we don't have an update thing. So we don't sort of automatically, routinely sort of look at recommendations in the same way. So -- and I do think there are some things that are worth talking about.

I think there -- I identified a half-dozen or so different policy issues that come out of this presentation, and a couple of them we've discussed in the fall presentation -- the low-income penalty issues that Shinobu mentioned, and the exceptions and appeals, the need for
And I don't think it's worth sort of repeating that discussion, at least for me, although I would note that the new Part D rule that raises some potential changes to the protected classes, I think, kind of ups the ante on the exceptions and appeals. If that were to go through the importance of exceptions and appeals could become even greater, and so the need to understand that process only increases.

The LIS sort of co-pay issue was addressed by the Commission a couple years ago. I think that's still an important issue, but I won't sort of say more about that right now.

The three that I wanted to focus on -- and one of them relates to the question Glenn just asked. But starting with the tiered pharmacy networks, you know, this is really an area that's jumped up quite considerably in the last couple of years, and there are a number, I think, of important issues.

There's a transparency issue. Do people who are buying these plans really understand the differentials in the network, the differential co-pays?
CMS has done some things to make the plan finder operate better because they now really push you to put your pharmacy into the plan finder and, therefore, get the prices that are linked to your pharmacy. Otherwise, you tended to get the preferred pharmacy price even if it turned out the only preferred pharmacy was, you know, 15-20 miles from your home.

And the question of how close the preferred pharmacies are -- Shinobu showed numbers that said in some plans it's as few of 10 percent of all network pharmacies although in other plans it's considerably higher than that. I'm trying to do some work to look at sort of distances to these preferred pharmacies.

And there are some pretty big cost-share differentials. So, even just for the general beneficiary, access and standards -- I think there's an issue there.

And then, as Shinobu points out and it came up in response to one of the questions, the extra cost that can be triggered for the LIS beneficiaries that goes to the program is a program cost.

Plus, CMS has identified that the prices being used at the preferred pharmacies are not always less than
the prices being used at the nonpreferred pharmacies, the other network pharmacies. And so, in those cases also, the program loses money even though the beneficiary saves on a co-pay.

So I think there are some important issues to address there.

And this is also addressed with one particular policy approach in the new Part D proposed rule. It's a form of an any-willing-pharmacy rule that may or may not be the best solution to that, but it's going to trigger this issue to have some policy discussion in the near term.

The second one I would go to is the reinsurance question, and I just want to reemphasize the numbers that Shinobu pointed out.

I mean, 80 percent of the benefit in the catastrophic phase is reinsured by the government. So beneficiaries are on the line for 5 percent of the payment. That means the plan is only on the line for 15 percent. So that's a very extreme version of reinsurance and really does seem to change the incentive.

So anytime you've got an expensive beneficiary or a very expensive drug, the plan's incentive to try and
manage that drug is much reduced.

And, again, it's not completely obvious what the right answer is, but I think it's an area that does very much justify some discussion. It's also much less of a reason for plans to try to negotiate prices or negotiate those rebates for the expensive drugs.

And, while the biologicals, many of them, are covered under Part B -- so it's not relevant to this part of the program.

And so far, the expensive drugs don't seem to be a big part driving the expensive enrollees, but they are likely to become a bigger role in the future. And so, if plans have minimal or less reduced incentive -- much reduced incentive -- to negotiate hard on those drugs where they're going to tend to be single-source and hard to negotiate anyway, I think it's something where, you know, it's worth some attention.

And related to that, sort of my third issue is the risk-sharing corridors, which are very tied in.

But, in addition -- and it goes back to just the logic that Glenn put out there -- in order to encourage plans to get in, not only did we do risk adjustment, which
we always think is important, but we did this very extreme
version of reinsurance and we added risk-sharing corridors.
So substantial profits or substantial losses are mooted in
the program.

And so a plan -- again, it reduces significantly
the incentives to really manage the expensive cases, and I
think that's something that really does justify some further
look.

You know, I think the only other one I would add --
and I don’t want to take any more time -- is the issue of
the protected classes, which is going to be a point of
discussion in the policy community. It is already since
Part B announced changes -- proposed changes -- in the rules
of how the protected classes -- this is the six classes of
drugs where plans must include all drugs on their formulary
and can't exclude any drugs.

So it's basically the mental health drugs,
antidepressants, antipsychotics, the HIV drugs, the cancer
drugs, the immunosuppressives for transplant patients and
anticonvulsants. It's those six protected classes that have
existed to date, and if you're a plan, you have to list
every drug in those classes on formulary.
And Shinobu had some analysis in the chapter on the fact that the price curves are very similar to the ones that are up on this graph. Whether those protected classes should be continued -- CMS is proposing to eliminate some of them in its proposed rule.

So, again, it may be an area where we want to think about and address.

And I don't have a clear view on what's the right answer there other than to link it back to the exceptions and appeals because if we do change and take antidepressants or antipsychotics off the protected class and, therefore, off some plan formularies, there is going to be a lot more people asking for exceptions to maintain drugs that they're using or to pick particular drugs that are off formulary.

So those are the issues that I wanted to highlight.

DR. BAICKER: There's a lot of interesting material here, and I'll take the chance to focus on one of my favorite topics -- the insurance value provided versus the incentives that are created at a number of different levels.
For beneficiaries, we clearly want to provide good insurance protection against these potentially very expensive medical opportunities.

And the goals of filling in part of the donut hole or insulating, in particular, low-income beneficiaries from excessive cost-sharing are laudable goals, but we clearly -- Shinobu has documented some instances where the incentives to use high value products, the least costly alternative to be able to get the health goals people are striving for, is so undermined in the service of improving the insurance value that we have some utilization that clearly seems low value.

So opportunities to think through the unintended consequences of some of the filling-in, especially for low-income beneficiaries, while preserving adequate insurance value, seems like an important area for us to consider.

On the insurer side, the reinsurance that Glenn brought up also seems like a case where our efforts to insulate others from risk have gone so far as to undermine any incentive to manage value in an aggressive way or at least in an appropriate way.

And, for insurers, I'm less concerned about their
exposure to risk than I am for low-income beneficiaries. They should be able to take on a fair amount of risk given that they're insuring pretty large pools of people and individual variability is bound to get wiped out for the most part.

So it seems as though the reinsurance is excessively insulating and, therefore, undermining those incentives.

So across those areas the common theme of thinking, yes, we want to be sure the program is providing good insurance value, but we want to do that in a way that provides incentives to steer patients, pharmacies, insurers towards the most valuable medicine seems a good opportunity for us to explore.

MS. UCCELLO: So I think this was a great chapter, and I'll focus on risk corridors and reinsurance.

So, just as a reminder, risk corridors protect against pricing uncertainty.

So, when the program began, this was a new, you know, standalone drug benefit that wasn't covered before, and insurers didn't have a lot of data with which to estimate premiums. That's no longer the case and argues for
removing the risk corridors.  

But -- and I think this is a huge but -- the risk corridors are resulting in plans actually paying the government these days instead of the other way around. It's protecting the government from these windfall profits of insurers versus protecting the insurers against pricing too low. So, if we remove it, we need to think of something that could act similarly to limit these windfall profits.  

Now the new MLR requirements for Part D plans -- I think we need to look into what the parameters of that requirement would be to see if that could act similarly -- have a similar result as the risk corridors are. So, before we would want to take away these corridors, since they are actually resulting in payments to the government instead of from the government, we need to look into that.  

In terms of reinsurance, I'm thinking that it may be worth considering using some type of reference pricing to act as how we pay the insurance plans.  

So, you know, one idea would be if a generic is available and appropriate for someone, to use that as the price when making the payment as opposed to the brand price, or some other type of price that then could be used to put
more pressure on the plan to manage their costs better and
maybe negotiate their prices more.

MR. BUTLER: So, following Jack and Kate and Cori, I almost want to be an economist and actuary and all in one. This is ripe territory for this kind of thing, and so my question actually is along the line of so much of what we're talking about is once you've picked a plan, the behaviors in the plan.

I'm always struck still by the health exchange-like apparatus that you have to go through to make your selection the first time, which is not insignificant. It doesn't get the same attention as the health exchange because the benefit is so good; people found a way to do it. But then I get the sense the likelihood of changing in year two or year three is not great unless something is flashing that is so obvious a reason to change.

So, my question. Really, there's not too much in the chapter around the impact of different premium prices and benefits and how frequently and reasons for people switching from one Part D plan to another.

So, if you could just comment a little on what the experience is -- I know the turnover among plans is not
great, but tell me some more.

MS. SUZUKI: So we've looked at the switcher issue last time around, and we found that about 13 to 14 percent of the people switch plans. And this wasn't due to a plan exiting the market or other reasons. So this seemed like a voluntary switching.

When I looked at the average spending before and after, it seemed like switchers, after switching, seemed to be, on average, using more drugs. So maybe that was one of the factors they considered -- better coverage of the medications they need.

And I think, Jack, you had looked at premiums a little.

DR. HOADLEY: In our switching analysis, we looked at the impact of premiums. If somebody's premium was scheduled to go up next year, yes, they are more likely to switch than somebody whose premium is stable or scheduled to go down next year. But many people, even facing a pretty substantial premium increase, still did not switch.

So it was maybe from 13 percent jumps up to 25 percent of the people facing, say, a $10 a month premium or, you know, on a base that might be typically $30 a month. So
they might be facing a one-third increase in their premium, or it may double the rate of switching, but still the majority don't make a switch in that circumstance. Again, maybe some of that is logical. They like their plan. They like other aspects of it.

We also think they're more sensitive to switching based on premium than really total cost because premium is the most visible part even though they can look at total cost. It's harder to do that. It's a more complicated analysis, but to the extent that we could look at that, we think they're more sensitive to the premium than to the overall cost -- the out-of-pocket cost for them.

DR. CHERNEW: Can I add one thing just briefly? There's a growing body of literature that suggests that the beneficiary choices aren't optimal for the beneficiary in a whole variety of ways. I'll just leave it at that for now.

MR. HACKBARTH: I read somewhere, Mike, that there are at least some pieces that say that it looks like the choices have gotten more optimal over time. Is that true?

DR. HOADLEY: There was one study that drew that
conclusion, but I actually think that study is significantly flawed.

There's another analysis that Jon Gruber with Abaluck did that actually shows the opposite. It showed that people making later decisions are not necessarily improving the optimal nature of the selection.

DR. CHERNEW: I think that point remains controversial.

DR. HOADLEY: Yeah.

DR. CHERNEW: But the first point, I think even in the ones who worry about whether it's getting better or worse would still argue it's still not very good for a variety of reasons.

DR. MARK MILLER: Can I just check on one thing? I hate to do things by memory.

But when we did this, when we did the switching thing, we found that the beneficiary was getting more drugs and that it kind of was a good -- you could understand why they were switching, but it wasn't necessarily working out that the program was benefitting from the switch.

MS. SUZUKI: Right. So it seemed like they were -- so their out-of-pocket spending generally went down after
the switch even though the total spending had gone up on
average.

DR. MARK MILLER: The anomaly is -- and I
definitely want you in on this because I'm sure you have --
but, you know, you kind of think of switching as driving
people into less expensive plans over time, and at least
some noise in the data suggested they may have come out with
a better deal -- the beneficiary. And that's a good thing,
but it didn't necessary translate over.

DR. BAICKER: And my reading of the literature,
which is less in depth than yours, I'm sure, is that the
switchers make sense. They're switching to get a better
deal for themselves, as well as they should.

It's the nonswitchers that are a mystery, where
you can calculate the amount of money left on the table by
people who have available to them plans that would cover
their basket of drugs at substantially lower costs and don't
switch. That's the mystery.

DR. MARK MILLER: And that would explain --

[inaudible comment.]

DR. CHERNEW: And that's a nontrivial number of
people.
DR. BAICKER: And a nontrivial amount of money.

It doesn't -- there is something interfering with the choice process, one suspects.

MR. BUTLER: Part of the reason for asking the question is when we looked at our -- what do we call them?

Premium support? Competitive premium?

MR. HACKBARTH: Price contributions.

MR. BUTLER: Yeah. We looked for lessons learned, and as we did, when we looked at that. You know, what are the lessons learned here in terms of choices at the front and that may apply to other sectors in Medicare as we evolve from a fee-for-service system.

DR. SOKOLOVSKY: Can I just add one thing?

We, MedPAC, actually did a lot of work on this, a lot of it with Jack, at the beginning talking about how people chose their plans, and the one thing we heard -- well, then it was certainly a focus on premiums, but the other thing we heard consistently was how hard it was and how many hours they spent.

And the thing that we hear year after year in our focus groups, when we go over this, when we ask about changing, is the majority say it was so hard to begin with;
we don't want to look at it anymore.

MR. BUTLER: That was my point.

DR. SOKOLOVSKY: Yeah.

MR. ARMSTRONG: So, first of all, I feel that Part D is part of the overall program that I'm much less familiar with than a lot of other parts, and so in some ways my questions are borne out of just not knowing things I probably should do.

But I do -- I'm really impressed by the analysis and agree on the final slide, when you describe ongoing future work, that this looks like an agenda that is a great focus for us and that, I think, is really an important topic and one I'm eager to spend more time really learning much more about.

Glenn, your comment about, you know, we talk about the different parts of the Medicare program and we distribute risk and we try to control costs in a variety of ways so that we really ought to be thinking about how is Part D set up in ways different or analogous to whether it's the MA plans or it's ACOs or bundled payments and, you know, various themes there. And I think that's also really worth exploring.
In particular, just as I think about this, in MA, we leverage the purchasing power through fee-for-service to get lower MA rates because MA plans use those fee-for-service rates as a point of reference. And it just strikes me that that's a real difference in Part D, where we're just completely dependent upon the Part D plans to negotiate the best rates possible. There's never any opportunity to leverage the full Medicare program for lower-per-unit prices, I think.

So, if that's the case, then I would be interested in learning more about that if it's not already covered in one of the bullets for the work plan going forward.

DR. SOKOLOVSKY: And you remember that that is in statute, that the Secretary not get involved in negotiating prices for drugs. So it actually would require a big change in the Medicare law.

MR. ARMSTRONG: Well, no, that was not clear to me. I guess that would make that a short analysis.

[Laughter.]

MR. ARMSTRONG: I'd be interested to learn more about what we can do and/or not do.

Thanks.
MR. HACKBARTH: So, as was pointed out, this was a part of the fundamental design of Part D -- it not have government-determined prices but, rather, market-determined prices.

But this also interacts with some of these other issues that we've been talking about -- reinsurance and risk corridors and all that.

If you're going to rely on competitively determined prices, but then take away a lot of the risk, that's not a combination that necessarily works together.

So, if we want a competitive program, we need to look at some other features in that same light to support that goal.

MR. ARMSTRONG: I also just was thinking; how do we know if we're getting a good deal for the Medicare program?

We know for MA how much we spend relative to what our prices for fee-for-service are. But, in Part D, how do we know?

You know, someone mentioned maybe we should compare more to some of the other private plans, or there are other points of reference. It doesn't have to be, you know, the government setting rates.
But I think that's a legitimate question for us to be exploring, and hopefully, there are ways within the statute that we could explore that.

DR. REDBERG: I think people also compare to the VA formularies for prices.

DR. HOADLEY: But the absence of full transparency on the rebate side of the prices, whether it's in Medicare or in the private sector, further prevents us from doing that.

And, while CBO or the actuary can look sort of in the aggregate at the magnitude of rebates, even they are pretty constrained in what they can do on sort of a drug-by-drug basis.

DR. SAMITT: Although it's not just a pricing issue we want to look at. We want to essentially look at total drug cost per beneficiary versus a similar market basket on the commercial side, and when we look at that comparatively, how much is Medicare spending for drugs per beneficiary versus how the commercial population is doing that.

DR. CHERNEW: I'll waive my turn [off microphone].

DR. CHRISTIANSON: Okay. Four quick, I hope,
suggestions or observations. I think getting the risk-sharing rate, as you folks are talking about, is very important. I'm more convinced of that after hearing Cori's comment. It's just complicated. There's a lot of moving parts here, and we need to spend some time talking about and focusing on that with some help from the Commission staff in terms of framing different alternatives.

I'd like to suggest that the language starting on page 43, there be something in there that really clarifies that the prices in those drafts are, I think if I understood what you said, prices faced by beneficiaries, they're not net prices paid by -- net prices that are received by drug manufacturers and suppliers for their product.

And then another general comment on the chapter is I think it starts out talking about, you know, the general status of Part D, including stand-alone plans and Medicare Advantage plans. And I think as you go forward there, there were places where I wasn't clear that the data were just applying to stand-alone Part D plans, if I understood some of your comments right. And so just being very clear about when you switch over from this general discussion of Part D coverage to here's some data but the data only apply to
stand-alone plans.

And then finally the other Part D issues there, the second bullet point, abusive prescribing. The other stuff there seems to have been supported by discussion in the chapter. I didn't see any discussion in the chapter on that. Maybe I missed that. There's a page at the end that talks about quality measures. It doesn't really deal with abusive prescribing. So how do we define abusive prescribing? How would we know it when we saw it? Why is it a Part D issue? I didn't see the support in the chapter for that as another Part D issue. I'm not saying it isn't.

DR. MARK MILLER: I'll take responsibility for this.

DR. CHRISTIANSON: Good, good. That's good.

DR. MARK MILLER: Just to defend myself for a moment --

[Laughter.]

DR. MARK MILLER: I wanted this chapter to bring you guys up to speed on the whole landscape out there, and there's been some recent work, ProPublica, that said they took the claims data and they looked at these providers, and I just wanted to make sure that everybody was aware of that
in case it triggered any interest.

There isn't a lot in the chapter. It was a late arrival based on my suggestion.

DR. CHRISTIANSON: In the next version of the chapter --

DR. REDBERG: In your defense, Mark, on page 10 in Tab A, it's the ProPublica story on some of the abusive prescribing, which was remarkable. I mean, a physician claimed that someone had gotten hold of his physician license and written -- $3.8 million had paid for -- Medicare had paid in one year for this one physician's drugs, which he claimed was all fraudulent. So I think that was --

DR. CHRISTIANSON: Yeah, I just didn't think that we should have this as another Part D issue at the same level as these two things without any discussion of it in the chapter. It just kind of got dropped in there.

DR. MARK MILLER: You're right. It was dropped in. That was my doing. Shinobu told me not to do it.

[Laughter.]

DR. MARK MILLER: Just for the record, Shinobu was right. Okay?

MR. GRADISON: I want to thank all of you for
working so hard to try to foster my understanding of a field
that I really don't know that much about. I am intrigued by
the very broad issue of whether we could -- what we can
learn, if anything, about how market pricing in this area
could more broadly be applied to other parts of our
responsibility, and vice versa.

The only thing that I've seen that might be a
little additional way to figure out what we're buying --
whether we're getting value for money is to look at the
organizations which buy pharmaceutical products and then
provide them to nursing homes and various assisted living
facilities. There's some very big for-profit companies in
this field. It's not exactly comparable because most of
them provide additional services. Specifically they often
provide the service of taking a look at each new nursing
home patient to review what prescriptions they're on, which,
by the way, on average means reducing the number by two when
the people come into the nursing homes. But it's just a
suggestion. There may be something there that would -- I
can't be specific about what it might be -- that might give
us -- these are other large purchasers who do provide -- who
negotiate prices with nursing homes, often with very big
chains, for the drugs and certain services in addition to just providing the drugs.

Thank you.

DR. NERENZ: Could you put up Slide 11, please?

In many chapters there are things that pop up that are clearly problems, and then our task is to try to figure out if there's some sort of a set of recommendations. My core question here is: Is this a problem? So let me just elaborate a little bit. I think, first of all, it's interesting, but the question is: Is it a problem?

If I'm tracking this correctly -- and there's text on this on page 36 of the chapter as well -- in the Affordable Care Act there's some language that changed the rules of the game here, and as a result of that, some fairly striking things happened in the 2011 to 2012 period that had not been happening before. And the key thing on this slide is that percent of people who moved into this catastrophic phase. The numbers here are about percent rather than -- or the additional percent or the changes, how many more got in, rather than absolute numbers. So one question is just what are the absolute numbers.

But the second sub-bullet there seemed to me, as I
read it, the key thing, that the manufacturer discounts are now counted against this out-of-pocket requirement, which strikes me as an interesting thing. It's different. I'm not sure I heard of this before, but, okay, I think I understand it. As a result then, what I think I can imagine happening is that as a year goes by and as spending occurs, the beneficiary who's moving through this up to the catastrophic phase spends less time in this doughnut hole or gap phase and also incurs less truly out-of-pocket expense and then hits the catastrophic threshold faster. Okay. So probably a little better for the beneficiary, all else equal.

What I can't quite understand then is between the manufacturer and the Medicare program who wins and loses when this happens, because the manufacturer presumably has contributed in some way this discount, but then the person runs through to the point where now the government, per Jack, is picking up 80 percent of the cost and maybe the manufacturer thinks net out all this is -- actually they come out ahead.

And sort of on the other side of the coin, the Medicare program is picking up 80 percent of the expense
more quickly than would otherwise have happened or more
often.

So, finally, is this a problem? Should we worry
about this? Or is this good? Is this all okay?

MS. SUZUKI: So I'll answer the easy one first.

We have been tracking a number of people who reached the
catastrophic, and for non-LIS enrollees it has been about
400,000 for the last few years. In 2011, when the
manufacturer discount began, it was 500,000, so it was a
pretty big jump that we hadn't seen before. And I can
probably figure out how much the manufacturer discount
accounted for from the claims data. But it's hard to figure
out how much of the reinsurance spending was because of the
manufacturer discount.

MR. HACKBARTH: I may be confused here, but one of
the things that struck me about this was it seems
inconsistent with the true out-of-pocket concept. Elsewhere
what we're saying is it's -- to get to the catastrophic cap,
It has to be true payments out-of-pocket. If it's covered
by some other insurer, et cetera, it won't count. But here
we're saying, well, this particular type of protection from
another party is okay. Is there some inconsistency?
MS. SUZUKI: That was an explicit law.

MR. HACKBARTH: Right. I understand that. But it seems inconsistent with the original philosophy of Part D.

DR. NERENZ: I'm sorry. I guess -- is it a problem or not a problem?

DR. MARK MILLER: The way I would answer that -- and some of this comes back to what Cori and the people over there said.

[Laughter.]

DR. MARK MILLER: I always look for an opportunity to hassle those guys.

But I would link this thought back to the risk discussion, okay? That what's happening in that gap may be beneficial to the beneficiary, and I think everybody wants to help the beneficiary. I think there are some questions about how much it drives people into the catastrophic cap and whether on balance, if we step back and listen to all of these comments that people are making about what is the risk structure here, I would link the thought back to that. And problem or not a problem, the point is I think we should be -- I'm hearing the Commission wants to step back and revisit the risk structure of Part D, and this is decidedly feeding
into that. That's what I would say. So I'm not litigating
problem/not a problem, but I'm kind of blowing it up to a
bigger question that I think you're all tracking on.

DR. CHERNEW: I would say it's a problem to the
extent to which you believe that more generous coverage
encourages more use, and that's true in a whole range of
things across the program, that there's a good side of it,
more generous coverage in a variety of ways, and a bad side
of it, it encourages more use and effectively then more
government spending.

DR. NAYLOR: So I also echo everyone's comments
about how beautiful this work is, building on the work that
you provided in the past. And I would love to build on this
notion of the problem. And as I understand the problem, it
is we are seeing rising Medicare costs. We're wanting to
make sure that the reason the program particularly focused
on low-income groups is to make sure that they had
appropriate, adequate access to prescription services.
We're watching that their use of the services seems to be --
that they are using the services, in fact, their drug use
per month is higher than non-income, and they're using more
brand relative to the lower income. So we're trying to say
how do we get that, and all of the wonderful comments from colleagues before about risk sharing and the whole notion of insurance and the network preferred pharmacies and so on I think is really important.

I do want to get back to George's comment at the beginning because we also have tackled this in earlier work to say isn't a huge part of this going to be about getting clinicians to change behaviors for a group of people that often are on way too many incorrect, inaccurate medications and getting beneficiaries to be better positioned. So I'm wondering as we go forward if we can continue the terrific work that you've done about literacy, engagement, shared accountability, and clinician behavior. I see this as central in solving this problem -- not that these other components are not important, but I think that they're part of a whole package which says we rely way too much on medications, and an elderly population doesn't do well under the burden of all of the prescription drugs that they are now on.

MR. GEORGE MILLER: All right. So I can ask this question now. I just want to bring that up as an issue.

You talked about really trying to drive appropriate behavior
and appropriate use, and we say education would help with
the correct selection of the appropriate drug based on
price, dealing with the generic versus the brand name, how
do we make that happen, particularly with the large amount
of marketing dollars spent on driving folks to certain
drugs. And Mary just raised an appropriate question, that
is, is it appropriate the type of drugs, the amount of
drugs, and the use? Rita talks about this all the time.
She finds patients being overmedicated and shouldn't be on
some of the drugs.

The other issue that Scott mentioned I wanted to
bring up as a point, and I think it was so eloquently
detailed on both days by the Chairman dealing with the
sequester versus law and what we think is appropriate. So
to Scott's point, is it appropriate today that the Secretary
does not have the right to negotiate prices? It made sense,
as Cori said, in the beginning of the program, but now that
we have data and information, should we recommend that the
Secretary have that power to look at the best value for the
dollars that we're investing in the program? And if that is
true, then we as a Commission should say that they give --
repeal the law and give the Secretary that power if we can
get better value by evaluating the value for the dollar, looking at what the other programs are doing as it relates to pricing for drugs and use that as the methodology to determine if that's appropriate.

MR. HACKBARTH: On this issue, which has now come up a couple times, of the Secretary negotiating, I have a vague recollection that at one point CBO was asked to do an estimate of how much money it would save if the Secretary were empowered to negotiate, and they came up with a surprisingly small number. Was it actually zero? And as I recall, CBO's logic was that the power to negotiate without also having the power to set the formulary is of little value. You have to be able to say we're going to steer patients to particular drugs in order to have real negotiating leverage. Am I remembering that correctly?

DR. HOADLEY: [off microphone] Yeah, in their statement.

MR. HACKBARTH: And so it isn't just negotiation. It is also the establishment of a formulary that would have to go with it.

DR. HOADLEY: Or some similar kind of leverage point.
MR. ARMSTRONG: But, Glenn, isn't that analogous to setting hospital payment rates without the ability to manage care?

DR. HOADLEY: It's partly the difference between Medicare paying hospitals directly, which it can just vary – I mean, the underlying questions are certainly relevant, but in the context of Part D where the payments are made from private plans to -- between private plans and manufacturers, I think that's the context in which CBO's statements were made. How do you give the Secretary authority in the context of a privately delivered benefit?

DR. BAICKER: But --

MR. HACKBARTH: And to go back to my Part D/MA comparison, so in MA the Secretary isn't setting the hospital prices that Scott pays. That's a privately determined transaction, as well as the networks, et cetera. And so, again, you know, I think there needs to be some consistency and logic.

DR. BAICKER: Yeah, I wanted to echo that idea that if the goal is to use market competition to drive down prices, if you had central pricing by the Medicare program and they weren't able to say this drug is on the formulary
and this drug isn't, there's no mechanism to get the prices right and to negotiate. There's no negotiating stance. And the analogy to MA I think is pretty strong in that the goal of MA is to try to get higher-value bundles of care by doing more aggressive management, more discriminating contracting, all of the mechanisms that MA has that the fee-for-service program does not. The analogy then to Part D is let them negotiate what things are on formulary, what things aren't, what things are in which tier, and try to, therefore, get a higher-value package. And that to me seems like -- if we're in favor of moving towards more sophisticated management tools through ACOs or MA, the analogy is moving less towards government centralized pricing and more towards the flexibility to design higher-value packages that doesn't really work with our fee schedule.

But then that augments the importance of what Glenn was saying about, okay, so if we're going to rely on these plans to do a more sophisticated package, putting them together and let people choose among them and find the highest-value ones, then they have to be real competitive actors. We can't say, "But we'll take away all the risk, don't you worry about that." Those two have to go hand in
hand if this has a hope of moving in that direction.

DR. CHERNEW: So let me just say one other thing, if I can. The first thing is, as interesting and important as this discussion is, I think there's a lot of nuances to it, and my fear is that if we got too distracted by it, we will miss opportunities to actually really make the program broadly better.

MR. HACKBARTH: What is the "it"? If we get distracted --

DR. CHERNEW: If we get distracted by worrying about whether the Secretary should set prices, we'll get -- which I don't think has much of a -- I'm actually not so convinced for a variety of reasons it's a good idea, just to be clear. I do think we could have an interesting debate about whether it's a good idea, but a lot of it hinges on how well you think the Secretary would actually do that. And so I think there's a lot of areas in Medicare where the Secretary or the government has the power to do a lot of things, and they actually do it really badly, despite the things that we might say, and I guess that is on the record now, so I did actually just say that.

[Laughter.]
DR. CHERNEW: But in any case, I do think there's a lot of examples where the government has the opportunity to set prices in areas, and the prices don't end up being the prices you would want for a variety of reasons. And I think often the proponents of negotiation assume it's going to work really well, and I think for a variety of reasons it might not.

But regardless of where you come out, because I think there's legitimate arguments on both sides, I think that in terms of the productivity of recommendations we can make, there's a lot more fruitful ways that we can make a positive difference than trying to take on something that was really central, frankly, to the fundamental design of where Part D was. And so it strikes me that that goes to the heart of relitigating the philosophy behind Part D as opposed to an approach to how to make it better. And I guess I'm in the latter camp of let's try and make the basic thing work within the philosophy that won the day, whether that was good or bad, as opposed to relitigate where Part D was. But that's just my opinion.

MR. GEORGE MILLER: While I appreciate the analogy, if I go buy a widget and Walmart goes and buys a
widget, there's no difference between pricing?

DR. CHERNEW: I'm not sure I--

DR. MARK MILLER: Who were the two actors in that?

MR. GEORGE MILLER: Me and Walmart.

DR. CHERNEW: Company X.

MR. GEORGE MILLER: Okay, excuse me. Company X.

DR. BAICKER: Yes, but suppose you --

MR. HACKBARTH: I'm not sure -- go ahead, Kate.

You're the economist.

DR. BAICKER: The analogy isn't I individually try to go buy something versus a giant purchaser tries to go buy something. The analogy is, you know, the giant purchaser can negotiate among different providers, but I have to go to all providers and say, okay, I'll take anybody -- I have no -- whatever kind of widget you want, whatever size you think is appropriate. It's not an analogy of individual purchasing power in the same operating space as giant purchasing power. It's, you know, medium purchasing power with the ability to pick and choose versus even bigger purchasing power with one hand tied behind its back. That wasn't a very helpful analogy either. I take [off microphone].
DR. CHERNEW: George, I guess I would just say it is certainly possible that with more pricing power in the government they could, should they choose, given all the politics and everything, they could, I believe, probably get lower prices. There's a whole range of issues related to that, some of which relate to innovation and a bunch of things that, you know, we don't want to go through; some of it relates to the politics of how we're going to get there.

My only point is I would love to have that discussion with you. I just think if that discussion replaces the discussion about how to redesign the reinsurance program or what to do about some of the other issues, we'll miss out on solving what those other problems are, because I don't think at the end of the day we're going to be able to solve the merits of free market economies working versus political economy.

MR. GEORGE MILLER: Great. Then why was it put in statute that the Secretary couldn't do it? That's just my question.

DR. CHERNEW: Yes, exactly --

MR. GEORGE MILLER: Political, okay.

MR. HACKBARTH: To favor a competitive approach
over a government-administered price approach.

DR. CHERNEW: This debate was had. For better or worse, it was had. And it come out a particular way, for better or worse.

MR. ARMSTRONG: Can I make just one more brief point on this? I don't want to debate the statute and all that, but to Kate's point, I do think it's constructive for us to really try to compare how does MA work versus fee-for-service versus Part D. And the way you were making that comparison, I would argue with you, and add that, in fact, the fact that there is a Medicare fee schedule does give MA plans real leverage. I mean, it really does, I think, makes -- I think makes that different than MA -- or Part D plans.

Anyway, I would just really want to make sure we explore those things, not because I want to change the statute necessarily. I just think we need to understand that.

DR. SAMITT: So I'm not going to join in and become embroiled in the discussion of price, because I want to go back to the discussions we had yesterday about the fact that some of the key drivers of excessive cost really have little to do with price and have more to do with
efficient utilization. And, frankly, I think that's where
the opportunity lies in the drug space as well.

So I would jump on to the notion of evaluating the
risk structure of Part D. In fact, I'd go further to say
it's not just the risk structure. I think we need to
evaluate the overall incentive structure of Part D. I
really like a lot of the ideas about re-evaluating
reinsurance because it's an escape valve right now to really
not effectively manage efficiently prescribing. Transfer
pricing was another really good idea. The thing we really
haven't talked about is what's being done to align
incentives with the providers, and I don't recall, for
example, whether of the 33 ACO quality measures, generic
prescribing is a measure that really looks at provider
effectiveness in prescribing and encouraging efficient
prescribing, whether it's generic or other potential
alternatives.

I think we didn't talk a lot about the concerns
specifically in the LIS population, and that the inability
to affect the cost sharing is really neutralizing the effect
of the tiers as well as neutralizing the effect of the
preferred versus non-preferred, if I really understand it.
And what do we do about that? I know it's wired into law, but are there other things that can be done? For example, can we require forced generic substitution when that opportunity exists? Or is there something different about the LIS population that the pricing differential for non-preferred pharmacies does not apply for the LIS population? Or other more creative thinking about how to de-neutralize the incentives at the user level.

So I like this. The chapter was exceptional and very clear, but I think there's a lot of future work to do that we can make more progress here.

MR. HACKBARTH: In Medicare Advantage, MAPDs, we have a single entity that has responsibility for Part A and B and D costs. In the freestanding Part D plans, we've got two different insurance pockets. The Part D plan has responsibility only for drug costs, and then Medicare is bearing the risk on Parts A and B. It seems to me that they create very different incentives. So if you're running a Part D-only plan, your objective is to hold down Part D costs. If you're running an MAPD, your objective is to hold down total cost. And it could lead, at least in the abstract, it could lead to differences in prescribing
behavior and how you think about managing drug costs.

Can we look at the differences in patterns between MAPDs and freestanding Part D plans? Have we done that?
And do we see differences? I think I've asked this question before, and the answer was there really isn't that much
difference. But --

MS. SUZUKI: Typically we're seeing lower spending
on average among MAPD enrollees compared to PDP enrollees,
but some of that is driven by the fact that most of the LIS
enrollees are in PDPs, and they're the higher -- they tend
to have higher costs. So it's hard to disaggregate how much
of it is maybe health status-related difference versus maybe
there's something about MAPDs that manage the drug spending
better.

MR. HACKBARTH: Yeah, actually I would have
thought maybe it would go the other way, that the MAPDs
would spend more on drugs and make sure people -- all the
people who need their meds get them and really follow up
because they have an interest in controlling total costs;
and the freestanding plans would say, "I'm really only
interested in the drug cost, and if people don't use their
prescriptions, hey, that's not too bad."
MS. SUZUKI: And part of it is that generic use is very different between MAPD and PDP, so when you talk about spending, some of the difference is also driven by the fact that generic use is higher among MAPD enrollees.

DR. SAMITT: I mean, I would encourage a similar analysis. I think your exact hypothesis plays out at Health Care Partners when we look at specific disease states and we influence before to after when we manage populations. In certain instances, drug costs are the only cost category that rises, and perhaps primary care services. But, in all the other areas, costs fall, and so you would imagine that that would be the right trade-off and why looking at aligning the incentives between A and B and D makes significant sense.

DR. HOADLEY: And to that ACO point you raise, I mean, the request for information that's out on the table now does ask, is there a way to bring the Part D plan, the stand-alone PDPs, into some kind of relationship with an ACO. I mean, it's complicated and that's why they're asking for ideas about it.

MR. KUHN: There's been a lot of good issues raised, and the ones I wanted to focus on were in the
proposed 2016 rule that just came out here a week or so ago.

And one, a question, and a second, an observation.

The question, in the area of negotiated rates. I understand as I read summaries and information I have found that they are going to revise the definition of negotiated rates, and so I'm just curious, is that revision significant enough that it's going to be hard to do future analysis in terms of savings as we go forward? You know, is it going to be where we are going to continue to be able to have an apples-to-apples comparison, or is it going to be apples-to-oranges comparison?

MS. SUZUKI: So, just to be sure, you're talking about when plans use non-preferred pharmacies, that whatever rebates they're getting, or --

MR. KUHN: Correct.

MS. SUZUKI: -- from the preferred pharmacies, that's reflected in the claims rather than on the back end, maybe through lower premiums or something.

MR. KUHN: Yes. That was the revision I was curious about, and is that going to impact any kind of future analysis? Is that a --

MS. SUZUKI: So that piece, we didn't talk about
in detail. We knew that CMS had found that maybe about a third of the plans that they looked at that had tiered network pharmacies had higher per prescription costs at preferred pharmacies, even though they are offering lower cost sharing in those pharmacies. But we were actually focused on low-income subsidy --

MR. KUHN: Okay.

MS. SUZUKI: -- portion of the cost.

MR. KUHN: Okay. Thank you.

And the second issue is on the category of preferred pharmacies. And, like Jack, I'm interested in the "any willing pharmacy" provision that's there. And then, also, in kind of the redefinition there, in the reduction of copayments and coinsurance for the preferred pharmacies, and was wondering as we go forward how that might be impactful, particularly in rural areas. Would that mean we would have fewer or the same or more preferred pharmacies in rural areas, and I was just worried about an access issue and the concern that the folks in rural areas always have is that you don't want to create medical deserts in certain parts of the country or certain communities and just wanted to make sure that we follow that one along to avoid those kind of
issues.

DR. REDBERG: Thanks. I think a lot of my fellow Commissioners have made really important comments, which I concur, so I was going to concentrate on the clinical part of it and really build a little bit on what Mary said. You know, clearly, a lot of drugs are very helpful and are treating chronic conditions that to our beneficiaries' benefit. But I have to say, also, that every week, I see a lot of Medicare beneficiaries in my practice that are on way too many drugs. That's why, when we can see the averages have certainly gone up and gone up higher for LIS versus non-LIS, but routinely, you know, once people -- anyone is on more than three to five drugs, you start to get a lot of interaction.

And I have started routinely, and actually, patients often ask me, "Can't I get off some drugs?" And you look at the list of even healthy Medicare beneficiaries and they're often on anti-depressants, PPIs, statins, biphosphonates, chronic pain meds, and that's another thing we haven't really talked about, but there is a lot of over-prescription or overuse of narcotic pain medication for chronic long-term low back pain, other things. People get
started and then somehow it just doesn't get stopped and that's a very large problem because of the risks of those medications.

But, as I said, certainly, some of these medicines are beneficial, but some of them, people feel much better when they come back the next visit and say, "I feel so much better now that you stopped some of my medications," which, for example, proton pump inhibitors are often prescribed acutely for gastric distress but are really supposed to be used for two weeks for most people and then stopped, but they're not stopped. And there are risks to all of these.

So, I guess I think if we can include in the tiering kind of the value to our patients. You know, right now, we look at tiering for other reasons. But is this a medicine that we know the benefits outweigh the risks for the patient, and create incentives for both patients and physicians to look at this more. I mean, there are guidelines, and I will say one drug you might be shocked to know I frequently stop because it's not -- I don't feel the benefits outweigh the risks are statins. And the recent cholesterol guidelines did suggest that statins should be stopped for primary prevention for most people over 75 years
old except for some very specific groups, people with known coronary disease and diabetes.

And so I think trying to incorporate the value into the tiering and other incentives would be a great benefit, because right now, we're spending a lot of money on drugs that some, of course, are helping our beneficiaries, but a lot of them are making them worse.

MR. HACKBARTH: [Off microphone.] Aren't there quality measures that get at this problem?

DR. SOKOLOVSKY: So, quality measures don't really get to this issue. They're more on the sense of there's a list, a controversial list of drugs that shouldn't be prescribed to the elderly, and it's a quality measure if they're being prescribed, although, generally, the literature says that people are going to hospitals and having adverse effects because they're taking too many drugs, not because they're taking the drugs that are on this particular list.

MR. HACKBARTH: Yeah.

DR. SOKOLOVSKY: But the Medication Therapy Management Program is supposed to deal with these kinds of issues. We -- it hasn't worked very well so far the way
it's set up, but there is a preliminary evaluation that did
come out which, to the extent that people actually had this
management, overall, they seemed to add drugs to people.
They switched some people to cheaper drugs, but there was
much less taking people off drugs. But, again, this was
very preliminary numbers and there were lots of questions
about --

MR. HACKBARTH: So, my recollection is that plans
are required to have a Medication Therapy Management Program
--

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: -- but that's pretty much it. You
have to have a program in place, is that --

DR. SOKOLOVSKY: Well, every year, CMS increases
the things that they -- in order to try to get it moving
more, it increases the responsibility of what plans are
supposed to do, and this year, in the 2015 rule, they're
limiting the number of drugs somebody has to be eligible and
they're doing some other things to try to get more people
involved. But, again, this preliminary analysis showed that
the majority of people that plans contacted, and there's no
clear way of knowing exactly how they contact them, but the
majority opt out.

MR. HACKBARTH: So, there aren't any established metrics of this is what a good Medication Therapy Management Program looks like. Here are the results that they produce.

DR. SOKOLOVSKY: Well, now, you have to actually provide a listing of -- a comprehensive listing of what drugs the person is taking. So, again, they keep adding requirements, but it's still not the way you might want.

MR. HACKBARTH: Yeah.

DR. CHERNEW: My sense, sort of in the spirit of that, or more broadly, what makes this area so hard is there is -- this is an area where there is a lot of under-use, where people are not taking drugs that we want them to take for a variety of reasons. They're not managing their chronic disease particularly well. In certain cases, and I'll defer to Rita, there's places where medical therapy could substitute for other invasive therapy. So, I don't know about medical therapy versus stenting or whatever it is, but there's areas where there's a very good --

It's also an area where there's a lot of overuse.

So, we think people are taking too many drugs and we think they're buying the drugs that they're buying inefficiently.
They're using the brand, not the generic. They're spending more than they need to use. It's always difficult to manage an area where you have both under-use and overuse, because you try and put something to reduce use and you exacerbate one problem, you know, or do -- it's just very hard, and it's particularly hard because so many of these things are important for quality of life in a variety of ways that are hard to get at and measure.

And so I do think there's a long history of trying to do a good job through medication management, for example, and we have struggled with what the right polices are, despite recognizing a lot of problems. We are doing a study now looking at the use of Beers List drugs, which are drugs you shouldn't be using, in nursing homes, where you would think people would be managed well, or in other places, and we find patterns that you would both not expect to see and it's not clear we have the tools to get at it at that micro level.

So, I guess my first point would be, there's a certain set of things we can control that are -- because the system is set up a little bit removed -- that I think are important. So, I would focus where it seems like we're
doing, on aspects of the basic program design -- how we deal with reinsurance, how we deal with the coverage gap issues, how we deal with the basic things that might make the design better and get some of the incentives right. In some of these places, we're going to have a discussion that's going to be incredibly important later about disparities and low-income things, and the concern is, of course, when you try to get the incentives right and charge people more, you create other types of problems. So there's a lot of trade-offs.

I do believe there are other tools that we might focus on, performance benchmarks for plans in certain areas. So, the solution might not be to make people pay more in the reinsurance, but to make -- you know, have a benchmark for how you have to behave if you're a plan in that area, and I'm not advocating that, but I would consider that.

And I do think quality measures, to the extent that we can figure out good quality measures for overuse or bad things -- I'm not the guy to do that, there are others that might -- I do think those types of things are very important.

The other areas which we haven't talked about as
much but I do think is important is, again, in the paradigm of Part D, it was set up with this structure of the belief that we're going to let plans compete and we'll let industry sort out all of these problems, basically so we don't have to. Different people have different views about the merits that private industry can solve those things relative to the government, and right now, it's not so important. But I do think there's increasing evidence that the markets don't work as well as economists would like, and as an economist, I feel bad taking a pot shot at economists, but nevertheless --

MR. HACKBARTH: Go ahead.

[Laughter.]

DR. CHERNEW: -- that remains, I think, true, the evidence of choice. And I do think there's a growing literature in economics about ways you might improve choice. So, I think thinking about auto assignment to people or putting them in plans or sending -- you know, there's actually a lot of tools now that researchers, at least, have used to identify people that could save significant amounts of money if they were in a different plan, a mechanism if said to somebody, you could save $300 if you switch to this
plan versus that plan, basically, ways to proactively help
search as opposed to what the standard economic paradigm is,
which is send them to a website and they'll pick what's
right for them. I think that latter view doesn't work as
well, in general, and certainly for this population.

   So, I do think it's worth some attention to figure
out how we can make that type of choice better to encourage
switching, and I think that it will be frustrating because
we don't in this plan, in the Part D program, have the
ability to go in and micromanage the same way that -- and I
think we find it hard in other areas, too, but we certainly
don't have that ability here. A lot of these important
decisions are, by the structure of the program, deferred to
the Part D plans or the MA-PD plans.

   DR. COOMBS: So, I was thinking of all the
comments around the room and this has been a real learning
session for me. Thank you, Jack, especially, because I can
understand now why I get aggravated by the Physician Health
Organization that sends me a note, why are you using this
drug as opposed to this drug?

   So, I would think that there are a couple of
things that, clinically, that I can think about, of having
the right people on the bus. If you have the prescription plan and you have the providers and you have the patients and you have all these things that are hooked together and we have the payer, one of the key components of that is this whole notion of what happens between the different pieces of the puzzle. And recently, there's a lot of literature out on protocolized care, and when it comes from within the organization, some component says, here's a benchmark, this is an algorithm, we would want the providers to be adherent to these guidelines, and there can be exceptions to the rule, my concern is how well have we looked at the prescription plans, Part D plans, in terms of looking at whether or not they have protocols for the main cost drivers, the mental health, the hypertension, the cardiovascular, because once you have this invoke now monitoring response, that in and of itself actually changes behavior.

And I know it changes my behavior, first of all, and most of the physicians in terms of someone saying, well, you're using this drug. You realize that the data just came out. This is no good anymore. I mean, I just -- I was just at the critical care meeting and they said, hypothermia is
changing in terms of 36 degrees versus 34 degrees. There was a conversion of the whole room, because that was information that was put out there. And how much better does it work to have what we see as an Accountable Care Organization within the Part D plan, so it's almost like transforming it into a mini-house or mini-medical home within the Part D plan.

I think that that kind of creativity lends itself to real adaptive challenges that move the meter in terms of changing DNA for the people on the bus. And so that's one of the things.

I think about one of the things that Rita said, which is really important, is this whole notion of people winding up on drugs. I can honestly say that people who come to the hospital who have some mental, maybe it's agitation, confusion, they get placed on certain drugs and they will stay on those drugs as a part of med reconciliation. When you get ready to discharge a patient, you say, well, this is what has stabilized this patient right here. They won't have an appointment with their doctor for maybe for two to three months, and they won't even understand -- the doctor in the office setting won't
understand why they were placed on those drugs and they will go into a chronic corridor of having this medication on for months until someone deciphers that this is not a medicine that they need to wear for the rest of their lives.

So, I think that's really important, is how patients actually wind up on the medications. Was it related to a hospitalization or not? Was it part of a medical reconciliation? And I think these are the important things.

MR. HACKBARTH: Alice has opened up another dimension of this that we haven't really focused on, and that is the relationship between the individual physician and the plan, the drug plan, in this case. To what extent have Part D plans -- let's set aside the MA-PDs because they're a special case here -- to what extent have the freestanding PDs tried to influence physician prescribing patterns? How do they do that? What tools do they use? And does it work? And what does it feel like from the physician's perspective inasmuch as their patients may have five or six or ten different plans that they're working with?

DR. SOKOLOVSKY: I can only report from what the
physicians tell us in focus groups, and for them, it's a pretty adversarial relationship, that they don't feel that the plan is really -- knows the clinical condition of their patient.

But, on the other hand, the switch to generic drugs, which happened particularly for the non-LIS population so quickly, happened a lot because the physician said, well, if I prescribe a generic drug, they're not going to hassle me. And so it really led to this very big switch.

On the other hand, the physicians will tell us that some plans are easy to deal with and they can talk to them and work out how to deal with it and other plans really don't want to deal -- and I think we talked about this a little in the grievance and appeals place. They will say it has to be the physician on the phone. It's the same number as for customer complaints, and the physician would have to be on the phone for 45 minutes on hold.

So, it's not -- they get papers from the plans a lot, they tell us, but they don't -- they see it as an adversarial relationship.

MR. HACKBARTH: Not much effective engagement between physicians and drug plans.
DR. SOKOLOVSKY: On the other hand, there was --

in the Innovation Center, they did a project with an ACO

doing its own medication therapy management and they

reported very good results, so --

MR. HACKBARTH: Rita.

DR. REDBERG: I would certainly agree with what

Joan said about the relationship, and probably if it does

come from within or you feel like you had some part of the

helpful suggestions, you're more receptive to them. But

just getting letters or being told that your choice wasn't

good for your patient is not generally well received.

But what I do think has been helpful, you know, we

have electronic health record, as most hospitals and

practices do, is that now the patient's plan is inputted

into the electronic health record, so if I am choosing a

drug, it tells me what's preferred, what's non-preferred,

and so that has been, I think, more helpful. So, it's easy

for me to choose the drug that is preferred by that

patient's particular drug plan, because you're right.

Patients have so many drug plans, there's no way -- and they

all have different formularies and cover something different

and no way you can track it. But the electronic health
record has been helpful with that.

DR. HOADLEY: Yeah. I was just going to add, I mean, I think where it's a drug class and it's a particular drug to choose within the class, that's the part that's gotten a lot easier in the new world. But, otherwise, the tools are the prior authorizations and the step therapies and the off-formulary. And so if you're trying to really address, does a person need to be on this drug, maybe you put a prior authorization flag in, but that goes into that adversarial, we're going to say "no" until you push back and it's going to be a huge hassle to get the one that needs the "yes," and maybe you get the "no" only because you just accept that it's too much hassle and if you do it it's in that adversarial framework, rather than some kind of educational outreach.

DR. CHERNEW: A lot of what goes on, and I think this is true in the Part D plans, but it's certainly true otherwise, is it's not just the plan. They often contract out the specialists. So, this is an area where there's, like, a pharmacy benefit management firm, which isn't necessarily the plan. So there are, in general, specialist people that think through and try -- there's just an
enormous amount of work in this area and there are still all
of the problems that we have. It just turns out for all the
reasons said to be very hard to get right, because there's a
lot of art in getting the right mix of medications for
somebody, which I think makes it very hard to know from any
distance what the right thing to do is, even though there
are some guidelines.

DR. COOMBS: I think it might be interesting to
look at successful or best products out there with the plans
in terms of what kind of formulation do they have in terms
of engagement with providers, to go the other way.

DR. HALL: Well, I don't want to add too much to
the clinician mafia here, but we do seem to sing in the same
choir all the time.

[Laughter.]

DR. HALL: I think there's an opportunity right
now to make some real progress in this quality area in
addition to all of the good things they did in this report.
It's an area of the literature that I follow, and this year,
there's been an unprecedented interest in articles talking
about adverse drug episodes, more than I've seen in a very,
very long period of time. So, I asked myself, why is that,
and it's probably the unintended consequence of a plan that works really well to give access to Medicare patients to legitimate pharmaceutical agents, and the flip side of that always is that there's no free lunch, and so there are going to be some side effects.

But, linking this to other things we've talked about, when people are looking now at attribution of why patients are being readmitted to hospitals within 30 days, what they're finding is that they are, more often than not, not admitted for the same diagnosis that was the initial diagnosis. We've talked about that a bit. And when one looks at these readmissions, a substantial portion of them, maybe even 20 percent of them, are related to some kind of drug misadventure, not because of incompetence or because people didn't do the right thing, nor of access, but really because there were complications of the drug. And we've all known this for a while, and it is complicated.

Mike, you mentioned, let's do -- every good idea should be looked at in its time. I think this is the time because I think this is going to become a really big issue in looking at attribution of readmissions. So, here we have an industry that's providing a service and we say, listen,
we're going to give you a 30-day guarantee on our service.
We're that confident. But, by the way, one out of every
five people we harm. You probably wouldn't buy that product
for very long and it wouldn't work in the military -- well,
I mean, it would work in the military. But in other areas,
it just isn't going to work.

So, I think this dovetails with a couple of other
issues that we're talking about that I think somebody -- CMS
-- should say, what is -- see, nobody is responsible for
this. We've all talked about, well, somebody could do
something. Somebody could do something. But it's not
happening. And so I'm kind of wondering whether we should
emphasize this a little bit as we continue to look at
improvement of Part D management, that this is a big problem
and somebody has got to be responsible for this.

DR. MARK MILLER:  [Off microphone.] Just to make
sure I understood where you were going with that, are you
saying that there should be some contract or guarantee
between a manufacturer and the --

DR. HALL:  [Off microphone.] -- analogies that
limp pretty badly, but the point is --

DR. MARK MILLER:  I didn't --
DR. HALL: The point is that we are -- the product we're delivering in aggregate, not pointing the fingers at any one group, fails one out of every five times. The therapeutic regimen after hospitalization leads to some sort of bad problem that it results in a rehospitalization. Everybody is interested in this right now, so this is a pretty good time to start talking about why is this the case and how do we straighten that out.

MR. HACKBARTH: Kate.

DR. BAICKER: A couple of comments that the clinicians have made, I think, highlight something Glenn said and something that you've been working on, which is the important connection between Parts A and B and Part D, and along with our theme of breaking down silos, there's the opportunity for better use of medicines to reduce hospitalizations. There's the possibility of inappropriate overuse or under-use of medications to increase hospitalizations. And we're concerned with the whole patient and the whole program, so this is a great opportunity to think about the cross-silo effects of the whole course of treatment.

DR. HOADLEY: And one area where we need Medicare
Advance claims data to do the comparison.

[Laughter.]

MR. HACKBARTH: Okay. So, we're at 10:20, have ten minutes remaining for this session. I actually accomplished -- you accomplished already much of what I wanted to do in round three, which was to have more of a free-flowing interchange among Commissioners as opposed to just going person by person.

DR. HALL: [Off microphone.]


[Laughter.]

DR. SAMITT: We weren't supposed to say anything.

DR. CHERNEW: I was, like, the substitute teacher.

MR. HACKBARTH: Right.

[Laughter.]

MR. HACKBARTH: So, what we do want to accomplish, though, is have a relatively clear agenda for staff on work going forward from here. Mark, do you have any concluding comments or need for clarification on some issues to build that agenda? And I would add Shinobu and Joan into that, as well.
DR. MARK MILLER: I think Joan and I should throw Shinobu under the bus in short order.

[Laughter.]

DR. MARK MILLER: Shinobu? So, this is what I took from it, and I'm not just saying this. I thought that was a really healthy and pretty complex and interesting exchange, so good job, guys. That's it.

[Laughter.]

MR. HACKBARTH: Well done.

DR. MARK MILLER: Thank you.

[Laughter.]

DR. MARK MILLER: All right. Shinobu?

[Laughter.]

DR. MARK MILLER: So, this is what I took out of it, if it were me and I was thinking about priorities, and I will cut through this fairly fast. I think we all -- I think we all agree that probably the first thing that is in our work, you know, more natural for our work, is to step back and think about the risk structure of the plans, okay, and I think that runs in a lot of directions, how the gap is being filled in and what's going on there, what's going on with the corridors, the catastrophic cap design, that type
of thing. And I think that's almost first and foremost
because it's the most natural thing that the Commission
would be about.

I think that and another point I'm just going to
make in a second links back to some of this discussion we've
been having where we've been saying, we've got to be
thinking about fee-for-service, ACOs, Part C, and how they
all relate to one another, and I think as we think through
that, the risk structures here, I think we should also be
looking back over our shoulders at these other items. So
that's one thought, and probably if somebody said, quick,
what's your highest priority, which I think he just did,
that's what I would say.

A second thing that I think -- and then this is
pretty high on there -- is that we have this tiered -- at
least the tiered network and the protected classes issue
being pushed forward because of the regulatory process, and
so I think we've got to pay some attention to that, and we
will do that.

Now, let me just say two other quick things, and
I'll stop. I think there's a set of beneficiary issues that
got teased out here, one of which is the choice issue and
money being left on the table or optimal choice, that type
of thing, and we can do some thinking about that. And here
again, I think we have to think about how beneficiaries
choose things, even if we're going to step back to this
question of fee-for-service, ACO, managed care, you know,
that type of thing.

Now, the more complex ones that I feel very --
that we've made runs at and ended up being fairly
disadvantaged on are things like we -- and I've got to tell
you, Shinobu and Joan have been on this issue for a while,
you know. The overuse and concern about over-medication is
something they have raised and we've discussed many times.
Exactly how to get to it, I've always felt encumbered, and
the MTM program, I think, is a word, but I just don't think
it's functioning well. But, I would say that we'll take
another run at it, see if we can't tease some things out
that captures a lot of comments around the table.

Then, you guys -- this is coming up to my last
comment -- raised the whole issue of the very structure of
Part D and government versus market price. Thanks a lot for
bringing that up. But, you know, the way, in all
seriousness -- in all seriousness -- the way that I thought
that conversation finished in a real constructive way, and the final transaction there -- and I just wanted to say, I wrote it down before you guys said it -- I think it raises a broader question of stepping back and saying, well, if we have some parts of Medicare that are market-driven and some parts of Medicare that are government-driven, then should we step back and start thinking about the benefits and the flaws in both of those, and at a minimum at least start thinking about better alignment across them and perhaps asking the question much more broadly than just litigating the piece of legislation that arrived at that particular decision when it created Part D. I think it does implicate broader and more interesting -- or broader questions, and you don't have to go right at that piece of legislation.

That was kind of my take-away.

MR. HACKBARTH: And on that last issue of the government's role versus the private sector's role, I do think that, at a minimum, we can try to say, if you want to use a competitive model, then to make it work, you need to pay closer attention to A, B, and C issues. If you don't want to use a competitive model, then you've got another set of issues that you have to deal with. But what strikes me
about Part D as it's currently structured is that, in some ways, it's at war with itself. It isn't as completely pursuing that competitive model as it might.

So, good discussion. Thank you, Shinobu and Joan.

And now, we will move to our last item of financial assistance for low-income beneficiaries.

[Pause.]

MR. HACKBARTH: Christine?

MS. AGUIAR: Today we will discuss assistance with Medicare out-of-pocket costs for low-income beneficiaries.

Before we begin, we would like to thank Carlos Zarabozo and Joan Sokolovsky for their help on this project

I'll begin with an overview of the issue. As you recall, the Commission recommended a series of redesigns to the Medicare fee-for-service benefit package in 2012. The redesigned benefit package includes better protection against high out-of-pocket spending, deductibles for Part A and B, and co-payments instead of co-insurance. The Commission's recommendation on the fee-for-service benefit design tried to protect beneficiaries against high out-of-pocket spending while at the same time create financial incentives for them to make better decisions about their use
of discretionary care.

However, even with the improved fee-for-service benefit package, low-income beneficiaries may have difficulty paying their out-of-pocket costs. During today's presentation we will explain how a recommendation the Commission made in 2008 to raise the income eligibility criteria for the Medicare savings programs, or MSPs, would help low-income beneficiaries afford their out-of-pocket costs under the redesigned fee-for-service benefit.

Please note that this presentation is largely informational, and it is intended to highlight the connection between the 2008 and 2012 Commission recommendations. Over the next few slides, I will go over background information on the MSPs and the 2008 recommendation.

This slide shows the Medicare Part A and B assistance under the MSPs and the Part D assistance under the low-income drug subsidy, or LIS. As you can see, beneficiaries receive varying levels of assistance based on their income. Beneficiaries must also meet asset limits in order to be eligible for the MSPs and LIS. The asset limits for both programs are 300 percent of SSI.
Beneficiaries in the middle two income categories on the table -- the 100 to 120 percent of poverty and the 120 to 135 percent of poverty -- are eligible only for Part B premium assistance. These two income categories correspond to the SLMBs and the QIs. Beneficiaries with incomes up to 100 percent of poverty are eligible for assistance with their Part A and B deductibles, co-insurance, and co-payments, in addition to premium assistance. Of the three MSP categories, only the QI program is fully financed by the federal government. The QMB and SLMB programs are jointly financed by the federal government and the states.

Note that in the final column on the slide, there is a gap between MSP and LIS assistance for beneficiaries with incomes between 135 and 150 percent of poverty. These beneficiaries are eligible for reduced Part D co-payments under LIS, but are not eligible for Part A and B financial assistance. This is because the income eligibility for the MSPs ends at 135 percent of poverty.

In 2008, the Commission recommended that the Congress align the MSP and LIS income eligibility criteria. If this recommendation were implemented, the gap we saw on
the previous slide between MSPs and LIS for the 135 to 150
income category would be closed, and beneficiaries with
incomes up to 150 percent of poverty would receive Part B
premium assistance.

Note that the Commission also recommended in 2008
that Congress align the MSP and LIS asset limits. Congress
adopted that portion of the recommendation in 2008.

The 2008 recommendation was based on an analysis
of out-of-pocket spending. The main findings are listed on
this slide. The Commission found that, compared to non-
Medicare beneficiaries under age 65, Medicare beneficiaries
age 65 and older were more likely to be poor or near poor
and they spent a larger percentage of their income on out-
of-pocket health costs. To some extent, this finding is
expected. A third was that beneficiaries eligible for but
not enrolled in the MSPs were more likely than MSP enrollees
to report avoiding needed health care because of cost.

Since the recommendation in 2008, these findings
remain generally true. For example, relative to non-
Medicare individuals under age 65, Medicare beneficiaries
are still more likely to be poor or near poor.

The illustrative example for the 2008
recommendation assumed that the MSPs would be aligned with LIS by raising income eligibility criteria for the QI program. This slide highlights some of the implications of that. For one, unlike the other MSP categories, the QI program is fully financed by the federal government. Therefore, increasing the income eligibility for this program would not increase state spending. However, it would increase federal spending. One way to possibly reduce the cost would be to provide a partial, rather than a full, Part B premium subsidy, or to set the Part B premium subsidy on a sliding scale.

Cost-sharing incentives at the point of service would be maintained because the beneficiaries would not receive assistance with their deductibles, co-insurance, or co-payments. Moreover, the Part B premium subsidy would free up income that could cover beneficiaries' other cost-sharing expenses. Finally, financial assistance for low-income beneficiaries would be directly targeted to those individuals.

I'm going to pause now for a moment to continue with the last point from the previous slide about directly targeting financial assistance.
The Commission stated in its 2008 report that the MSPs are a direct and efficient way to target low-income supports. But less targeted approaches have arisen in policy discussions. For one, some believe that higher payments to Medicare Advantage plans are a way of providing assistance for the low income. However, the Commission has argued that MA payments are not a direct or efficient way to target assistance because all enrollees in a given plan receive the same extra benefits whether or not they are low income.

In addition, during the Commission's discussions on the effects of supplemental coverage, some argued that Medigap plans are important for protecting low-income beneficiaries from catastrophic financial liability. Although Medigap plans fill in some or all of Medicare's cost sharing, their premiums are much higher than their expected benefits. Moreover, cost-sharing incentives at the point of care may not be maintained under supplemental coverage. For these reasons, Medigap plans are neither a targeted nor efficient way to provide assistance to low-income beneficiaries.

Moving on now, this slide shows the relationship
between the Commission's 2008 and 2012 recommendations. The 2008 recommendation would effectively provide a Part B premium subsidy to beneficiaries with incomes up to 150 percent of poverty. For 2014, the Part B premium subsidy would amount to about $1,300 a year. This additional premium subsidy is a direct and targeted form of assistance to low-income beneficiaries. This additional assistance would free up discretionary income to help beneficiaries pay the remainder of their out-of-pocket costs under the Commission's redesigned fee-for-service benefit. For example, the average cost-sharing liabilities for beneficiaries enrolled in the QI program were about $1,900 in 2011.

To summarize, the MSPs are a direct and targeted way to provide financial assistance for low-income Medicare beneficiaries.

Moving forward, the Commission should keep in mind this issue of financial assistance for low-income beneficiaries as you continue work on synchronizing fee-for-service, ACO, and MA payment policies. For example, should financial assistance be in the form of premium assistance? If so, should the premium assistance be a full or partial
subsidy? Or should additional cost-sharing assistance with deductible, co-insurance, or co-payments be provided? Note that cost-sharing assistance raises the issue of whether states would continue to pay the cost sharing on behalf of Medicare beneficiaries or whether the federal government would fully subsidize the cost sharing. Again, these are not issues for you to resolve today, but for you to keep in mind as the Commission's work moves forward.

This concludes the presentation, and we look forward to your questions.

MR. HACKBARTH: Round 1 clarifying questions.

MS. UCCELLO: So on Slide 5, the third bullet says that folks in the MSPs were less likely to avoid care than those not enrolled. And I was wondering whether and how that may have differed across the different types, whether it was more with the QMBs that also offer the out-of-pocket cost-sharing assistance, or was it also true when just premium assistance is provided.

MS. AGUIAR: We could go back to the original study to see if they actually looked at it that way. The way that the study was reported in the 2008 chapter and how we summarized it here did not have that level of detail, but
we'll go back to the original report to see if it does.

DR. HOADLEY: On Slide 3, on the LIS section, I think your X's refer to where there's a full premium subsidy, so I think it's important to clarify that in the next to the last row there under the 135-150 it is a partial premium subsidy, and that, of course, relates to some of what you say thereafter.

MS. AGUIAR: You're right, yes. So those -- exactly right. The details of exactly what -- under the LIS program what each income group is eligible for is highlighted specifically in the paper. But you're exactly right for the slide that that is what that means.

DR. COOMBS: So on page 7 you actually give a good estimate of the third category, the QI. But for the fourth category, what's the number that that involves, the number of beneficiaries for the last row?

MS. AGUIAR: I'm sorry, for the QI --

DR. COOMBS: No, not for the QI. For the 135-150 percent of the federal poverty level. I'm sorry, column.

DR. CHERNEW: Last row [off microphone].

DR. COOMBS: I mean the last column. I'm sorry.

DR. LEE: So using 2011 numbers of all Medicare
beneficiaries, it's about 4 percent are not duals but Part D LIS. So it's the 135-150.

DR. COOMBS: Okay. Is there a cost projection for what that would be? I know it's hard, but based on 2011 data?

DR. LEE: The cost in terms of what part of the cost?

DR. COOMBS: The part of actually increasing it to the 135-150 --

DR. LEE: That is actually multiplying two numbers. The increase in the benefit is just Part B, the premiums, so that's Part B premiums for 2014 is about $105 a month, and 4 percent of Medicare beneficiaries is a little under two million.

DR. NERENZ: On this slide, is there any simple way in which we should think about information on this slide and the concept of dual eligibles? How do these go together?

MS. AGUIAR: Sure. Again, in the interest of time, we explain that a little bit more in the paper, but didn't want to have to go through that here. So if you look at it, so we'll start with the income bracket of up to 100
percent FPL. Those are the QMBs. Everyone in this program is eligible for the cost-sharing assistance that you see on that slide.

Now, there are some people within the QMB program that meet their state's eligibility for full Medicaid benefits, and that differs by state, as you know. So those QMBs that are eligible for full Medicaid benefits we call QMB-plus because they are full-benefit dual eligibles. The QMBs that are eligible only for the cost-sharing assistance you see here, we refer to those as QMB-only's, and they are the partial-benefit dual eligibles.

DR. NERENZ: Okay. So you may have already answered without having to walk through. So what we're displaying here are federal programs and --

MS. AGUIAR: Yes.

DR. NERENZ: -- the question of whether someone then goes into the category of dual eligible is really somewhat a separate issue based on state criteria for Medicaid eligibility. Is that a fair statement?

MS. AGUIAR: Well, not entirely, because everyone in the QMB, the SLMB, and the QI program here, whether they are eligible for full Medicaid benefits or not, are
considered dual eligibles. We just break them up into partial benefit because they only get the cost sharing or, you know, full benefit because they're eligible for more.

MR. HACKBARTH: Any other clarifying questions?

DR. CHRISTIANSON: Yeah, here and there in this chapter you actually present the numbers, here is what the deductible, here is what the Part B premium would be and so forth. It would be helpful to have a table that had those so we could put this in perspective. So what does it mean to cover the Part A premium? What's the size of the Part A premium? You've got Part B, $1,300, you've got some co-pays and stuff.

MS. AGUIAR: Sure. Yes, I agree with that, and that could be a change that we'd be happy to --

DR. CHRISTIANSON: [off microphone] -- how important it is to a beneficiary. What is the Part A premium?

MS. AGUIAR: Right. We do have that in the appendix.

DR. CHRISTIANSON: Okay. But what is the Part A premium?

DR. LEE: The Part A premium is -- for Part A
premium, there is -- if you have 40 quarters, if you have
ten years of a work history, that Part A premium is zero for
the beneficiary.

DR. CHRISTIANSON: That's what I thought, and
that's the kind of stuff that when you look at this, I don't
-- okay. So do we know how important that is, how many
people would --

DR. LEE: For the low-income, there are many
beneficiaries who do not satisfy that requirement. So in
that case, the state actually buys -- or has the option of
paying for part --

DR. CHRISTIANSON: Do we know how many [off
microphone]? 

MR. HACKBARTH: So how many people pay a Part --
are liable for a Part A premium?

DR. LEE: Actually I do not have that number.

MS. AGUIAR: We don't have that in front of us,
but we will go to see if we could calculate that. I believe
that we can.

DR. MARK MILLER: And it sounds like the other
piece of this question is -- and when that happens, there's
been a calculated Part A premium that somebody has to pay
when they fall in that bucket.

MS. AGUIAR: Yes.

DR. MARK MILLER: And it sounds like he's saying, "I want that number, too." He can speak for himself, but I think we need to --

[Laughter.]

DR. LEE: Yeah, that number is 426 a month.

DR. MARK MILLER: Well, there you go.

MR. HACKBARTH: Any others?

[No response.]

MR. HACKBARTH: Okay. Let's see. Dave, do you want to lead off Round 2?

DR. NERENZ: You caught me by surprise there.

MR. HACKBARTH: That was my goal [off microphone].

DR. NERENZ: I'm sorry?

MR. HACKBARTH: That was my goal.

DR. NERENZ: Okay. Well, it worked.

I have this very general question about administrative burden that perhaps you could speak to, because when we think about these various programs, they're driven by information that must come from somewhere about income, and then in a couple of these places assets are also
part of the issue. And presumably we're asked to think about how these might evolve in the future and where they need to be expanded or perhaps contracted or whatever. And it seems to me part of that discussion is how hard is it, either on the beneficiary or on the Medicare program, to actually administer these? What information bits are required? How often? How much hassle is it for everybody who has to work with it? Can you speak to that just a little bit?

MS. AGUIAR: I can speak to that a little bit. I do knot that Joan has done far more research on this, so after my comments, Joan, you are welcome to come up if you have anything to add.

We touched a little bit about this in the paper. With the MSP program, the income and eligibility criteria and the benefits are set by the federal government, but they are administered by the states. So in the 2008 report, really one of the impetuses of making the recommendations that they did was concern over the fact that a lot of beneficiaries that were eligible for the MSPs were not actually enrolling. And because of all of these, the administrative requirements but also confusion about whether
or not they were eligible and that sort of thing, and, you
know, some individual state processes that might have made
it difficult for them or discouraged them from actually
enrolling.

And so since -- I believe that one of the
recommendations in 208, the first one, was to increase
funding for the SHIPs, and since -- sort of for them to help
to reach out to these beneficiaries, to help point out that
they are eligible for these programs and to enroll them.

And we have seen -- actually enrollment since 2008 in the
MSPs has gone up a little bit, but, yes, you are completely
right to focus on that, that there are administrative
difficulties, and on the beneficiary perspective, just a lot
of confusion about whether or not they're eligible and, you
know, sort of where to do. You know, as I said, since state
processes vary across states, it is a very confusing -- my
understanding is that it is a confusing program to actually
really implement.

DR. NERENZ: I guess that leads to a question I
didn't anticipate in the first thing. Because these are
administered by the states, does that make them sort of
outside our purview? Or can we still speak to them because
of how closely this is all linked and it is essentially a
means of administering a Medicare benefit or a Medicare --

MS. AGUIAR: Right. So there's sort of two parts
to that that I'll answer. The 2008 recommendation, which
was, as you know, to increase the QI program, income
eligibility criteria, from 135 to 150, that is fully
financed by the federal government. So the federal
government appropriates that and gives out a block grant.

DR. NERENZ: Okay. Just a quick aside. My only
concern here is just this issue of the administrative
task, not where the cutoff is set. I mean, that, I realize it's an issue, but whether it's 135 or 150,
somebody still has to document the income or document a
change in income, and it's more that that I'm thinking
about.

MS. AGUIAR: Oh, I see, yeah. I don't believe --
and, Joan, if you want to come up here? I do not believe
that we anticipated any burden, extra burden on states by
that recommendation.

DR. MARK MILLER: I think the reason that she's
mentioning that, different of these columns are financed
differently. So QI is completely federal, but SLMB and QMB
actually have a state share.

MS. AGUIAR: Yes, that was the second part that I was going to get to that.

DR. MARK MILLER: So let me just get there. So I know you started to say, "But that's not what I care about."
Your question was: Can we speak to it? So even on the administrative front, if we say either the state needs to do something or the federal government needs to do something to make it simpler, we have to be cognizant of anything that we do imposing or relieving the state of, you know, federal -- or I'm sorry, the --

DR. NERENZ: Yeah, yeah.

DR. MARK MILLER: And that's why I think she originally started and said, well, understand that the state's involved in some of this and not in others. And that's why --

DR. NERENZ: Okay, okay.

MS. AGUIAR: So I'll just quickly finish the second point. So if the Commission were to think about, for example, expanding the QMB program from 100 percent FPL to 120, 135, 150, that really implicates not only state administrative costs or processes, but it implicates state
financing. It implicates whether or not that will continue to be jointly financed between states and the federal government, or the federal will assume the cost. And so it's much more complicated there. But I'll let Joan...

DR. SOKOLOVSKY: So in terms of the administrative issues, right now these programs are federal Medicare programs, and they're set -- the standards, like income and how you measure them, are set in law. But states have the flexibility to disregard some income -- in the law, $25 a month is disregarded, but states can do that higher. They can disregard all assets, and there are five states that don't do an asset test at all. QIs, you have to follow the federal guidelines, but for the others there's a lot of state flexibility.

One of our recommendations, one that was not fully taken by the Congress, was if people are applying for the low-income subsidy and they apply there to Social Security, let Social Security also screen them for eligibility for these programs and enroll them if they're eligible. Well, what Congress did was have Social Security screen them, but then give the names to the states. And the result is that some states, it's a fairly smooth process; but other states
who are not anxious, presumably for fiscal reasons, to enroll more people will then give you a full Medicaid application that you must fill out. And they can be very administrative complex for both state workers and the beneficiary. But the states that want to make it easier, you put it down as kind of presumptive, and then the IRS checks.

MR. HACKBARTH: Let me just make explicit something that I think is implicit in what we've discussed to this point, and that is, if we're going to make recommendations in this area, I think we ought to make recommendations about the federal government's responsibility and not make recommendations that would increase state financial responsibility.

Now, it is worth noting that this is an area where, again, Part D sort of took a different approach. You know, Part D basically federalized the responsibility for the low-income people as opposed to shared it with the states. A and B, it's still this mixed federal-state responsibility. But given that we are a federal advisory body, I think we really ought to focus our recommendations, if we have any to make, on what the federal government
MR. GRADISON: I'm struck that these break points -- a couple things about the break points. First of all, there are four of them. I have to imagine people move back and forth now and then, maybe rather often, between them. I was wondering about grouping, whether there might be some administrative merit and certainly some simplification in general about combining them.

A second related point is that this doesn't seem connected to the new option of going to 138 percent of poverty for Medicaid, and I kind of wonder whether we ought to be maybe thinking about two categories here. One would be, let's say, 100 to 138 and the other might be above 138, so that to tie it in and saying, for example, that in the states which go to 138 -- and it's still their option -- that then would have implications in terms of the federal subsidy for people in those categories.

I'm just raising the question. I'm not trying to suggest an answer. But these break points seem like they're -- I understand why they're there. But I think they're sort of from the past rather than in terms of the structure that we're gradually moving towards.
More generally, I know a lot of us and certainly I have been concerned with our lack of success in altering the fee-for-service package. I was involved, maybe some of you were, too -- it was years ago -- with the attempt to add a catastrophic benefit, something we certainly would like to -- I think we all would like to see added one way or the other. And I am intrigued by the question as to whether getting this right, modifying it, would in any way help to move the decisionmakers in the direction of the kind of fee-for-service package -- the packages that we've talked about. I don't know. That's sort of a judgment call.

More specifically, since I'm on that point -- and I won't take long to develop this, but as I think about the idea of an alternative package, my recollection is that the notion, whether you're talking about Medicare catastrophic, the ill-fated legislation, or our own proposal in more recent times, it was sort of an all-or-nothing thing, we're going to move this program from this to that. I've been wondering what would happen if we said we're going to have two fee-for-service options. You can stay with the one we have, with the deductibles and the various different deductibles for different kinds of expenditures and lack of
catastrophic, or you can move to an actuarially equivalent
package which -- take your choice. Something just to think
about maybe for the future.

MR. HACKBARTH: Bill, on your first point, at the
hearings that I testified at on the benefit redesign
recommendation we made, a common question was, well, what
about low-income people, and is there some way that we can
better address their needs? And so that's one reason that
we're going back to this issue.

DR. CHRISTIANSON: I don't have much to say about
this other than to thank you for bringing me up to date. I
was unaware of what the Commission's previous positions on
this were and how they came to them, and I think it is an
important issue.

It would be helpful to me to actually translate
some of this into dollars. Even in the appendix there's no
-- I don't have in my mind immediately what the federal
poverty level is, for instance, and that's nowhere in the
chapter. So I would like to sort of see some information
that says in those categories here's the dollar income level
we're talking about, here is what the dollar impact is of
providing this coverage and this coverage and this coverage,
1 and then net, what does that mean for the beneficiary in
2 terms of actual dollars. Just in terms of educating me and
3 helping me get my hands around this issue, that would be
4 helpful.

5 MS. AGUIAR: We're happy to do that. The one
6 caveat that I just want to give is where when we do try to
7 quantify this -- and we do quantify this in the paper --
8 this is, again, specifically for the deductibles and the co-
9 insurance for Parts A and B. We are only able to calculate
10 those beneficiaries' cost-sharing liability, but not how
11 much was paid for the QMBs. So just so you are aware of
12 that. We're not actually able, because of limitations in
13 the data, we won't be able to say to you the liability was
14 this and what the state paid was that.

15 DR. CHRISTIANSON: That's fine. Yeah, I saw Table
16 3 that had the average liability, and just anything that
17 would even put that in context would be helpful to me.

18 MS. AGUIAR: Sure.

19 MR. ARMSTRONG: Just very briefly, I want to
20 affirm I think the work is excellent. I think what we're
21 trying to do is strike a balance between creating access in
22 a program that right now is pretty complicated and as much
as we can, simpler terms, and I really applaud that. And I look forward to supporting this work going forward.

MS. UCCELLO: First, I just want to thank you for the really nice discussion in the chapter laying out all the different QMB, SLMB, all that stuff, and dual, you know, plus and all that. It's very complicated, and I've never -- I've looked before to find something like that, and so I was so pleased that it was there, and you did just a fabulous job. And it is very complicated.

In terms of, you know, what's the best way to address some potential access problems for low-income folks, I agree that our charge should be to try to look at things from the federal side and not try to impose anything more on the state side. But I'm just trying to understand better what the behavioral impacts and what the true impact on access is for a premium reduction or elimination versus an at the point of service cost-sharing reduction, because in theory, yes, not having to pay the premium frees up some money. You can use that for something like your cost sharing. You could also use it for something else. And maybe some of this is already in that 2008 chapter, I don't know, but I think it's something that I
need to understand more to really assess what the right way
to go is.

DR. CHERNEW: I think Kate was reaching for her
button, too. Maybe we were going to say the same thing.
But in any case, I think the evidence would suggest that if
you give someone just a lump sum, reduce their premiums by
$100 but still charge them at the point of service, they
respond to the higher price. So that's, in fact, how the
RAND Health Insurance experiment worked. They gave people
money to participate, but they didn't -- you know, they
still responded to the price of service at the point of
service.

MS. UCCELLO: And that's exactly what I'm
concerned about with just focusing on the premium side.

DR. BAICKER: I really also appreciated the
distinction drawn between subsidizing -- the subsidy for
premiums versus cost sharing. My reaction was a little
different from Cori's in that especially in light of our
discussion about Part D, thinking about ensuring that low-
income beneficiaries still face some cost sharing to steer
them towards higher-value services, I think argues for
subsidizing premiums more and leaving some cost sharing in
place. But then what's the right level of cost sharing?
That clearly depends on income, the level, the dollar amount
that helps steer low-income beneficiaries towards higher-
value services might be a much smaller dollar amount than
what's appropriate for higher-income people. So it's not
that income shouldn't be taken into account. I think it
should. But I think that it should -- we should work to
ensure that we maintain appropriate incentives across
different types of care.

MR. HACKBARTH: So we've talked about premium
subsidy and cost-sharing subsidy. Another potential
variable here is an out-of-pocket limit on cost that is
income related. Have we thought at all about that and what
the implications are? I think that could be done through
the federal -- a federal change only.

Julie has a skeptical look on her face.

DR. MARK MILLER: That's just because you're
looking at her [off microphone]. I was a bit unclear how to
take that, too. So why did you think that that just had a
federal piece to it?

MR. HACKBARTH: Well --

DR. MARK MILLER: Because I was looking at --
MR. HACKBARTH: Just consider that an assertion as opposed to a logical thought. So you could say the Medicare cost-sharing liability is income related, and after some point, the beneficiary incurs no additional cost-sharing liability so there's nothing for the state to contribute. It would reduce state burden. It wouldn't increase state burden in any way.

DR. LEE: Actually I thought what you were saying was that it's out-of-pocket maximum that's income related. And so, for example, low-income beneficiaries would have a lower out-of-pocket maximum.

MR. HACKBARTH: Yeah.

DR. LEE: And there would be -- once they reach that maximum, then all the cost-sharing liability will be paid --

MR. HACKBARTH: By the federal government.

DR. LEE: By the federal. So we had -- on our discussions on the benefit redesign, we have not discussed this particular form of that design. I think a proposal from Urban Institute actually takes on this flavor but we --

MR. HACKBARTH: I remember that.

DR. LEE: As a Commission I don't think we had
discussed that. I think the kind of argument for the redesign was -- or discussion on the benefit redesign was we actually took the low duals out of that particular discussion in the recommendation. But the kind of main argument for the redesign was for all Medicare beneficiaries, the basic benefit, what should that look like?

MR. HACKBARTH: Right. And I understand all that.

I agree with that. But if we're concerned that simply relieving low-income beneficiaries of the premium burden may still -- and leave them with the same cost sharing as everybody else, may have a disproportionate impact on their use of services because of their low income for the reasons that Mike just stated. I'm trying to think of other variables that you can adjust to deal with that.

One of your slides said, you know, if you relieve them of the Part B premium, that's a $1,300 annual savings, and the average cost-sharing liability is $1,900. Well, one of the issues, though, is there's lots of variability around that $1,900 average. And so the low-income people that are also burdened by illness would be particularly hard hit, and, you know, the out-of-pocket maximum is a variable that
could address that.

Please don't count this as advocating that. I really haven't thought through it, but it just occurred to me based on this conversation.

DR. LEE: The one I think that will have a different effect is actually the conversation between Cori and Kate on -- for the -- what you are doing is you are making the basic cost sharing in place for a narrower spending range, so low-income beneficiaries are still going to face the same incentives as before, but now at a lower spending level, now you are taking away all of their financial incentive. So then you are facing the problem of not having incentives early on. So it's kind of a shifting that you are going to -- it has different implications than the behavioral response.

DR. HOADLEY: I had thought about bringing an issue like that up. If you layer that onto the current system, of course, you've got a lot of administrative issues, especially with the different ways states fill in cost sharing and the different -- if you're sort of going to a complete rethinking, including all the QMB, SLMB, and all the kinds of things there, than you might be able to go
along the lines we just had.

I think one of the things that's frustrating is, as, you know, the point was made on Table 3 in the text, you know, they can show us the cost-sharing liability for these people. They can't actually show us how much people are paying, so we can't even look empirically at -- unless maybe somehow with some of the joint data with the Medicaid data there's a way to do this. And I don't know if there's any of that. But, you know, even to illustrate sort of what people under the current structure are actually paying as opposed to what they're liable for, because what they're liable for is pretty huge compared to the income levels we're talking about, which also goes to Jon's point about being able to relate those to dollars and incomes and help to understand what a $1,900 liability would mean, if they were actually paying it, which we think many -- some of them, many of them -- some number of them aren't.

I don't know if that helps to think about it at all, but I was going to make a different point, which actually goes back to the question that -- oh.

DR. MARK MILLER: Just before you go on, could we have a couple of reactions. When you were saying about the
complexity of this, you know, and so we'll call it the Glenn-Jack idea, since you both have taken such a strong stand on this. But in all seriousness, to give it a second, you're absolutely right that as it currently stands in the system, you would have all -- it would be very complex. But if you were to pursue something like this, I would think you would immediately move to a federal determination and pull that out of all of the state, otherwise it would be unadministerable or --

DR. HOADLEY: Yeah, I mean, I think -- and you'd have to have it -- I mean, I think it would be very hard to layer it on the current QMB cost-sharing support that we don't even know how much happens. But if you rebuilt that and either federalize it all like the way you do in LIS or something in between --

DR. MARK MILLER: This is getting complex fast. But one other thing. Christine, did I notice that you wanted to react on whether the dual-eligible data -- I don't want to put you on the spot, but --

MS. AGUIAR: Sure. This is not a major point, but I did want to let you know that we have been working for the duals data book with MACPAC, and we do have a combined --
now it's 2009. We'll be working on 2010 MSIS and Medicare claims data set. And we have really looked at this issue closely, and we'll hopefully be able to continue to, but we have not yet been able to verify whether or not the variables in the MSIS that say how much states are actually paying are accurate. There's just a lot of concerns with that.

So we've looked and we've tried to calculate how much states actually are paying, and sometimes it just really doesn't reconcile with what the liability should be. So it's something we are still going for, but just so that you know with that data set we haven't yet been able to.

DR. HOADLEY: And I know there are other issues under the current rules with the states that won't pay the co-pay that exceeds what they would normally pay in Medicaid, and then that may never be collected, but it may show up somewhere sort of as if collected, and that's obviously a further limitation. I get that.

The other point I was going to come back to was the point where Joan jumped in and said part of what I was going to say. I mean, I think there is a role to think about to sort of go back to that issue of saying, you know,
when somebody right now comes into the Social Security Administration to sign up for Part D, and they're judged eligible for MSP, and, you know, we previously recommends, as I understand it, that that might then become relatively automatic, completely automatic, something, a federal action, it doesn't now. The states don't fully follow up on it. We could go back and sort of repoint that, but particularly if we align, as was all part of, I guess, that 2008 recommendation, then there is a real logic to deeming the full eligibility once you come in on either program of getting in, so you create both some administrative efficiency and actually a more effective result.

So I think it was actually thought through pretty well by the Commission's recommendation. Unfortunately, it hasn't all happened.

MR. HACKBARTH: And why did the Congress take part of the recommendation and not the other part? Maybe that's a question for Joan or --

MS. AGUIAR: Do you mean for the one about the income and the asset limits or the one for the SSI -- I mean Social Security Administration.

MR. HACKBARTH: The Social Security
Administration, when we said that there ought to be -- when people are determined eligible for LIS, we ought to also make a determination about MSP eligibility.

MS. AGUIAR: It is a question for Joan. She's coming up.

DR. SOKOLOVSKY: I can't give you a definitive answer, but my impression -- because it wasn't made public, but my impression was that the states had objections to that.

DR. HOADLEY: The states are liable for part of the cost.

DR. SOKOLOVSKY: Yeah.

DR. HOADLEY: That would be the logic, I would think.

DR. SOKOLOVSKY: Yeah.

MR. HACKBARTH: Yeah. Okay.

DR. HOADLEY: And the only other point I was going to add on that general theme is, I mean, there really is a further issue with outreach and education on this. The point has really been made, I think, but, you know, the number I always like to point to on the LIS where it is a more federal role, of the people who are not automatically
LIS eligible based on their Medicaid or SSI eligibility, the ones who need to apply on their own for LIS, the best data we still have from CMS says less than half of the people who we think are eligible actually apply. And, you know, there may be a lot of reasons underlying that, but that does suggest an area where we really need to do better, and we know the MSP take-up is also very low. In some cases I've seen numbers even lower, well below half.

DR. HALL: Thank you. This is news to me, most of this. Linking premium support to the federal poverty level is causing some problems in administration of insurance exchanges for a younger population, but I assume that most of these Medicare-eligible people don't have that much income change year to year, so that's -- I mean, how much migration is there between the eligibility for these levels of support?

DR. SOKOLOVSKY: When we looked at this previously, there wasn't that -- there's some change, but not a great deal of change.

DR. HALL: Right.

DR. SOKOLOVSKY: The biggest issue is if you have to reapply, a lot of these people don't remember to reapply
when it's due, and that's where you lose a lot of people.
New people come on, and people who are still eligible didn't
reapply and lose eligibility.

DR. HALL: So you wonder if we gain much by -- or
CMS gains much by categorizing this each time you go up by a
20 percent or 15 percent increment. I don't think there's
much change. Once people qualify, that's probably where
they are the rest of their lives. But I don't know. I'm
just trying to simplify things if we can.

DR. LEE: I think for a large number of Medicare
beneficiaries that their income is Social Security benefit.
DR. HALL: Right.
DR. LEE: So that is pretty constant over time.
However, unlike exchanges where the subsidy is based on the
IRS definition of AGI, whereas here it's based on the SSI
definition of income, which includes, you know, other
assistance that people may receive. So empirically I don't
know how much fluctuation or variation that exists over
time.

DR. HALL: Thank you.

MS. AGUIAR: And I would just quickly add to that,
when the fluctuation that we have heard in terms of people
falling in and out of these categories is much more on the side of whether or not they qualify as a full dual for full Medicaid benefits within their state, it really seems to be -- that's a little bit more of an issue than -- and, again, this was in our joint data book analysis that we did with MACPAC, was where we saw some of the more shifts between partial and full dual as opposed to between, you know, dual and non-dual, that sort of thing.

DR. COOMBS: So as I read the chapter, one thing I would have loved to maybe had this kind of information, and that is, how well does support, partial/full support correlate with things like ED visits or outcome-driven kind of analysis on -- because we all assume that the more Medicare D support you might have in terms of not having barriers to get your medications, you know, the admission rate may be altered by some of the policies that you have in the drug plan and things like congestive heart failure, but also emergency room visits which don't reach the bar in terms of as much of a cost driver as a full-blown admission, but it would be interesting to see if there's some data out there that ties those two things together.

MS. AGUIAR: I just want to clarify that. Is your
question more that those in the MSP program who get this financial assistance then -- is it an access-to-care issue? Or is it how does their utilization change?

DR. COOMBS: How does their adherence and utilization change as a result of their position that they have -- we move them on the curve in terms of their wealth, their element of wealth.

MS. AGUIAR: Okay. So, again, not to keep promoting this data book, but in that data book we do have data for, you know, all duals. We break it up between partial and -- and, you know, as one would expect, it is very high. We have not yet, though, looked at -- done sort of a longitudinal analysis and looked at people who were, you know, pre-duals and then became duals, and then to sort of see how that changed. And that is something that we could do.

DR. COOMBS: That's really a persuasive argument for the support.

DR. CHERNEW: So a few basic things.

First, this issue of point of service versus premium subsidy is important to me for a variety of reasons. One of the issues sort of just as a general theme is that
you worry about cost sharing at the point of service because it discourages the use of care, and you worry about cost sharing at the point of service because it increases -- it can increase care. So, for example, it's another underuse/overuse thing.

What we'd like to do, if we could do it administratively, is target the subsidies to the people for the things you really think are important, but allow cost sharing, higher cost sharing for the things that we don't. That just turns out to be very hard to do. That's sort of a value-based insurance design kind of notion, which sounds good in meetings like this, and if we could figure out a way to at least at the margin make it work, that would be better than not. But I recognize it's hard.

So that gets to this question -- the first question I have is about the administrative burden of doing anything at the point of service. We've been talking a lot about the administrative burden of enrolling people into plans, and I believe that's administratively burdensome in general. But the question I sort of have is: If you were trying to set differential co-pays or deductibles or even out-of-pocket maxes based on income, that somehow has to be
known and adjudicated in a much more complicated way than just whether you get into a plan or not, because it changes over the course of the year. And that's even before you worry about value-based insurance design. That's just a whole separate thing.

So I would like to know more about administrative challenges of doing things at the point of service, which I believe is important, particularly for high-value things, because I worry that as lower-income people have to pay more, some work we did suggested that charging lower-income people more for high-value services led to disparities in access to high-value things. And we were very worried about that. But finding the solution in a way that doesn't lower the co-pays for everything, creating the LIS story before where they don't use generics, you know, is, I think, just a fundamental and very difficult problem, but that doesn't mean that it's not a very important problem.

My second comment is really just a question about -- just showing complete ignorance. Do people on Medicare, if they can't pay, go bankrupt? Is there a big -- and this isn't, incidentally, just low-income people. You could be a moderate-income or high-income person. There's no out-of-
pocket max, which is a concern we've raised in the past. So anybody with a severe enough illness could conceivably, you know, go bankrupt, or at least not be able to pay. So do we think people don't use the services? Do they go bankrupt? Or are providers writing off these expenditures? So I'm low income, this person can't pay whatever it is, we're just going to put that into charity care or bad debt or something like that. I would just be interested to know broadly about what happens across the income spectrum, although I think it's clearly more often the case for lower-income people when they have high expense -- when they're liable for high expense relative to their income, what happens? Do they go to collection agencies? I just don't know, and I would love to know relative to this.

MS. AGUIAR: So I have only a partial answer to that. What I do know is that some of the pathways, that people become full duals, so an example of this is SLMB-plus, are people who normally have income and assets that would exceed -- that would prohibit them from becoming -- from being eligible for Medicaid benefits to begin with. And then they do have high health care costs, for example, let's say a hospitalization, then followed by a nursing home
stay, a long nursing home stay, and they exhaust their income and their assets to the point that they then qualify for Medicaid benefits.

DR. CHERNEW: So just to be clear, what I hear you saying is if I'm not Medicaid eligible now, and I have no supplemental insurance, just for the purposes of this discussion, and I get hit by a bus or something, and I have very high expenses, at some point I would then become eligible and then all my expenses after that point could qualify for some of these other --

MS. AGUIAR: Exactly. You would qualify for that program. And so that -- and, again, so I can't answer as to whether or not people go bankrupt. I don't know. But I just do know this is one pathway where people incur -- one situation where people incur very high costs and then end up needing Medicaid assistance.

DR. CHERNEW: And just a Jon Christianson-type question in this regard. Roughly where is that in the income threshold? In other words, would I have to spend down to -- it's sort of an absolute threshold, so I'd have to spend down to 150 percent of poverty? Is that the way I should think of it?
MS. AGUIAR: So, again, because those individuals would become full-benefit dual eligibles, that threshold varies by states. In some states it's called "medically needy." In some states I believe it's 300 percent SSI. But it does vary by state.

DR. CHERNEW: So let me just -- I guess I'll just ask my last and more complicated question. Are there asset tests related to that, so I have to spend down not just as a share of my income but I have to spend down my assets in order to get to that point?

MS. AGUIAR: Yes, there are assets tests for that as well, but as Joan had alluded to before, there are some states that do tend to waive those asset tests. So, again, it varies state by state.

DR. HOADLEY: And aren't there some states that don't do any kind of a spend-down?

MS. AGUIAR: Yes, there are some states where you couldn't even qualify for Medicaid under that scenario. We could give you more information on this if you'd like.

DR. CHERNEW: My concern just broadly speaking is I'm very concerned about the protections. One of the issues I would ask is my sense -- and you can correct me if I'm
wrong -- is there's an odd sense of patchwork things that
are in place to try and protect people in a variety of ways
that aren't codified in a presentation as clear as yours.
And it's possible -- and I could be wrong -- that that is --
complicated and as frustrating as that patchwork of stuff
is, that it's actually doing okay and it's not as big of a
problem. Or it's possible that it's a disaster and there's
a lot of people that are losing their houses, going
bankrupt, whatever it is, that we should know about. And
I'm just not sure of how that's all playing out, and that's
what I was asking about.

MS. AGUIAR: You're right. it is very
complicated. But we could come back to that if you would
like to.

DR. MARK MILLER: I would have said part of the
ability to get back to the how many people and whether the
house was lost was complicated by the fact that these
decisions are so eccentric across the state for both income,
asset, and whether they do it at all. If I were in your
position, I would be very nervous that I could answer your
question in the end.

MS. AGUIAR: Well, with the --
DR. MARK MILLER: [off microphone].

[Laughter.]

MS. AGUIAR: In the instance of housing recovery, again -- and I'd have to go back to refresh my memory about this -- my understanding is that -- I wouldn't say all states or most states -- some states do have policies that say that if you enter a nursing home and then you become on Medicaid, then basically that they are able to get your house, for lack of a better word. But I have -- and there's a term for it which is --

MR. GEORGE MILLER: Spend-down.

MS. AGUIAR: Spend-down, right -- a term that's escaping my memory right now. "Housing recovery" I think it's called. However, if that's on paper, it is also my understanding that for the states that have that policy, it is not always actually implemented, to further complicate it.

DR. CHERNEW: I wasn't asking for some pristine number that you have to defend. I was trying to get a generic sense about how good or bad this informal safety net system is, and also, frankly, how much it's burdening providers. In other words, another part of the safety net
is providers just don't collect whatever it is, and so you just never had to pay it.

DR. CHRISTIANSON: If I could just quickly jump in, I agree we don't need a pristine answer. It would be really helpful to me to have you run two or three or four hypotheticals and just say, here's how these -- for this person, here's how these different programs would interact in this state.

Just, it's so complicated, and keeping it all in mind is very hard.

So the hypotheticals don't need to be based on what you think would be the average or, you know, we don't need to pin you down to that, but just something that illustrates how all of this works together or doesn't work together.

DR. REDBERG: Thanks for a very helpful chapter.

I have been like, I think Bill, just trying to think of ways to simplify, but the more I think I understand it the more I don't know how much is possible for us because so much of this is related to varying state requirements and how states -- but it did occur, and I think Bill Gradison mentioned this.
If it's possible to change -- and again, QMB and SLMB have state components and QIs are only federal. But with the ACA and the 138 percent of federal poverty level, at least -- is it -- 25 of the expansion states will use that criteria. If it was possible to simplify this in any way, I think it would be helpful for me.

No, I think it would be helpful.

DR. SAMITT: I want to just come back to some of the comments about, you know, striking the balance here because, obviously, the challenge here is we want to enable greater accessibility to the impoverished for the Medicare programs, but we also want to align incentives with that same population to choose value-based care alternatives.

So I'm interested in the comments in your future work about aligning or evaluating across fee-for-service, ACO and MA, and you know, the chapter was beautifully done.

And I think where I was going next with questions is, is there a way to see a comparative analysis on how this population is managed across these various sectors?

So, for example, how do D-SNPs or other MA plans strike the same balance about accessibility versus alignment of incentives?
And do we see different scenarios regarding drug utilization or access, or use, of other services in MA plans versus in fee-for-service or ACO, which I would imagine are the same fee-for-service and ACO today?

So I'd be interested in the future work really helping us look not just with the scenarios that maybe Jon had suggested but also looking across to the various corners of the Medicare program to see if we can learn anything from that as well.

MR. GEORGE MILLER: Again, I will just add to what my colleagues have said, that this is just a fascinating chapter and great work.

As I read the chapter, I was struck by the differences in the different states and the amount of subsidies provided, or lack thereof.

And I'm wondering; because of that, is there any movement from state to state because of a better or richer benefit as we see in other programs in this particular case, and does that impact federal spending?

And is there a way, if that is the case, to make this simpler so that the impact is not as -- so that it's a better benefit to the patient and aligns the incentives?
DR. CHERNEW: There was actually a recent paper that came out that found there was not movement.

MR. GEORGE MILLER: Okay.

DR. CHERNEW: This wasn't in Medicare, but just in general there was not movement across states in Medicaid, to get better Medicaid as a general rule.

MR. GEORGE MILLER: Medicaid, okay.

DR. NAYLOR: So thank you for teeing up a great conversation with your great work.

One question now that this generates for me -- and it really was stimulated by Jack's comment about education and outreach. And we have seen this so many times in terms of even accessibility of existing opportunities and people not knowing about them or finding it too complicated to be able to get to them.

And I'm wondering; on your table 3, on page 8 in the chapter, when you talk about the percentage of beneficiaries who are current, I'm assuming -- and this is excluding the duals who are currently receiving -- is that those who are actually using it or those who are eligible?

DR. LEE: Those are people who are actually currently participating in those programs.
DR. NAYLOR: All right.

DR. LEE: So, presumably, the --

DR. NAYLOR: It would be much greater given --

DR. LEE: It would be larger --

DR. NAYLOR: Larger.

DR. LEE: -- given that not all eligible beneficiaries are participating.

DR. NAYLOR: Okay. I don't know if your data book or others can help uncover how many potentially eligible and how many are actually using. I think that would be very helpful, if there's any way to try to peel away that part of the onion.

MR. HACKBARTH: [Inaudible comment.]

DR. NERENZ: Caught you by surprise.

DR. MARK MILLER: It's fairly thin, but a couple of things that could potentially come out of this conversation because remember what the purpose of this was. It was this is a very complex and important area. It is hard to keep in mind for, you know, any moment.

And we wanted to bring you guys back up to speed and also to bring you back up to speed on something that had happened in the Commission a while back because it does kind
of fold into some of the conversations about benefit redesign. In that sense, that's really all it was about.

A couple of things that I could take away from this.

One is there was a couple of requests for information to understand better.

And I admit that I kept thinking, God, it would be really hard to get to an average number of X, Y, or Z, but the notion of scenarios does kind of lend itself to -- and it might be something of a public service to kind of lay out a few things and say: By the way, mechanically, this is how this works. Now, if you took another state, this is how it would work in that state.

And it would be representative to the extent that it was one person, one state, one thing.

And, even there, I swear there will be caveats.

If the state actually does X, then -- but there might be some public value there.

The other thing that occurred to me -- and this has potential to be wildly misunderstood if we were to do it and present it in public -- would be to take one scenario.

So, for example, Glenn and Jack were talking about this
notion of income relating to the stop-loss. And, use that
to illustrate how many different directions the policy would
go in.

Okay, these are all the administrative issues.

You could -- you know, federal, state and then implications
for all of that.

These are all the issues for financing that start
to get implicated -- federal, state, that type of thing.

And not say we're doing it but say, this is when
you think about an idea like this; this is how many
different directions it runs in and the issues that get
implicated.

Again, more as a public service to try and
illustrate for people how these things hang together.

That was one thought. Now that doesn't take you
to a policy or anything, but hopefully, I've given you
enough time to say something more.

MR. HACKBARTH: Yeah, but you have not succeeded
in giving me enough time to say something better.

DR. MARK MILLER: I gave it a shot.

MR. HACKBARTH: But say something, I will,
nonetheless.
So this is sort of overwhelming in its complexity, but if you go back to basics, I think what I hear here, as I heard in 2008, is it doesn't make sense for there to be less generous support for low-income people under Parts A and B than under Part D; so we ought to move towards equalizing assistance.

If we accept the constraint that we should not be recommending increases in state fiscal burden, that really limits our options and may limit it to just premium support contingent on this analysis of the issues raised by income-related catastrophic limit.

Now we acknowledge that maybe just the premium support will --

DR. BAICKER: [Inaudible comment.]

MR. HACKBARTH: Yeah. Premium assistance.

Premium assistance, yeah.

We acknowledge that maybe the premium assistance would still leave us with some issues about impaired access to care for low-income beneficiaries because of the cost-sharing that they would still face.

But, if it compared to the status quo, it's clearly better. It may not be better than some perfect
model that we can't achieve in this complex web of federal and state responsibilities, but it would be better than the status quo.

And so, I support all of this and our analysis and all of that, but I think there are still some basics here that we probably agree on, and I just don't want them to be lost in all of the discussion.

DR. MARK MILLER: That was good, Glenn.

MR. HACKBARTH: Not bad, okay.

Okay. Thank you very much, Christine and Julie and Joan.

Okay, we are now to our public comment period.

[Pause.]

MR. HACKBARTH: Seeing none, I think we are adjourned until next time.

[Whereupon, at 11:38 a.m., the meeting was adjourned.]