

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
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9:41 a.m.

COMMISSIONERS PRESENT:

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AGENDA	PAGE
The context for Medicare payment policy - Julie Somers, John Richardson	3
Medicare Accountable Care Organizations (ACOs): Recent developments and future directions - David Glass, Jeff Stensland, Katelyn Smalley	63
Public Comment	126
Issues for risk adjustment in Medicare Advantage - Dan Zabinski	129
Patient engagement and health disparities - Joan Sokolovsky, Katelyn Smalley	195
Part D exceptions and appeals - Shinobu Suzuki, Joan Sokolovsky, Lauren Metayer	261
Public Comment	301

1 P R O C E E D I N G S [9:41 a.m.]

2 MR. HACKBARTH: So welcome to the people in the
3 audience. We appreciate your interest in MedPAC's work. As
4 you know, we're beginning a new annual cycle, and it is now
5 established tradition that the first presentation of the new
6 cycle pertains to the context chapter, which goes into our
7 March report.

8 For the people in the audience who may not know,
9 the statute that creates MedPAC says that one of the things
10 that we should do is consider the budgetary and overall
11 context of Medicare as a foundation for our recommendations.
12 And so one of the reasons for our context chapter each year
13 is to fulfill that mandate from the Congress.

14 So, Julie, are you leading the way?

15 DR. SOMERS: I am. Good morning. As Glenn said,
16 we'd like to talk to you today about the context for
17 Medicare payment policy, and consistent with the draft
18 introductory chapter in your mailing materials, John and I
19 would like to quickly run through the topics listed on this
20 slide.

21 Health care accounts for a large and growing share
22 of economic activity in the United States. The orange line

1 in this graph shows total health care spending as a share of
2 GDP. Total health care spending grew from about 9 percent
3 of GDP in 1980 to about 18 percent in 2011. It is projected
4 to rise to almost 20 percent of GDP by 2021.

5 The green line is private health care spending,
6 and the red line is public health care spending. Notice
7 that public spending begins to exceed private spending in
8 2014 as enrollment in Medicaid expands, subsidies for
9 coverage purchased in the new health insurance exchanges
10 begin, and Medicare enrollment accelerates due to the aging
11 of the baby-boom population.

12 The purple line at the bottom of the graph is
13 Medicare spending. Medicare spending has also grown as a
14 share of the economy from a little over 1 percent of GDP in
15 1980 to 3.6 percent in 2012. By 2021, Medicare is projected
16 to total 4 percent of GDP.

17 While historically growth in health care spending
18 has outpaced GDP growth, in recent years it has slowed.
19 From 2009 to 2011, you can see the orange line flattening
20 out as total health care spending grew at roughly the same
21 rate as GDP, maintaining health care spending at about 18
22 percent of GDP for those three years.

1 Researchers are still analyzing the slowdown and
2 trying to determine and quantify its causes. Some analysts
3 attribute the slowdown to the recent economic recession from
4 2007 to 2009 and the slow recovery and its aftermath. Under
5 that view, health care spending growth is expected to
6 rebound as the economy continues to recover.

7 Other analysts attribute the slowdown to
8 structural changes in health care markets, such as reduction
9 in the rate of introduction of new medical technology.
10 Under that view, the slower growth rates may persist even
11 after the economy fully recovers.

12 Though the causes of this slowdown are still being
13 studied, there has been a growing consensus that the
14 slowdown began before the most recent economic recession and
15 can be attributed to the slow economic growth experienced
16 for the past decade, the decline in real incomes, and shift
17 to less generous insurance coverage.

18 From 2000 to 2011, real median household income
19 declined by 10 percent, and the proportion of the population
20 with employer-sponsored insurance declined while the
21 Medicaid and uninsured portions increased. For those with
22 employer-sponsored insurance, deductibles and cost sharing

1 rose. It is not known if the slowdown will be sustained as
2 the economy continues to recover and as insurance coverage
3 expands beginning in 2014.

4 For Medicare, projections by CBO and the Medicare
5 trustees show growth in spending per beneficiary beginning
6 to pick up as the economy fully recovers, but it does not
7 reach the high growth rates of the past.

8 Private health insurers and Medicare both
9 experienced the slowdown in the growth rate of health care
10 spending. But according to a study of private sector claims
11 data by the Health Care Cost Institute, the slowdown in the
12 private sector was caused by low volume growth in the use of
13 services. The study still found robust price growth.
14 Because of that price growth, per capita spending grew by an
15 estimated 4.6 percent in 2011 for private insurers.

16 In contrast, in fee-for-service Medicare, where
17 prices are set administratively, per capita spending grew by
18 less than 1 percent that same year due to both low volume
19 growth coupled with low price growth.

20 One key driver of higher prices in the private
21 sector is provider market power. Hospitals and physician
22 groups are increasingly consolidating, in part to gain

1 market power over insurers in order to negotiate higher
2 payment rates.

3 The Medicare trustees project that total Medicare
4 spending will grow at an average rate of about 7 percent per
5 year over the next 10 years. This figure shows spending
6 growth (indicated by the red bars) broken out between growth
7 in enrollment (the green bars) and growth in per beneficiary
8 spending (the striped bars). While the growth in per
9 beneficiary spending has slowed in recent years, it is
10 projected to pick back up beginning in 2014.

11 Historically, Medicare enrollment has grown about
12 2 percent per year. But over the next decade, Medicare
13 enrollment growth is projected to average about 3 percent
14 annually, increasing Medicare enrollment from about 50
15 million beneficiaries today to about 70 million by 2022.

16 This graph illustrates how as Medicare spending
17 grows, general revenues will grow as a share of total
18 Medicare financing, adding significantly to federal budget
19 pressures. The white line at the top of the graph depicts
20 Medicare spending as a share of GDP. The layers below the
21 line represent sources of Medicare funding. All the layers
22 below the yellow portion are dedicated funds collected

1 specifically to finance Medicare spending such as payroll
2 taxes and beneficiary premiums.

3 However, as indicated by the yellow layer, the
4 single largest share of Medicare funding today comes from
5 general revenues, or in other words, from general tax
6 dollars. The blue area below the Medicare spending line is
7 the deficit indicating years for which Medicare spending
8 exceeds Medicare's funding.

9 One important takeaway from the graph is that it
10 is the combined areas of the deficit and general revenue
11 transfers that's financed through general tax dollars, the
12 same dollars for which education, infrastructure investment,
13 and other national priorities are competing.

14 Another important takeaway is that because general
15 revenues finance a large and growing share of Medicare, and
16 Medicare is a significant share of the federal budget --
17 currently representing about 16 percent of federal spending
18 -- Medicare's fiscal sustainability is tightly linked to
19 that of the overall federal budget, federal debt, and vice
20 versa.

21 This graph depicts the federal debt as a share of
22 GDP. Federal debt equaled 36 percent of GDP at the end of

1 2007 as the economy entered the last recession. In response
2 to the recession, tax revenue declined and federal spending
3 increased as more people qualified for unemployment
4 compensation, food stamps, and Medicaid. As a result, the
5 debt climbed reaching 73 percent of GDP in 2012.

6 As indicated by the green line, under current law,
7 the debt is projected to remain historically high for the
8 next decade due to growing interest payments to finance the
9 sizable debt, the pressures of an aging population, and
10 rising health care costs. By 2023, if current laws remain
11 in place, the debt will equal 74 percent of GDP and continue
12 to be on an upward path.

13 Unfortunately, the fiscal situation could be even
14 worse. Current law assumes that physician payments will be
15 reduced by 25 percent in January 2014 and automatic budget
16 cuts -- known as the sequester -- will continue through
17 2021. If instead Medicare's physician payment rates are not
18 cut and the sequester is removed, the debt projections would
19 follow the orange line labeled "Alternative fiscal
20 scenario." In that case, debt would reach 83 percent of GDP
21 by the end of 2023, the largest share since 1948.

22 With that, I will turn it over to John to discuss

1 the context of the health care delivery landscape from the
2 perspective of Medicare beneficiaries.

3 MR. RICHARDSON: I'm going to cover the issues
4 summarized on this slide, including the demographic and
5 population health trends of the 85 percent of Medicare's
6 enrollment that is age 65 and older and how emerging trends
7 in insurance coverage and design may affect the wave of new
8 Medicare beneficiaries as they enroll in the program over
9 the coming years.

10 This graph shows the Census Bureau's most recent
11 projections of the number of Americans aged 65 and older
12 from 2012 to 2060. The vertical yellow lines show 10-year
13 cut points. The 65-and-older population is projected to
14 grow from 43 million people in 2012 to 60 million in 2022,
15 75 million in 2032, and 80 million in 2042.

16 At the same time, the average age of the Medicare
17 population will decline slightly and then increase, as the
18 bulk of the baby-boom generation ages into Medicare
19 eligibility, which you can see from the bulge in the dark
20 blue area, starting now through about 2030. By 2042, the
21 fourth yellow line from the left, over half of Medicare
22 beneficiaries will be age 75 and older, with almost one-

1 fifth age 85 and older.

2 In addition to growing rapidly in overall size,
3 the Medicare population will become more diverse racially
4 and ethnically, with increasing percentages of older
5 Americans identified as African American, Asian American,
6 and Hispanic. The largest increase will be among the
7 proportion of Americans age 65 and over identifying as
8 Hispanic, which is projected to triple from 7 percent to 21
9 percent between 2012 and 2060.

10 Turning now to look at the health of the Medicare
11 population, a recent CMS analysis found that over two-thirds
12 of Medicare fee-for-service beneficiaries in 2010 had
13 multiple -- that is, two or more -- chronic conditions, as
14 shown in the bar on the left of this graphic. Chronic
15 conditions in this analysis included hypertension, high
16 cholesterol, heart disease, arthritis, and diabetes.

17 Similar to other analyses you are very familiar
18 with, CMS found that most Medicare spending in 2010 was
19 concentrated among the percentage of beneficiaries with
20 multiple chronic conditions. The roughly one-third of
21 beneficiaries with four or more chronic conditions accounted
22 for almost 75 percent of Medicare spending in 2010, as shown

1 on the right-hand bar.

2 This pattern is particularly worrisome given
3 trends in the prevalence of multiple chronic conditions
4 among the population that will be aging into Medicare over
5 the next 20 years. Recent work by researchers at the CDC
6 found a significant increasing trend from 2007 through 2010
7 in multiple chronic conditions among adults age 45 to 64,
8 and a significant increase from 2001 through 2010 in the
9 share of that cohort reporting four or more chronic
10 conditions.

11 In addition, just the aging of the Medicare
12 population will likely increase the prevalence of multiple
13 chronic conditions, simply because older beneficiaries are
14 more likely to have multiple chronic conditions. In the CMS
15 analysis I discussed earlier, about 63 percent of younger
16 fee-for-service beneficiaries in 2010 had two or more
17 chronic conditions, but 77 percent of the next oldest group
18 had two or more. The difference was more pronounced for
19 beneficiaries with six or more conditions, which was 9
20 percent of 65- to 74-year-old cohort and 18 percent of 75-
21 to 84-year-olds.

22 Shifting gears again to look at recent changes in

1 the private health insurance market, we observe that the
2 millions of beneficiaries coming into Medicare over the next
3 few decades will have different experiences with health
4 insurance coverage and out-of-pocket costs than earlier
5 cohorts.

6 As Julie mentioned, employer-sponsored insurance
7 is becoming less generous as benefit designs across all
8 types of plans require covered enrollees to pay increasingly
9 higher deductibles and cost-sharing amounts. It is also
10 worth noting that this trend applies to employer-sponsored
11 Medicare supplemental policies as well.

12 Restricted provider networks are much more common
13 in private health plans in contrast to the array of
14 unaffiliated and unconstrained provider networks typical in
15 fee-for-service Medicare today.

16 Last, there has been a very rapid growth in
17 enrollment in high-deductible health plans over the past few
18 years, and these plans by definition have high cost-sharing
19 liabilities for covered persons. Twenty percent of workers
20 covered by private health plans in 2013 are enrolled in a
21 high-deductible health plan, compared to just 4 percent in
22 2006.

1 Medicare beneficiaries are not exempt from the
2 financial challenges of increasing cost-sharing liabilities.
3 As discussed in your mailing materials, Medicare premiums
4 and cost sharing have been consuming a growing share of the
5 average Social Security benefit, and as shown on this slide,
6 the actuaries estimate that this trend will continue under
7 current spending projections.

8 And as if all of that weren't good enough news,
9 several patterns in U.S. health care spending, and in
10 Medicare in particular, suggest inefficiencies where health
11 care spending does little or nothing to maintain or improve
12 population health outcomes. Multiple studies of health care
13 delivery within the United States and internationally have
14 documented geographic variation in service use and spending
15 that cannot be fully explained by differences in disease
16 burden or the severity of illness in local populations, and
17 that is not related at all to differences in quality of care
18 or population health.

19 Medicare policies such as "any willing provider"
20 facilitate its chronic vulnerability to fraud, which seems
21 to persist despite increased law enforcement and
22 administrative policing efforts.

1 Another factor is the use of low-value services
2 such as when the risks of a test or treatment outweigh the
3 potential benefits or where the service has not been proven
4 effective at all for a given purpose. Poorly targeted
5 Medicare payment policies do not provide incentives for the
6 efficient delivery of care, and disparities in access to
7 high-quality care for Medicare beneficiaries living in
8 predominantly minority and low-income areas within the
9 country exist. All of these patterns suggest opportunities
10 for payment reforms that could curb spending growth while
11 improving quality of care.

12 To sum up, we see that Medicare spending growth
13 will continue to outpace economic growth and consume a
14 greater share of society's resources for the foreseeable
15 future, because despite the recent slowdown in spending per
16 beneficiary, accelerating enrollment growth will continue to
17 drive spending growth. Because Medicare is such a
18 significant share of the Federal budget, the Congress will
19 be under inexorable pressure to find Medicare savings
20 opportunities to restrain growth in annual deficits and
21 eventually reduce total federal debt, and if they want to
22 find any offsets for other spending priorities.

1 With that, we conclude, and look forward to your
2 questions, comments on the mailing materials, and your
3 discussion.

4 MR. HACKBARTH: Okay. Thank you, Julie and John.
5 Are there any clarifying questions for Julie or
6 John?

7 I have Bill and then John and Rita.

8 MR. GRADISON: Looking at the page 24 -- the point
9 that you made in the briefing paper we had in advance, with
10 regard to beneficiaries entering the program having a
11 different experience -- there's a quote in our tab A from
12 Jeff Goldsmith that says that more than 40 percent of each
13 cohort of Baby Boomers aging into Medicare, including him,
14 are selecting Medicare Advantage. I hadn't seen that number
15 before, and I wonder whether that is least-order-of-
16 magnitude correct.

17 And the reason I raise this as a question is that
18 there had been projections a few years ago that with the
19 change of reimbursement and other factors that the
20 proportion of Medicare beneficiaries in MA plans would go
21 down, and it has done just the opposite. And this might be
22 an explanation; that is, people just sticking with something

1 they're accustomed to.

2 So the specific question is, is that 40 percent
3 something in the right ballpark?

4 DR. MARK MILLER: Yeah, I'd like to come back on
5 that because I don't want to speak to that specific number
6 without a little background work.

7 MR. GRADISON: Thank you.

8 DR. CHRISTIANSON: Just some clarification, John -
9 - on your slide 14, when you talked about the percentage of
10 people, the slide says 2 or 3, 63 percent with 2 or 3
11 chronic conditions, and in your presentation you said 2 or
12 more.

13 And the same thing underneath that -- it says two
14 or three. In your presentation, you said two or more.

15 So I'm assuming two or more is correct.

16 MR. RICHARDSON: I'm sorry. What? Could you --

17 DR. CHRISTIANSON: If you go to your slide 14,
18 please? The bottom.

19 In your presentation, you said 63 percent had 2 or
20 more conditions. In your slide, you say --

21 MR. RICHARDSON: Yes, two or more is correct.

22 DR. CHRISTIANSON: Yeah, so you might double-check

1 in the chapter and make sure that you have --

2 MR. RICHARDSON: We will make sure they're
3 consistent, yes. Thanks.

4 DR. REDBERG: Thank you. That was excellent.

5 My question is on figure 2. I was just trying to
6 get a rough ballpark. In the mailing materials, where you
7 have the pie chart of how much was the share of spending on
8 personal health care, can you kind of approximate how many
9 beneficiaries are in each of those pie wedges?

10 And my other question is, how many of the Medicare
11 and Medicaid are duals, and how does that spending fall out?

12 DR. SOMERS: Do you want to know how many
13 beneficiaries are in each of these wedges?

14 DR. REDBERG: You don't have to get that to me
15 now.

16 DR. SOMERS: Let's see. Okay, well, around 50
17 million in Medicare.

18 DR. REDBERG: Right.

19 DR. SOMERS: And, yes, I would have -- to be sure,
20 I better get back to you.

21 DR. REDBERG: Thank you.

22 MR. HACKBARTH: We'll get that for Rita and

1 include it in future iterations of the chapter.

2 Other clarifying questions?

3 [Pause.]

4 MR. HACKBARTH: Seeing none, let's go to round 2.
5 I'm going to ask Mike to lead off round 2.

6 DR. CHERNEW: So, thanks.

7 And, first, let me say I like this very much, and
8 one of the things I like in particular is in addition to
9 looking at spending by site or type of care, which we often
10 do by hospital, there's a section that talks about spending
11 by people in the clinical things, like the number of chronic
12 conditions. I like that orientation, and the more we see
13 about the clinical characteristics related to spending
14 growth as opposed to just the site of care I think the more
15 it helps us orient away from the silos that we typically
16 look at.

17 The second I'll say is I've been very interested
18 in this issue of the spending slowdown, and I personally
19 believe -- and it is controversial. I personally believe
20 that the slowdown in spending is not primarily due to the
21 recession or income declines or benefit buy-downs, and I
22 think it tends to be related to broad cultural changes in

1 the medical community or technology stuff.

2 But the important thing is whether I'm right or
3 wrong is a little bit beside the point. I don't think the
4 slowdown should be used as an excuse to let up on our
5 efforts to improve the health care system to become more
6 efficient, and I think it would be a shame if we looked at
7 the slowdown as a reason not to help the system reform.

8 And even if a slowdown was due to those other
9 things -- culture, technology -- there's no reason why that
10 has to persist into the future. So we could still have
11 spending come back into the future regardless of the cause
12 of the slowdown in the past.

13 So I think the chapter, I think, does a reasonable
14 job of that, but I think it's important to understand that
15 slowdown or not, moving forward in a productive way is
16 really what's important.

17 And the last thing I'll say about the chapter --
18 and you alluded to this in a few places. I think on slide
19 10. I'm not sure I got my slide number right, but -- I
20 believe there's going to be a continued trend towards less
21 generous retiree coverage provided by employers, and as we
22 know, there are a lot of holes in the Medicare benefit

1 program.

2 For a variety of reasons we have talked about on
3 the Commission, there are some inefficiencies associated
4 with supplemental coverage. So I don't think full
5 supplemental coverage is necessarily optimal, but I do think
6 we have to worry about what the quality impacts and
7 disparity impacts that would arise as Medicare beneficiaries
8 potentially have less generous coverage in the future.

9 And I think that's important, and I think the
10 chapter tees up that concern. As much emphasis -- you know,
11 maybe a little more emphasis on that would be my taste.

12 DR. BAICKER: So I wanted to follow up on what
13 Mike was saying about the slowdown, and I thought the
14 treatment in the chapter was very balanced about some people
15 this share is attributable to general conditions versus
16 changes in health system delivery; some people think this
17 share. And that may be exactly where we want to end up.

18 I don't know if we as a body or the staff have
19 opinions about the quality of that evidence that would make
20 us shade towards one end of those estimates versus the other
21 in our own assessments of what's likely or whether we
22 totally want to stay out of trying to arbitrate among those.

1 But it came -- the tone overall I read was here's
2 a bunch of evidence on different sides; that's all we're
3 going to say.

4 And that might be fine, but it was noteworthy to
5 me because I think it's such a key question for going
6 forward.

7 I also thought the issue of what supplementary
8 coverage people had and what it looked like came up a couple
9 of different places and also in some of the other chapters
10 we're going to talk about in terms of a key determinant of
11 how different policies are going to propagate through to the
12 beneficiaries' incentives at the end.

13 And so I didn't know if we wanted to load in even
14 more detail on what the projected shape of those in the
15 future is going to look like in terms of enrollment in
16 different types of plans or whether there's enough
17 information floating around about Medigap policies
18 elsewhere, that we don't want to load up this chapter too
19 much, but that was another issue that seemed like it was
20 going to come up again and again.

21 MR. HACKBARTH: Any reactions?

22 DR. MARK MILLER: I can take the first one. We

1 were very carefully not trying to pick a side. We think
2 that there might even be people on the Commission who have
3 different views about this.

4 So we were not trying to pick a side. We thought
5 we'd let you guys hash that out, but you did pick up on the
6 fact that we're trying to say there are different thoughts,
7 and so that was very purposeful.

8 On your second thing, we were talking a little
9 about this just the other day, about how much more we could
10 get on what the ESI coverage was going to look like in the
11 future.

12 MR. RICHARDSON: That's all I was going to say,
13 too. We can certainly bulk that up.

14 And you were specifically -- I think both of you
15 were -- referring to the supplemental coverage and the
16 richness or lack thereof in that. Okay.

17 MR. HACKBARTH: And, Kate, on your first point,
18 I'll just say that's a potential candidate for a round 3
19 discussion. No guarantee, but you're in the running.

20 [Laughter.]

21 DR. NAYLOR: So let me just echo. I think this
22 chapter is comprehensive and addresses all, or most that I

1 would be aware of, the key issues affecting the Medicare
2 population going forward.

3 So I just have a couple comments in terms of how
4 you might think about reframing especially the beginning
5 session which highlights and tries to bring together
6 thoughts.

7 One is that all this is here, but when you talk
8 about the growth and then you talk about the growth in the
9 short term being a younger age population, linking that much
10 more explicitly with that, not necessarily meaning the
11 younger age, older adult is not someone living with multiple
12 complex conditions as evidenced by your 45 to 64. I think
13 kind of drawing that more explicitly together.

14 I think the issue of diversity is exceedingly
15 important. This probably -- if I were to highlight a key
16 element in the diversity of the population. Again, you've
17 done it in terms of age and ethnicity.

18 Language -- we heard recently at a meeting about a
19 hospital where they have 200 interpreters for people with
20 different languages as an essential part of dealing with
21 diversity of a population.

22 So I think that that's really going to be

1 important.

2 One area that I thought was a little -- I wasn't
3 as clear about, especially in light of the IOM geographic
4 variation report, is talking about regional differences.
5 But I think maybe highlighting how much or how little we
6 know about the relationship between spending and quality --
7 in fact, the IOM title calls don't target geography; target
8 decision-making, because of what we understand as -- or what
9 we don't understand about patient preferences and market
10 forces and other dimensions of health services.

11 So I probably would have paid a little bit more
12 attention to -- I mean, on page 36, you draw attention to
13 this, but I would have paid more attention -- paid less
14 attention to naming all of this around geography.

15 And that finally leads to the last thing, which is
16 a real opportunity here for evidence to build our
17 understanding about spending and quality -- reinforcing
18 that.

19 Thank you.

20 DR. NERENZ: Just quick agreement with Mary's
21 point about the importance of some of these nonclinical
22 conditions, like literacy or low English proficiency -- I

1 think as we look at the effect of these things on cost
2 utilization and project them into the future, the more we
3 can bring that into the discussion, the better.

4 The second point is in the discussion of the
5 chronic conditions, I was curious in reading the report the
6 extent to which the control of those conditions plays into
7 the cost projections. It seems like intuitively it must,
8 meaning uncontrolled hypertension leads you down one path;
9 well controlled leads you to another path.

10 So, as continue to have this discussion, if we
11 could try to weave that in, it would be useful because I
12 think it has some interesting implications on things like
13 you construct risk adjustment models. You could
14 conceivably, for example, give people credit for not doing a
15 good job of controlling hypertension if simply the presence
16 of the condition is presumed to produce higher costs --
17 uncontrolled, yes; controlled, no.

18 So it would be good if we could weave that in
19 somehow.

20 MS. UCCELLO: Well, Kate has set the bar high,
21 apparently.

22 And, with respect to that question, I think the

1 issue of the balance of the discussion about the slowdown, I
2 think, is appropriate. The balance is appropriate, given
3 Mike's comment that we don't -- regardless of what share of
4 the slowdown is permanent, we want to keep the pressure on.

5 So it seems to make sense that having a balanced
6 discussion and not going one way or the other -- seems to
7 make sense.

8 My other comment is with respect -- I think the
9 chapter is great, and I'm just wondering if we want to use
10 the context chapter more to more assertively state some of
11 our principles. They're kind of in there, but do we want to
12 use this to say more that we want to pay providers at the
13 level of the efficient provider; we want to target payments;
14 we want to have choice but a level playing field and those
15 kinds of things, whether or not this is an opportunity for
16 us to kind of state that more explicitly?

17 MR. BUTLER: One general comment and then a
18 specific question.

19 The general is that this chapter has tended to
20 focus on the reasons for growth in spending and has had less
21 information around comparisons with other countries in terms
22 of why we're so much higher. And I think there's still a

1 lot to be learned there, or there are maybe
2 misunderstandings. You know, we think that it's because we
3 don't let people die in this country, or we have all kinds
4 of other things, but in fact our unit prices are, I think, a
5 lot higher for what we pay. We pay a lot more for labor.

6 So the gap in the opportunity between what we do
7 here and what is done around the rest of the work, I think,
8 can help inform. And so in the future I think a little bit
9 more detail around those rather than just the reasons for
10 our own increases in expenses would be helpful.

11 The second relates to my own wanting to understand
12 the high-level message. So, on slide 7, we articulate the
13 deficit there, and I assume that everybody kind of wants to
14 fix that deficit as a goal, not the only goal, but a goal.
15 And it's expressed as a percentage of GDP on the horizontal
16 side.

17 So, if you go and you say, okay, we're trying to
18 address that -- and now go back to the slide 6.

19 I'm trying to get at the number that it takes in
20 terms of percent increase to -- what's the high-level number
21 that we say, okay, if not this, what do those numbers have
22 to be to close that gap?

1 And then stated yet in another way, obviously, the
2 red line is the aggregate, and then you've separated the
3 growth in enrollment per beneficiary spending.

4 And we, as a Commission, don't work too much on
5 enrollment unless we want to say delay until 67 or something
6 like that and then we can decrease the number of enrollees,
7 but -- we don't have a lot to do with the 3 percent growth
8 in enrollment per year, but we have a lot to do with per-
9 beneficiary spending.

10 So it's a long way of saying, what does that per-
11 beneficiary spending have to be in terms of an increase to
12 get to the goal of closing the deficit on the next page?

13 What's the kind of high-level message that the
14 number would take?

15 It kind of gives you a sense of how difficult this
16 task is if, in fact, that deficit is the goal that we're
17 trying to achieve on page 7.

18 MR. HACKBARTH: Remind me, Julie; the deficit is
19 the HI Trust Fund deficit, or how is that calculated?

20 DR. SOMERS: It isn't anymore. This is from the
21 trustees' report, and they no longer call it the HI deficit
22 because this is showing all of Medicare Parts A, B and D and

1 it's a bit of a mixture. It's the HI deficit plus what's
2 going on in the Part B program when there are surpluses or
3 deficits from year to year.

4 DR. MARK MILLER: Right, but I think it's -- isn't
5 it fair to say that's largely the HI deficit at the top of
6 that chart?

7 DR. SOMERS: Yes, a little muddy.

8 DR. MARK MILLER: Right.

9 DR. SOMERS: Yes.

10 DR. MARK MILLER: I think I understand, and most
11 of these comments I wanted to just without comment and then
12 sum up when we get to round 3.

13 The reason your question is complicated is we
14 could probably calculate it for the HI Trust Fund.

15 In a sense, the HI Trust Fund has this much money.
16 How are we spending out? You could calculate and say, I
17 know how to get back into that box.

18 The big yellow part, and what Julie's point was
19 trying to make, is as Part B -- just in convenience terms --
20 grows, the general revenues follow it.

21 And so how much you slow down there in order to
22 fit it into what is kind of the question. There's not a

1 real trust fund there. There's just a tax dollar chasing
2 it.

3 So, to answer your question, what you'd really
4 have to say is, if you want Medicare to grow at X rate, what
5 would you have to bring the per capita down to? That's --

6 MR. BUTLER: Right, and it should be in the
7 context of the whole federal deficit, not just the -- you
8 know.

9 But, yeah, I'm just trying to get our heads around
10 that -- what contribution were we making to the bigger
11 picture of solving not only a balanced Medicare but the
12 federal deficit picture overall?

13 DR. MARK MILLER: So, for example, as an exercise,
14 we could say, if you wanted the per capita to grow at the
15 rate of GDP, then the growth rates over time would have to
16 be X; and if you wanted to bring it down to some percentage
17 of GDP, the growth rates over time would have to be X. But
18 you have to kind of pick a point that you were trying to
19 hit.

20 And we can mess around with that and bring you
21 back some information, but it's not as straightforward as
22 just, oh -- as straightforward as it would be if it's an HI

1 Trust Fund question. That you can pretty much calculate.

2 DR. HOADLEY: Thank you. You do a nice job in a
3 set of material that can obviously expand to many, many
4 pages of different things and just kind of picking a
5 manageable amount of stuff.

6 I had a few comments that are down in the weeds,
7 and I'll just sort of flag them, and I can give you more
8 later.

9 There's a statement on page 6 in the chapter where
10 you talk about the impact of insurance on spending, where it
11 sounds like all the increased spending is unnecessary
12 spending. I found it read that way, and I don't think that
13 was the intention, but I'll flag that.

14 There are a few specific things on the
15 prescription drug spending, some of which I shared in
16 advance.

17 And the statement in your short section on
18 Medicaid where you look at -- talk about Medicaid as a
19 percentage of state spending. But there are always those
20 two ways to measure that, which is with or without the
21 federal transfer funds, and it might be useful to put both
22 of those in. I can give you more details on all those

1 later.

2 The other more general comment comes off of slide
3 14, the multiple chronic conditions, and I was wondering if
4 there's a sense -- you know, you talk about the increased
5 prevalence in the age group of 45 to 64.

6 I mean, it seems like there are two potential
7 scenarios, one of which is people are just getting these
8 conditions earlier, and it's not necessarily that that means
9 they'll be sick; they'll just come into Medicare a little
10 sicker, and at some point they will have caught up to where
11 they would have been when they're 70. The other is,
12 starting from a sicker base, they're just going to have more
13 and more things accumulate.

14 And I wonder if there's any sense in that
15 literature of which of those scenarios might be more likely
16 because they really have kind of different implications from
17 the Medicare perspective.

18 MR. RICHARDSON: Yeah, we can try and tease that
19 out.

20 The other variable is the introduction of the
21 Affordable Care Act and whether to some extent this reflects
22 people's uninsurance or under-insurance and how that's going

1 to change over the next tranche of time.

2 So it won't be crystal clear, but we can certainly
3 try to tease out the disease burden and sort of how much of
4 it is there just as a result of maybe environmental or
5 social conditions as opposed to insurance, and see if we can
6 look at that.

7 DR. REDBERG: I just wanted to comment from a
8 clinical perspective as a physician that I think it's very
9 important to look at chronic conditions, but not all chronic
10 conditions are created equally. You know, in some areas,
11 we've become -- we've lowered the bar for diagnosing a lot
12 of these, particularly the top two. We have kept moving
13 down on what we call high blood pressure and high
14 cholesterol.

15 I mean, many people will live a whole lifetime
16 with high cholesterol and never suffer any ill for it. It's
17 not a disease in the sense that diabetes is a disease;
18 Alzheimer's is a disease.

19 And so I think that's part of why there are so
20 many more prevalent and so much earlier chronic conditions.

21 MR. GRADISON: Can I jump in on that quickly?
22 Because this is a point which, in a sense, is one raised by

1 Dave, Jack, and Rita. I'd like to see a breakdown of these
2 chronic conditions rather than lumping them all together.
3 It's such a big difference, as Rita has pointed out. It's
4 like the difference between prostate cancer and pancreatic
5 cancer. You know, they're all cancers, but if I have a
6 choice, I know which one I'd take. And so I think it would
7 be useful to break it down, if you can, if the data is
8 available, rather than lumping them all, it's three or it's
9 six or whatever.

10 MR. RICHARDSON: I think we can get more detail on
11 that.

12 DR. SAMITT: I thought the chapter was
13 outstanding, and I know that the purpose is really just to
14 declare the facts. But what I would love to see -- and it's
15 somewhat comparable to Cori's comments -- I'd love for us to
16 inject a bit of a dose of optimism. It's a hard chapter to
17 read. It relays the facts. But it really is very short on
18 what interventions can we recommend on principles that we
19 can apply to really influence either the continuation of the
20 slowdown or resolution of what is a bleak projection of
21 what's happening with Medicare. So if there's a way we can
22 end it on a positive note or have a supplemental chapter, I

1 think that would be useful.

2 The other thing that I want to tag onto with a bit
3 of a different twist than others, I also glommed onto this
4 notion of the chronic diseases, and what I'm concerned about
5 is to some degree we are inheriting on the Medicare side
6 things that the commercial population or the younger
7 generations or the private insurers really should be playing
8 a more central role in wellness and prevention. You know,
9 we wouldn't have as significant a disease burden of chronic
10 disease if perhaps something else was happening in younger
11 generations. And so beyond just, you know, David's comment
12 about control of these chronic conditions, I wonder whether
13 we play a role in understanding to what degree commercial
14 institutions, physicians, and younger generations are
15 preventing chronic disease. And I'd even be interested in a
16 longitudinal study to say in the younger generations, pre-
17 Medicare, which types of institutions are preventing chronic
18 illness later in life better than others. And maybe we
19 should be making recommendations pre-Medicare for how other
20 institutions can improve the health of the pipeline that
21 ultimately comes into Medicare.

22 So just something to consider, I know our plate is

1 already full, but something to consider that we should look
2 into pre-Medicare as another growth opportunity for us.

3 MR. GEORGE MILLER: I'd also like to echo what my
4 colleagues said. This is an excellent chapter, and I
5 greatly appreciate the information on both diversity and
6 disparities. And I really loved how that was teased out.

7 Along with what Craig just said, I'd like to just
8 pose questions concerning especially on page 18 of the
9 chapter, Figure 3, as we looked at historical and projected
10 growth rates for Medicare per beneficiary, if we looked at
11 under the current scenario or if there may be, because of --
12 and I hate to talk about silos, but if there's a shift, for
13 example, in one segment or one silo of the health care
14 continuum that with this large bubble of baby boomers
15 coming, if it would adversely affect or -- I shouldn't say
16 adversely affect, if it would change the projection if a lot
17 of folks went into long-term care versus hospice as an
18 example or other of the post-acute care, if it would have a
19 different impact on the spending. Should we even address
20 that issue? Or is the assumption that it would continue on
21 the way the projection is today? That's a question I just
22 wanted to pose. Or are there things we can do before, as

1 Craig talked about, making recommendations to make sure that
2 we have a positive impact on the direction of health care in
3 the United States.

4 MR. HACKBARTH: So here is my thinking about this
5 chapter. I think of it as an important chapter because it
6 fulfills part of our mandate and because, as I understand
7 it, it's actually a resource that some people on the Hill
8 use, sort of a quick reference for updated figures on
9 Medicare trends, cost trends, et cetera.

10 Because of our resource constraints as an
11 institution, I'm a little leery about it starting to
12 transform into a chapter that opens up new, complex analytic
13 or policy questions, because that will divert resources from
14 the agenda that we've chosen to select. That's not to say
15 the issues aren't important. It's just, you know, a
16 question of how we manage our finite resources.

17 In past years, you know, we've sort of fiddled
18 with making this more policy focused and less reporting and
19 come back to what I think is a very good report, updated
20 report, and tried to stay away from the more complex issues.
21 That's how I'm striking a balance. I don't know that it's
22 the right way, but it's the conclusion I have come to.

1 DR. HALL: Julie and John, thank you. This was
2 really very good, and I think I would agree with Glenn. I
3 think if something isn't too broken, we shouldn't try fixing
4 it. So I think you present the facts, and that's really
5 what we wanted.

6 One thing that I thought was potentially missing,
7 although it's obvious, I think, is -- you mentioned that the
8 major drivers for increasing costs are actual patient
9 services and hospital costs. We don't say anything about
10 fraud and abuse or administrative costs in the Medicare
11 program. And if you read anything in the popular press,
12 that's what's considered number one and two when people are
13 surveyed as to why is Medicare becoming unaffordable.

14 I'm not suggesting that we have a curve that shows
15 the anticipated rise in fraud and abuse spending over time,
16 but to the extent possible, maybe to sort of say that those
17 two factors are not the major drivers, if that's what we
18 believe.

19 MR. RICHARDSON: Sure, and I did touch on that a
20 little bit, and we can certainly expand on that.

21 MR. GRADISON: I hope this doesn't just come
22 through as sort of a hangup, but -- and if it does, I

1 apologize, but my first job here was at the Treasury. I
2 don't like the use of the term "general revenue transfers"
3 because it gives a suggestion that it's from revenue rather
4 than borrowing. I acknowledge the word "revenue" might -- I
5 guess borrowing is a form of revenue, but I'm not
6 comfortable with that.

7 It shows up, for example, in the Chart 7 of this
8 series. It shows up in the document itself. For example,
9 on page 12, there are other places I found it, page 19. I'm
10 not saying you need to necessarily spell this all out and
11 say "from tax revenues plus borrowing," but I'd like you to
12 give a little bit of thought to how to phrase that. In one
13 very recent year, 40 percent of all federal government
14 spending was borrowed, so it's not a trivial amount involved
15 in the question.

16 I just want to share that hangup of mine. Thank
17 you.

18 MR. HACKBARTH: Would "general revenues plus
19 borrowing" suffice?

20 DR. MARK MILLER: We don't disagree with the
21 point. I think in the presentation we're trying to point
22 out that a lot of that is deficit spending. So we don't

1 disagree with the point. We'll get the label right.

2 MR. GRADISON: Thank you.

3 DR. CHRISTIANSON: So I will try to take your
4 caution not to introduce new, complex analytic or policy
5 questions.

6 I think the part of this chapter that will get a
7 lot of attention -- it all should get attention -- is the
8 section on Medicare spending over the next ten years because
9 that sort of sets a framework for where we should be
10 directing our attention as a Commission. And so I'm a
11 little bit bothered with the reliance on Figure 3, which is
12 the board of trustees, as the framework for thinking about
13 that.

14 It's interesting to look at that figure because
15 there's this huge zoom-up of per beneficiary spending
16 assumption from 2015 through 2018. And I know that -- I
17 think you at least need to mention that that is in contrast
18 to what a lot of the popular press and analysts have said,
19 which is, gee, the skewing -- the baby-boom population
20 entering the Medicare program will skew things to a
21 healthier average demographic, so almost inevitably the per
22 beneficiary spending over the next few years is likely to

1 decline. So all else equal -- all else isn't equal here
2 because what the trustees have done is assume that physician
3 fees will increase by 0.7 percent per year beginning in
4 2014. Instead, the payment reductions mandated by the
5 sustainable growth rate.

6 So, in effect, I worry that the Commission is --
7 by using this graph, which has that assumption built in and
8 results in that sort of zooming up there, you know, do we
9 put our stamp of approval on this? Do we say, yes, this is
10 our assumption, too? I don't think we should. So that 's
11 one comment.

12 A second comment I guess is just a question; that
13 is, if you read the financial news, the big news there in --
14 well, first of all, half the financial pages are written by
15 people who are 55 and older, so they're all about
16 retirement. And they talk about postponing retirement as
17 the most sensible thing to do in terms of assuring a
18 comfortable retirement. And obviously all people who
19 postpone retirement don't have private sector health
20 insurance to rely on when they're over 65 years. But how
21 much in these projections of Medicare beneficiary growth,
22 how much does that take into account projections of

1 postponing retirement and the percentage of people who, when
2 they postpone retirement, will be staying on private health
3 insurance and not be entering Medicare as soon as they might
4 have? So two thoughts.

5 MR. HACKBARTH: Jon, on the first -- and it's
6 Figure 3 in the chapter that Jon's referring to -- is the
7 issue just the 0.7 percent assumed increase in physician
8 payment, is that your principal concern?

9 DR. CHRISTIANSON: I'm trying to figure out --
10 well, sure, that's a concern because this is what we -- the
11 conclusion of Medicare spending over the next 10 years,
12 we're just repeating what the trustees said.

13 MR. HACKBARTH: Right.

14 DR. CHRISTIANSON: And the trustees made that
15 assumption, and do we want to make that assumption? Do we
16 want to endorse that? But it also runs contrary to a lot of
17 what you read in terms of the policy analysis would suggest
18 that as on average the Medicare population gets healthier,
19 per beneficiary spending ought to at least not go up. So
20 why does it go up? The only thing I can think of is that
21 adjustment.

22 DR. CHERNEW: So there are two things I would say.

1 The first thing is I think it's important that whatever
2 figure goes into Figure 3 it come from some external source
3 that's credible one way or another, be it OACT or CBO. I
4 think the 0.7 there is what they probably have in their
5 alternative scenario. That's what you've chosen. And the
6 alternative is not to pick some other number that we think
7 might be better. But the alternative has the big SGR cuts
8 and a whole bunch of things and isn't considered as
9 realistic. So if you're going to go with an authoritative
10 source in OACT, if that's what you're going with, I actually
11 do believe that the demographic changes that you're talking
12 about actually are in here, that they do have it adjusted
13 for that.

14 You could agree or disagree with their analysis of
15 how they've done that, but I think they've tried to take
16 into account the demographic things, and they've tried to
17 give you what they think is a more realistic version of
18 things like SGR, and 0.7 might not be the right one.

19 DR. CHRISTIANSON: Maybe we need some more
20 discussion about that, how that is one assumption of -- I
21 mean, where did 0.7 come from? It is one assumption of
22 many. We've had a discussion earlier today where 0.5 was a

1 possibility.

2 DR. SOMERS: I think 0.7 is from the growth rate
3 in the MEI.

4 DR. CHERNEW: Yeah, it's essentially -- they use --
5 -- this might be a round three thing, so I'll just stop.

6 MR. HACKBARTH: I was just going to say I think
7 Mike's principal point was his first one, that given the
8 nature of this chapter, it's reporting as opposed to our
9 proposing updates, we need to use an authoritative source.
10 And, you know, it's basically the trustees' report or OACT,
11 which does the trustees' report.

12 DR. CHERNEW: Or CBO.

13 MR. HACKBARTH: Or CBO. And, you know, maybe we
14 can make it clearer in the accompanying text that the fact
15 that we're rerunning this OACT projection doesn't mean that
16 we're endorsing a 0.7 percent increase. But this is simply
17 their projection.

18 Now, they do at least two. They do the
19 alternative scenario, which I think is what this is.

20 DR. CHERNEW: Right.

21 MR. HACKBARTH: And they do with the current law,
22 which has a very large physician cut. Do they do a third

1 scenario?

2 DR. SOMERS: No.

3 MR. HACKBARTH: So it's just these two that we
4 have to choose from.

5 DR. SOMERS: Right.

6 DR. CHRISTIANSON: What is the CBO scenario?

7 DR. SOMERS: As well, current law, a 25 percent
8 cut in 2014, and they do an alternative that includes other
9 budgetary alternatives on tax policy and the like, but
10 includes a 0 percent payment update.

11 MR. HACKBARTH: For physicians.

12 DR. SOMERS: Yes.

13 MR. HACKBARTH: So let us look into this, Jon, and
14 potentially we could substitute the CBO alternative scenario
15 for OACT. Let's just --

16 DR. CHRISTIANSON: Or give some sense of the range
17 of scenarios, not just here's the projection?

18 MR. HACKBARTH: That's a possibility also.

19 DR. MARK MILLER: And we can do that, and I'll
20 take responsibility for this decision here. I felt -- and
21 I'm sorry for this, Craig. You know, I shouldn't put
22 numbers on the table that are the most optimistic. And so I

1 thought if it's not quickly understood by the reader that
2 this assumes actually a 25 percent reduction in physician
3 expenditures and that's unlikely to happen, that's
4 misleading. And so I was trying to make sure that we had
5 something realistic.

6 But your point about the sensitivity of the
7 estimates, that's no problem. We can work through that.
8 And at least one of her slides was aimed at trying to show
9 that if you make that different assumption, the percentage
10 of the GDP that is debt is influenced like that. And we'll
11 just work that up in the paper and make it clear that there
12 are different ways you could make an assumption about this.

13 DR. CHRISTIANSON: One more quick comment. This
14 goes back to Mike's thought. You worry about if things get
15 looking too rosy, will it take the pressure off doing
16 something? And one of the concerns I've heard expressed
17 regularly is because healthier people -- we're going to have
18 a bigger proportion of healthier people on Medicare for the
19 next ten years, things are likely on a per beneficiary basis
20 to look more rosy.

21 MR. ARMSTRONG: So let me just very briefly weigh
22 in on a comment several other Commissioners have made. I

1 think this has done a really excellent job of painting a
2 balanced picture of a fairly sober future. I would love us
3 to -- I think Peter first raised this. Imagine how -- it's
4 still a report. It's not, you know, taking sides relative
5 to policy issues. But being a little bit more specific
6 about, well, what are the implications of what the analysis
7 tells us? What would spending trends need to be as, you
8 know, the example you offered? But I think there could be
9 several others that begin to kind of frame what the policy
10 imperatives will be rather than necessarily weighing in on a
11 point of view on what the -- you know, what the best policy
12 direction might be.

13 The one other point I would make would be just
14 reflecting on the issues I face in the work that I do is
15 that when I worry about the longer-term future, I also add
16 to the long list of things that are in here already, the
17 terrible mismatch between the demand on our health care
18 industry that this picture paints and the capacity of our
19 workforce to be able to keep up with it. I mean, a lot of
20 the people who are retiring are today's nurses and doctors
21 and pharmacists. And I just wonder if that is within the
22 scope of some comment on that of this particular chapter.

1 DR. REDBERG: I just wanted to comment on the
2 slowdown issue. I think we've kind of been saying it's a
3 slowdown in spending, but it's not a slowdown in spending.
4 It's a slowdown in the rate of growth of spending. But I
5 just want to highlight -- I mean, we are still continuing to
6 spend a lot more every year on health care than we have the
7 year before. Just the rate has come down a little bit.

8 And to Mike's point, I think to me the most
9 important thing is going forward, then, you know, we
10 certainly want to continue to work on efforts that would
11 improve quality and lower cost per beneficiary, which I
12 think is a win-win. And we are still spending a lot of
13 money on things that are making beneficiaries' health worse.
14 You know, not intentionally but it's happening. And so, you
15 know, no matter what we think the slowdown is from, I still
16 think that should be our emphasis.

17 And my other comment, I noted on page 14 in the
18 mailing materials, you know, it goes through and compares
19 rate of growth in private insurance and rate of growth in
20 Medicare over a number of different inpatient hospital and
21 hospital outpatient professional services, and Medicare is
22 holding down costs even more than private in all of those,

1 except, of course, prescription drug spending. And the
2 note, of course, is that Medicare doesn't set prices
3 administratively and can't readily control price control
4 growth. I realize that's set by statute, but I think it was
5 very notable because the rate of spending was so much higher
6 for Medicare drugs than for private sector drugs. And that
7 is disappointing because I don't know that we're getting
8 good value for that investment, just higher prices.

9 MR. KUHN: Julie and John, I want to add my
10 comments with others. This is very good work, and I
11 appreciate this.

12 If I could ask you to put up Slide 6, please? So
13 as I look at this -- and what I'm thinking about here is kind
14 of my comment and my question at the same time. Where is
15 our opportunity as a Commission as we look at this data on a
16 go-forward basis?

17 So if you look at the dark green line, it talks
18 about the growth of enrollment. And as you said in the
19 chapter, between 1967 and, I think, 2012, growth in
20 enrollment was 2.2 percent a year. For the next decade,
21 it's supposed to move to 3 percent. But if you look at the
22 chart, enrollment growth is going up, but yet on this chart

1 it's actually -- as a percent of increased spending, it's
2 actually going down. So what it says to me is then the per
3 beneficiary spending is eclipsing that and is even more
4 greater than we would have thought as a result of that, if I
5 am reading this right.

6 So I guess my question here is: As you look at
7 the per beneficiary spending continuing to grow, and
8 particularly when you get out to 2022, was there anything in
9 the OACT report or the Board of Trustees report that talked
10 about what was driving that and where are opportunities.

11 So, for example, is it more technology? And if
12 it's more technology, the work of PCORI and other
13 comparative effectiveness is going to be an opportunity for
14 us as we look in the future. Is it more uncoordinated care
15 because of the chronic conditions? Is that the opportunity?
16 Or is it more institutional care? And then that tells us we
17 need to continue to work to refine some of the payment
18 systems in fee-for-service or whatever other areas.

19 So I'm just curious about that per beneficiary
20 spending and if there was any granularity of what's driving
21 that as we look at opportunities.

22 DR. SOMERS: Generally OACT talks about drivers of

1 health care spending, and as you say, medical technology is
2 a primary one and hard to predict. They do get into
3 granularity. They break it down by, you know, Parts A, B,
4 and D, if that's what you're interested in. Part D will be
5 growing more -- or at a higher rate than Parts A and B
6 simply because there are more downward price pressures from
7 PPACA in the next decade that hit Part A and B.

8 MR. KUHN: That would be helpful. What I was
9 thinking a little bit -- so, you know, with the surge of,
10 again, 3 percent growth of beneficiaries, and as we all
11 know, a decade from now we're going to have a large number
12 of beneficiaries that are age 75 or age 80 and above that
13 are out there, obviously these folks might be higher
14 consumption as a result of their activities. So, again, did
15 they kind of speculate, would they be consuming more
16 technology and more institutional services? Would it be
17 more for the lack of care coordination? So that's kind of
18 what I was looking for. But it doesn't sound like they go
19 to that level of detail.

20 DR. SOMERS: No, I think this is really -- for the
21 first decade, the projections are really built up from a
22 base level. What are the payment rate changes that are in

1 current law over the next decade? And then out into the
2 future, it is just incorporating historical trends and per
3 capita spending, and their projections, you know, say, out
4 in 2030 and beyond are something -- just a little bit over
5 the growth rate of per capita GDP.

6 DR. CHERNEW: On the projections, the only place
7 they explicitly look at things like technology are in Part D
8 because they look at new drugs and drugs coming off patent.
9 They have historically overestimated, in other words,
10 spending growth. At least recently, the amount of new drugs
11 has been much lower than they originally thought, and the
12 shift to generics has been much faster than they originally
13 thought. But that's the only sort of clinical area. The
14 rest of it is A and B, is much more broadly lumped into
15 that, and they don't do much at all on types of conditions.
16 So, again, they do it by site and type as opposed to people
17 with multiple chronic conditions or people with any of the
18 many complex sets of chronic conditions that we're talking
19 about around the table.

20 But, again, that's just to get to the OACT figure.
21 There's a lot of other people who try and think about
22 things.

1 DR. COOMBS: Thank you, Julie and John. I have
2 just some general comments regarding workforce and also the
3 nature of the type of patients that will be in the system
4 going forward. And I'd like to title it, "The Right People
5 on the Bus." I think with the ACA we need a separate
6 section somewhere talking about the different type of
7 patient that's going to come into the Medicare system,
8 hopefully as a result of the ACA going forward. And that
9 means that patients who may not have had coordinated care or
10 any care whatsoever prior to 65 may now be cared for in a
11 better quality -- receive better quality health care. So
12 there's a plus on that side in the sense that patients may
13 be better off as a result of ACA coming into Medicare. And
14 that's a little different than, I think, what other people
15 might speculate. And so that if you have more interventions
16 in terms of being able to have better disease control and
17 maybe avert some of the complications of diabetes and
18 chronic illnesses, you might actually wind up with a better
19 Medicare patient. So that's one piece of it, not just the
20 numbers. So I think that when you look at something like
21 this, you're looking at numbers and per beneficiary
22 spending. Actually the numbers may go up, but the per

1 beneficiary spending may actually go down because the
2 patient has had some kind of intervention in terms of health
3 care literacy and empowerment and following through with
4 specific things. So I think that we should consider a
5 chapter actually dealing with what happens to the DNA of the
6 patient who arrives in the Medicare system after the ACA.
7 And I think that's really important.

8 In terms of the demographics, I really do
9 appreciate how well you did that. You did an excellent job
10 on that. But one of the things that I'd like to talk about
11 is this whole notion of what happens to the cost variation
12 in terms of spending in the Institute of Medicine report and
13 looking at providers in those areas. I think that when we
14 look at socioeconomic factors and the vulnerable
15 populations, you have to consider that provider are toiling
16 with some issues that are specific to being in an area
17 taking care of vulnerable populations. And those factors
18 are things that may govern the spending of those providers
19 in those areas. So it's a separate confounding variable, if
20 you will, dealing with what happens to the provider, the
21 missionary provider who says, "I want to take care of these
22 types of patients." And so that provider may not be

1 equipped with the same infrastructure of someone who is in
2 an elite institution under the ivory dome and can have all
3 the infrastructure necessary. So their spending might be
4 related to their support system, if you will.

5 And just to dovetail on workforce, I think it's
6 really crucial for us to have something in the chapter and
7 to deal with this issue of workforce. I know we've talked
8 about how we can streamline and stay focused on some things,
9 but we can't -- I don't think we can get to the next chapter
10 of health care spending unless we deal with workforce,
11 whether it's this whole process of looking at the patterns
12 in terms of how we do physician training and nurse
13 practitioner training and where we get to whether it's
14 palliative care, end-of-life care, that directly correlates
15 with what happens with the big picture.

16 Lastly, on Table 1 on page 12, there's a physician
17 fee schedule that says that 12.2 percent of Medicare program
18 spending in 2012 was due to physician fee schedule. And I'm
19 looking at the rest of the billions that were allocated to
20 other resources. Is there a way in which you could -- and I
21 know this is probably a big wish list -- look at whether or
22 not this is a pure factor and tease out what role nurse

1 practitioners play or other providers, non-physician
2 providers play in the cost chart?

3 DR. SOMERS: Yes, we could break it out by nurse
4 practitioners and physicians.

5 DR. COOMBS: And physician assistants as well.

6 DR. SOMERS: Let's see.

7 MR. GRADISON: Another problem on that chart, it
8 has a separate line for hospice, but then under "other," in
9 footnotes, "Other items include hospice." So we've got it
10 in there twice.

11 DR. SOMERS: I think it's Part A versus Part B
12 hospice. I should make that clear in the footnote.

13 DR. MARK MILLER: We can do some disaggregation
14 for the other professionals, is, I think, Julie's other
15 point.

16 DR. COOMBS: Thank you.

17 MR. HACKBARTH: Okay. So lots of good
18 suggestions, and we are, in fact, out of time already, but I
19 do want to offer a proposal that combines at least several
20 of the suggestions. I'm picking up on what Kate had said,
21 and Cori and Craig. I'm trying to weave those into one.

22 So I do think that there is a lot of interest in

1 the topic of why the slowdown, and I know when I've
2 testified, I've been asked about it. You know, what do we
3 think is going on? And so I think that's a topic that's
4 important for the chapter.

5 Now, as Kate points out, we've said sort of on the
6 one hand/on the other hand. I don't know enough, I don't
7 have the analytic skills to have a firm view on what has
8 caused the slowdown, and so I'm sort of agnostic on that.
9 But I think there are actually three distinct issues here.
10 One is, Why the cost slowdown in the past? A second is,
11 What will happen in the future? And then the third is, What
12 are implications of all that for policy?

13 I don't know about what's caused the slowdown in
14 the past, but I do have stronger opinions about whether
15 whatever happened in the past is inevitably sustainable into
16 the future. You know, in the 1990s, we had a dramatic
17 slowdown that proved not to be sustainable because it
18 provoked a reaction from patients and providers. And so
19 even if you agree with the Chernew view that much of this is
20 due to changed behavior by providers, that doesn't mean that
21 it will necessarily continue out into the future. And I
22 think that's why Mike says it's important to make the policy

1 changes that we talk about.

2 So I think that's one point that I would like to
3 see come through in the chapter when we're addressing
4 Congress. You know, there's lots of debate about what
5 happened in the past, and I'm even willing to take a
6 stronger position if more knowledgeable people than I think
7 we now what caused the slowdown in the past. But in terms
8 of going forward, there are real questions about
9 sustainability, and it doesn't really alter the policy
10 agenda that we've been advocating.

11 Just one last word, and then I'll let you -- Mike
12 and I have argued about this many times already.

13 DR. CHERNEW: Friendly.

14 MR. HACKBARTH: Friendly. And I think that that
15 last part might be an opportunity for us to introduce what
16 Cori and Craig suggested. Let's say something about our
17 principles, you know, efficient provider, et cetera, very
18 concisely. Those are the same, regardless of what you think
19 happened in the past about why the cost slowdown.

20 Did that come through clearly? Does that make
21 sense as sort of a place for us to come down on this?

22 DR. CHERNEW: I agree with that. I just wanted to

1 say often it is said that we had a slowdown on spending in
2 the 1990s and then spending ramped up again. And it's
3 sometimes said as if that was some natural thing that just
4 happened no matter what we did, it was inevitable, when, in
5 fact, there were some policy choices and some changes that
6 happened around then which had spending return to where it
7 was as opposed to just naturally that's where spending
8 always is. And I think pointing out that what's going to
9 happen in the future is as much a function of what choices
10 we make now as it is other things going on matters.

11 DR. BAICKER: I like that way of framing it, and
12 clearly Craig is not an economist because we're always
13 trying to inject a note of pessimism.

14 [Laughter.]

15 DR. BAICKER: And the idea is that, you know,
16 there's no -- no matter how you read the evidence, there's
17 nothing to suggest that everything's fine and we can stop --
18 we can be less vigilant on our efforts to try to get higher
19 value, slower spending growth. All the evidence is
20 consistent with being worried about managing this more
21 efficiently in the future.

22 DR. SAMITT: I feel I need to defend myself now

1 about being optimistic.

2 [Laughter.]

3 DR. CHERNEW: That's a compliment, not being an
4 economist.

5 DR. SAMITT: I took it as such. But I think, you
6 know, my comments about optimism are really about
7 interventions, not about ultimate results that, you know,
8 yes, we need to remain prudent and vigilant in making sure
9 that we can maintain a slowdown. But I would like to be
10 able to say our principles, and some of the avenues by which
11 we feel we can influence future trends, we should be more
12 vocal about those and optimistic about our ability to
13 influence total cost of care and clinical quality outcomes.
14 I think that's what I mean by optimism.

15 MR. HACKBARTH: Any other reactions to what I'm
16 proposing?

17 MR. BUTLER: I think it's a good reaction. I
18 would reinforce -- and I've been around a long enough time
19 that I think -- and as somebody who's managing that,
20 observing, I think it's different. I do think that this is
21 a more sustainable change in thinking about how we're
22 delivering services. So I am optimistic.

1 DR. HOADLEY: I just wanted to add a quick thing.
2 It seems like there's a little bit of intersection with some
3 of the points that Jon was making, because as the chapter
4 very explicitly says early on, OACT has sort of taken the
5 view that the slowdown will not be sustained, and so that is
6 part of what they're putting into those projections that
7 lead to the numbers that we're presenting. So maybe sort of
8 remaking that point, I mean, so they may be doing it -- you
9 know, who knows why they're sort of making that kind of
10 statement, but they may be doing it partly out of that same
11 spirit of, well, whatever happens. But if we can sort of
12 frame that a little bit, that might be helpful.

13 MR. HACKBARTH: Okay. Thanks, Julie and John.
14 And so we will see a revised version of this chapter --
15 when, Jim?

16 DR. MATHEWS: Within the next couple of weeks.

17 MR. HACKBARTH: And we're going to be -- well,
18 this will just -- there won't be another public discussion
19 of it. It will just be distributed --

20 DR. MATHEWS: There will not.

21 MR. HACKBARTH: -- for comments.

22 DR. MATHEWS: Correct.

1 DR. MARK MILLER: And given some of these
2 comments, we can revisit how fast we can turn this around.
3 There's a little more than I [off microphone].

4 MR. HACKBARTH: And, Jon, so the process here is
5 Jim has these blue forms, and if you wish to review a
6 chapter and have the opportunity to make comments on it
7 before it's published, sign up on that blue form, and Jim
8 will make sure that you get the next revised version.

9 [Pause.]

10 MR. HACKBARTH: Okay. Now, we're moving on to
11 Accountable Care Organizations. David.

12 MR. GLASS: Thank you. Accountable Care
13 Organizations, or ACOs, have been in the news and are
14 developing rapidly, so today, we are giving a brief update
15 on recent developments in Medicare ACOs and outline some
16 considerations for the future.

17 I will very briefly review the background of how
18 ACOs came about and where they fit in the payment spectrum.
19 We will then look at recent developments in Medicare ACOs,
20 look at some shorter-term opportunities for program
21 refinement, and look at some future directions the
22 Commission may want to pursue longer term.

1 Very briefly, policy makers wanted something like
2 ACOs because Medicare volume growth was thought to be
3 unsustainable, quality uneven, and care uncoordinated.
4 Wanted to create an MA-like incentive to control volume
5 without requiring an entity that could accept full capitated
6 payment and the risk that goes with it, and also that does
7 not require an entity to create contracts with providers and
8 pay claims. The other motivation was they did not want to
9 lock the beneficiary into a limited network, wanted to allow
10 them choice of provider.

11 Conceptually, if a pure fee-for-service is at one
12 end of the payment spectrum and MA at the other, ACOs are
13 somewhere in between. In pure or unaccountable fee-for-
14 service, payment is by service. It is silo-based. Some
15 quality incentive, as in the VBP program. And no provider
16 is at risk for total cost of care.

17 ACOs are a step toward integration. Although ACO
18 members still get fee-for-service payments, they also have a
19 chance to receive some form of shared savings and there is a
20 quality incentive. They can also be at some risk, depending
21 on the model.

22 At the other end of the spectrum, we have the MA

1 program. Here, entities get fully capitated payments, are
2 at full risk, and have to contract with providers and pay
3 claims. In essence, they are insurance companies. Another
4 way of thinking about it is moving from individual service-
5 based payment to population-based payment. The ACO payment
6 is kind of a mix between service-based and population-based.

7 Medicare ACOs are health care organizations formed
8 around a core group of primary care providers serving at
9 least 5,000 fee-for-service Medicare beneficiaries. Those
10 providers could be, for example, physicians, nurse
11 practitioners, or physician assistants. While an ACO must
12 have primary care providers, having a hospital or specialist
13 in an ACO is optional. Beneficiaries are assigned to ACOs
14 using primary care claims, and the details differ somewhat
15 between models. ACO beneficiaries are still free to use
16 providers outside of the ACO, and if they go to a specialist
17 or hospital outside of the ACO, the ACO remains responsible
18 for their spending.

19 Providers both inside and outside the ACO continue
20 to be paid their normal fee-for-service rates. ACOs can
21 share in savings with the Medicare program if their
22 expenditures are lower than the target and they exceed a

1 minimum savings threshold. The ACO can then pass those
2 savings on to providers who are members of the ACO.

3 There are two Medicare models, the Pioneer ACO
4 Demonstration and the Medicare Shared Savings Program, which
5 was created in statute. The two programs have much in
6 common. Beneficiaries are assigned, not enrolled. No lock-
7 in to an ACO network. The ACO is responsible for spending
8 and quality.

9 However, there are some differences between
10 Pioneer and Shared Savings ACOs. Pioneers tend to be
11 larger. That is the 15,000 versus 5,000 there. They are at
12 risk for losses, although some only start in the second
13 year. And they need to have other payers in ACO-like
14 arrangements. And they competed to be in the demo and were
15 chosen based on their experience or readiness for ACO sort
16 of payments. Finally, they tend to have a higher share of
17 savings because they are more at risk.

18 Medicare ACOs are already fairly widespread across
19 the nation. All but four States have ACOs, and there are
20 quite a few in States such as Florida, California, and
21 Texas.

22 There are now about 220 ACOs in the Medicare

1 Shared Savings Program and 23 in the Pioneer Demonstration.
2 They are disproportionately in higher-spending areas, as we
3 discussed last April. About half of ACOs are physician
4 groups without hospitals. And there are ACOs serving rural
5 areas as well as metropolitan areas and many serving a mix
6 of both.

7 The Pioneer Program started over a year ago.
8 There were 32 ACOs in the program with about 670,000
9 beneficiaries by the end of the year. CMS reports that 13
10 of the ACOs had enough savings to meet the minimum savings
11 threshold, generally about one percent. Two ACOs shared in
12 losses. The other 17 had either savings or losses below the
13 minimum threshold or were in a payment arrangement that did
14 not share losses in the first year.

15 So, nine of the 32 ACOs withdrew from the
16 demonstration in July. Twenty-three ACOs are staying in the
17 demo. Seven are reported to be applying for the MSSP
18 program and two likely will not be Medicare ACOs.

19 From our discussions with ACOs and CMS thus far,
20 we hear that the incentives in the program are enough to
21 induce ACOs to make changes to better manage care and work
22 across silos, for example, to try to reduce readmissions or

1 improve care coordination for high-cost beneficiaries.
2 Although there were some concerns about quality benchmarks,
3 ACOs all did report on quality and many did better than
4 nationwide fee-for-service.

5 CMS reports Pioneer spending growth of 0.3 percent
6 -- that is spending per beneficiary -- and growth for
7 similar beneficiaries nationwide to have been about 0.8
8 percent. And the difference is considered program savings
9 of about 0.5 percent.

10 CMS reported program savings, and as we noted,
11 some ACOs achieved savings and others did not. What we
12 would like to know is how much of these savings and losses
13 are real and how much random variation. Also, will
14 benchmarking, that is, setting targets, need to be refined?
15 We also want to think carefully about what is required for
16 overall system savings. In the first year, CMS reports
17 program savings of 0.5 percent, but if the cost of running
18 an ACO is about one or two percent, is the system as a whole
19 achieving savings, and from the provider's perspective, is
20 it sustainable? How large do savings need to grow to
21 justify the cost of running an ACO? And will savings
22 increase over time and make that possible?

1 It is worth noting that the 0.8 percent increase
2 for similar beneficiaries is very small and may not have
3 been what the ACOs were thinking of when they signed up. It
4 is more difficult to get savings of one or two percent when
5 fee-for-service is increasing at less than one percent a
6 year than when it is increasing at four or five percent a
7 year.

8 There are a number of near-term options for
9 refining the ACO program that the Commission could consider
10 addressing. By near term, we mean things that could be put
11 in place before the three-year MSSP contracts begin to
12 expire in 2015. Some of these, the Commission has already
13 raised with comment letters.

14 First, we suggested that visits to RHCs, FQHCs,
15 and non-physician practitioners be counted in the assignment
16 algorithm for the Medicare Shared Savings Program. This was
17 addressed in a somewhat convoluted way. The second stage
18 was included in the assignment algorithm that allowed those
19 visits to count if there was a triggering visit to a primary
20 care physician in the ACO, as well. CMS maintains that the
21 statute requires that approach. We could recommend a change
22 in statute.

1 We also proposed assessing benchmark spending and
2 savings with standardized prices to approximate service use.
3 This would help establish congruence in targets and
4 performance across the country and avoid problems when
5 things like the wage index changes or the sequester hits.

6 CMS did remove DSH and IME payments from the
7 calculation for the Medicare Shared Savings Program.

8 We could also consider refinements on beneficiary
9 and quality issues, which we discuss on the next two slides.

10 We raised some issues with the quality measures
11 and scoring for ACOs. We suggested a smaller set of
12 measures focused on outcomes and more predictable scoring.
13 ACO reduced the number of measures from 65 to 33, but did
14 not change the scoring method in the Medicare Shared Savings
15 Program.

16 There's also the question of whether fee-for-
17 service quality incentives should continue to be operative
18 if providers are in ACOs. Continuing them could reinforce
19 incentives. For example, both the hospital and the ACO
20 could have a readmission reduction policy. But that could
21 be thought duplicative and unnecessary. For example, the
22 ACO should already want to avoid excess readmissions because

1 they are accountable for costs.

2 DR. MARK MILLER: [Off microphone.] You haven't
3 gone through the beneficiary incentives, right?

4 MR. GLASS: Oh, I'm sorry. Did we miss --

5 DR. MARK MILLER: I think you might have just
6 jumped out of sequence.

7 MR. GLASS: Oh, I'm sorry.

8 DR. MARK MILLER: Okay. And could you just get a
9 little closer to the microphone.

10 MR. GLASS: I will attempt to. All right. Let us
11 try again on the beneficiary incentives.

12 DR. MARK MILLER: [Off microphone.] David, you
13 are doing great.

14 MR. GLASS: At issue --

15 [Laughter.]

16 MR. GLASS: Yeah. Thank you, Mark.

17 An issue that the Commission has raised in the
18 past is that the beneficiary should share in some way if
19 savings are achieved, perhaps through lower cost sharing in
20 the ACO. Lower in-network cost sharing could increase
21 engagement, but its effectiveness may be limited because
22 many beneficiaries have supplemental insurance that already

1 pays their cost sharing.

2 One way around that problem might be something we
3 are calling a Medicare Select ACO Medigap Plan. We have
4 included in your mailing materials a description of how such
5 a thing could be designed. The basic idea is that there
6 would be lower cost sharing for primary care from ACO member
7 providers. The beneficiary would need to buy the Select
8 Plan and the lower cost sharing would increase loyalty to
9 the ACO primary care providers. Decreasing leakage is
10 something ACOs have said is important.

11 If beneficiaries can sign up for a Select Plan and
12 specify a primary care provider who is in an ACO, then this
13 would essentially allow attestation. This could be looked
14 upon as a good thing to inform and align beneficiaries, make
15 them a more active partner, or perhaps it could be
16 confusing. We can go into more detail on this concept in
17 the question period.

18 Now, we will turn to the quality issues.

19 So, in the comment letters, we raised some issues
20 with the quality measures and the scoring for ACOs. We
21 suggested the smallest of the measures and the CMS did go
22 from 65 to 33, but it didn't change the scoring method.

1 Then we've also raised the question of whether
2 fee-for-service quality incentives should continue to be
3 operative if providers are in ACOs. Continuing them could
4 reinforce the incentives, but they could be thought
5 duplicative and unnecessary. For example, the ACOs should
6 already want to avoid excess readmissions because they're
7 already accountable for costs. In the MA program, fee-for-
8 service quality incentives are not a factor.

9 Finally, and this is verging into a longer-term
10 issue, should we consider that the design of quality
11 incentive programs differs among fee-for-service, ACOs, and
12 MA? Each system uses different metrics and fee-for-service
13 operates on a provider basis rather than on a population
14 basis. A common platform would need common metrics and,
15 ideally, a population emphasis, for example, rates of
16 complication or avoidable admissions and perhaps a
17 geographic area.

18 There are several issues the Commission may want
19 to consider looking forward. The first issue is, in the
20 future, do we want to move to a level playing field across
21 traditional fee-for-service, ACOs, and MA? We already
22 mentioned the quality aspects of this question, but it

1 rises, as well, for payment. A level playing field could
2 promote efficiency because beneficiaries could choose MA
3 plans if they were more efficient and offered extra
4 benefits, where ACOs might be able to achieve shared savings
5 by being more efficient.

6 To achieve a level playing field, we would first
7 need to harmonize benchmarks across the programs. Now, ACOs
8 and MA take two different approaches. In ACOs, the
9 historical experience of the beneficiaries assigned to the
10 ACO is the starting point and the actual nationwide trend is
11 used and the calculation is made retrospectively. In MA, a
12 local fee-for-service baseline is used with a projected
13 national trend and payment is prospective. In addition, the
14 benchmark can be anywhere from 95 to 115 percent of local
15 fee-for-service in MA and there is a system of bidding and
16 rebates. We have described this briefly in your mailing
17 materials and Scott and Carlos can answer questions about
18 how it works in detail.

19 If benchmarks were harmonized, we would also need
20 to harmonize risk adjustment. ACO uses essentially the
21 historical baseline and the categorical or demographic
22 method. MA plans use hierarchical condition categories, or

1 HCCs, for risk adjustment. These two methods differ and
2 each has its strengths and weaknesses. Dan will talk about
3 HCCs in more detail later today.

4 We will continue to update you as additional data
5 come in on the ACOs' first year performance. To make sense
6 of the data, we plan to interview ACOs and CMS. We have
7 engaged a contractor to help us interview Pioneer ACOs as a
8 start.

9 For today's discussion, you may want to consider
10 steps to refine beneficiary notification and opt-out, also,
11 engaging the beneficiaries through lower cost sharing. One
12 way to address this is the Medicare Select Medigap plans we
13 discussed. We are interested in what you think of that idea
14 and if there are other approaches you would like to discuss.

15 We have also raised the issue of a measure of
16 service use instead of spending to make ACOs and their
17 targets more comparable across the nation, and also moving
18 towards common quality measures across fee-for-service,
19 ACOs, and MA.

20 This slide lists some potential longer-term issues
21 for discussion. Should there be a common platform for
22 payment? If so, should it start with the improvement over

1 historical, the ACO method, or with local fee-for-service as
2 a benchmark, the MA approach? Should the target be set in
3 advance? That is, should a projected trend be used, or
4 should the budget be based on actual spending? The
5 retrospective ACO method is more precise, but the target is
6 not known until the year is over. The MA method is less
7 precise, but the benchmark is known from the start. A
8 common platform would also require a common approach to risk
9 adjustment. Should the historical spending categorical
10 trend approach of ACOs be used or the ACC approach that is
11 used in MA?

12 We look forward to your discussion and would be
13 happy to try to answer any questions you may have.

14 MR. HACKBARTH: Okay. Round one clarifying
15 questions. Let me see everybody's hand who has a clarifying
16 question. I see George, Peter, Dave. Okay. We'll go that
17 way. George, Peter, Dave.

18 MR. GEORGE MILLER: Just right quick, on Slide 15,
19 as we had an earlier discussion, how are we defining a level
20 playing field with respect to these three on this slide?
21 Have we figured that out yet?

22 MR. GLASS: Well, we are kind of raising that for

1 your discussion.

2 MR. GEORGE MILLER: Oh, okay.

3 MR. GLASS: You know, one --

4 MR. GEORGE MILLER: You want me to define it for
5 you?

6 MR. GLASS: -- from the spending point of view,
7 you have to -- presumably, you might want to start with the
8 same benchmark and you might want to update it the same way
9 and you might want to have the same risk adjustment. So
10 those are the first things we thought of. There may be a
11 lot of others that would be required.

12 DR. MARK MILLER: Yeah. I think, again, back to
13 some of the discussion, it's more, George and others, if
14 this is on your mind, the notion of trying to at least pay
15 attention out of the blocks to big gaps and seams and
16 differences between these systems that might create funny
17 cross-incentives, I think is -- and we needed to pick some
18 set of words in order to not have to say these words every
19 time.

20 MR. GLASS: And I guess another way of thinking of
21 it is there are a lot of refinements that would be possible
22 to the current model, but do we want to spend a lot of time

1 doing that or do you want to spend more time thinking about
2 making them match up to MA?

3 MR. HACKBARTH: George, did that --

4 MR. GEORGE MILLER: [Off microphone.] Yes.

5 MR. HACKBARTH: Okay. Peter.

6 MR. BUTLER: So, Slide 8. So, my understanding is
7 there are about four million people in ACOs. They may not
8 all know it, but there are roughly four million or about
9 approaching ten percent of the Medicare beneficiaries. So
10 the half of the physician groups that are physician groups
11 without hospitals, you know, I've looked at the list once,
12 but I've forgotten. How -- and, by the way, if you have 243
13 altogether, that is, like, 16,000 lives per ACO, just to put
14 it in perspective.

15 But the size of the physician groups, in general,
16 most of them are a heck of a lot smaller than Dean Health,
17 for example. Do you know, have a sense of how big the
18 physician groups are, on average, that are the 100-plus
19 participants?

20 MR. GLASS: No, I don't. We can find that out for
21 you. But I think you'll find that some are like Monarch or
22 something very large, or Health Partners --

1 MR. BUTLER: I think an awful lot are as few as --

2 MR. GLASS: And then a lot of them could be very

3 small, yes.

4 MR. BUTLER: -- five, ten physicians in a primary

5 care group.

6 MR. GLASS: Right, who --

7 MR. BUTLER: Not a small number, right?

8 MR. HACKBARTH: I don't know how it breaks down --

9 MR. GLASS: Yeah.

10 MR. HACKBARTH: -- but some of the physician-

11 sponsored ACOs are quite small.

12 MR. BUTLER: Okay.

13 MR. GLASS: Right, the limit being they have to

14 have over 5,000 beneficiaries.

15 MR. HACKBARTH: But that's not a very big group.

16 Dave.

17 DR. NERENZ: Bottom of Slide 4, please. Just a

18 semantic question, payment delivery system. Is this to mean

19 that payment and delivery are more integrated with each

20 other as you go to the right, or does it mean that payment

21 and delivery as two separate things are more integrated

22 within each of their separate domains as you go to the

1 right?

2 DR. MARK MILLER: What I would have said, yeah, is
3 that what it's really referring to is delivery system
4 integration, and then payment is changes as you're moving
5 from left to right. More the latter than the former.

6 MR. HACKBARTH: So, could you help me and just
7 sort of explain more --

8 DR. MARK MILLER: [Off microphone.] -- question.

9 MR. HACKBARTH: Yeah. What's behind your
10 question?

11 DR. NERENZ: Yeah, I don't think delivery system
12 integration is more apparent on the right, and it's not
13 inevitable on the right. I'm not sure it necessarily
14 happens on the right. I just didn't know if that's what you
15 meant or not what you meant.

16 MR. HACKBARTH: I agree with what you said. It's
17 not inevitable, but it may be a somewhat greater tendency as
18 you move down the right.

19 Others?

20 [Pause.]

21 MR. HACKBARTH: Okay, so let's go to round 2. And
22 I would really like to get to round 3 this time, and so I

1 urge people to be really concise in their comments.

2 And, Craig, I'm going to start with you.

3 DR. SAMITT: Sure. I think it was an excellent
4 overview. Thank you very much.

5 And I'll look forward to sharing our own
6 experiences with shared savings program in the Pioneer.

7 But the observation that I'd make from my own
8 experience is this notion of a level playing field between
9 the three major groupings -- Fee-for-Service, ACO and
10 Medicare Advantage -- is really not level, and it's
11 imbalanced.

12 And I guess the perspective that I would have is
13 that on the provider side the investment that's needed to
14 perform in the ACO world and in the Pioneer world is far
15 closer to Medicare Advantage, but the patient population and
16 the expectations and what they're used to in terms of care
17 delivery methods to the beneficiary are much more like Fee-
18 for-Service. And it creates a significant imbalance, where
19 the providers need to make a large investment, but it's very
20 hard to bend the curve and influence either quality or cost
21 because of historical expectations of the Fee-for-Service
22 populations.

1 So I very much like the short-term and long-term
2 issues that you've raised.

3 And I think the improvements really need to focus
4 on moving to a somewhat more middle ground with ACOs and
5 Pioneer being somewhat more middle-based between Fee-for-
6 Service and MA, and that would include lower cost-sharing in
7 ACO to encourage reduced leakage and in-network use. And I
8 like the alternative proposal that you made in that regard -
9 - the select option.

10 But I do think benchmarking and risk adjustment
11 should be more MA-like because right now, again, it's too
12 balanced or directed toward the Fee-for-Service methods.

13 The one other comment that I would add is when we
14 think about level playing field on slide 15 I think we also
15 need to think beyond just Fee-for-Service and ACO and
16 Medicare Advantage. I think we need to know; are all
17 providers who are getting into the ACO space also on a level
18 playing field?

19 So, when you look at how the ACOs are doing and
20 how the Pioneer programs are doing, are we finding that
21 certain types of institutions are staying in and certain
22 types of institutions are getting out, and have we created a

1 scenario which creates an inappropriate balance?

2 So, for example, you talk about nearly half of the
3 ACOs being in physician groups without hospitals. How are
4 those types of ACOs faring versus ACOs that are more
5 hospital-driven and hospital-directed?

6 I think that's worthy of more attention because I
7 would argue we want all kinds of ACOs to thrive, and we
8 should be studying that a little bit more thoroughly. So,
9 as we look at short-term and long-term issues, that's the
10 only one that's missing that I would add to the list.

11 DR. CHRISTIANSON: Yeah, just a couple of
12 thoughts.

13 The discussion of harmonizing was interesting, but
14 I would like to see more discussion on the issues around
15 trying to get the right level of reimbursement for ACOs
16 independent of harmonizing. I think that's going to be the
17 key to the success of this program.

18 And what do I mean by right? That's what we have
19 to talk about, but I think it's a level that's high enough
20 to succeed in attracting and retaining participation but low
21 enough so that Medicare is going to save money and, in the
22 long run, something that won't be subject to some of the

1 political issues that have arisen in terms of reimbursing
2 MAs.

3 So I'm actually a little more optimistic here than
4 I would be more for Medicare Advantage plans.

5 In part, this gets me into the second point I want
6 to make, and that is the whole issue of patient engagement
7 and the notion that if people knew they were in an ACO or
8 were kind of enrolled, that would create more patient
9 engagement.

10 It also would recreate the political environment
11 that the health plans have used to great success to maintain
12 their rates, which is to mobilize the people who are
13 enrolled in plans to say don't take away my plan.

14 So, if you don't know you're enrolled in a plan --
15 that mechanism -- we're sort of ending up with rates that
16 are higher than possibly they should be, which I think many
17 of us think has happened historically based on the research.

18 So we have to be careful between sort of how we go
19 about the patient engagement thing so that we don't just
20 recreate some of the same problems that have plagued the
21 rate-setting process in the MA program over the years.

22 And then one final comment on leakage -- leakage

1 is an opportunity for managers to try to become more
2 efficient in terms of the way they establish their delivery
3 systems.

4 So I know in the private total-cost-of-care
5 contracts that I work with, having the data to show that
6 patients are going somewhere else and seeing that, gee, it
7 costs less when they go somewhere else than when they stay
8 in-system is turned around to try to figure out how to
9 become more efficient internally -- what are we not doing
10 that those people are doing?

11 And so leakage -- the whole notion of leakage is
12 implicit in this program, but I think it's an opportunity
13 for managers to become more efficient. And I don't think
14 it's something that in the short run we should wring our
15 hands about too much, but we should try to learn from ACOs
16 that are trying to manage that leakage efficiently.

17 MR. HACKBARTH: Are there any plans to survey
18 Medicare beneficiaries assigned ACOs to determine how much
19 they understand about what's going on, whether they know
20 they've been assigned to an ACO? Does CMS have any plans on
21 that?

22 MR. GLASS: I don't know the answer. We will look

1 into it.

2 MR. ARMSTRONG: Just to echo a couple of the other
3 points just made, I think the way in which the discussion
4 issues both in the short term and the long term are
5 organized -- I think it's excellent, and it builds on the
6 analysis that was here.

7 What we're trying to do, I think, at least based
8 on my experience with a non-ACO ACO, is that we're trying to
9 reconcile the fact that the way you achieve these
10 distinctive outcomes is really a package deal.

11 I mean, it comes from reforms to how you pay
12 providers, and that's really where we pay most of our
13 attention. But it also has to come from the innovations and
14 changes in care delivery itself that, hopefully, you inspire
15 through payment changes, but is an investment in a product
16 that is much more complicated than just payment alone will
17 necessarily construct.

18 And then, third -- and this touches on it -- you
19 have to have a relationship with the beneficiary themselves.
20 You have to know who they are. They need to care about
21 their health, and they need to be not just examined in our
22 exam rooms but inspired to own some responsibility for

1 advancing their own health.

2 I feel like we're laying out issues that do a
3 pretty good job through our agenda of touching on as many of
4 those three different areas we can, but it just feels a
5 little like a mismatch.

6 And I think our best hope will be to hold that
7 tension as we go forward, but that's -- and I think we're
8 doing a great job of that, but I think issues around the
9 kind of systemness that achieves better outcomes will
10 continue to be a part of the work that we do as we go
11 forward.

12 One other smaller point I would make is that we
13 talk about harmonizing and being able to compare
14 utilization, quality, service, cost, whatever the outcome
15 might be, across different kind of payment models. I assume
16 we're also imagining in that continuum not just these three
17 spots but bundled payments for post-acute care or some of
18 the other issues that we're talking about.

19 I realize today is about ACOs, but I don't want to
20 lose the prospect of harmonization that's more than just
21 around these three different spots along our continuum.

22 DR. REDBERG: It was an excellent chapter, and it

1 really laid out much more clearly for me the issues of ACOs,
2 but it really made me realize how complex it is and what a
3 chess game it is because when you don't know -- when you
4 haven't chosen to be in an ACO, you obviously don't have the
5 same kind of investment in the ACO. You know, you may or
6 may not, but as you may be in it without even knowing, it's
7 not.

8 And so the idea I thought you presented of lower
9 cost-sharing was great. But then, of course, what about
10 supplemental insurance which takes away any of the benefits?

11 And then you proposed the Medigap, but it's just
12 so complex an issue and really important to address because,
13 otherwise, I think it's going to be very hard for these ACOs
14 to be successful.

15 And I am concerned about the leakage, as you noted
16 in the report, because right now Medicare beneficiaries
17 commonly have multiple physicians, multiple primary care
18 providers and specialists, and especially without having
19 chosen to go into an ACO and without them seeing any
20 advantage to changing their usual pattern of care, I think
21 it's going to be hard for any ACO to be successful.

22 And so I think those are really important issues

1 to address, and they were all addressed in this report, with
2 different possibilities. But I think there will need to be
3 changes for ACOs to be really successful.

4 I would also be interested in two things you
5 alluded to in the report -- the alternative quality
6 contracts in Massachusetts and how those savings have
7 increased over time and what we could learn from that and
8 bring back to Medicare.

9 And also, I'm just interested in particularly
10 looking at what -- because I'm not that familiar with that -
11 - what are the costs of maintaining an ACO?

12 I think you said \$10 to \$20 per month per
13 beneficiary, but what is it generally spent on?

14 MR. GLASS: From ACOs we've talked to so far, it's
15 been like 1 or 2 percent, Jeff?

16 DR. STENSLAND: Yes.

17 MR. GLASS: I don't know. What are they spending
18 it on?

19 DR. STENSLAND: A lot of it is like care
20 coordinators. So a lot of the common strategies are let's
21 pick out who are the 10 percent of the people that cost us
22 the most money last year. Let's get a care coordinator to

1 talk to them about, you know, monitoring their weight,
2 monitoring their blood pressure, getting into their regular
3 visits -- that type of thing.

4 Some of the stuff they spent it on is, okay, let's
5 just analyze our data. You know, why do our Fee-for-Service
6 or these ACO people spend 20 days on average in the SNF and
7 our MA people spend 10? Something's up here -- that kind of
8 thing.

9 MR. KUHN: Two quick points and two questions.

10 The first one goes to the issue of beneficiary
11 incentives. I really like the part of the paper where the
12 discussion of the Medigap plan option, the Stark referral
13 issues that have to be worked through -- but I just think
14 the more we can think about beneficiary incentives because
15 Craig is absolutely correct.

16 As I talk to a lot of ACOs, the issue of
17 investment without some kind of better understanding of the
18 market is very difficult to continue to drive that forward.
19 So I think anything we can continue to think about in that
20 area and drive policy would make a lot of sense.

21 The second issue is throughout the paper and
22 throughout the conversation all the conversation has been

1 about efficiency and quality, but nowhere are we talking
2 about improvement of access. So anything that we could
3 develop before the future paper about improvement of access
4 and what ACOs bring to that part of the dimensions of the
5 Medicare benefit would be great.

6 On my two questions, one is the issue of
7 attribution. I understand -- and tell me if I'm inaccurate
8 here, but -- for both Pioneer and MSSP you use different
9 attribution models. One uses HCC scores. Pioneer uses
10 something different. Is that correct?

11 MR. GLASS: You mean risk adjustment?

12 MR. KUHN: Attribution. When they make a
13 determination of the attribution for them, do they use
14 different, or are the attribution models the same for the
15 two.

16 MR. GLASS: The attribution doesn't use HCC or --

17 MR. KUHN: Okay, but are the assignments are the
18 same?

19 MR. GLASS: It's not quite the same.

20 MR. KUHN: Okay.

21 MR. GLASS: There's something they call -- what is
22 it -- qualifying E&Ms or primary care services or something

1 like that.

2 MR. KUHN: So when they engage an evaluation
3 contractor to look at the performance of the two, how will
4 they adjust for the different attribution efforts, or do we
5 have any sense of that?

6 MR. GLASS: Yeah.

7 MR. KUHN: Just so we really kind of understand
8 which one is performing better as we go forward on that.

9 MR. GLASS: Well, I guess you might look at how
10 are organizations choosing. Some are leaving Pioneer to go
11 into MSSP. We could investigate why they -- or, you know,
12 some of the issues on that.

13 MR. KUHN: Yeah, and whether there are any other
14 differences between the two would be interesting to know,
15 particularly when they get an evaluation, to help us kind of
16 understand that.

17 MR. GLASS: Yeah.

18 MR. KUHN: And then the third, or the final,
19 issue, again, is thinking about the investments and
20 certainty of this model.

21 And I've heard from -- or, I think I've read, I
22 should say, in some periodicals where there is still this

1 notion where the Federal Trade Commission is kind of out
2 there looming. And they may or may not look at this model
3 in the future primarily because you basically have providers
4 talking to one another and talking about prices, talking
5 about different things out there, as part of this on a go-
6 forward basis.

7 When you're out on the road, interviewing ACOs, if
8 that's something that would be -- you could ask them that
9 question. If that is a concern, if that even plays into
10 their thinking of whether to make future investments in
11 these -- I'd just be curious about that one.

12 MR. GLASS: To be clear, you're saying whether the
13 anti-trust concerns are slowing development?

14 MR. KUHN: Yes.

15 DR. MARK MILLER: Let me add one thing just to
16 keep in your minds. We could take this posture of, okay,
17 let's see how each of these things perform and how did we
18 control for differences, or do the evaluators control for
19 differences.

20 The other way you can be thinking about this
21 conversation is trying to pull input out of the environment
22 in a relatively rapid time of the ACOs' experience.

1 And how would you as a commission say, look,
2 there's going to be a new contract cycle. How would we want
3 that contract cycle to be influenced?

4 And whether it's a matter of waiting for
5 additional evidence or trying to make -- you know, if you
6 want to change the way the beneficiary is incented and
7 engaged the next contract cycle, or you want to change the
8 way the attribution rules work, one of the things we could
9 recommend to the Congress or the Secretary, depending on
10 which way it has to go, is to say, look, move to this
11 attribution rule and use it everywhere and move the shared
12 savings program in this direction.

13 So, in addition to gathering information and
14 trying to get it out of the system in real time, bear in
15 mind that the other thing you can do is to say there's
16 enough feedback at this point to say make the next
17 generation move this way.

18 DR. COOMBS: So I have a couple points.

19 One is looking at the ACO and what they do at a
20 larger scale in terms of public health and community health
21 and what's the health care outcome. Are there ways of
22 measuring that?

1 And this is something that Herb said, and I
2 thought about this -- looking at the percentage of new
3 enrollees in some of the pilots that are already out there,
4 to look at the comparison between MA and ACOs.

5 I think that one of the underlying assumptions
6 that this graph implies on 4 is that we're going from 1 to
7 the other, but it's possible that you might have a triangle
8 or you might have a direct Fee-for-Service to an MA plan,
9 and that might be an easier path in some scenarios.

10 Lastly, we use on slide 15 the 2 risk adjustments.
11 It might be possible come up with something that's an
12 amalgamation of the two as an end product, and that would be
13 something that maybe the Secretary could look at.

14 DR. CHERNEW: So, two points.

15 The first one is very much in the spirit of what
16 Mark said. I think it's useful for us to spend some time
17 thinking about how we'd want the rules to develop as they go
18 to their next contracting cycle and thinking about of the
19 many aspects of the rules which ones are most important.

20 My three most important are the assignment rules,
21 the risk-sharing provisions -- downside, not how much -- and
22 what I'll call broadly, regulatory relief.

1 I'm worried that we're going to put a regulatory
2 burden on these organizations in a way that will not make
3 them succeed. I don't know how much that's true, but I'm
4 worried about that.

5 Then, with regards to slide 6, you have -- slide 6
6 is the one that has the shared savings in a Pioneer
7 comparison. It would be interesting for me to think about
8 MA on a slide like that and then to begin to think in a big-
9 picture world where -- there's going to be a ton of
10 differences between the ACOs and the MA program and even
11 within the ACOs, as the slide illustrates. What are the
12 big-picture types of seams, if you will, that we should
13 think about harmonizing -- because we're not going to
14 harmonize all of them.

15 The ones that, again, are my top choices in the
16 spirit of what Jon said -- the payment rate, particularly
17 the benchmark. How are they -- you know, how is the payment
18 rate working? The risk adjustment has to be consistent with
19 that. Authority over benefit design. Aspects of the
20 quality measurement. Those are the things that I'm most
21 concerned about.

22 The other one, which I actually don't think we

1 have authority over, which I think matters, is aspects of
2 regulation and reserve requirements when providers are doing
3 things.

4 I'm sure there are others, but I think before I
5 know what the most important ones are, having a laundry list
6 of which ones might be really big differences, that are
7 problematic, that we could spend our time trying to sort
8 through, would be useful.

9 DR. BAICKER: One bigger-picture point and one
10 smaller point. Trying to combine the points made by David
11 and George about what we mean by leveling the playing field
12 and the point raised by Jon about wanting to focus on the
13 right level of payment, when I think about leveling the
14 playing field, I'm thinking about being neutral about where
15 patients get particular types of care, but not neutral about
16 how efficiently that care is delivered. So we're willing to
17 pay whatever the right amount is to achieve the outcomes
18 that we think can be achieved without being very dictatorial
19 about where patients get that care, what combination of care
20 gets them to that outcome. That attitude would result in
21 favoring more efficient mechanisms for achieving those
22 outcomes. If we're paying for the outcome and somebody's

1 better at doing it, that will get patients towards that site
2 or that provider or that mode of care.

3 So I think we explicitly don't want to be neutral
4 about some things while being neutral about letting patients
5 achieve those ends in the ways that match their preferences,
6 their family's preferences, their tolerance for different
7 side effects, things like that, and that goes towards some
8 sort of reference model that we're leveling, not the
9 particular payment to the particular entity.

10 The smaller point is I remain nervous about
11 beneficiaries opting out of being counted in ACOs. I think
12 there's a lot of rationale for saying that they can opt out
13 of having their providers know their information, although
14 that ties the providers' hands in then improving their care.
15 But I still worry that with even a relatively small share of
16 patients opting out of having their data counted, it's all
17 too easy to make sure that it's the expensive people who are
18 opted out, and there are ways around that that will allow
19 patients to opt out but do better risk adjustment based on
20 the share opting out. There are technical ways to address
21 this, but I think in thinking about whether we think that's
22 a good idea or not, we have to be cognizant of the net

1 effect on spending that even a small amount of gaming for
2 expensive people could generate.

3 MR. HACKBARTH: Do you see the risk in ACOs of
4 encourage to disenrollment as greater or smaller than
5 Medicare Advantage?

6 DR. BAICKER: I don't have a great answer to that
7 except that the extent to which risk adjustment is
8 successfully built into the MA payments, then when you
9 discourage patients, you lose the payment for them, and you
10 lose the risk. Whereas, with ACOs -- I may be
11 misunderstanding the detail of what happens when a patient
12 opts out of being counted. The provider still gets
13 reimbursed for that patient, right? And so the difference
14 is that MA, if you get people to disenroll, you lose their
15 risk and you lose their payment. And so if the risk
16 adjustment is okay, that's all right. Whereas, with the
17 ACOs, if you're still getting paid, yeah, so I think that
18 that introduces -- but it's a smaller share of the risk that
19 they're taking on and how those two factors --

20 DR. MARK MILLER: I want to work through this for
21 a second here. So when the beneficiary in this particular
22 instance opts out, they're still in the ACO. The ACO is

1 blind to their data.

2 DR. BAICKER: And I was saying that I can
3 understand more versus -- there's discussion in the chapter
4 about what would happen --

5 DR. MARK MILLER: Allowing them [off microphone].

6 DR. BAICKER: -- allowing them to just opt out
7 altogether, and that concerns me more.

8 DR. MARK MILLER: Now I understand [off
9 microphone].

10 MR. GLASS: Right, because they can opt out, but
11 the fee-for-service payments will still flow in.

12 DR. MARK MILLER: [off microphone].

13 DR. NAYLOR: A terrific report, and I do not want
14 to repeat a lot of what my colleagues have said. A caveat,
15 of course, is that I think we're still very early in our
16 understanding about the model and its impact and
17 sustainability, and I think you've done a great job of
18 highlighting that.

19 I do want to highlight, you know, reinforce the
20 principles and Herb's around the issue of access and quality
21 and efficient providers, and it's in that line that I'll
22 highlight just a couple things.

1 I think beneficiary engagement is exceedingly
2 important, and so all of the recommendations around
3 exploring how they perceive this option, including them in
4 the interview process, however that's done, I think is going
5 to be a really important adjunct to whatever is being
6 planned in terms of meetings with providers of ACOs, et
7 cetera.

8 In terms of clinicians, I think that here is an
9 opportunity to really think as a Commission about removing
10 barriers to allowing access to all providers of primary
11 care. So there is that convoluted process that you
12 describe, but we can, in thinking about updating and
13 recommendations to the statute, and that is one that would
14 have to be done very, very quickly, as you've already
15 pointed out, to be ready for January 2016. But,
16 specifically, I think that we need to be thinking about, you
17 know, the 12 percent of beneficiaries that get primary care
18 from non-physician clinicians and 33 percent that include
19 them.

20 I do think the quality metrics really need a lot
21 of attention, and it's another opportunity to recommend that
22 parsimonious list that's more relevant to people. I really

1 liked your ideas about thinking about days where I didn't
2 have any of these problems that maybe encounter the health
3 care system.

4 And, finally, this notion of a rapid cycle
5 evaluation of what's happening in each of these environments
6 I think creates an opportunity for more systematic and more
7 relevant and timely review of what is going on in these
8 environments.

9 So I think there's a great opportunity here.
10 Thanks for your work.

11 DR. NERENZ: Just two quick things about the
12 planned interview process. First is I would suggest you
13 think about interviewing entities who could be ACOs but who
14 are not. We look that there are 250 of them now in the
15 Medicare program. We may take that to be an impressively
16 large number given the newness of the program. But there
17 clearly must be thousands and thousands of entities out
18 there who could be ACOs in this program who are not, and I
19 would be interested in knowing why they are not.

20 Then the second point is on Slide 11 you talked
21 about what I think is a very striking point: average
22 savings in the pioneer program looking like 0.5 percent;

1 cost to run it, 1 to 2 percent. The question is: Is that
2 sustainable? It doesn't seem so. So I'd be interested in
3 your interviews to find out why do the ACOs think that that
4 will evolve to a better balance in the future. Or do they?

5 MS. UCCELLO: So I thought it was a great chapter
6 of providing a lot of the details that matter when we're
7 thinking about this stuff. I really focused on the
8 beneficiary incentives part. I'm very much supportive of
9 allowing for lower cost sharing, but I'm still a little
10 confused on how this will work.

11 But before we get to that, can you just -- Jon's
12 comment made me a little confused about what the leakage
13 issue is. I was thinking that it was a problem of
14 beneficiaries going to specialists outside the network that
15 are more expensive and the ACOs being responsible for them.
16 And is it a specialist issue or a primary care issue? And
17 is that the right way to think about the leakage?

18 MR. GLASS: Well, I think from the ones we've
19 talked to so far, yeah, going to a specialist outside seems
20 to be an issue. I'm not sure about seeing primary care
21 outside. Jeff, did you pick --

22 DR. STENSLAND: I think they're both a concern,

1 and I think part of it is when we talk to ACOs, they think,
2 well, I have this many people who are going to be in my ACO,
3 8,000, and then they end up with, well, why do we only have
4 5,000? Because 8,000 of these people are seeing my primary
5 care doctors, but some of them are maybe going to this
6 primary care doctor, then they go to another primary care
7 doctor, and they're not going to the same one. So leakage
8 for both those things.

9 DR. MARK MILLER: When we have these
10 conversations, when the ACOs come in and talk about the
11 leakage problem, that's what they're -- it's your
12 understanding, whether it's specialists or primary care,
13 that's the way they've been talking to us about it.

14 DR. CHRISTIANSON: Just a quick comment. I think
15 when we talk about leakage, we need to understand that the
16 issue varies tremendously depending on the ACO and the
17 organization. There's a lot of ACOs that don't spend much
18 time worrying about leakage at all because they have a
19 pretty broad continuum of services. And if they don't have
20 the service in-house, they have longstanding relationships
21 with specialist systems, and so the patients that are used
22 to seeing those primary care physicians are also used to

1 being referred to those specialists.

2 So I think earlier, pointing out that, you know,
3 it's a very different environment when you have a relatively
4 small physician group, that's assuming, you know, the
5 responsibility of an ACO versus a large integrated delivery
6 system has a lot of this stuff in-house.

7 So leakage is a question that varies, I think, a
8 lot across the continuum of ACOs in terms of how important
9 the ACO thinks it really is.

10 MS. UCCELLO: But this also suggests then that
11 allowing for lower cost sharing should be not just for
12 primary care but also for specialists. And that didn't seem
13 to be part of this.

14 MR. HACKBARTH: Suffice to say if we elect to
15 pursue this track of specially designed supplemental
16 policies, there are a lot of issues that we need to think
17 through that we haven't at this point.

18 MS. UCCELLO: Okay. All right. So maybe in the
19 interest of time, we probably don't want to get in the weeds
20 here, but I still -- I want to talk with you guys more about
21 how this would actually work, because I'm still a little
22 concerned about this, people getting the benefit only if

1 they have a Medigap plan, not if they don't. And just some
2 other things. So we can talk about that later.

3 MR. BUTLER: So we've talked about the costs and
4 logistics of getting into an ACO and not making it maybe too
5 burdensome, but we find unlike a lot of pilots in Medicare,
6 suddenly there are 4 million people, and there could be 8
7 million people in another year. And I think we think far
8 less about the exit strategy versus the entry strategy,
9 because I think nobody knows if ACOs are going to be the
10 middle ground permanently. Most would speculate you're
11 going to maybe migrate to more MA enrollment coupled with
12 maybe an enhanced different looking fee-for-service system,
13 and maybe the ACO world kind of drifts towards those two
14 ends. I'm not sure. I don't think any of us know.

15 So my concern is on Slide 6, with this in mind, as
16 you look at the contract cycle -- I'm trying to get to be
17 helpful on the contract cycle -- is that -- my question
18 about the physicians is if you have, let's say, a 10-member
19 primary care group with 5,000 members in it, and this
20 constitutes, say, 50 of the ACOs now and more of them in the
21 future, and they only have maybe 10 percent of the premium
22 dollar in their offices and 90 percent of it is downstream

1 revenue, and they do a wonderful job in the first couple of
2 years of managing that down, and then have a huge -- you
3 know, and then we put in more risk sharing and more -- and
4 suddenly we're back to the nineties where, you know, they
5 have no reserves, and they go belly up, and now we've got 8
6 million or whatever number of Medicare beneficiaries, what
7 is the landing point for those groups and those patients
8 when that occurs versus a fairly big organization -- it
9 could be physician only -- that kind of takes this on as a
10 way of organizing care and has maybe not 5,000 but 20,000
11 enrollees, so you know they're kind of on a more permanent
12 path that could go to an MA world, or other options that
13 occur.

14 So I do worry about that backlash that, Glenn, you
15 keep coming back to. If you get too many of these things
16 and then suddenly you've entered your three-year cycle, now
17 what, is what I think needs to be anticipated as part of the
18 entry into these things that seem, well, why not, and then
19 suddenly you've got a lot of unwinding to do.

20 MR. HACKBARTH: David, could you say a little bit
21 about the contract cycle? We've got a bunch of people that
22 went in on three-year contracts? When does that first

1 cohort of contracts expire? When will CMS be proposing
2 revised rules for the second contract cycle? Will there be
3 a public opportunity to comment on those proposals?

4 MR. GLASS: All right. Well, first this is a
5 permanent program. It's not a pilot, so it doesn't go away.
6 You know, there's not some evaluation at the end and they
7 decide whether to keep it or not. As far as I know, it's in
8 statute. It just continues.

9 But to your question, the first MSSP group started
10 in April of 2012, so three years, 2015 would be their new
11 start date. Then we have 87 in June of 2012, and then 106
12 joined in January of 2013.

13 MR. HACKBARTH: So let's take that first group
14 that are essentially halfway through their initial contract
15 period. Has CMS said anything publicly about when it will
16 establish the new rules of the game for the second contract
17 cycle for the first cohort?

18 MR. GLASS: Not that I know of.

19 MR. HACKBARTH: Okay.

20 MR. GLASS: So the first three years could be
21 bonus only, essentially, one-sided risk.

22 MR. HACKBARTH: Right.

1 MR. GLASS: But then the second three years they
2 have to start in at risk. Jeff, is that right?

3 DR. STENSLAND: That was the idea. I don't know
4 if that's in law.

5 MR. HACKBARTH: Yes.

6 DR. STENSLAND: But I would assume next year, a
7 year from now, they would be having some new proposed rules
8 for the next cycle.

9 MR. HACKBARTH: So it is not in law that you have
10 to move to risk-bearing ACOs. In fact, I'm not even sure
11 that they're allowed to do that, but that's a call for
12 somebody else to make. But the statute does not
13 specifically contemplate that these all have to move to
14 risk-bearing. That will be a policy judgment that is made.

15 MR. GLASS: We should check that.

16 MR. HACKBARTH: Yeah. And so I'm very interested
17 in the timing of this because it will dictate when we need
18 to reach some judgments for CMS. So let's try to nail that
19 down, some recommendations.

20 DR. CHERNEW: I swear this is related clarifying
21 question. So for the shared savings plans, we don't worry
22 about them failing so much because it's only upside risk, at

1 least right now. But for the pioneers in some sense you do,
2 and that's Peter's exit strategy question. My understanding
3 is apart from trying to collect money that they might owe if
4 they didn't do very well, which is a separate issue, the
5 exit strategy for the provider system would basically be
6 they're back in fee-for-service, and the pioneers were built
7 on fee-for-service anyway, so it's --

8 DR. MARK MILLER: I took Peter's comment just a
9 little bit differently, and you tell me if this is right.
10 If as a Commission you were to come together and say I'm not
11 sure about this bonus-only strategy, does it create the
12 incentive to effect change, and the contract -- I'm just
13 saying. I'm not saying that you're saying this. And you
14 were to say we need to move toward risk-based contracts, I
15 think Peter's point then is the small groups will have to
16 really think about what the proposition is going forward.
17 And I took your comment as if you let that string out for a
18 really long period of time and then say now we're going to
19 go to risk, you may have a large number of, you know, groups
20 that need to make that decision. I think your point simply
21 is, well, they fade back into fee-for-service.

22 DR. HOADLEY: So I'm going to put my time on the

1 beneficiary engagement issue, although I think there's a
2 linkage to this last discussion. I mean, the extent to
3 which beneficiaries are aware and engaged has something to
4 do with what happens if you get into these exit strategies
5 if they're dropping out. To the extent that people are not
6 so engaged knowingly in them, there's less of an issue. But
7 if they are, we'll have, you know, Medicare Advantage
8 withdrawal kind of syndrome again.

9 I guess what I really want to do, I mean, a lot of
10 the policy questions have been talked about, but it seems
11 like there are a bunch of empirical questions, and you
12 raised the question, Glenn, about whether there's any plans
13 to do a survey. And it seems like something like that
14 probably is needed, and it may not be something we can do.
15 But I want to know, you know, are the people -- the
16 beneficiaries who are in these ACOs aware that they're in
17 it. Do they understand? Are they engaged? You know, each
18 of those is sort of a higher level of engagement. And then
19 do they like them? Do they think they're getting something
20 out of it? Or are they confused by it?

21 It seems like there's an array of those questions,
22 and to some extent you might be able to get at them on your

1 site visits and, you know, just even what the plan --
2 because another side of the question is what are the ACOs
3 doing to engage people. They have got to have some sense of
4 -- I mean, I was intrigued by -- you had a comment about one
5 ACO that didn't send out the welcome letters because they
6 didn't think they needed the data and they didn't need to
7 offer the opt-out, so does that partly mean they don't even
8 care whether people are aware? But, you know, I think
9 there's a number of interesting empirical questions.

10 And then I think that also spills into this
11 Medicare Select option because to me it seems like -- I
12 mean, it may be confusing in terms of how you want to set it
13 up from the point of view of insurance and risk and so
14 forth. But it seems like it's an option that could be even
15 more confusing to the beneficiaries. And I don't remember
16 all the experience with the original Medicare Select program
17 with the Medigaps, but it seemed like I recall that there
18 was relatively low takeup and a fair amount of confusion on
19 that. And I don't know if we know more about sort of how
20 that played out.

21 But I would really worry that, you know, despite
22 some of the reasons for doing it, people don't understand in

1 general their insurance arrangements and their supplemental
2 arrangements and putting in something like this, especially
3 if you're going to say it's mandatory to participate,
4 participate in what, I don't even know I'm in that.

5 Anyway, that's sort of my set of empirical
6 questions with some of the spillover from them.

7 MR. HACKBARTH: Let me just use that as a
8 launching point for a couple of comments.

9 If, in fact, the next iteration -- the second
10 contract cycle -- includes downside risk, I think that will
11 create certain predictable tensions, and some of them will
12 have an impact on the beneficiary.

13 My hypothesis would be that not immediately, over
14 time, when providers have to bear some downside risk,
15 they're going to want tools that allow them to influence
16 where beneficiaries go, whether it's a specially designed
17 supplemental policy or some other mechanism, to try to exert
18 more control over patterns of care, if they're bearing
19 downside risk.

20 It's less of an issue in an upside-only
21 arrangement; potentially, a more pointed issue in a two-
22 sided model.

1 From the beneficiary perspective, if you go to a
2 two-sided model, you're also now starting to raise questions
3 about: Wait a second. I thought I was a traditional
4 Medicare beneficiary. I don't want Medicare Advantage. I'm
5 being forced into this without having ever elected it
6 myself.

7 And they talk to their physician about, well, I
8 don't -- their primary care physician. I don't want to be
9 in an ACO.

10 And, basically, the physician says, your only way
11 out is to leave my practice.

12 That will not go down well. There will be a huge
13 reaction to that.

14 So I think that, in fact, for this program to be
15 effective in terms of changing patterns of care, both on
16 cost and quality, we need to move away from the one-sided
17 Fee-for-Service-based shared savings model.

18 I remember, Jeff, when we did our chapter on this.
19 Was it in the June 2009 report?

20 Jeff had some really nice, simple examples about
21 and illustrating how weak the incentives are in a one-sided
22 Fee-for-Service-based model, and I continue to believe that

1 to be the case.

2 So I think if this is going to be meaningful it's
3 got to evolve, but as quickly as this second contract cycle,
4 there could be some real stress points in this program for
5 both providers and beneficiaries. We need to get ahead of
6 that.

7 DR. SAMITT: I mean, to underscore that point,
8 we've used an analogy before that all the programs that have
9 been created -- ACO, bundled payments, the primary care
10 initiatives -- are kind of on-ramps to a highway to value
11 from volume.

12 I mean, the two things I'm most interested in are:
13 Do we need to close some of the on-ramps?

14 So is the one-sided model -- will that continue to
15 work? Will bundled payment continue to work?

16 If we want to keep moving people further down, do
17 we need to start making some changes in terms of how to get
18 onto that pathway?

19 The other thing I'm even more concerned about is,
20 are we focusing on what will keep people on the highway?

21 So I'm very interested in knowing the intentions
22 of the current ACOs. Are any of them thinking that they

1 won't renew, and if so, why?

2 I'm very interested in understanding the Pioneers
3 that have exited because they may give some very good
4 information that would highlight why the one-sided ACOs may
5 not want to do two-sided, you know, up and down. So we may
6 want to understand very clearly.

7 I'm also interested; are the higher performing
8 systems the ones that are getting out of Pioneer or exiting
9 the highway -- because if we're not keeping the best, then
10 all we're keeping are those who have so far to go in terms
11 of improvement. Is that the model that we're really trying
12 to create?

13 So I think your research should hopefully give a
14 lot of information on how to make changes to the contracts
15 going forward.

16 MR. HACKBARTH: As I understand it, Craig,
17 HealthCare Partners was among those exited the Pioneer
18 program. Is it unfair to ask

19 you at this point why that was?

20 DR. SAMITT: Well, I mean, I think I said to David
21 that we're happy to get together.

22 I think there are a number of reasons, many of

1 which were already discussed here today -- really
2 identifying the beneficiaries, encouraging the beneficiaries
3 to receive care within the value-based network that we've
4 created, you know, the benchmarking methodology and the
5 financial implications of starting with a higher level of
6 performance, and is it achievable to go even higher and not
7 bear a significant risk, and the beneficiary education and
8 implications.

9 So, if we invest in a team of care coordinators
10 who reach out to patients, to focus more on wellness or
11 coordinated care population health, but the beneficiaries
12 say, well, that's not the Medicare I signed up for; you
13 know, I don't seek out services that way; then you've
14 invested in a value-driving enhancement that the
15 beneficiaries don't want to really use. And that's a
16 problem. It creates a cost problem without the potential
17 benefits of utilization savings.

18 DR. COOMBS: I was going to make that same point -
19 - is that looking at the data from what we have already, the
20 Pioneers spoke with their feet and left. I'm not sure that
21 that won't be a trend next year and the year going forward
22 based on the setup. So we have to say that there's

1 something different about the Pioneer ACO -- the risk,
2 number 1 -- that makes it not conducive for success for
3 those 8 out of 32.

4 And then just the shared savings plan, in terms of
5 the sheer numbers of the ACOs that are assigned to the two-
6 sided risk versus the one-sided risk -- I know that one of
7 the questions that we grappled with, with the AQC, was this
8 benchmark -- the historical benchmark -- in terms of
9 spending for each of the providers.

10 There were some providers who were in Western Mass
11 who may have had some relatively good data to start with.
12 So, if they started off really, really good, then their
13 potential to be realized was going to have to be really
14 aggressive for them. So that benchmark of someone who's a
15 high performer to start with and how much more they're going
16 to achieve in terms of savings was an issue.

17 DR. CHRISTIANSON: I think I have a couple of
18 comments that build off of both of those -- just I think we
19 need to keep a real open mind about how this is going to
20 evolve over the next couple of years.

21 One Pioneer HMO that's no longer -- or ACO that's
22 no longer going to be an ACO is now offered as part of an MA

1 plan as a care system option. So that means they can use
2 that organizational framework, they don't deal with how to
3 set the right rate, they negotiate that with the MA plan,
4 and people enroll. So they have their capture.

5 So I'm not sure, you know, how we view that.

6 Okay, is it terrible that they're not going into the ACO
7 program, or is this the way things may evolve for more
8 sophisticated organizations that weren't able to fare well
9 under the historically based pricing system of the Pioneer
10 ACO?

11 The second thing; on Mike's comment about focusing
12 on the shared savings/shared risk issue, in the private
13 sector, when I talk to provider systems that are engaged in
14 total-cost-of-care contracts, some of them are saying: We
15 don't do that at all anymore -- the shared savings business.
16 What we negotiate is a rate, and we negotiate a stop-loss
17 just like a private sector self-insured employer. So we're
18 not worrying about 1 percent savings, 2 percent savings,
19 whatever.

20 So it would be interesting if we had any
21 information about how that shared savings business is
22 evolving in the private sector total-cost-of-care contracts.

1 Maybe it's evolving away from worrying about whether it's 1
2 percent, 2 percent, have to achieve 1 percent, and in some
3 cases it's just simply going to what providers and insurance
4 companies know, which is stop-loss contracts on reinsurance.

5 MR. HACKBARTH: Jon, on your first point, I agree
6 completely.

7 And I suspect in HealthCare Partners' case they
8 made a business decision that the Pioneer model was less
9 attractive than just the Medicare Advantage chassis where
10 they've been so active in the past. And so, why do this?
11 Let's just focus on the Medicare Advantage.

12 I would assume. I don't know that.

13 And so the question is, is that a bad thing when
14 organizations make that choice?

15 And I don't know the answer to that question, but
16 part of the initial concept of doing ACOs was to see if we
17 could come up with a model that would extend the benefits of
18 good coordinated care, and the benefits being both cost and
19 quality, to a population beyond those electing -- a Medicare
20 beneficiary population beyond those electing to enroll in
21 Medicare Advantage.

22 So that was the original policy objective within

1 the traditional Fee-for-Service construct. Can we develop a
2 model that will disseminate coordinated care more rapidly?

3 And, if what is going to happen is that the
4 leading care organizations that are best at this are saying
5 I don't want that model; I'm just going into Medicare
6 Advantage; that's an issue of whether ACOs are then
7 accomplishing their policy objective.

8 And I mean to frame that as a question, Jon, as
9 opposed to an answer, but I think we need to have that
10 conversation.

11 DR. CHRISTIANSON: So just to be clear, they
12 aren't going in as a plan themselves; they're going in as a
13 narrow network option within a plan offering?

14 MR. HACKBARTH: Right.

15 DR. CHERNEW: I think one of the challenges is
16 this is so complex that we don't have a particular easy
17 process for working through all the alternatives, and so I
18 think we need to think about the process by which we'll at
19 least get things on the table to vet. And a lot of times
20 that will come from the staff in general, but I think
21 hearing more about what you think the options are matters.

22 And I think one of the challenges is the private

1 sector is much better able at dealing with heterogeneity in
2 local conditions and across the country and particular
3 organizations whereas for the ACO program even though --
4 it's hard to have multiple regulatory setups although now
5 they have two, and then they add more.

6 And so thinking about how to come up with a
7 regulatory framework for payment that can't be correct
8 always in every market and how that will work out, I think
9 becomes important.

10 And I think right now we're a little bit at rift
11 with what the right tweaks would be.

12 So how to get the right payment rate, for example,
13 is what you said. What that means in concrete for our
14 recommendations is something that is a real challenge.

15 MR. HACKBARTH: We're running behind time. Let me
16 just conclude with, I think, two issues that I think when we
17 come back to this we really need to focus on.

18 One is, what is our stance on the issue of CMS
19 moving to requiring two-sided risk in the next contract
20 round?

21 We've said, or at least strongly implied, in the
22 past that we think that that is a good thing to do. We need

1 to think through the implications of that for both the
2 organizations and beneficiaries and what the potential side
3 effects will be that need to be addressed and really come up
4 with a thoughtful position on that issue in advance of CMS
5 contracting.

6 A second issue for me -- and this is of much lower
7 importance, but it builds on Alice's comment. I think
8 particularly if you move to two-sided contracts, where
9 there's downside risk, this issue of how the targets are set
10 is going to become a much hotter button.

11 You know, I think -- Mark and I were talking
12 before the meeting. I think about Boston, the market that I
13 know best, and when you see Partners Pioneer ACO making
14 money and Harvard Vanguard Atrius losing money I suspect a
15 big part of that is the targets and one having a really
16 generous target and the other having a much less generous
17 target. I don't know that, but I suspect that that's part
18 of what's going on.

19 And, if we're moving to two-sided risk across the
20 country and people are losing money because they're being
21 punished for being efficient in the past, there's going to
22 be a lot of unhappiness.

1 So those are some issues that I think really
2 require our attention in advance of this next contract
3 cycle.

4 MR. GLASS: If I could say one thing, I think the
5 idea of the historical spending starting the baseline -- I
6 think part of it was to say we don't want Medicare to spend
7 more money on these beneficiaries than they would have.

8 So do we want to maintain that, or do we want to
9 say, okay, but they're more efficient and they'll pull more
10 people in and then total spending would go down?

11 MR. HACKBARTH: You're absolutely right, and it's
12 tricky in terms of what the budget implications are.

13 And we also have to look at what's in the statute
14 versus what's in CMS's regulatory authority on both the two-
15 sided risk and how the targets are set. I don't know the
16 answer to that.

17 DR. SAMITT: And, Glenn, just to clarify, when you
18 talk about moving from one-sided to two-sided, it's for the
19 existing ACOS, not new ACOs. So there's no going back or
20 staying where you are. Once you start, you need to keep
21 moving forward.

22 But the one-sided option, I would assume you'd

1 advocate that that is still available for organizations that
2 are not yet ACOs.

3 MR. HACKBARTH: Entry.

4 DR. SAMITT: The entry.

5 MR. HACKBARTH: Well, I think that's a policy
6 question that CMS will have to make a call on when they go
7 to subsequent rounds.

8 DR. SAMITT: We don't want to discourage sort of
9 new progress toward value.

10 MR. HACKBARTH: Right.

11 DR. SAMITT: If it were only an option of two-
12 sided, would that discourage new participants?

13 MR. HACKBARTH: So, for the people in the
14 audience, I worry that when we have conversations like this
15 it comes across as unduly negative. Oh, you know, MedPAC is
16 against ACOs and sees all sort of problems.

17 That's not how I feel.

18 I feel like this was and is a constructive step in
19 the proper direction, but I do think that where we go from
20 here requires a lot of careful thought because I think there
21 are some really sharp issues for both the organizations and
22 beneficiaries that are not very far down the road, and we

1 need to prepare for those.

2 Okay, thank you.

3 We will now have our public comment period before
4 lunch.

5 So, before you begin, let me just repeat the
6 ground rules. Please begin by identifying yourself and your
7 organization. You will have two minutes for your comments.
8 When this red light comes back on, that's the end of your
9 two minute period.

10 I would remind people that this is not your only,
11 or even your best, opportunity to provide input on the
12 Commission's work. The best opportunity is to meet with our
13 staff. Another opportunity is to file comments on our
14 website. A third opportunity is to write letters to
15 Commissioners. People do, in fact, read them.

16 So with that, your two minutes begins.

17 MS. LLOYD: Danielle Lloyd with Premier Health
18 Care Alliance.

19 Very quickly, one of the Commissioners asked about
20 looking into some of the reasons there are organizations who
21 aren't coming into MSSP. I just wanted to raise one very
22 quickly.

1 It is actually a difference between Pioneer and
2 MSSP, having to do with the actual definition of ACOs.
3 Under the MSSP, they consider the ACOs a collection of Tax
4 Identification Numbers, or TINs. Under Pioneer, it's both
5 TINs and NPIs.

6 The reason this is important is if you have large
7 integrated delivery networks, for instance you have multiple
8 hospitals across multiple states, numerous markets, it
9 prevents them from splitting up the organization by market
10 and bringing those in maybe piecemeal, or maybe there are
11 some markets they don't want to bring in at all.

12 The other implication is that it's an all-in for
13 the physicians under this TINs and not, in some cases under
14 a TIN yo don't actually want to bring them all in.

15 So it's something that has precluded some well-
16 positioned ACOs, or potential ACOs, from coming into the
17 program.

18 Thanks.

19 MR. HACKBARTH: Okay, we will adjourn for lunch
20 and reconvene at 1:15 p.m.

21 [Whereupon, at 12:17 p.m., the meeting was
22 recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:16 p.m.]

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MR. HACKBARTH: Okay. It is time to begin our afternoon session and our first topic is issues in risk adjustment for Medicare Advantage.

DR. ZABINSKI: Just Medicare.

MR. HACKBARTH: Just Medicare -- okay.

DR. ZABINSKI: It's a little broader than that. That's all I'm getting at.

MR. HACKBARTH: Well, the title actually says Medicare Advantage.

DR. MARK MILLER: It does, and that's my mistake. The reason that I want -- I think it's actually an important distinction is you should definitely listen to this conversation as to how to improve risk adjustment for MA, but also think of the conversation you just had about ACOs, MA, fee-for-service, and there will be some issues at the end of this that are much broader than just an MA issue. But you're right, the title said that.

MR. HACKBARTH: Yeah. I didn't mean to make a fuss about that. But let me just even go one step further. At our July meeting, we talked about the importance of good risk adjustment in a very generic sense. It doesn't mean

1 just risk adjustment of Medicare Advantage or even ACOs, but
2 whenever we move to a new bundled payment model, we need to
3 take care that the payments are as accurate as possible and
4 don't impose an unnecessary burden on providers who care for
5 more challenging patients. And so there's sort of a
6 narrower and a very broad use of risk adjustment. We need
7 to worry about both. And Dan will tell us which he's
8 worried about right now.

9 DR. ZABINSKI: That's a pretty good lead-in to the
10 first slide. Risk adjustment is important in Medicare for a
11 number of reasons. First, nearly 30 percent of Medicare
12 beneficiaries are in Medicare Advantage plans and payments
13 to these plans are risk adjusted.

14 Second, payment neutrality among fee-for-service
15 Medicare, MA, and ACOs can improve efficiency in Medicare
16 and effective risk adjustment is necessary to obtain that
17 payment neutrality.

18 And, finally, if providers are asked to take on
19 more risks through mechanisms such as single payments for
20 entire episodes of care, these payments need to be risk
21 adjusted if they are going to accurately reflect the
22 patient's costliness.

1 First, we'll discuss some background on risk
2 adjustment in MA. Within MA, plans receive monthly
3 capitated payments for each enrollee and these payments are
4 risk adjusted based on how much each enrollee is expected to
5 cost. Payments are higher for sicker enrollees who are
6 expected to be high cost and payments are lower for
7 healthier enrollees who are expected to be lower cost. CMS
8 uses the risk scores to do the risk adjustments where the
9 risk scores indicate how much each enrollee is expected to
10 cost relative to the national average beneficiary.

11 And CMS uses a model called the CMS-HCC, which
12 uses data from each enrollee to determine the enrollee's
13 risk score. The enrollee's data falls into two broad
14 categories, demographic and conditions, which are from
15 diagnoses that are coded on claims from hospital inpatient
16 stays, hospital outpatient visits, and physician office
17 visits that occurred the previous year. The diagnoses are
18 then collected into broader condition categories and CMS
19 uses the demographic data, the condition categories, and
20 Medicare fee-for-service spending data in a regression model
21 that produces coefficients for each demographic variable and
22 condition category, which CMS then uses to determine the

1 risk scores as follows.

2 Suppose you have a male who is age 74 who is on
3 Medicaid and has diabetes without complications and COPD.
4 The coefficients for each of these variables are in the
5 second column on this table and sum to \$9,249, which is the
6 beneficiary's expected cost. The third column is just the
7 national average cost. And the fourth column is the
8 coefficients from the second column divided by the national
9 average cost in the third column. You can think of these as
10 the contributions to the risk score of each of the
11 characteristics in the first column. Then at the bottom of
12 the fourth column is the beneficiary's risk score. It is
13 the sum of the other values in this column and equals 0.997,
14 which is close to the national average of 1.0.

15 The performance of the CMS-HCC model has received
16 much scrutiny. Now, perhaps the most important result is
17 that it explains 11 percent of the variation in
18 beneficiaries' Medicare costs. While 11 percent may not
19 sound like much, keep in mind that much of the variation in
20 costs is random and can't be predicted. So, all told, the
21 CMS-HCC model may be explaining about half of the variation
22 in predictable costs.

1 And being able to explain a high share of the
2 predictable costs helps reduce opportunities for favorable
3 selection where plans would benefit financially by
4 attracting low-risk beneficiaries and avoiding high-risk
5 beneficiaries. And a recent study by Newhouse and others
6 found that the CMS-HCC model has reduced the extent of the
7 favorable selection in the MA program by a substantial
8 amount. But, some selection issues may remain.

9 In particular, for all beneficiaries who are in
10 the same condition category, the CMS-HCC adjusts the
11 payments by the same rate, no matter the level of the
12 patient severity. Also, patient severity and cost vary
13 within a condition category. So, for a given condition,
14 plans could benefit if they attract the lowest-cost
15 beneficiaries who have that condition. Also, the CMS-HCC
16 still under-predicts the costs of frail and high-cost
17 beneficiaries. Therefore, plans such as PACE and SNPs that
18 focus on frail beneficiaries may be adversely affected.

19 And to address the remaining selection issues, we
20 examined three possible modifications to the CMS-HCC model
21 in our June 2012 report. First, we added socio-economic
22 measures to the model, specifically, beneficiaries' race and

1 income, and we found that they would not improve how well
2 the model predicts costs.

3 Second, we added indicators of the number of
4 condition categories that each beneficiary maps into and we
5 found that this would improve the model's performance,
6 especially in terms of accurately predicting the cost of
7 beneficiaries who have many conditions. And this may be
8 helpful to SNPs and PACE plans that focus on frail
9 beneficiaries.

10 Then, finally, we used two years of diagnosis data
11 to determine condition categories rather than the single
12 year that CMS uses. And we found this would improve the
13 predictive accuracy for beneficiaries who have many
14 conditions, but not by as much as adding the number of
15 conditions to the model would.

16 Over the last few months, we have analyzed two
17 other ideas for improving the performance of the CMS-HCC
18 model. First, we added measures of beneficiaries'
19 functional status. We looked at this because the Commission
20 is interested in episodes of care, which could include post-
21 acute care. We used beneficiaries' ability to perform six
22 activities of daily living to measure their functional

1 status and we found that adding these measures of functional
2 status would do little to improve the model. And this is
3 consistent with other work that has analyzed adding
4 functional status to broad models, such as the CMS-HCC.
5 But, 3M Health Information Systems has found that functional
6 status is important in more focused models, such as those
7 risk adjusting episodes of care that include post-acute
8 care.

9 We also analyzed separating dual eligible
10 beneficiaries into those who have full Medicaid benefits and
11 those who don't. Currently, the CMS-HCC model treats these
12 full and partial duals the same, making the same adjustments
13 for both groups. And we found that separating the dual
14 eligibles into the full and partial dual categories would
15 improve the payment accuracy for these two groups, and this
16 would help plans that focus on full dual beneficiaries.

17 Okay. As we discussed at the outset, risk
18 adjustment is relative in many areas of Medicare beyond MA,
19 including payment neutrality among fee-for-service Medicare
20 MA and ACOs as well as the possibility of providers facing
21 more risk from changes, such as single payments for episodes
22 of care. In the broader context, we may need to consider

1 changes to risk adjustment beyond the relatively small
2 changes discussed on the previous two slides, and we will
3 discuss a number of possible changes which were also
4 effectively discussed in a recent synthesis paper by Eric
5 Shone and Randy Brown of Mathematica. This is a very well
6 done paper and much of what I will say is drawn from that
7 paper.

8 The topics we will cover include replacing the
9 CMS-HCC model with a different model; the effects of adding
10 other sources of data to the sources currently used in
11 standard risk adjustment models; concurrent risk adjustment;
12 hybrid models which combine prospective and concurrent risk
13 adjustment; inclusion of beneficiaries' prior year costs or
14 service use as a risk adjustor; and truncation of costs from
15 high-cost claims, that is, if a claim has costs that exceed
16 a pre-set threshold, the plan would not be responsible for
17 costs above that threshold.

18 First, let's consider replacing the CMS-HCC model
19 with another model. All possible replacements use
20 beneficiaries' diagnosis and demographic data to predict
21 their costliness, as does the CMS-HCC model. Although they
22 have some differences in terms of how beneficiaries are

1 classified, there's not much difference in terms of the
2 performance of these other models and the CMS-HCC.
3 Therefore, replacing the CMS-HCC model with another broad
4 risk adjustment model would be unlikely to improve the risk
5 adjustment issues in the Medicare program.

6 A second change to consider is adding data beyond
7 what CMS uses right now. Earlier, we mentioned that adding
8 additional years of diagnoses would make a small improvement
9 in how well the model fits the cost data. And we also saw
10 that adding beneficiaries' functional status would do little
11 to improve broad models, such as the CMS-HCC, but it would
12 improve more focused models, such as episodes of care that
13 include post-acute care.

14 Another form of data to consider is diagnoses that
15 are based on drug information, but adding this would do
16 little to improve the performance of models covering a wider
17 array of conditions.

18 Finally, the synthesis paper indicates that
19 including patient severity is potentially powerful, but the
20 diagnoses from claims typically don't convey patient
21 severity, so severity data is costly to collect. But the
22 synthesis paper hypothesizes that as the electronic health

1 records become more widespread, it may become easier to
2 collect the severity data.

3 Another possible change is to move from
4 prospective to concurrent risk adjustment. The CMS-HCC
5 model is currently used as a prospective model, meaning that
6 diagnoses from last year are used to predict beneficiaries'
7 costliness this year. The rationale for prospective risk
8 adjustment is that plans should be paid to manage care for
9 conditions that beneficiaries have already, not to treat
10 conditions as they occur. Also, prospective payment better
11 reflects the information that plans have to make enrollment
12 decisions.

13 In contrast, concurrent risk adjustment uses
14 diagnoses from the current year to predict costs in the
15 current year. Arguments in favor of concurrent risk
16 adjustment is that it improves the R-square of any risk
17 adjustment model to improve the model's predictive power.
18 This occurs because it captures more of the costs of
19 unpredictable events as they occur, such as strokes and
20 heart attacks. It also decreases incentives for plans to
21 encourage high-cost cases to disenroll.

22 But arguments against concurrent risk adjustment

1 is that plans would have less incentive to manage their
2 enrollees' care to avoid future illnesses because if an
3 enrollee does acquire an additional condition, plans are
4 immediately paid for it. Also, plans would have greater
5 incentive to upcode.

6 And to combine the best of concurrent and
7 prospective risk adjustment, hybrid models that mix the two
8 have been considered. The idea is to identify a small
9 number of conditions that are chronic, costly, clearly
10 identified, and easy to verify for purposes of auditing to
11 prevent upcoding. And beneficiaries who have one of these
12 conditions would be subject to concurrent risk adjustment.
13 All other beneficiaries would be subject to prospective risk
14 adjustment.

15 Dudley and colleagues examined a hybrid model and
16 they found it would make strong improvements to the
17 predictive power of a standard HCC model, increasing the R-
18 squared from 0.08 to 0.26. A strong caveat, though, is that
19 the sample was from a non-Medicare population. If they had
20 used a Medicare-based sample, their results may have been
21 different. Also, the authors selected 100 conditions for
22 concurrent risk adjustment, but they made it clear that they

1 selected 100 conditions simply because 100 is a round
2 number, and more work is needed to identify which conditions
3 should be on the concurrent list. Well, at least they were
4 honest.

5 The reason concurrent and hybrid models improve
6 predictive power over prospective models is that they
7 capture more of beneficiaries' costs. And another way to do
8 this is to add beneficiaries' prior year costs or service
9 use to a standard risk adjustment model. This is an
10 excellent predictor of future costs and substantially
11 improves predictive power, increasing the R-squared by five
12 to six percentage points. This is due, in part, to the fact
13 that prior year costs capture factors that other measures
14 don't, including patient severity, patient preferences for
15 health care, and provider practice patterns.

16 But a paper from the Society of Actuaries strongly
17 warns against using prior year costs because, like
18 concurrent risk adjustment, it weakens plans' incentives to
19 manage their enrollees' care and contain costs and penalizes
20 plans that do so.

21 By in the synthesis paper, Schone and Brown are
22 supportive of prior year costs as a risk adjustor, but they

1 do recognize the potential for undesirable incentives. In
2 response, they offer the idea of using a proxy, the number
3 of non-preventable hospitalizations in a plan in the
4 previous year. But they don't make it clear how these non-
5 preventable hospitalizations would be defined, nor is it
6 known how well they would work as a proxy.

7 And an obstacle facing standard risk adjustment
8 models is that beneficiary-level costs are very skewed and
9 standard prospective models do not effectively handle high-
10 cost cases. A strategy often discussed for managing the
11 high-cost case is to truncate plans' high-cost claims so
12 that they are not responsible for costs above a threshold.
13 This would definitely improve the performance of standard
14 risk adjustment models, increasing their R-squared by three
15 to five percentage points. Moreover, it reduces incentives
16 for plans to encourage high-cost cases to disenroll.

17 But a lot of questions would need to be addressed
18 ahead of time. First, what to do about the costs above the
19 truncation point. Should they be covered by reinsurance or
20 should plans be paid on a fee-for-service basis? Also, at
21 what level should the thresholds be set? Finally, different
22 conditions have different cost distributions, so should

1 different conditions have different thresholds. In
2 addition, it may be difficult to know the costs incurred by
3 plans for individual cases.

4 So, the final topic today is payment neutrality
5 among fee-for-service Medicare, Medicare Advantage, and
6 ACOs. Before ACOs came into being, the Commission
7 recommended payment neutrality between fee-for-service
8 Medicare and MA, and one reason for this recommendation is
9 that it encourages beneficiaries to enroll in the sector
10 that is more efficient in the geographic area where they
11 live. And now that ACOs exist, we should consider whether
12 there should be payment neutrality between fee-for-service,
13 MA, and ACOs.

14 David covered the broad issues of payment
15 neutrality earlier, so I won't cover them here, but I will
16 discuss the role of risk adjustment, which is very
17 important, and I'll use the payment system in MA to
18 illustrate why.

19 The MA payment rates are the product of a
20 beneficiary-level risk score and a local base rate, and if
21 the base rates equal local fee-for-service spending, then
22 payment neutrality between MA and fee-for-service can be

1 obtained, but only if risk adjustment works properly.

2 Important issues to be aware of in regard to
3 payment neutrality and risk adjustment include that ACOs are
4 responsible for their enrollees' hospice and ESRD expenses,
5 but MA plans aren't. Also, the current method of risk
6 adjustment for ACOs has no incentives for code creep, but
7 under the alternative system, ACOs may be able to code creep
8 like MA plans. Moreover, if you want payment neutrality
9 among MA, fee-for-service, and ACOs, the potential changes
10 discussed earlier need to be considered in the context of
11 payment neutrality.

12 And, finally, CMS uses data from fee-for-service
13 beneficiaries to calibrate the CMS-HCC model but uses it to
14 predict the costs of MA enrollees. An important point is
15 that the relative costs of treating some conditions has been
16 found to be higher in a large MA plan than in fee-for-
17 service, and for other conditions, the cost is lower in MA
18 plans relative to fee-for-service. And to the extent this
19 is widespread among MA plans, plans could benefit
20 financially by attracting beneficiaries with some conditions
21 and finding ways to avoid beneficiaries who have other
22 conditions.

1 At the same time, CMS is collecting data from MA
2 enrollees, and using the MA data to calibrate the CMS-HCC
3 model would eliminate these incentives for plans to
4 discriminate on the basis of conditions. But, using the MA
5 data would eliminate the financial rewards that plans get
6 for being more efficient than fee-for-service Medicare at
7 treating some conditions and would move us away from
8 financial neutrality between fee-for-service and MA.

9 And for the Commissioners' discussion today, we
10 offer three possible areas. First, as we mentioned earlier,
11 nearly 30 percent of Medicare beneficiaries are enrolled in
12 an MA plan and risk adjustment is an important component of
13 plan payments. Therefore, we may want to discuss this
14 issue. Possible directions include staying with the CMS-HCC
15 model and making no changes; making small changes to the
16 model, such as adding number of conditions or using multiple
17 years of data; or making large changes, such as using it as
18 a hybrid model, truncating the costs of high-cost cases, or
19 using service use from the prior year as a risk adjustor.

20 Another possibility is to discuss risk adjustment
21 in the context of potentially broad reforms that would
22 expose providers to greater risks, such as a single payment

1 for episodes of care.

2 And then, finally, the Commission may want to
3 discuss risk adjustment in the context of payment neutrality
4 in fee-for-service MA and ACOs.

5 And now, I turn things over for questions and
6 discussion.

7 MR. HACKBARTH: Okay. Thank you, Dan.

8 So, round one clarifying questions. Any? Mike,
9 Alice, and Craig.

10 DR. CHERNEW: When you use the term "predictive
11 power" on your slides, you mean essentially R-squared, not
12 predictive ratio? That is a question. The word "predictive
13 ratio" comes out in the materials in other places.

14 DR. ZABINSKI: I was a little imprecise with that.
15 Yeah. In the slides, I was more talking about R-squared,
16 yes. But if I -- and the reason we want to talk about R-
17 squared here, when you are talking about a lot of models,
18 that's an easy point of comparison. If you're going to
19 analyze a specific model, I find that predictive ratios are
20 probably a better measure.

21 DR. MARK MILLER: And in the work that we've done
22 in the past, we've focused more on the predictive ratio --

1 DR. ZABINSKI: Right.

2 DR. MARK MILLER: -- like the changes that we've
3 made haven't had big boosts in R-squared, but they've
4 improved the predictive ratios across different conditions
5 and different kinds of conditions.

6 DR. CHERNEW: And, of course, the opposite could
7 also be true. You could improve the R-squared without
8 improving the predictive ratios.

9 MR. HACKBARTH: Okay. I'm probably going to
10 regret asking this, but --

11 [Laughter.]

12 MR. HACKBARTH: -- on behalf of the non-
13 quantitative people in the group, is -- I don't even know
14 how to ask the question.

15 DR. CHERNEW: Is this a clarifying question?

16 MR. HACKBARTH: So, the question was, which is a
17 better measure, R-squared or predictive ratio. Can you just
18 say something about the implications of that choice for us
19 laymen?

20 DR. ZABINSKI: Here's my shot, okay. The
21 predictor ratios, they're for a group. They tell you how
22 much the model predicts somebody will cost, you know, a

1 group of people will cost for, say, a particular condition
2 like diabetes divided by their actual cost. And the closer
3 you are to one, the better you are. And that's sort of how
4 -- you know, if plans are going to select, I guess that's
5 how they make their decisions. They don't focus on an
6 individual. They focus on a type of person, you know,
7 entire groups. So it's in that sense that the predictive
8 ratios are a little more useful.

9 But, as I was telling Mike, when you're trying to
10 compare different models, you're going to have a lot of
11 predictive ratios and it makes it really cumbersome to make
12 comparisons. R-squared is one statistic, and so the
13 comparison is easy, but sort of an individual-type,
14 beneficiary-type measure. So in that sense, it's a little
15 bit of a weaker measure in terms of model performance, I
16 would say. That's sort of my opinion, to a certain extent.

17 MR. HACKBARTH: Okay. We'll let him slide with
18 that answer. Are you done?

19 DR. CHERNEW: That was terrific.

20 MR. HACKBARTH: Yeah. Are you finished clarifying
21 now?

22 DR. CHERNEW: I asked a very simple clarifying

1 question about the words being used. You asked the
2 complicated question.

3 MR. HACKBARTH: Okay.

4 [Laughter.]

5 MR. HACKBARTH: Alice.

6 DR. COOMBS: So, on Table 1, you have the list of
7 conditions on top -- I'm sorry, in the reading material

8 DR. ZABINSKI: Okay.

9 DR. COOMBS: And then you have the number of
10 conditions on the bottom.

11 DR. ZABINSKI: Yes.

12 DR. COOMBS: But I assume that the standard model,
13 you're looking at the R-factor. You've given a number, an
14 assignment to the multiple conditions. There's no
15 consideration of if it's one condition that's a type of
16 condition or when you add those conditions up, like four
17 conditions, you have a value of 1.03.

18 DR. ZABINSKI: Yes.

19 DR. COOMBS: What does that mean?

20 DR. ZABINSKI: What that tells you -- what
21 condition is it, by the way?

22 DR. COOMBS: Well, you didn't specify in the

1 second group of conditions.

2 DR. ZABINSKI: Oh, I see. I see. I see. What
3 that tells you -- okay, so how many conditions, then?

4 DR. COOMBS: Okay. Four conditions.

5 DR. ZABINSKI: Okay. That tells you that people
6 who have four conditions -- it can be any four conditions in
7 the model, as long as they have four --

8 DR. COOMBS: It doesn't matter which conditions?

9 DR. ZABINSKI: It doesn't matter which conditions.
10 That the predictive ratio is 1.03. In other words, the
11 costs that are predicted by the model for those people are
12 three percent higher than their actual cost. That's the
13 0.03. That's what that tells you.

14 DR. COOMBS: Okay. I have a comment, but I'm
15 going to hold steady.

16 DR. SAMITT: When we say payment neutrality among
17 fee-for-service, MA, and ACOs, what do we mean by that?

18 DR. ZABINSKI: That's -- well, traditionally, we
19 meant that you paid the plan, an MA plan, basically what the
20 person would be expected to cost if they were in fee-for-
21 service.

22 DR. NERENZ: The same slide, second bullet point.

1 When we say doing that will encourage enrollment in the most
2 efficient sector, briefly, what's the mechanism by which
3 that effect would occur?

4 DR. MARK MILLER: [Off microphone.] Which slide
5 are you on?

6 DR. NERENZ: Slide 16.

7 DR. ZABINSKI: Glenn always explains this really
8 well, but, okay, I'll give it a shot.

9 [Laughter.]

10 DR. ZABINSKI: Sixteen. Wait a minute. I'm on 9.
11 Okay. Efficiency. Okay. It's sort of the idea of, okay,
12 you have an area where the fee-for-service costs relative to
13 the national average are low, okay, and plans -- so,
14 basically, fee-for-service is kind of efficient in that area
15 and plans are not going to have much opportunity. They are
16 not going to be able to get -- they probably will not be
17 able to meet fee-for-service and get a bid that's below the
18 average fee-for-service beneficiary cost, okay.

19 So you may have very few or no plans in that area
20 because the plans just aren't as efficient as fee-for-
21 service, while if you have an area where fee-for-service is
22 very costly and plans find it easy to get, you know, have

1 their costs below what the fee-for-service rate is. You are
2 going to have a lot of plans. They are going to be able to
3 offer a lot of additional benefits and so forth and attract
4 a lot of beneficiaries. So the plans are the more efficient
5 and the beneficiaries are going to head in that direction.

6 MR. HACKBARTH: Bill, a clarifying question?

7 DR. HALL: The assumption here is that there's
8 sound evidence that MA plans are trying to manipulate risk?
9 I guess the adverse selection? Are we approaching a problem
10 that needs a solution?

11 DR. ZABINSKI: Okay. I'm looking at Mark. A
12 stare-down here. Okay. I'll go ahead --

13 MR. HACKBARTH: Well, actually, let me take a
14 crack at it.

15 DR. MARK MILLER: He wants to go [off microphone].

16 MR. HACKBARTH: I don't think the assumption is
17 that the plans are necessarily trying to manipulate.
18 Selection can occur because of a conscious strategy by a
19 plan to identify low-cost individuals, enroll them, and
20 disenroll high-cost people. That can happen, probably does
21 happen. But selection can also happen without the plan's
22 involvement based on the choices that beneficiaries make.

1 So, for example, sicker beneficiaries that have
2 really well-established relationships with both primary care
3 and specialty care may be on average more reluctant to go
4 into at least plans that have restrictive delivery systems.
5 It may require a change in physician relationships.

6 To the extent that that's happened, plans haven't
7 necessarily done anything, but the beneficiaries think,
8 "This doesn't work for me. I'm high cost. I use a lot of
9 care. I'm going to stay out."

10 Of course, the two merge together. You know, some
11 plans may think strategically about their networks so that
12 they are more attractive to some types of patients than
13 others. But I want to avoid the implication for the
14 audience that anytime we see signs of preferential risk
15 selection in MA plans, we think it's because of a nefarious,
16 conscious strategy on the part of plans. That's not
17 necessarily the case.

18 DR. CHERNEW: But can I just say, historically the
19 risk profiles across the sectors have differed.

20 MR. HACKBARTH: Yes. Did that help clarify? [off
21 microphone].

22 DR. HALL: For now, yeah. That's fine.

1 MR. HACKBARTH: So let's move on to round two,
2 and, Jon, do you want to kick off round two? Comments or
3 more detailed questions?

4 DR. CHRISTIANSON: No.

5 MR. HACKBARTH: No? Scott.

6 MR. ARMSTRONG: No [off microphone]. So the
7 question is: Are these categories outlined the right
8 categories for the direction we want to take the discussion?
9 And I would just affirm I think they are. This may be a
10 round three point, but I just would say, for me, just what's
11 so hard about this and always has been -- it's not unique to
12 this moment -- is that risk adjustment is so vitally
13 important to the work we're trying to do and the program and
14 some of the reforms that we're trying to drive. But we get
15 into the conversations, and I go numb, and I just don't get
16 it. And so we have to figure out some way of more
17 effectively keeping the technical dialogue connected to the
18 real policy implications that most people can relate to.

19 MR. HACKBARTH: Yeah, that's a good comment. So
20 let me take a crack at that and invite reaction to it.

21 As Mike says, on average, we've got some evidence
22 of favorable selection into Medicare Advantage plans, which

1 corresponds with a potential overpayment to those plans
2 relative to, as Dan said, what we would have spent had those
3 same patients remained in fee-for-service. So potentially
4 that's a policy problem, and that was sort of a broad one
5 that could be addressed with a number of strategies, as Dan
6 indicated in his presentation.

7 Another type of problem or a subset of that
8 problem might be, you know, the evidence shows the real
9 selection opportunities are disenrollment. You know, we
10 talked about that earlier. And, you know, if you're a
11 really smart plan, you don't worry so much about who comes
12 in. You worry about who goes out. You have to move a
13 relatively small number of individuals to reap a big
14 financial gain. And so maybe the policy problem that we're
15 focused on is identifying ways to diminish the incentives
16 for selective disenrollment of patients that turn out to be
17 high cost.

18 And so I give these as examples. I'm not saying
19 that I know that. But I think that that sharpening the
20 question, as you suggest, Scott, is important for some of us
21 to get a grip on this. What is the problem we're trying to
22 solve? Is it generalized overpayment or particular types of

1 overpayment? Or underpayment, as the case may be.

2 MR. ARMSTRONG: Just the corollary to that I would
3 say is not just what's the problem we're trying to solve,
4 but more in the affirmative: Why is improving risk
5 adjustment so important to the program going forward? And
6 it's partly around cost and risk. It's partly around
7 quality of care. It's partly around creating the right
8 incentives and paying the right amount. We're also talking
9 about creating this ability to translate between different
10 programs within Medicare as accurately as possible. And I
11 just think to be really sharp about why this is so important
12 for us to get right, then I'll worry less about getting kind
13 of bogged down in some of the technical pieces, so long as
14 it's headed in the right direction.

15 MR. HACKBARTH: Let me just say one more thing,
16 and then I'll shut up on this. So Dan in his introduction
17 said, you know, the R-squared for the HCC is 11 percent.
18 Based on Newhouse's work, the general belief is that about
19 twice that is predictable risk; the rest is random. And so
20 that sort of begs the question from my perspective: How do
21 we know when we are "good enough"? And, you know, how close
22 do we have to get to that 22 or 25 percent of predictable

1 variation?

2 The reason I raise that is one approach to it is
3 forever trying to refine the calculations that underlie the
4 risk adjustment. But another factor that affects how good
5 the risk adjustment needs to be is what are the rules of the
6 game. And to what extent do the rules of the game inhibit
7 potential for risk selection?

8 So moving from month-to-month enrollment to annual
9 enrollment, I think Joe Newhouse says, you know, that
10 diminished opportunities for risk selection, and that means
11 that your risk adjustments have to be a little less powerful
12 than they'd have to be in a month-to-month system.

13 So we need to think not just about tweaking these
14 formulas, but an overall package of rules that get us to
15 fair payment. Does that make sense? I've talked too much
16 already, so I'm going to stop.

17 DR. REDBERG: Just kind of following on from what
18 you were saying, I think it would be helpful to have a
19 feeling, because it seems like a lot of work in going in
20 these additional risk adjustments, is what is -- how much
21 better does it get and how much more work does it take?
22 Because if it doesn't improve the model so much -- I can't

1 tell how many of the additional variables are administrative
2 data versus -- I mean, some are from the CAPH studies of the
3 functional status, the six ADLs. It would be worth it, I
4 think --

5 DR. ZABINSKI: In general, other than the ADLs,
6 the functional status, the data aren't hard to come by. I
7 guess the other one is if you want to do the truncation, as
8 I said, knowing how much a particular individual costs in a
9 plan at a particular time really isn't available either,
10 although CMS is collecting data from MA plans. I'm not sure
11 if that information will be available on that, but in
12 general, the data aren't hard to come by. But I see your
13 point. It's a good question.

14 DR. MARK MILLER: So to then follow up, if they
15 had this list, the Commissioners have this list of
16 possibilities in front of them, it sounds to me like one of
17 the things we should do is come back and say, you know, the
18 potential gain from a hybrid model or whatever this -- at
19 least to the extent the literature has addressed it, is
20 this: And then they would have some ability, if I'm
21 following Rita's comment, to say let's put a lot of time and
22 effort into it, but -- or for two points on the R-squared

1 and not much movement in the ratios, I'm not sure it's
2 really worth the trouble. I think that's what I hear you
3 saying.

4 DR. REDBERG: Very well said, Mark.

5 DR. MARK MILLER: I want to make sure we heard it
6 so that when we go back to the office...

7 DR. COOMBS: So one of the things that -- I'm
8 looking at the model. I have a problem with the conditions
9 and the type of conditions and inter-condition variability
10 in terms of diagnosis. And just, you know, looking at the
11 standard model and looking at cancer, I mean, we know that
12 there's variability in terms of what type of cancer there
13 is. So it makes me question the validity of the model when
14 I see that, you know, taking care of a patient, having been
15 an internist at one time in my life, and someone rolling
16 through the door with congestive heart failure and diabetes
17 is very different than a basal cell carcinoma and mild
18 depression.

19 So, I mean, those conditions are very different,
20 but in this model you wouldn't make any kind of -- you
21 wouldn't be able to predict any differently based on your
22 condition. So I'm saying that there should be some

1 variability that might be synergistic that the conditions --
2 the two conditions in and of themselves may be much more
3 variable than the model is indicating from the R factor.

4 DR. ZABINSKI: Okay. I'm trying to catch up to
5 you on -- okay. So at least one of your concerns is that
6 the model just has cancer and doesn't distinguish --

7 DR. COOMBS: Yeah, well, that's part of it.

8 DR. ZABINSKI: Okay. Maybe, yes, I need to
9 probably enhance the table. Cancer, there are actually four
10 cancer categories in the model, and it is generally based on
11 severity. So there's some demarcation in that sense. It is
12 quite different how much the additional cost -- the lowest
13 level cancer versus the highest level is really different.
14 So the model does make distinctions there.

15 Also, it adds together. If you have cancer and
16 congestive heart failure, other things, you know, they are
17 added in there as well.

18 DR. COOMBS: And so the next point is that there's
19 some non -- you cannot quantify some risk that is incurred
20 on the provider that's not measurable in terms of an index
21 that has to do with these multiple conditions. And I don't
22 know how we get our arms around it, but it's very different

1 in terms of why adverse selection happens in the first
2 place, because you can have some conditions and, you know,
3 it's very hard to find a physician to kind of say I can
4 coordinate the care of this patient or a system that I can
5 easily inculcate that patient within their system.

6 So I think that, you know, this is great, and I
7 know you said socioeconomic factors did not pan out and ADL
8 didn't, but those two things, in addition to the variability
9 within the conditions, make me suspect of the model in and
10 of itself. And so I do have some concerns about that.

11 MR. HACKBARTH: Is there a tradeoff in developing
12 these payment systems between multiple different factors?
13 You're trying to optimize. So you want a high degree of
14 explanatory power, predict as much of the predictable
15 variation as you can. You want to minimize the complexity
16 and burden associated with the data that are required to run
17 the model. And then, finally, you want to avoid basically
18 re-creating fee-for-service incentives by saying, you know,
19 we have a payment for every individual patient, which is
20 basically what fee-for-service is. And so you're trying to
21 optimize among those things. That's a question.

22 And so, yeah, there are probably some things that

1 you could add to any model to get incremental improvements
2 and explanatory power, but maybe at the cost of something on
3 the other two variables. Is that --

4 DR. ZABINSKI: Yeah, I think that's pretty
5 accurate. I would say -- and, Mike and Kate, definitely
6 correct me if you think this is wrong. I think the biggest
7 problem facing just your standard models is the skewness of
8 the cost data and that they just can't handle the high-end
9 cases. And there's ways to do it that aren't really all
10 that difficult where you could handle it must better, but
11 you might bring in some really undesirable incentives.

12 DR. CHERNEW: And there are other ways you might
13 deal with those particular patients outside of the risk
14 adjustment model, as you said. But that's not my second
15 round comment. That's just a response.

16 MR. HACKBARTH: Kate, do have anything to say on
17 that before Mike goes?

18 DR. BAICKER: Thanks. So I think one of the key
19 things is not just how well the model does in predicting the
20 variation, but how well the model does in predicting the
21 variation relative to how well the insurer can do in
22 predicting the variation.

1 DR. MARK MILLER: Absolutely [off microphone].

2 DR. BAICKER: And in some sense, if we're all
3 guessing about 10 percent of the variation, that's fine
4 because then they don't have any additional incentives to
5 cream skim or risk select.

6 So what I would like to see is not just how well
7 our models do, but how well they do with data that's
8 available to the insurers. Do we have any evidence that the
9 insurers can do a better job and the reduction in risk
10 selection seen in the empirical work by Newhouse and others
11 is reassuring that the HCCs as now written out are doing a
12 better job of that? But to me that's the key.

13 To the extent that we're going to under-predict --
14 to the extent that we're not doing as good a job at
15 predicting as the insurers are, the sort of ex post,
16 retrospective, either risk adjustment or reinsurance can
17 help dull the incentives to cream skim on the part that's
18 left that they're better able to predict on. So I think for
19 that reason, doing some concurrent or retrospective squaring
20 up could be helpful. I'm less concerned about the
21 concurrent risk adjustment of the squaring up from the undue
22 risk and the skewness of the distribution and insurers being

1 stuck with a more expensive population than they had
2 bargained for insofar as they've got lots of covered lives.
3 Sure, it's really skewed, but if you look at the total risk
4 they're facing relative to, like, you know, buildings
5 falling down and things like that, they're insurers, they
6 should be able to handle a fair amount of risk without
7 reinsurance, except insofar as the reinsurance picks up the
8 piece of the imperfect risk adjustment that was driving
9 incentives.

10 MR. HACKBARTH: So, Kate, I like this framework
11 that you've presented. Let's think about how good our model
12 works compared to what insurers can do based on the
13 information they have.

14 Now, that way of thinking about it suggests to me
15 that one of the areas that bears a lot of attention is the
16 disenrollment risk, because there they will have very good
17 information about the patient, their needs, the kind of
18 costs they've incurred. And so policy adjustments that are
19 aimed at attenuating the incentives for disenrollment,
20 disenrolling high-risk people, are potentially important.
21 Does that follow?

22 DR. BAICKER: Yes, and I very much agree with the

1 point that you made before, that the importance of the
2 failure of risk adjustment interacts strongly with the
3 policy environment in which people are being enrolled and
4 disenrolled, and you want to think about the combined effect
5 of how much room there is for insurers to do better risk
6 adjustment and what the opportunities are to use that
7 information to game the system. So I think we want to be
8 limiting opportunities to game the system without unduly
9 limiting beneficiaries' choices or things like that, and
10 minimizing the gap between the information we're using and
11 the information the insurers are using.

12 MR. HACKBARTH: So I hear Scott's plea as let's be
13 crisper in our definition of the problem we're trying to
14 solve as opposed to just talking in general about how good
15 these different models are. And so that's where I find
16 Kate's comment particularly useful.

17 DR. CHERNEW: So the first thing I'll say is it's
18 not just relative to what insurers know. It's also relative
19 to what patients otherwise might have done. As you pointed
20 out earlier, differential selection isn't just an insurer
21 action. It might just be the way patients are inherently
22 sorting. So my first comment is: I have a very, very

1 strong preference to use predictive ratios as the metrics of
2 success relative to R-squares, and I think the correct way
3 to think about predictive ratios is in a plan context as
4 opposed to by populations. Because what matters is how
5 skewed is the distribution of individuals across plans and
6 to what extent can plans or anyone else affect that
7 skewness. And if people are sort of randomly distributed
8 across plans, it doesn't matter how much we get this right
9 or not.

10 So let me just finish my last other -- my second
11 point, anyway, which is in that spirit and relative to what
12 Kate just said, I'm much more concerned about gameability
13 than I am about R-squared. So when you put in things to
14 model like drug spending or concurrent spending or anything
15 like that that has the potential for gameability, I'm very
16 worried about what things the plans can influence by
17 selection, which we've discussed, but also by coding -- they
18 can code things differently; that really makes a big
19 difference -- or by practice. So if you know you get paid
20 more for somebody taking an expensive drug, I don't want
21 that in the risk adjuster because I don't want the plan to
22 have an incentive to put everyone on that drug because

1 they're going to get paid for that in the risk adjustment
2 system. So I'm very worried about the gaming compared to,
3 say, something like the R-squared.

4 I have one other comment, but it sounds like you
5 want to respond.

6 DR. ZABINSKI: This is just a really technical
7 question. One thing I've always felt, okay, I agree with
8 you; I like the predictive ratio. Another measure kind of
9 in the same -- I don't know -- family, if you want to call
10 it that, is the mean average prediction error. I sort of
11 like it better than predictive ratio.

12 MR. HACKBARTH: We'll let you [off microphone].

13 [Laughter.]

14 DR. CHERNEW: I think there's like three people in
15 the room that find that a really interesting comment. But
16 since I'm one, but I'm self-aware, I'm not going to say --

17 [Laughter.]

18 DR. MARK MILLER: Remember, Dan, they ask the
19 questions [off microphone].

20 DR. CHERNEW: No, that was a good question. So
21 let me just make my other point, which is related to David's
22 clarifying question about using the incentive to get people

1 in the right sector. Imagine that managed care plans are
2 better treating patients with diabetes. If we use separate
3 risk models for managed care -- for fee-for-service and
4 HMOs, we would take away any incentive that the managed care
5 plans have to enroll patients with diabetes. And we would
6 want the plans to pull those people in.

7 So I like the idea of a single model based on fee-
8 for-service and allow the managed care plans to have an
9 incentive if they can produce care cheaper for those types
10 of people to find those people, if you will, profitable. I
11 like that feature.

12 MR. HACKBARTH: I think that's what we said [off
13 microphone] the last time we looked at this issue.

14 DR. CHERNEW: Yeah, right, and I just want to --
15 I'm done.

16 DR. NAYLOR: I'm pretty sure whatever I say, I'm
17 taking a risk right now following -- so let me start by
18 saying that I totally agree with Kate and Mike.

19 [Laughter.]

20 PARTICIPANT: Whatever they said.

21 DR. NAYLOR: Whatever they said, I'm with them. I
22 don't even know if I'm in the right ball park here, but I

1 thought, even actually with the title, "Issues for Risk
2 adjustment in Medicare," that as we think about this whole
3 area, do we need to think about first the global big
4 picture, how do we get it right for Medicare in the short
5 term, and then think about how to move toward payment
6 neutrality for ACOs and MAs and fee-for-service as a longer-
7 term goal?

8 I do agree with Winkelman, et al., that using
9 prior year costs seems to have a huge risk associated with
10 it. But in the area of thinking about improvements -- and
11 because so many people are focused on function, I just
12 wanted to make a comment that functional status in so many
13 studies has been shown with people who have -- you know, if
14 I have diabetes plus heart failure plus depression, and
15 that's what I have; or if I have diabetes, heart failure,
16 depression, and a functional deficit, my costs are up two to
17 three times.

18 So the real question around functional status I
19 don't think is just do ADLs show little added value to the
20 HCC, but whether or not ADLs are the right metric of
21 functional status, and others have looked at many, many
22 other measures.

1 To I think Alice's point, the issue of clustering
2 of conditions, not just adding them, is also -- I mean, some
3 really exquisite latent analysis work showing when you see
4 someone has heart failure plus this plus that, they are your
5 high-cost users, and not because of adding but because of
6 the integration of these three or four conditions in the
7 same human being and so on. So that is the little that I
8 can [off microphone] add around this.

9 DR. NERENZ: I was going to follow on Mike's
10 point, and now I find myself following on one of Mary's
11 points as well, in agreement with both, this issue about the
12 incentives, or particularly the question of do you include
13 the prior year cost. As Mike was describing the incentives,
14 for example, a group of patients with depression, if you
15 want to create an incentive for them to go into an MA
16 environment that's particularly good at caring for them,
17 that incentive only last current year if then what you do on
18 top of it is include past year cost into the next year,
19 meaning you say -- you control cost, you manage well in the
20 current year, and now your reward for being a good plan,
21 CMS, is you get a lower premium next year because those
22 costs have now been dropped down. And w may decide that

1 that's still an okay thing because the alternative would be
2 effectively to let the profits, so-called, continue on
3 indefinitely in the future. Maybe that's not quite right.
4 And so maybe embedded in here has to be some kind of a
5 shared savings sort of concept that would be embodied in
6 some sort of a hybrid risk adjustment model where you
7 include some of the prior year cost or some fraction of them
8 or something but not all of them, because the problem is
9 with just including it straight out, you essentially reward
10 plans for being inefficient, and you punish them for being
11 efficient. But the pure alternative I'm not sure is great
12 either. So I think that point ends up being complicated.

13 MR. HACKBARTH: And I think blended models
14 actually have some potential for dealing with people at the
15 extremes. It has always seemed logical to me that you may
16 want to have a mixture of purely perspective with either
17 previous year data or even concurrent data, or, you know,
18 retrospective adjustment where you have a blended rate that
19 combines the two.

20 DR. NERENZ: And my point was just that a lot of
21 those things, if done in sort of a pure or complete fashion,
22 it means that any savings that the plans themselves produce

1 are then taken away. And you may want to leave some of
2 those in the plan as the incentive to do more of that
3 behavior.

4 DR. MARK MILLER: But you understand at least in
5 the MA world, not the ACO world where I think your
6 statements are true, if I take --

7 DR. NERENZ: I meant in MA. I realize it's not in
8 MA now, but I was saying that that may be a direction to
9 consider.

10 DR. MARK MILLER: Okay, but I want to make sure I
11 understand one thing you said because I might follow what
12 you said or I might now.

13 In an MA plan, if you take a particular population
14 and you manage better than Fee-for-Service -- the Fee-for-
15 Service cost is this, and in the risk model, this is the
16 adjustment, but you are delivering at this -- that doesn't
17 follow your plan as long as the Fee-for-Service world
18 continues to mismanage. You will continue to get that
19 adjustment over time, and you won't be penalized for getting
20 -- for improving.

21 Your risk doesn't follow your behavior. The risk
22 score you get is based on the general Fee-for-Service

1 population.

2 And when you were saying they get penalized, I
3 wasn't quite sure where you were going.

4 DR. NERENZ: Yeah, and I was perhaps making an
5 additional assumption that was not valid in here. I was
6 making the assumption that that plan's own history would
7 follow itself into the subsequent adjustment.

8 DR. MARK MILLER: Currently, it does not.

9 DR. NERENZ: Currently, it doesn't, but I know
10 we're talking about future scenarios.

11 DR. MARK MILLER: Right.

12 DR. NERENZ: And I was thinking that part of the
13 future scenario that then I was cautioning against would
14 have the plan's own savings essentially then held against it
15 in future years. I understand that's currently not how we
16 do it.

17 DR. MARK MILLER: Now I see.

18 DR. NERENZ: Okay.

19 MR. HACKBARTH: Cori.

20 MS. UCCELLO: Well, first of all, I will let my
21 friend, Ross Winkelman, know that he's got a fan club.

22 I agree with the comments already made about

1 gaming and those kinds of concerns. So I won't repeat them.

2 Instead, what I'll do is think about nonrisk
3 adjustment ways to address some of these issues. And I
4 think to some extent they're already incorporated into MA
5 requirements, but they may be worth keeping an eye on.

6 So things like benefit package requirements,
7 making sure that plans cover a comprehensive range of
8 services so that when someone gets cancer they can get what
9 they need within that plan, making sure the provider
10 networks are, again, comprehensive enough and that include
11 the types of providers that people with different types of
12 needs would have -- those will come out, I think, on the
13 enrollment and disenrollment sides.

14 On the enrollment side, more would be marketing
15 issues -- making sure that plans aren't targeting
16 inappropriately to certain people.

17 MR. HACKBARTH: Let me ask you this, Cori; you
18 know a lot about this program. So there are a lot of those
19 rules, as you say, already in place on marketing and benefit
20 design.

21 Are you aware of any nonpayment opportunities to
22 address -- better address -- risk selection that you think

1 we and the Congress, ultimately, or CMS ought to be really
2 thinking about?

3 MS. UCCELLO: I am concerned about the use of
4 consumer data, to use that in marketing to enrollees --
5 consumer data coming from like Affinity Card purchases and
6 things like that -- where these companies combine all these
7 data, learn more about people and then where companies can
8 then use this information to kind of figure out more of what
9 the risks associated with those people are.

10 MR. HACKBARTH: So let me just press you one step
11 further. I can imagine how that creates opportunities, but
12 what would Medicare do about that?

13 MS. UCCELLO: What would you do about it?

14 MR. HACKBARTH: Yeah.

15 MS. UCCELLO: Yeah, other than just not allow it -
16 - yeah, I don't know how you.

17 MR. HACKBARTH: That doesn't seem feasible.

18 MS. UCCELLO: Yeah, I don't know.

19 So maybe it's framing it as a -- you know, I don't
20 know. As a discriminatory kind of -- yeah.

21 So I think these things work in theory, but I
22 don't know as much in practice how to get at it.

1 MR. HACKBARTH: Okay.

2 MS. UCCELLO: It's not as helpful.

3 MR. HACKBARTH: Well, as Scott has led us, I think
4 that's the way we need to get a handle on this conversation
5 -- not, you know, an abstract discussion of formulas, but
6 where are the problems and where are the Medicare
7 opportunities, whether in the payment formula or regulatory
8 limits?

9 MS. UCCELLO: I agree, and I'll try to think about
10 this some more.

11 Just another very unrelated kind of sidebar to
12 this is that we keep talking about there are some
13 conditions, maybe in particular, that are treated much
14 different and much more cheaply, or inexpensively, in MA.
15 Do we know that that's -- are there -- is it that there are
16 certain conditions that just have a whole different
17 distribution of costs, and can we look at those some more to
18 gain more insight into how to better treat these kinds of
19 things?

20 MR. HACKBARTH: This is where Craig is supposed to
21 say something or ask a question.

22 DR. SAMITT: Well, you know, I think if we had

1 more information.

2 MR. HACKBARTH: Yeah. When are we getting the
3 encounter data on MA plans?

4 DR. SAMITT: On MA plans, that would be helpful.

5 DR. BAICKER: [off microphone.] Well, we have some
6 of that [inaudible].

7 MR. HACKBARTH: Yeah.

8 DR. CHERNEW: The Newhouse paper does that. One
9 Newhouse paper.

10 MR. HACKBARTH: And they're using HEDIS data?
11 What data set does Newhouse use?

12 DR. ZABINSKI: They got data from one plan. You
13 know, they can't -- in the paper, they can't say which.

14 MR. HACKBARTH: Okay.

15 DR. ZABINSKI: You know, it's a large one. That's
16 all they can say about it.

17 DR. SAMITT: And I think what we've also discussed
18 before is we can't just look at MA plans on average.

19 MR. HACKBARTH: Right.

20 DR. SAMITT: That we need to understand, are there
21 differences even between MA plans versus Fee-for-Service?

22 I would venture to say -- Cori, to answer your

1 question, the answer is absolutely yes, that we will see
2 optimal outcomes at lower costs as we dig deeper into the
3 data, looking at Medicare Advantage plans, if that's what
4 you're asking.

5 MR. HACKBARTH: And when are the plan encounter
6 data supposed to be available for --

7 DR. ZABINSKI: My understanding is 2014. Yes,
8 Carlos?

9 [Pause.]

10 DR. ZABINSKI: Yes.

11 MR. HACKBARTH: It's always one year in the
12 future.

13 DR. SAMITT: I'll stop asking until 2014.

14 MR. HACKBARTH: Twenty fourteen -- is that --
15 whoever knows the answer to that. Carlos, is that --

16 MR. ZARABOZO: That's what we're saying now, yes.

17 MR. HACKBARTH: That's what they're saying now,
18 all right.

19 DR. HALL: So if I'm the administrator of a large
20 successful MA plan and MedPAC comes to me and says, you
21 know, your success is clearly related to that you've been
22 able to avoid adverse selection, either by selecting out

1 people or disenrolling, and here's the data from the year
2 2013 to support that.

3 And I say, well, duh, what do you think we do in
4 MA plans? We address the management of chronic illness more
5 aggressively, early in the disease, and there are plenty of
6 scientific data to say that we can at least postpone the
7 problems of -- the complications of diabetes; we can make
8 people with congestive heart failure have better function.
9 And, of course, it's going to be that way. That's why our
10 plan is an advantage to people.

11 I mean, I guess I'm coming from the standpoint of
12 a great deal of humility of trying to prognosticate anything
13 about older people. It's very, very, very complicated.

14 So what do we say to the plan that says you're
15 penalizing me for my success of doing exactly what you asked
16 me to do, and that is to create a better population over,
17 say, some finite period of time -- five years?

18 DR. ZABINSKI: Okay. I think that's where the
19 idea of the payment neutrality comes into play. If -- you
20 know, the idea there is to pay the plan how much the
21 beneficiary would have cost in Fee-for-Service. So if
22 they're able to be efficient that way, they get the benefit.

1 And I don't think CMS has any issue with that.

2 MR. HACKBARTH: I think Bill's hypothetical
3 question is so a plan enrolls a really complicated patient
4 that has multiple chronic conditions and does a really good
5 job, and as a result of that, maybe some of the conditions
6 go away and aren't reported in the next round for that
7 patient. Had that same patient stayed in Fee-for-Service,
8 they may not only have the four they started with but two
9 more. The plan has improved, but when they get their check
10 next time it's going to be for a healthier patient and,
11 therefore, lower.

12 And so they've improved relative to Fee-for-
13 Service. The gains, however, will not accrue to them.

14 I think -- is that --

15 DR. HALL: Yeah, that's more or less it -- that if
16 you -- you can do a lot of case management for lots of
17 patients for the same cost as one day in the hospital for a
18 very sick Medicare patient.

19 DR. ZABINSKI: At the same time, you know, most of
20 the conditions that are risk-adjusted are chronic
21 conditions. So, once somebody has them, a provider can code
22 them until the person is dead.

1 MR. HACKBARTH: Indeed.

2 DR. ZABINSKI: And so the sense of--I don't know.

3 I don't think the sense of getting penalized is
4 all that great here.

5 DR. MARK MILLER: And that's right where I would
6 have gone, too. If I have a diabetic patient and I manage
7 their condition, I'm still every year reporting that that
8 patient has diabetes, and the payment adjustment says you
9 have a diabetic patient.

10 And this is part of our conversation. You have a
11 diabetic patient. It's just now out of control.

12 Whereas, in Fee-for-Service, that diabetic patient
13 looks like this, you've managed it to this point. And your
14 payment still reflects this, but the patient still has
15 diabetes.

16 And I think most of what goes into this model is
17 that type of thing.

18 MR. HACKBARTH: Okay, Peter.

19 MR. BUTLER: I was going to make that last point.
20 The worst part about the Fee-for-Service system is that
21 we'll do everything we can and make money off of keeping
22 people from dying, and we'll do everything we can to make

1 sure that they don't get better because then we won't have
2 the money either. It's a weird system for sure.

3 But I think what -- why are we doing this, Scott?

4 I think this is really, fundamentally, pricing
5 accuracy in the fact that we have worked on trying to get
6 pricing accuracy under the current Fee-for-Service system as
7 good as we can and we are moving to more and more passing
8 off risk to somebody else. We're trying to get the prices
9 right to create the behaviors and alignment.

10 So I think at the heart of it, the more we get
11 these new models or even more in MA plans, the more
12 important it is to get the pricing right.

13 So a couple quick guiding principles as I look at
14 it -- and forgive me; this is a little bit redundant but not
15 totally.

16 Working inside and outside of MA, as you pointed
17 out, is important. So this ought to apply consistently to
18 ACOs, to episodes if they take off and even to things like
19 readmission rates. We have to think about this in the same
20 kind of fashion, I think. It's not just an MA plan, in or
21 out, in a given year.

22 I think my vote is for sale between predictive

1 ratio and R-squared, but I understand the point.

2 I think -- on the gaming issues, I think, Mike,
3 there are two sides to this to me, and one is simply your
4 point about do not reward treatments or services as a
5 variable because that's not a condition; that is, you're
6 getting rewarded for and paid more because of how you're
7 treating, not because of the condition of the payment.

8 Taken to extreme, when we created the ventilator
9 with tracheotomy and a DRG payment with X weight kind of
10 think, I think that's different from potentially other
11 gaming that could go on in just the diagnostic codes. It's
12 quite a different kind of issue. Both are forms of gaming
13 that you need to be alerted to.

14 And then the final point I would make is nobody
15 has mentioned ICD-10, but we're going to exponentially
16 increase the number of codes, potentially increase the
17 explanatory power maybe, maybe not, but it's just a factor
18 out there that could also increase the gaming possibilities
19 as well. And that ought to be -- I don't know how we factor
20 it in other than recognize that that is on the horizon here
21 in the next year.

22 DR. HOADLEY: So I want to sort of go back to

1 Scott's challenge to us, with an example from Part D and
2 with two examples that I think have relevance.

3 So Part D came in with both risk adjustment and
4 reinsurance at the same time. So it's different in that way
5 from Medicare Advantage and some of the other systems. In
6 fact, it has a pretty extreme reinsurance because the plan
7 is only responsible for 15 percent of the cost of the
8 highest-cost cases, or highest-cost patients, over the year.
9 It's based on the year.

10 I'm thinking about two different issues that came
11 up in Part D. One was a suspicion or a concern that plans
12 were trying to avoid the low income subsidy patients.

13 And there was research, some of which was
14 sponsored by the Commission, to look into that and some
15 issues raised with the risk adjustment system and eventually
16 some corrections made to the risk adjustment system, which
17 potentially -- I don't know if there's been a clear look
18 back at this, but probably -- helped to illuminate that
19 phenomenon of plans trying to avoid the LIS patients.

20 It seems like there's a parallel there to some of
21 these adjustments that Dan talked about with either the
22 Medicaid full or partial, or things like that.

1 If we think there's a particular thing that's
2 going on and we got some refinements that could help to fix
3 that, then those would make a lot of sense. On the other
4 hand, there are some special issues with LIS bidding on the
5 Part D system that made that a particular issue.

6 I think on the high-cost cases the reinsurance --
7 I certainly have a sense that the reinsurance probably has
8 been overdone. So putting the plans only 15 percent at risk
9 for the most expensive patients is taking away a lot of
10 their incentives to try to manage the use of high-cost
11 drugs.

12 And so that's something that probably should be
13 reconsidered somewhat within the Part D world. But there
14 are, I think, lessons there. It shouldn't necessarily
15 completely be put away, so maybe looking some more at that
16 issue, where we haven't.

17 And I think there are some Medicaid programs that
18 use some 100 percent Fee-for-Service or high percent Fee-
19 for-Service rates for the most expensive cases as well. And
20 maybe by looking at some of these instances where these
21 other -- which we're calling truncated cases here in this
22 presentation, where that kind of methodology has been used,

1 see the extent to which it helps and the extent to which it
2 doesn't help, or even hurts. From that other perspective,
3 maybe we could learn something and figure out whether
4 there's a role for truncation, reinsurance, whatever name
5 you want to put to it, but for a particular way to treat the
6 high-cost cases and when to use it and how deeply to use it.

7 MR. HACKBARTH: So, Jack, let me ask you a
8 question.

9 So Part D has, from the outset, used reinsurance
10 on high-cost cases. Analytically, is there a reason that
11 might have been done in Part D but never in Medicare
12 Advantage?

13 I would think that you would take that approach
14 where there is more skewing of the cost. I don't think
15 that's true in drugs versus other services, but I don't
16 know.

17 DR. HOADLEY: It's not particularly true in drugs.

18 I think the issues probably were two things. One
19 was the sort of concern that the notion of creating
20 standalone drug plans was this untested thing, and so it was
21 sort of going overboard --

22 MR. HACKBARTH: Yeah.

1 DR. HOADLEY: -- in hindsight, to try to make sure
2 we'd have plans participate.

3 So we did not only those two, but we also had risk
4 corridors. We actually had three methods that were
5 redundant methods, potentially, and maybe it was an over-
6 thing.

7 The other thing is that the drug costs are more
8 predictable from year to year. So knowing things about
9 people gives some information. In that sense, the context
10 is a little bit different.

11 MR. HACKBARTH: Yeah.

12 DR. BAICKER: I just want to follow up on what
13 you're saying.

14 My loose impressions is that the aggregate risk
15 faced by health insurers is pretty manageable, pretty
16 smooth, relative to lots of other types of insurance where
17 you see like flood insurance in an area, or fire insurance,
18 where you can have -- where insurers face enormous, highly
19 correlated losses. These health insurance losses are
20 uncorrelated enough that it's just a manageable problem for
21 the most part.

22 But do you have -- is that right, or is that

1 intuition not so right?

2 DR. HOADLEY: I'm not sure I can necessarily direct
3 that. I mean, I think -- directly answer that.

4 I think certainly the general direction of what
5 you're talking about is right.

6 I think the question is, how far does it go?

7 And, you know, some notion -- I mean, I think
8 that's why we're trying to look at some of the cases. In
9 Part D, we've got some clean data, and we could do some of
10 that.

11 You know, it's maybe even more complicated in Part
12 D because of the donut hole that meant there was no
13 liability, and that's changing, but no liability in that in-
14 between period as well. So the point where the full
15 liability ended was actually quite low, but maybe we could
16 look at some of those data and try to get a sense of sort of
17 what's going on with the high-cost cases.

18 What you can't do is say, well, what would have
19 happened had the plans been more at risk, unless you're
20 willing to change some rules and try some things out.

21 DR. SAMITT: So I'll start with Scott's charge to
22 us as well.

1 I don't remember who had mentioned, maybe Peter,
2 that one of the key drivers here is pricing accuracy, but I
3 think it's more than that. I think it's also that we want
4 to create a level playing field so that organizations that
5 deliver higher quality care or better access to highly
6 complex patients at a lower cost are rewarded as well as
7 those organizations that don't do that. And so I think the
8 level playing field is important to motivate these high
9 performing systems.

10 I would say the third thing is I think we would
11 all agree we want to move the industry from one that is
12 volume-based to value-based. So to what degree are these
13 risk adjustments important to keep the momentum going in
14 that direction?

15 I guess I'll be even a bit provocative. Do we
16 really want a level playing field?

17 Or, do we advantage, even from a risk-adjustment
18 perspective, those organizations that are demonstrating
19 better outcomes, lower cost, as opposed to a pure level
20 playing field?

21 If, in essence, we have the same number of
22 beneficiaries staying in Fee-for-Service versus other

1 alternatives, then how do instigate and motivate a shift to
2 a better world?

3 And I don't know to what degree risk adjustment
4 can play a role in that.

5 MR. GRADISON: I just want to add a word to what
6 Jack had to say.

7 My sense is that there certainly will be
8 opportunities for additional studies and improvement of the
9 risk adjustment of systems that have been in effect to date.

10 I'm a little confused, frankly, or uncertain, as
11 to why there hasn't been more studies that I'm aware of
12 about the use of outliers or reinsurance along with a risk
13 adjustment system to try to improve their effectiveness.

14 MR. HACKBARTH: In a minute, I'm going to turn to
15 Mark, but let me just sort of sum up where I think we've
16 been.

17 In June 2012, I think it was, we did a chapter on
18 risk adjustment and Medicare Advantage and made a couple
19 very concrete recommendations for improving the formula,
20 namely, how many conditions and using two years' worth of
21 data. As yet, CMS has not adopted those.

22 I don't think, at least from my perspective, that

1 another round of, you know, here are ways that the formula
2 can be tweaked in the abstract would be a high priority for
3 us to do.

4 However, if we have specific problems that we've
5 identified -- for example, disenrollment of high-cost
6 patients, so we need to figure out either a regulatory or a
7 payment or a combination means to address that -- I think
8 that would be a very important, high value use of time. But
9 I think our work needs to be focused on solving some
10 identifiable problem that we see as opposed to let's tweak
11 formulas.

12 So my question for you, Mark, is, number one, do
13 you have a sense of particular problems that you would like
14 to see us not answer right now but at least do some more
15 investigatory work on, or do you just disagree with my way
16 of --

17 DR. MARK MILLER: In public, right?

18 MR. HACKBARTH: Be bold.

19 DR. MARK MILLER: No, no. This was what I would
20 say. In all truthfulness I can't answer your second
21 question yet, like which problems, but this is what I take
22 away from the conversation here today. And I do feel like I

1 have some direction even though I can't answer your second
2 question.

3 And I would alter one thing you said just a little
4 bit. I agree that I think coming back in front of this
5 group and having big, long discussions about some of the
6 small changes that were identified is probably not a good
7 use of Commission time.

8 But I will also say that, for example, when we
9 stumble across something like the difference between the
10 parameters for the dual eligibles -- I won't get deep here
11 very much -- actually, there are people out in the
12 environment who are dealing with certain populations in the
13 MA program who see those kinds of changes as a big deal, and
14 they're more willing to stay in the game if they feel like
15 the risk adjustment system is sort of your point, Craig,
16 there at the end, which is I'll stay in this game and I'll
17 take this risk if I feel like I'm being treated fairly.

18 I think to the extent that we run across those --
19 and they can be written up in the chapter, but they don't
20 have to be litigated. Sometimes they're so obvious and
21 straightforward.

22 So that's a small difference.

1 MR. HACKBARTH: Or, we may not even need a
2 chapter. You know, we could put those ideas for CMS in a
3 comment letter --

4 DR. MARK MILLER: Exactly.

5 MR. HACKBARTH: -- on something and not really
6 need to process it with the Commission because they're
7 technical issues that we don't add a lot of value to.

8 DR. MARK MILLER: Right.

9 Do you want me to go on?

10 DR. COOMBS: I just wanted to say something to
11 that point.

12 It doesn't mean that we have to be the heavy on
13 it. It might be something directed to CMS.

14 I mean, if there are issues to disclose here, I
15 think if we let that moment slip by -- I mean, there might
16 be some crucial things that we should strike while we can.

17 DR. MARK MILLER: To the larger point -- and I
18 think Scott set us off on the right direction -- what I take
19 away from this is any reentry into this room and discussion
20 with you needs to be framed as a policy question. This is
21 what you're trying to solve as opposed to models can be
22 improved this particular way. So I have a take-away there.

1 And I think your second question is the question.
2 I think I need to process a little bit and come back and
3 say, okay, this is an issue; here's how that issue could be
4 addressed.

5 I also think another takeaway here is trying to
6 evaluate how much gain there would be in pursuing some
7 option. This will be small, so maybe we shouldn't spend a
8 lot of time. Or, here, there probably is some big gain.

9 Then there's kind of a bifurcation between --
10 well, let me say this. I do think what we're trying to
11 solve here or what we're trying to do at its most
12 fundamental level is be sure it's accurate.

13 And I say accurate because, like you, Craig, it's
14 keeping people in the game. I'm willing to take risk
15 because I feel like I'm being treated fairly, and mitigating
16 selection.

17 And that's for two reasons, not just the
18 government and its situation, but competitors. So if I'm
19 out in the field and I'm trying to do the right thing and
20 this person is engaged in selection -- you want.

21 Now that brings us back to this point in my mind,
22 which is there are some things you can do in the model. And

1 I'll try and be much more careful of when I come back in the
2 room and say, here is a mechanical issue within the model.

3 But things within the model, I think, are probably
4 multiple conditions and coincident condition types of things
5 to improve the model and the notion of exploring maybe these
6 hybrid ideas.

7 I think big gains in prediction, however measured
8 -- gentlemen, however measured -- come along with them
9 mechanisms that generally undermine the incentives that
10 you're trying to create.

11 And so I think you can do some of the hybrid stuff
12 if you carefully select conditions that are not gameable. I
13 could see us exploring that a bit.

14 The big wholesale increases by let's go to costs,
15 you know, you're back into cost reimbursement. And I'm
16 being very glib, but -- that notion.

17 Then my last point -- and I'm sorry this is long-
18 winded -- is there was a real emphasis on and all of the
19 other stuff. There's the model, but then there's, what
20 about disenrollment rates and this plan that has aberrant
21 disenrollment rates? Maybe you start focusing efforts
22 there. Reinsurance. You mentioned the marketing things,

1 and there was also the mention of standardization, that type
2 of thing.

3 And so I think another big takeaway for me is
4 looking at the things that go around the model to manage
5 this problem, but most importantly, coming back framed in
6 the context of: Here's the problem. Here are a couple of
7 solutions, whether they're model or policy solutions, you
8 can consider.

9 That's the most fundamental takeaway.

10 MR. ARMSTRONG: I just want to say I thought that
11 was really an excellent summary of a lot of the ways in
12 which we've evolved in our conversation on this topic.

13 I do still feel a little bit as if we're looking
14 at this risk adjustment methodology as a process we need to
15 protect from inappropriate manipulation rather than a
16 process that we need to find how our industry can embrace it
17 as a way in which it will help expand confidence in
18 prepayment, whether it's ACO pilots or bundled payments or
19 any number of other things. So, I mean, I think the way you
20 walked through that we struck the right balance between
21 those things.

22 And then the last point, which might have been

1 your last point, is that our role is largely defined around
2 -- and we've been talking about -- the methodology and the
3 accuracy of it and so forth.

4 But there is -- when we think about bridging
5 strategies from where we are to where we want to get to in a
6 reformed future, there is a whole world of complex
7 operational and administrative issues that come along with
8 doing this well for groups contemplating taking risk within
9 an ACO pilot. If we're going to advance, when we get into
10 those bridging discussions, we need to be thinking more
11 broadly.

12 And, not unrelated to that, this is, by the way,
13 not just about Medicare. I mean the exchanges, where risk
14 adjustment is kind of becoming a reality to many, many parts
15 of our health care industry that never thought they would
16 have to figure it out.

17 MR. HACKBARTH: Thank you, Dan, David.

18 So now we'll turn to patient engagement and health
19 disparities.

20 [Pause.]

21 DR. SOKOLOVSKY: Good afternoon. As many of you
22 requested this summer, we are continuing with our work on

1 shared decision making. Today we are going to focus on a
2 specific aspect of shared decision making and patient
3 activation: whether they can be effective strategies to
4 reduce health care disparities.

5 After discussing the study design, we will focus
6 on the role of poor communication between patients and
7 providers as a factor leading to health care disparities.
8 Then we will examine efforts to improve communication and
9 reduce those disparities through shared decision making and
10 patient activation programs.

11 We have discussed shared decision making often
12 before. I'll quickly remind you that it's a process that
13 involved giving patients specific information about their
14 clinical condition, possible treatment options, likely
15 outcomes, and the probabilities of benefits and harms for
16 those treatments. Patients communicate how they value the
17 relative benefits and harms so they can participate in
18 decision making. It generally includes decision aids that
19 give them objective, current information on those treatment
20 options.

21 "Patient activation" is a new term for us. It's a
22 general term and involves teaching patients that they have

1 an important role to play in their care and providing them
2 with the tools they need to communicate better. Shared
3 decision making can be thought of as a kind of patient
4 activation process.

5 And another new term that comes up a lot in this
6 literature is "health literacy." Although there's no clear
7 definition, by this we mean the ability of patients to
8 understand health communication and to understand the
9 services that they would receive.

10 Individuals who are older, poorer, and often
11 minority status are often measured as having lower health
12 literacy.

13 For this presentation we surveyed the literature
14 on shared decision making, patient activation, and
15 disparities. We used telephone interviews of program
16 organizers. We conducted focus groups with beneficiaries
17 who participated in shared decision making, and we visited
18 sites that were testing shared decision making programs.

19 As you will see, this presentation is put together
20 from many pieces, and most of these studies are
21 demonstrations including control groups, and generally the
22 sample sizes are quite small. So we cannot generalize from

1 these results, but they are suggestive of strategies that
2 can help to reduce health care disparities.

3 Poor communication between patients and providers
4 can be a problem for all patients. One study of patient
5 comprehension of emergency department care and discharge
6 instructions found that 78 percent of all patients did not
7 understand their diagnosis, their treatment, and/or their
8 follow-up care. The biggest gap was in understanding their
9 discharge instructions. Further, the majority didn't
10 realize their lack of comprehension -- in other words, they
11 didn't know what they didn't know.

12 Nevertheless, the problem is more acute for racial
13 and ethnic minorities as well as the elderly and other
14 patients with low health literacy. Poor communication is
15 not the only cause of health care disparities, but most
16 researchers would agree that it plays a role. In AHRQ's
17 annual survey of health care disparities, Hispanic and
18 African American patients consistently report poorer
19 communication with health care providers than do whites.
20 There has been no significant change in this percentage
21 since 2002.

22 Individuals with higher incomes are less likely to

1 report poor communication. However, differences between
2 whites and members of racial and ethnic minorities hold at
3 every income level although there is a narrowing of the gap
4 at the highest income level.

5 Not only do patients have problems communicating
6 with their providers, providers may not understand their
7 patients' preferences and concerns. They may mistake poor
8 communication with disinterest in shared decision making.
9 In the same AHRQ survey, black and Hispanic patients
10 reported being less likely to be asked their preferences in
11 treatment decisions than white patients. In another study
12 of patients being treated for diabetes in community health
13 centers, African American patients reported receiving less
14 information and having fewer opportunities to ask questions
15 than white patients being treated in the very same
16 facilities. But they expressed an equal desire for shared
17 decision making.

18 In order to bridge the communication gap from the
19 physician perspective, some teaching hospitals have begun
20 shared decision making programs aimed at teaching new
21 physicians or future physicians how to better communicate
22 with all patients. For example, Massachusetts General and

1 Sophie Davis Medical School have incorporated the techniques
2 of shared decision making and patient activation into their
3 medical training.

4 Another innovative program was developed at the
5 University of California-San Francisco breast cancer center.
6 Pre-med students help patients prepare for, participate in,
7 and remember their visits. The student coach contacts a
8 patient who has been diagnosed with cancer and offers her
9 shared decision making support, including providing decision
10 aids, helping the patient to make a list of her questions
11 and concerns, and accompanying her to her appointment to
12 make notes about what the physician says. The coach also
13 records the medical encounter so that patients can play it
14 back at home as often as needed. The coach ensures that the
15 physician receives a copy of the questions before the
16 clinical appointment. Student coaches are not permitted to
17 provide additional medical information or advice.

18 Although the program is not designed specifically
19 to reduce health care disparities, the center doesn't have
20 sufficient coaches to meet the demand from all their
21 patients. Therefore, they prioritize patients facing
22 particular challenges -- for example, those who are

1 unaccompanied, have low literacy, are older, or are non-
2 English speakers. The program is seeking to recruit more
3 student coaches and expand its focus to additional cancer
4 clinics and other specialty clinics. Alumni of the program
5 report that participating in the program has helped them as
6 physicians to listen more carefully to their patients.

7 Shared decision making for minorities and others
8 with low health literacy may benefit more from video
9 decision aids compared to the traditional booklets. For
10 example, researchers have compared the effects of shared
11 decision making booklets on advanced care planning with
12 people who received both booklets and videos on the same
13 subject. They have found that the videos improved knowledge
14 and participation in advanced care planning among minority
15 patients compared to those individuals who only received the
16 traditional booklets.

17 In our focus group in Philadelphia, minority
18 patients also reported that viewing the videos in groups
19 helped them to understand that they were not alone and let
20 them discuss strategies for managing their diabetes with
21 others in the same condition. Program organizers said that
22 almost no patients used the booklets.

1 Because the data are limited, we can't make a
2 definitive statement that minority groups benefit most from
3 shared decision making. However, we were consistently told
4 that in our interviews with ongoing programs that patients
5 with lower health literacy received the most benefit from
6 these programs. This is most striking when we compare
7 results from the Philadelphia clinic population with other
8 demonstration sites sponsored by the Informed Medical
9 Decisions Foundation. Remember that the Philadelphia
10 clinics are attended by very poor or sometimes homeless
11 minority populations. On the slide the green bars represent
12 Philadelphia, and the blue bars are the other demonstration
13 sites.

14 Before the demonstration, overall medication
15 adherence for diabetics was lower in Philadelphia than in
16 the other sites. While adherence increased at all the sites
17 following the intervention, as you can see from the chart,
18 it increased in general the most at these clinics, reaching
19 or sometimes even exceeding adherence elsewhere. Because
20 the number of minority patients in these groups outside of
21 Philadelphia was generally low, we can only say that this
22 approach looks promising. And in most cases we can't

1 disentangle the effects of education and income from the
2 effects of minority status.

3 Now Katelyn is going to talk to you about patient
4 activation programs, a more general approach to improving
5 communication between providers and patients.

6 MS. SMALLEY: As Joan mentioned, the Commission
7 has become familiar with shared decision making over the
8 last few years, but there are other methods for engaging
9 patients in their care. Patient activation is a much more
10 general approach that stems from the idea that more
11 confident patients are better participants in their health
12 care. They communicate better with their providers about
13 their own goals, concerns, and preferences, and ask
14 questions about the things they don't understand. These
15 same patients are more likely to carry this concern with
16 them out into the community, and thus will engage in healthy
17 behaviors like physical activity, healthy eating, and
18 medication adherence.

19 The evidence regarding this pathway is limited at
20 this point, but it is suggestive, particularly with respect
21 to patient-provider communication and self-management, which
22 we will address in further detail in a moment.

1 In a way, shared decision making can be viewed as
2 a kind of patient activation activity. Its goal is still to
3 have more confident, better informed patients who are active
4 participants in their care. However, shared decision making
5 is condition-specific, whereas patient activation aims to
6 equip patients to ask the right questions about their care
7 in any number of different health care situations.

8 As Joan described earlier, minority patients may
9 experience poor communication with their providers for a
10 number of reasons. Although the evidence is not clear on
11 this point, these deficits in communication could account
12 for some of the racial and ethnic disparities we see in
13 health behaviors and outcomes. Because one goal of patient
14 activation is to improve patient-provider communication,
15 patient activation may be used as a tool to address these
16 disparities.

17 In general, patients often do not realize that
18 they will have to make decisions during a visit with their
19 provider or that they are allowed to ask questions about the
20 information provided in the visit. As a consequence,
21 patients are often not prepared to make informed choices.
22 Highly activated patients are more able to engage with their

1 providers, assert their preferences and concerns, and ask
2 questions. Because on average, minority patients tend to be
3 less activated than white patients, they may have more
4 trouble reaching informed decisions about their care.

5 An organization called the Right Question Project
6 aims to help low-income individuals advocate for themselves.
7 In the health care setting, this means asking questions of
8 providers, asserting their concerns and preferences, and
9 sharing in decisions about their care.

10 The Right Question Project developed a patient
11 activation intervention for these low-income patients that
12 was designed to be administered in a very short time frame.
13 The program works like this: A health coach or other type
14 of volunteer trains a patient one-on-one. After a patient's
15 initial level of activation is assessed, the training
16 begins.

17 First, the coach and the patient work together to
18 define the word "decision" generally and demonstrate how
19 asking strategic questions might lead to better decisions.

20 The coaches then help the patients to choose a
21 focus for their current visit and to brainstorm and
22 prioritize questions that are relative to that focus.

1 They then strategize about how to self-manage
2 after the appointment or to have a conversation about that
3 self-management with the provider in the consultation.

4 And then the intervention is meant to be open-
5 ended rather than content-focused, and it takes about ten
6 minutes.

7 The Right Question Project intervention has been
8 adapted in several different ways. The focus is always on
9 low-income, minority patients, but different demonstrations
10 are structured slightly differently.

11 For instance, at Sophie David Medical School,
12 medical students lead the training for patients at a primary
13 care clinic. A pilot of this program was so well received
14 by both the patients and the students that participated that
15 participation in the program as a trainer is now required
16 for graduation from Sophie Davis. In addition to the
17 benefit to the patient, students at Sophie Davis and at the
18 other programs Joan mentioned report that being involved in
19 programs like this help them become better doctors.

20 Another new demonstration that uses the Right
21 Question methodology is Massachusetts Medicaid managed care.
22 The program targets the plan's high-risk beneficiaries,

1 including dual-eligibles, and follows them longitudinally
2 with community health workers that combine information from
3 both a clinical and self-management or activation
4 perspective to track beneficiary progress over time. They
5 are in regular contact with beneficiaries, both over the
6 phone and in-person with home visits. This program is still
7 in very early stages, so there is little information about
8 results at this point.

9 The demonstration programs seem to improve
10 patients' participation in their care, as patients were more
11 likely to keep appointments, ask questions of their
12 clinicians, and take medications than they were before the
13 training. Likewise, patients who had undergone the training
14 were more likely to avoid the emergency room.

15 In a study of Latino patients undergoing mental
16 health treatment, both English-speaking and non-English-
17 speaking patients who received the patient activation
18 intervention were more engaged in therapy after the
19 intervention.

20 However, in both cases it is unclear how long the
21 effects of the training last. As more research is done in
22 this area, it will be important to know if the training

1 needs to be repeated periodically in order to maintain the
2 same effect.

3 At this point, I'd just like to reiterate our key
4 findings. I'd like to make it clear that while our focus
5 today was on racial and ethnic minority populations, the
6 small size of the studies we reviewed make it difficult to
7 be confident that the effects we see are exclusively a
8 result of disparities based on race and ethnicity. Income
9 and education may also contribute to the disparities that
10 these programs attempt to address.

11 With that being said, we find that some shared
12 decision making programs help providers to better
13 communicate with their patients, and audio-visual decision
14 aids and group meetings can help beneficiaries with low
15 health literacy participate in shared decision making.

16 Some limited data suggest that minority groups may
17 benefit the most from shared decision making, and patient
18 activation seems to improve patients' willingness and
19 ability to manage their care and better communicate with
20 their providers.

21 As we move into discussion, we'd like you to
22 consider the next steps that you would like the Commission

1 to pursue with respect to shared decision making.

2 As you heard earlier today, beneficiaries can be
3 engaged to a certain extent with their ACO through cost
4 sharing. ACOs are also required, as a part of both their
5 initial application and their quality metrics, to engage
6 beneficiaries. Medical homes also have some requirements
7 around engaging and informing patients. We could review
8 these current requirements more deeply and identify the
9 places that they could be strengthened or expanded. One
10 issue to consider here is how prescriptive the Commission
11 would want such a policy to be. Should ACOs and medical
12 homes be encouraged or required to provide programs like
13 shared decision making or patient activation specifically?
14 Or should they be responsible for the outcomes that may be
15 associated with engaged patients?

16 Another line of discussion could be on programs
17 that elicit patient preferences on advanced care planning.
18 We discussed this briefly at the April 2013 meeting, and
19 there have been some Commissioner inquiries into the topic.
20 We could look more broadly at the many different kinds of
21 programs around the country that attempt to address this
22 issue and come back to you with findings that may be able to

1 drive policy, and also if there are any other topics that
2 you would like to discuss.

3 With that, we look forward to your discussion and
4 to answering any questions you may have.

5 MR. HACKBARTH: Thank you very much, Joan and
6 Katelyn. Round one clarifying questions, do we have any?

7 DR. HALL: Thank you for the presentation. On
8 your preliminary analysis, were you able to find out what
9 sorts of indicators might be used in the actual
10 administration of patient care that are in use in the United
11 States now?

12 DR. SOKOLOVSKY: If you're talking about what ACOs
13 and medical homes are measured on, I can tell you that there
14 are HCAHPS modules, and I have, in fact, brought with me,
15 just in case someone asked, what those questions are, and we
16 can go through them if that is what you're asking. I'm not
17 quite sure if that's what you mean.

18 DR. HALL: Well, I don't know if everyone is
19 familiar with the so-called HCAHPS, but could you just read
20 the questions relevant to doctors, what the patient has
21 asked on HCAHPS, just so we're all on the same page.

22 DR. SOKOLOVSKY: On the shared decision making

1 module, they'll ask: Provider talked about the reasons you
2 might want to take a prescription medicine

3 Second question: Provider talked about the
4 reasons why might not want to take a prescription medicine.

5 And then there's a similar one about procedures,
6 both why you would want and why you wouldn't.

7 And then when talking about surgery or a
8 procedure, provider asked what you thought was best for you.

9 Provider talked about including family or friends
10 in making a health care decision.

11 Provider talked about how much of your personal
12 health information you wanted to share with family or
13 friends.

14 Provider respected your wishes about sharing
15 personal information.

16 And provider let you bring a family member or
17 friend with you to talk with the provider.

18 Then there are two other modules, one is about
19 team-based care, and --

20 DR. HALL: The only point is that these surveys
21 are given almost always near the point of discharge.

22 They're done in a very hurried fashion for the most part,

1 and there's not a hospital in the country that doesn't
2 emphasize among their staff that -- and, by the way, the
3 answers are not yes-no, but they're never, sometimes,
4 always, was my care exceptional, that sort of thing. Our
5 hospital is full of signs everywhere, in doctors' lounges
6 and places where nurses aggregate, suggesting that in our
7 hospital patients should be encouraged to say that their
8 care has been excellent at all times, because the rating
9 scales are very much at a ceiling effect, so that basically
10 hospitals compete for being a tenth or even a hundredth of a
11 percentage point difference than their community rivals.

12 I think we can do better, is the only reason I --
13 but I just want to make sure that we're -- that is sort of
14 the gold standard right now.

15 MR. HACKBARTH: Any other clarifying questions?

16 [No response.]

17 MR. HACKBARTH: George, do you want to lead off
18 round two.

19 MR. GEORGE MILLER: I will. Thank you. And thank
20 you for this chapter. I want to thank the staff for going
21 through this. This was excellent, and I really appreciate
22 it, because I've asked many of these questions before.

1 I want to comment, and I don't want this to be
2 taken as a criticism. It's just an observation. And I
3 don't think it was intended, but it came across this way, at
4 least to me.

5 On a couple points, like on Slide 4, health
6 literacy, we talk about the individuals, but we don't talk
7 about the providers. One of the things I think that while
8 the health literacy deals with the consumer or the patient,
9 one of the issues that I wrestled with as I read the chapter
10 is that we did not talk about the competencies of the
11 providers to take the responsibility to explain things in
12 ways that the patient could understand.

13 Also then on Slide 6, at the top it says, "Poor
14 communication between patients and providers influences
15 health care disparities." That's a true statement, but the
16 bullet points only list issues between the patients. Subtle
17 issue, but we didn't listen. Problems of the providers.

18 I'll give you a perfect example. My mother was a
19 nurse, a charge nurse at Miami Valley Hospital. My father
20 was an electrical engineer, one of the smartest guys I knew.
21 But they would never, ever -- and this may be more
22 generational and when they grew up and where they grew up.

1 They never would question the doctor. Not ever. And my
2 mother was a nurse. Not ever, not until I started -- when
3 they got older and I started going to the doctor with them.
4 And I questioned them. I am a product of the 1960s and the
5 1970s. It's a different generation. And they both grew up
6 in the South. And there are some minorities that just don't
7 question authority, and I think it's the responsibility or
8 should be the responsibility to get some of those questions
9 out from the providers. And that's a competency issue and
10 put it in terms that they understand.

11 But I'm also very much encouraged by Slide 8 where
12 they talk about what Mass. General is doing and the medical
13 school. I think that's the right thing to do, and I applaud
14 them for doing that.

15 Now, going over to the chapter, there's a
16 statement in the chapter that really struck me as some of
17 the concerns I have with the chapter and the tone. I don't
18 think it was intentional, but the tone that says when
19 patients are more confident and empowered, then they can
20 participate in their care. What about if the patients are
21 treated with dignity and respect and treated like decent
22 human beings? They then can feel empowered. And, again,

1 it's just a subtle tone, but the inference is that they only
2 become more confident if they're taught things versus if
3 they're treated that way from the beginning. A little
4 subtle difference, but that resonated with me.

5 Again, I appreciate the tone of the -- I
6 appreciate the chapter and the things that are covered and
7 the recommendations. I did like the SDM programs. I'd like
8 to know more shared decision making programs, and also using
9 different ways to communicate with visual and booklets. I
10 think those were excellent also and would love to learn more
11 about other organizations in America that are using them.

12 And then to the question about future work, what
13 programs are being tested, elicit patient preference on
14 advanced care planning, possible topics, I would like to
15 know more about that as well.

16 I thought Joan and Katelyn did a good job. Thank
17 you.

18 DR. HALL: I will just say I really applaud the
19 Commission and all of our staff for taking this subject on.
20 I think it's at the very heart of the delivery of medical
21 care.

22 And just as a personal comment, I think as good

1 and as important as comprehensive electronic health records
2 are to the delivery of health care, they have started to
3 blunt this whole issue of the time engaging with patients in
4 this regard. That's not a necessary outcome, but it is one
5 that seems to be becoming more and more prevalent, and I
6 think it adds strength and prestige to the whole issue of
7 how important this is that MedPAC is talking about it.

8 MR. GRADISON: I, too, am glad we're taking a
9 close look at this, and I was interested that some of those
10 questions mentioned having a family member or friend
11 present.

12 On discharge, a lot of patients are not in very
13 good shape to receive all this and retain it. We're
14 hustling people out of the hospitals pretty fast these days,
15 and often there may be the delayed effects of anesthetic or
16 just not having a good night's sleep for a couple of days.
17 And my own observation -- and it's purely anecdotal -- is
18 that everybody needs a patient advocate. I mean absolutely
19 everybody needs a patient advocate, somebody to literally
20 check up and make sure that the hospital and the nurses are
21 doing the right job with regard to the dispensing of
22 medications, that the food is appropriate. And some of the

1 more important but more subtle things that George mentioned
2 are true. And I might just say, George, I certainly
3 acknowledge the valuable contribution you've made by talking
4 about your own family experiences. I think there also is a
5 generational factor here. Doctors aren't quite as much God
6 as they used to be, and I really choose those words
7 carefully. I think there's a lot to that.

8 But I also -- you asked if there's additional work
9 you'd like to focus on. I'd like to know if it's possible
10 to find out whether we can get useful suggestions from any
11 of the more organized plans, like the MA plans, that might
12 shed some particular light on this subject that say that.

13 The second thing is that I'd be very interested in
14 whether there's anything we can learn from on-U.S.
15 experience. Generally I don't suggest this because, you
16 know, every country is different. But to the extent I've
17 been reading up on this subject, it's almost all, if not
18 entirely, based on U.S. experience. I'd personally be very
19 interested in what the National Health Service and other
20 systems, maybe even more the Canadian system -- which is, in
21 terms of delivery, more like ours, kind of a free
22 enterprise, fee-for-service system -- what, if anything, we

1 could learn from these other countries that might be helpful
2 as we move forward in thinking this through in terms of
3 what's best in this country.

4 DR. SOKOLOVSKY: Just to quickly take your
5 questions, last to first, Canadians are very active in this
6 field. Some of the earliest work has been done in Canada,
7 and they spearheaded -- there's an international
8 organization that talks about the criteria for decision aids
9 and what it would mean to be an acceptable decision aid,
10 spearheaded by Canada. And there's a lot of work in the
11 U.K. and Australia.

12 When we come down to MA plans, you really should
13 listen to Scott because Group Health has done the most of
14 any place in the U.S. They have the largest demonstration
15 project, and that's what I talked about last year, but maybe
16 not sufficiently. But he's the one who really should answer
17 that question.

18 MR. GRADISON: Thank you both.

19 DR. CHRISTIANSON: Just a couple of comments, I
20 guess. One is just to be clear that -- and I think the
21 people who wrote the chapter are clear on this, but the
22 concept of shared decision making is a very different

1 concept than patient activation, and we're putting them
2 together in the same chapter. But shared decision making,
3 as you know, is for situations where there are clear
4 alternatives; there is not a clear appropriate medical route
5 to go. Patient preferences enter in -- patient preferences
6 with respect to outcomes of both pathways come into play.
7 And that's where patient decision aids are very helpful in
8 helping people reach a conclusion, make a decision that
9 they're ultimately satisfied with.

10 Patient activation refers to people's ability --
11 making consumers better consumers, patients better
12 consumers, better able to manage their own care. It's often
13 a term -- the research on this has been done primarily for
14 people with chronic conditions, so it's not the sort of I've
15 got a decision to make about a screening test, I've got a
16 decision to make about a surgery. It's how do you get
17 people more self-confident in managing their own conditions
18 and making decisions on their own.

19 So they're different -- they clearly cross at some
20 point, but they're really different kinds of concepts, and I
21 think in this chapter, you know, we have to continue to try
22 to make sure that we don't confuse people when we go back

1 and forth between the two.

2 And then I guess one more question to kind of
3 piggyback on what George said is I think training clinicians
4 to ask the right questions is just as important as training
5 patients to ask the right questions in terms of patient
6 engagement. And, clearly, there's less time for that for
7 physicians than there might have been in the past. But
8 there are other alternatives to doing that. We just
9 finished publishing the results of a randomized trial where
10 non-clinicians in primary care offices were taught to do
11 motivational interviewing with patients, get them engaged in
12 managing their own care with sort of incredibly positive
13 low-cost results.

14 So there are ways to get patient engagement that
15 don't involve or in addition to involving training patients
16 to ask questions, training patients to be better decision
17 makers, and probably we need to focus on both aspects of
18 this to get patient engagement.

19 MR. ARMSTRONG: First of all, I would just say,
20 after the compliment you made about my organization, this
21 was the best presentation I've ever heard.

22 [Laughter.]

1 MR. ARMSTRONG: More seriously, this is excellent
2 work and I think a topic that is important for us to learn
3 more about and find the right ways to apply to our policy
4 work. But I have to say I was a little bit confused about
5 what we are -- what the problem is we're trying to solve.
6 Is this about disparities? And shared decision making or
7 activation is one way of solving a disparities problem we
8 have in the Medicare program? Or is disparities just one
9 potential symptom, improved management of disparities a
10 symptom of advancing patient engagement and activation? And
11 so I think we kind of have to decide that, unless we
12 already know the answer to that question. From reading the
13 material, I think you could go both ways on it.

14 My point of view would be -- and we might not all
15 agree on this -- that I'm not convinced this would be the
16 best way to deal with a disparities issue. But I think
17 talking about patient engagement is important, but I also
18 think, to the point, Jon, you were just making, patient
19 engagement isn't a set of tools. It's not a training
20 program. To me, it's a feature or characteristic of how a
21 health system is organized. And for an organization like
22 the one I work at where shared decision making is, in fact,

1 something we've invested a lot in, I would just say it is
2 just a relatively small component part of an overall set of
3 system features that are designed to engage our patients
4 actively as participants and owners in their health, whether
5 it's interacting with their provider or it's deciding
6 whether they're going to eat good food.

7 And so at least for our work here at MedPAC, I do
8 think -- maybe those are two different issues, and we need
9 to deal with them both. But we need to sort through are we
10 really advancing ways of incorporating patient engagement
11 into Medicare through our policy or are we trying to deal
12 with the problem of disparities in the program.

13 MR. HACKBARTH: Do you want to respond, Joan?

14 DR. SOKOLOVSKY: I don't know if I want to respond
15 to that.

16 [Laughter.]

17 DR. SOKOLOVSKY: I mean, I would say that this was
18 not meant to say this is the focus we should take for shared
19 decision making. But we have been talking about disparities
20 since I've been here. We point them out in every sector.
21 We rarely talk about anything that involves addressing it.
22 So I thought it was worth, since we have been doing -- this

1 is like my fifth presentation on shared decision making. I
2 thought it was worth taking one of those and using it to say
3 here are some programs that are, in fact, trying to address
4 it.

5 MR. ARMSTRONG: My own view would be to build on
6 that, but I think this is another case point for why shared
7 decision making and patient engagement is important for us
8 going forward. That's the way I would approach it.

9 MR. HACKBARTH: So it may just be me, but I feel
10 like we're sort of in a deja vu moment here. It was in the
11 spring of this year that we had your last presentation on
12 shared decision making. Did we actually include a chapter
13 in our report? Now, we didn't. And my recollection of the
14 spring discussion was that there was unanimous agreement
15 that this was an important thing, "this" being that there
16 was an ethical responsibility to engage with patients and
17 especially around, as Jon was saying, where the choices that
18 need to be made are, by definition, preference-sensitive.
19 And there's no clinical right answer. It really turns on
20 patient preferences, and we need to do a better job of
21 helping patients make those decisions. So it's a good
22 thing.

1 But my recollection of the discussion in the
2 spring was also that we said even though it's a very good
3 thing, what exactly is it that Medicare can do to make it
4 happen? Is it really something that Medicare can
5 effectively promote? And the key part of that conversation,
6 as I remember it, was Scott's report on what a challenge it
7 is to do this even in an organization like Group Health that
8 has physicians and other clinicians that are really
9 committed to the principles, a really organized delivery
10 system and a supportive payment system.

11 MR. ARMSTRONG: You need a good risk adjustment
12 methodology.

13 MR. HACKBARTH: Right.

14 [Laughter.]

15 MR. HACKBARTH: And so, you know, if it's really
16 difficult, challenging, and took years of work, ongoing work
17 actually, to do it there, are there really payment levers or
18 regulatory levers that Medicare can pull that are going to
19 make this happen in much less structured delivery systems?

20 And so to me that's sort of where we left it in
21 the spring, and I feel like, you know, we're not taking off
22 from that point, but sort of going back to, oh, this is a

1 good thing again. And I don't think that's in question.

2 The issue is: What can we do about it?

3 DR. CHRISTIANSON: So this was many years ago, but
4 some of the early proponents of shared decision making and
5 the use of patient decision aids, when pay for performance
6 was first coming on the scene, were advocating for including
7 a pay-for-performance metric around the use of shared
8 decision aids. So if you want to be specific -- now, I
9 don't know where that went, and I don't know if anybody has
10 ever done that. So, I mean, I'm just remembering reading
11 some of the early literature on that and remembering that
12 that was something that they were pushing for, obviously
13 having a strong self-interest, you know, in seeing that
14 happen.

15 MR. HACKBARTH: I don't want to respond and have a
16 comeback like, oh, you know, I have all the answers and all
17 that, but my -- I think we talked a little bit about that in
18 the spring. And so what does that entail? That entails
19 Medicare prescribing that, A, here are appropriate, high-
20 quality materials, because the materials vary a lot in their
21 content and quality; and, B, it's not a matter of just
22 throwing materials at patients. The whole idea is engaging

1 with patients, which is very soft and difficult -- not soft.
2 It's difficult to measure from a distance. And so if you
3 really want an effective pay-for-performance system, I think
4 it's very challenging to do.

5 I'm not trying to throw cold water on this, but I
6 don't want to just have the same discussion we had in the
7 spring. I want to figure out is there something that we can
8 do with the tools that we have available. So I'll be quiet
9 and, Rita, you're next.

10 DR. REDBERG: Thank you. That was a good lead-in
11 to what I wanted to say, anyway, Glenn. And that was an
12 excellent presentation.

13 I think this issue is really, really important,
14 and it really goes to the core of medical care and sort of
15 things we can do to improve certainly care for Medicare
16 beneficiaries and all patients, because it really is about
17 patient-centered care and communication. And I do think
18 that sort of patient activation and shared decision making
19 are similar; they're kind of on a continuum of communication
20 with your patient, you know, where patient activation is
21 just getting more communication, and shared decision making
22 usually has a specific decision ahead of you. You know, a

1 lot of the current aids are around prostate cancer, breast
2 cancer, or on cardiology interventions.

3 But there has been tremendous resistance, I'm
4 sorry to say, in the medical profession to take it up for a
5 lot of reasons, and I think we could have an input there.
6 You know, for example, one of my colleagues at UCSF tried to
7 do a PCI, a stent decision aid, because that's a very
8 elective decision for most people, whether you want to have
9 medical therapy or stents. But it is clear from the
10 literature on decision aids that they always result in a
11 reduction in procedures. Once patients understand the risks
12 and benefits and that you do equally well with the
13 conservative as well as the more invasive therapy, they tend
14 to opt for a conservative treatment, and that means volume
15 goes down of very lucrative procedures. And so physicians
16 do not embrace these, hospital systems do not embrace these.
17 And, you know, we get back to the problem with we have a
18 fee-for-service system that rewards very generously these
19 procedures, and decision aids are not consistent with these
20 high-volume, very highly reimbursed procedures. And so
21 there's very poor uptake for decision aids.

22 You know, we tried to do a pilot in California for

1 a PCI decision aid, and they said, well, you have to pay --
2 the professional group said you would have to pay
3 cardiologists to make up for the loss in volume of PCI from
4 using this decision aid, which I said, "Well, that implies
5 that you're doing a lot of PCIs that patients would not opt
6 to have," which is kind of the unwritten thing. But it
7 didn't go anywhere. And I think we really do -- I mean,
8 we've talked a lot about changing reimbursement, but you
9 really have to have a lot better communication and better --
10 it's really also changing medical culture and just talking
11 to patients.

12 You know, I think the stories George told still go
13 on today. I have lots of patients I see every week, and I
14 say, you know, "You have a scar. What surgery did you
15 have?" "I don't know." "Why did you have it?" "I don't
16 know. The doctor said I needed the surgery."

17 You know, I think that we still have tremendous
18 room for improvement on doctor-patient communication. And,
19 you know, some of those, I'm not saying they weren't
20 necessary surgeries, but there's definitely a gap between
21 what patients would like to know and what they do know, and
22 a lot of trust in physicians, which is great, but -- so I

1 think that shared decision making programs are really
2 important in going that, and that, again, we really have to
3 kind of change our reimbursement, because continuing to pay
4 very highly for procedures is not encouraging the shared
5 decision making.

6 And just the last thing I wanted to say is we
7 really have to define sort of what the goals are. In these
8 studies that were cited, you know, you could have lots of
9 different goals, like do you just want patients to say they
10 felt better about the visit, you know, should they feel
11 better about their decision, or should their actual outcomes
12 be different? You know, you can look at what were their
13 choices, how did they do after having -- and all of those
14 are important, but I think they're all sort of different
15 goals.

16 MR. HACKBARTH: Jon, is it on -- [off microphone]?

17 DR. CHRISTIANSON: Yeah, exactly. So a lot of the
18 support for -- and the way that shared -- patient decision
19 aids get in the hands of people is not through providers.
20 It's through self-insured employers who buy access to shared
21 decision aids. So some of this happens despite, you know,
22 the fact that providers might resist the use of them.

1 They're out there and sort of being used.

2 And with respect to the measurement issue, I think
3 if we knew that patients should choose one thing rather than
4 another, the case for having a shared decision process would
5 be a little weaker. So I don't think we can be prescriptive
6 about saying it worked if they chose not to do surgery or if
7 they chose to do this. I think the reason that the metric
8 is usually how happy are you after the fact with your
9 decision is that that's exactly what those decision aids are
10 trying to accomplish.

11 DR. REDBERG: That's true, but patients can be
12 very happy after having chosen unnecessary surgeries.

13 DR. CHRISTIANSON: Of course [off microphone].

14 MR. KUHN: Glenn, picking up on your thought about
15 kind of what do we do next, let me ask if -- I know -- I
16 think it was back in 2010, the Assistant Secretary for
17 Health laid out an initiative which they called the National
18 Action Plan to Improve Health Literacy. So they laid out
19 this major strategy, all these action steps and these
20 strategies to kind of move forward with a major health
21 literacy effort. Is there anything that was part of that
22 report or anything they've done in the last two or three

1 years that could be actionable that we could look at to
2 build on to help support the Medicare program. That would
3 be my one question. And I don't know if you're familiar
4 with that report, but we could go back and look at it and
5 see.

6 And then the second thing, picking up a little bit
7 on Jon's point -- I was thinking about that -- I, too was
8 thinking about others out there. So is there anything like
9 a Khan Academy that's generating shared decision making
10 tools that are up on the website free for everybody to kind
11 of access and use?

12 DR. REDBERG: Foundation for Medical Decision
13 Making?

14 PARTICIPANT: They're not open-source though.

15 MS. SMALLEY: I don't think they're free.

16 MR. KUHN: But I was thinking like the Khan
17 Academy where everything is just kind of out there available
18 for anybody to access whenever they want.

19 DR. SOKOLOVSKY: Mayo Clinic has a set of decision
20 aids that are available for anyone. They're very different
21 -- it's a very interesting, different kind of model.
22 They're meant to be used by the physician with the patient

1 during the encounter. For example, if you're treating a
2 patient with diabetes, there are set of seven cards for
3 seven different medications you could be taking, and the
4 physician asks the patient sort of, "What's the most
5 important thing to you about controlling your diabetes?"
6 And if you say one thing, you move to a particular card, and
7 then there's a list -- and including cost -- to try to
8 figure out what should be prescribed that would be patient
9 centered. And those are available.

10 DR. REDBERG: I think Victor Montori, an
11 endocrinologist at Mayo Clinic, has done a lot of that work,
12 and it's very nice because he's getting back to health
13 literacy. They actually have pictures on a lot of them, and
14 it shows you like 100 people, and then they color them. If
15 you take this drug, you know, five of them -- and they color
16 them in red -- will have this side effect, and two of you
17 will avoid this other adverse -- and so because it -- health
18 literacy is a big issue for everyone, even certainly for
19 uneducated people but even for educated people to try to
20 explain, you know, because typically most drugs that we
21 prescribe will benefit maybe 5 out of 100 people taking
22 them, and people always assume -- and we don't explain it

1 well enough -- that, no, it's really just 5 out of those
2 100, and the rest won't make a difference. And so the Mayo
3 Clinic -- and it is available -- uses those circles and
4 different colors to try to explain the number needed to
5 treat concept.

6 MR. KUHN: And so then the other kind of question
7 on that, that information be available, whether it's through
8 Mayor or a Khan Academy-like thing somewhere in the future,
9 is -- Rita made an interesting point about most folks, when
10 they go through this, will choose the more conservative
11 decision. But is it also possible, as this information
12 continues to generate, that some of the different folks
13 could put together videos or decision aid tools, like drug
14 companies, device companies, that could actually induce more
15 utilization in different ways. And so it kind of depends
16 how it's all skewed and how the data is presented where you
17 can generate other kinds of results that would choose a
18 higher-priced drug because they think it's more efficacy,
19 things like that. So is that going on out there as well?

20 DR. REDBERG: I think it's called direct-to-
21 consumer advertising.

22 DR. SOKOLOVSKY: But beyond that, I think Herb is

1 exactly right, that some drug companies and device companies
2 are partnering with other firms to produce these kinds of
3 decision aids, and as things stand right now, there's no
4 certification process that says this is objective, current
5 information.

6 MR. HACKBARTH: I've been sort of experimenting
7 with a less structured round two.

8 DR. COOMBS: I noticed.

9 MR. HACKBARTH: But right now we're going to a
10 rigid -- we're going to get through, and so let's just
11 proceed with Alice and get through --

12 DR. COOMBS: This is one day that I wish I was
13 over there. I'll be brief.

14 First of all, I think that the shared decision
15 making makes a difference if it's titrated with not so much
16 as -- and I hate to use this, I hope it's not offensive --
17 as a "soft outcome." How shared decision making links up
18 with other kinds of outcome data I think is really
19 important.

20 For instance, limb-salvage surgery is one of those
21 things that, you know what? You can have a bypass, and you
22 can save a limb. You can have a different outcome in terms

1 of the patient's longevity versus having an immediate
2 amputation. There's so many stories, literature that
3 supports this notion that blacks and Hispanics do not get
4 the same kind of aggressive interventions when it comes to
5 things that are protective, such as CABG surgery. I mean,
6 the data is very compelling.

7 So on one hand, we're talking about shared
8 decision making as more of in the office kind of thing, but
9 I think of shared decision making on a whole -- when it
10 comes to the surgical perturbations that are made to make a
11 difference in outcome.

12 There's one specific thing that I can remember.
13 In 2006, my brother had a stroke, and I'm in the ICU, and
14 you should be able to get tPA and make a big difference in a
15 patient's course with a non-hemorrhagic stroke. That wasn't
16 offered to him because there was no neurologist on call, and
17 it wasn't even discussed.

18 So when we talk about shared decision making, I
19 think it's good for us to tie it to an outcome, because what
20 happens is there are these paternalistic defaults that are
21 kind of done by the provider, and it has a lot to do with
22 both sides of the equation in terms of the cultural

1 competency of the provider. And I think that the Commission
2 has actually looked at all of these things, and physician
3 awareness is really an important part of health disparities
4 and health care disparities.

5 I think, you know, going forward, it would be good
6 for us to look at that. The Office of Minority Health has a
7 monogram, and I think that that's a wealth of information
8 that some of those concepts can be used. But I'd like to
9 work with you off-line, if possible. But I think that I'd
10 like to talk more, but I'm going to be disciplined.

11 DR. CHERNEW: So, my enthusiasm for shared
12 decision making is tempered only by my trepidation over
13 policies that reach deeply into the processes of care. I
14 think the operational details of defining what qualifies for
15 the right process and who did it and all of those things end
16 up adding a sort of administrative overhead layer that may
17 eat away all the potential gains from it.

18 So, I do think there are ways to go forward. I
19 know CMMI has several -- at least one, I think two,
20 demonstrations on shared decision making going forward that
21 they control a lot of these details. So I do think it's an
22 important issue and I do think there's a way of going

1 forward, but I think the challenge is, as Glenn said before,
2 finding the right policy, and I'm skeptical of many obvious
3 ones.

4 DR. BAICKER: Yeah, I agree. This is a wonderful
5 opportunity, but one that we and the program are hard
6 pressed to drive without risking the kind of micromanagement
7 that often backfires. So, that leaves us in a little bit of
8 a conundrum.

9 But, I very much agreed with Scott's rejiggering
10 of the way we think about disparities and shared decision
11 making in that I think our goal is to improve the number of
12 patients who get the care that's actually the care they
13 want, that aligns with their preferences, with their
14 tolerance for various side effects, all those other things,
15 and we want to reduce disparities in people not getting what
16 they want by ensuring that everybody gets the right care for
17 him or her and that if there's a gap in that based on race,
18 ethnicity, income, education, we want to raise the bottom.
19 We want to target the people who are not getting the care
20 that's right for them.

21 Now, it might be that if everybody got his or her
22 preferred care, there would be disparities along some of

1 those dimensions, differences in what people ended up
2 getting, because it might be that people of different
3 backgrounds, living in different places, prefer different
4 things. And that's not a problem as long as they all have
5 access to the full range and get what's right.

6 So, I would hate to target the outcome as we want
7 everyone to get the same care, and if there's a difference
8 in the rate at which patients are getting procedures that
9 have -- where there are legitimate differences that might be
10 driven by preferences, that's not the right thing to target.

11 There are clearly exceptions. There is nobody --
12 there are very few people who could rationally prefer to
13 have their blood sugar out of control. There are some
14 things where we know the right answer is everybody should be
15 moving in this direction. But a lot of the shared decision
16 making aids, which I know are just a subset, focus on cases
17 where different patients may correctly, based on their
18 preferences, choose different things. And so let's just
19 keep that in mind, that the goal is to focus on -- to give
20 people the care that's right for them, which isn't
21 necessarily the same care.

22 DR. NAYLOR: I may have mentioned this before.

1 Tuesday of this week, the IOM released its most recent
2 study, committee report, on cancer and its intersection with
3 aging. It's all about achieving higher quality cancer care.
4 And the first recommendation among ten is about the critical
5 need to promote patient engagement. There were also
6 recommendations, and I think CMS and others were part of the
7 set of recommended activities around needing to really
8 become actively engaged.

9 Another recommendation was around the critical
10 role of advanced care planning. We also had a paper
11 published this week which is a review of all the systematic
12 reviews on patient engagement, which I'm going to send, too.

13 But I would say that in terms of the opportunity
14 here, it is a tremendous opportunity for the Commission to
15 begin to think about, because we talk in every session about
16 beneficiary engagement and what does that mean, and usually,
17 how that's defined is a deliberate and consistent set of
18 actions on the part of clinicians, the clinical teams,
19 health care organizations, to put patients at the center of
20 care and to very involve them.

21 It's not just shared decision making. I mean, it
22 is literally a conceptualization that, foundationally, is

1 built on health literacy, and we have not -- the IOM report
2 earlier pointed out how many deficits we have in creating
3 literacy and particularly for lower-income minority
4 populations. And it moves its way all the way through
5 accountability. So you come to informed decision making
6 where relevant shared decision making accountability.

7 In terms of policy, I think we should be promoting
8 as a Commission quality metrics or measures that really do
9 acknowledge as outcomes that people say their care is
10 aligned with their preferences, needs, and values.

11 In terms of payment, we know from evidence that
12 aides alone do very little, that it is only aides when used
13 by -- supported by counseling, the time and investment in
14 making people go through a process of understanding. We
15 don't have the support for innovative workforce models that
16 include community health workers or others that could play a
17 major role, and so maybe supporting demonstrations that help
18 us to understand how we can get a society right now that is
19 not very engaged, sometimes doesn't want to be engaged, to
20 become more informed members.

21 There are tremendous barriers associated with
22 aging, the unique needs of aged people who are cognitively

1 impaired and need to rely on others for support. Then where
2 does engagement end, and I don't think it ends with that
3 patient. It maybe involves a family caregiver.

4 So my own view is I think it's a great opportunity
5 for us to begin to think about turning it around so that the
6 beneficiary is at the center of it all.

7 DR. HOADLEY: Yeah. Earlier in this round, I
8 think there were a couple of questions raised about what
9 exactly is the policy problem that we're trying to address
10 here, or perhaps in other words, why are we even talking
11 about this, and it seemed to me -- in fact, this is what my
12 notes were as I read the materials -- there's a very direct
13 question that would seem to put this squarely in the middle
14 of our bullseye and that is the question of should Medicare
15 pay for this activity?

16 There are payment questions. If the general
17 answer is yes, then you have the detailed questions of how,
18 how much, to whom, through what mechanism. But I was
19 curious as I read through this report, particularly, about
20 how do we pay for this? A number of people have said that
21 it is an essential part of the activity to have clinician
22 time. It is not just a booklet. It is time.

1 And then, I think, Glenn, it's perhaps in your
2 comments, you used the phrase "payment levers," and then
3 earlier there was a comment about quality metrics in P4P
4 programs that would reflect the use of this. But it seemed
5 to me that those are sort of indirect pathways where we
6 could also talk direct pathways. For clinician pays, spends
7 30 minutes with, engaged with a patient in shared decision
8 making, should that not be a billable service? Those seem
9 to be things we can debate.

10 Now, if prior to my time on the Commission these
11 were debated and settled, then that's an issue. But that
12 struck me as the answer to a question of, why are we talking
13 about this?

14 MS. UCCELLO: When I was reading through this,
15 which was excellent, I was thinking about, well, what are
16 the barriers to implementation? And from Scott, you hear
17 about, well, some just cultural issues. Rita brought up
18 some payment system issues. But are there other -- and I
19 don't know the answer to this, but are there other barriers
20 that Medicare can help kind of address, whether they are,
21 you know, payment, if it's a money issue, if it's a resource
22 issue, who is going to be doing this, those kind of things.

1 But thinking about this as what are the barriers to adoption
2 to this as part of a system.

3 MR. BUTLER: So, we obviously in the title,
4 "Patient Engagement and Health Care Disparities," have
5 acknowledged that we don't do either one very well as
6 presented, despite the fact you have some wonderful
7 examples. So I'm more encouraged or more interested in the
8 impact Medicare can have on the disparity side as a deeper
9 dive versus the patient engagement and shared decision, if I
10 had to pick between which of the two.

11 I first want to ask a dumb question, because --
12 and somebody can correct me, maybe Herb or somebody quickly.
13 We just had to complete as part of the Accountable Care
14 Organization a Community Health Needs Assessment. Is that a
15 Medicare -- it's technically a Medicare requirement?

16 MR. KUHN: I think that's an IRS requirement.

17 MR. BUTLER: Okay. Right. So, it was just to
18 protect our tax-exempt status, among other things. I know
19 it does that, but I -- hopefully. But, okay. So --

20 [Laughter.]

21 MR. BUTLER: So, alarmingly -- I mean, it's not
22 that we don't look at this, but our primary care service

1 area has 67 percent obesity, doubling of diabetes in the
2 last ten years. You're 50 percent more likely to die from
3 breast cancer if you're an African American woman. That's
4 disparities. That's the upstream. And so when we look at
5 our own -- and we are required to have a plan around what
6 we're going to do about some of these things to justify our
7 tax-exempt status and move forward, and they're the right
8 questions.

9 So our medical school has a block by block,
10 literally, in the Hispanic community around diabetes. They
11 have, whether it's health fairs or involvement in churches
12 and engagement at, actually, the level that people want to
13 be engaged at. And, obviously, this exercise enters way
14 upstream at the point of the interaction of the care that's
15 being provided. So I have a hard time doing this without
16 that bigger context because, actually, most of our programs
17 of engagement, as I said, including our training ones, are
18 more focused on really engaging in the community at that
19 front-end level and what to do as opposed to in a
20 physician's office.

21 And so I think if we just dropped it in without
22 that context, people would say, you think that you're

1 addressing disparities? You missed the boat. So that would
2 -- I don't know what that means for Medicare program policy,
3 but I think that that's a little bit of a backlash we might
4 get if we entered it the way we've got it now.

5 DR. HOADLEY: I just want to say, thank you for
6 this chapter, but I think all my comments have been well
7 covered around the table already.

8 DR. SAMITT: You know, I also want to separate the
9 notion of disparities from the other critical issue, which
10 is shared decision making and patient engagement to drive
11 appropriate utilization patterns. And I, frankly, have to
12 say, I don't think there is more that we should do from a
13 policy perspective in this regard. As I listen to the
14 debate, it really underscores the imperative for an
15 alternative payment methodology here.

16 To Rita's point, if there are providers that are
17 saying, "I'm not going to do shared decision making or
18 patient engagement because it's diminishing some of my
19 future revenues," then we've got the incentives misaligned.
20 I'd be curious to know, from my world, we can't do shared
21 decision making fast enough. It's not about an
22 unwillingness to adopt it. In the world of value,

1 capitation, shared savings, it's one of the first things
2 that we want to do.

3 So, I would say, let's not micromanage, to
4 Michael's point, shared decision making. Let's encourage
5 systems to focus on population health and doing the right
6 thing by the patients, and shared decision making should be
7 one of the top things on the list that organizations will
8 come to.

9 From a disparity standpoint, I would say the same
10 is true. We should be measuring disparities. Shared
11 decision making and patient engagement is one tool to really
12 diminish disparities, but let's measure disparities and
13 encourage the absence of them to health systems, not
14 micromanaging key process elements to it.

15 MR. HACKBARTH: Okay. So, the title of the
16 presentation was "Patient Engagement and Disparities," and a
17 piece of good news is there's at least some early sort of
18 tentative evidence that, in fact, that if we work -- improve
19 our patient engagement, that it may help with disparities,
20 but more work needs to be done on that. It sounds like it's
21 still quite an early, tentative finding.

22 We've had several comments here that these are

1 both important subjects in their own right and maybe need to
2 be considered separately as opposed to one piece. I want
3 to, for right now, focus on patient engagement, not because
4 it's more important than disparities but because this is the
5 second time we've talked about patient engagement in the
6 last, like, three meetings, and I want to figure out where
7 we're going, if we're going anywhere at all, before we use
8 still more time and resources on it.

9 Now, Mary and Dave mentioned, I think, two pretty
10 concrete ways that Medicare might contribute to better
11 patient engagement. Mary said, you know, as part of our
12 assessment of performance, this is one of the things that we
13 should be measuring and rewarding or penalizing.

14 Now, as Bill Hall pointed out at the beginning,
15 there are, in fact, in our CAHPS instruments questions that
16 at least begin to touch on how well is the physician-patient
17 or clinician-patient communication working from the
18 patient's perspective. It may well be that there's a huge
19 opportunity to improve that assessment, but that's really
20 not MedPAC's work. There are organizations that are
21 responsible for improving the CAHPS assessment tools, and
22 it's, as you well know, a very specialized field that I

1 don't think we can add a whole lot to. But we could say
2 that we think this is a really important part of performance
3 assessment.

4 A second issue that Mary touched on and then Dave
5 sort of also hit was, well, shouldn't people be paid for
6 doing this activity if it's important? Now, Kevin, correct
7 me if I'm wrong about this, but the way it works right now
8 in the professional fee schedule is that counseling is a
9 factor within some of the codes and you can get a higher
10 payment for counseling intensity, but there are not separate
11 codes for counseling, is that correct?

12 DR. HAYES: [Off microphone.] Yes, that is
13 correct. What we're talking about here is evaluation and
14 management services, and so an example of that, of course,
15 would be office visits. And so we have, within office
16 visits, we have a potential for five different levels of
17 office visits, depending upon -- normally, the movement from
18 one level to another is dependent upon three factors, the
19 history that's taken, the physical exam, and the complexity
20 of medical decision making. However, there is an exception
21 to that, which is that if most of the service involves
22 counseling of one sort or another, then it's possible to

1 move up that scale depending upon the amount of time spent
2 on these counseling activities.

3 MR. HACKBARTH: My vague recollection is that, in
4 fact, the system has been moving more and more of the E&M
5 activity is at the high end of the scale, right? It's sort
6 of been shifting that way over time.

7 DR. HAYES: Yes. Yes. What we just don't know is
8 whether that shift has been due to more counseling or
9 whether it's due to the other way of reporting on these
10 visits.

11 MR. HACKBARTH: So, the question would be, is this
12 mechanism sufficient or do we need to break out of it and
13 say there are completely separate codes for patient
14 engagement counseling --

15 DR. NAYLOR: So I -- I'll go first. I believe, as
16 others have articulated, that we should be focused on
17 outcomes, which is to say that people are health literate,
18 that people are able to make informed decisions, that we
19 have -- you know, so I am not interested in adding codes.
20 That would not be my recommendation. But I would say that
21 we -- I would hope that we would pursue this as a chapter
22 that would help people to understand the complexity of

1 patient engagement, that health literacy is a responsibility
2 of the Medicare program in the sense of we should be paying
3 for care that acknowledges how critically important it is
4 for people to be engaged, to be literate, to be informed,
5 and the challenges associated with that, that we may need to
6 be supporting innovative workforce models and new
7 competencies among the emerging workforce in order for this
8 to happen.

9 I totally do not believe that we should be
10 processing this out, but I think we need to be very explicit
11 that this is a big challenge for an increasingly diverse
12 Medicare population.

13 MR. HACKBARTH: Yeah. So, let me put that in my
14 words. I think we're sort of headed in a similar direction,
15 but I do want to emphasize that in the paper, there was this
16 focus on training, that people aren't born necessarily with
17 the skills to do this and certainly our health professions
18 education hasn't always focused on this as a necessary
19 skill, and there's some interesting work, it sounds like,
20 going on to teach medical students and others how to be more
21 proficient.

22 But what resonated with me, Mary, in your comment

1 is let's not reward the process but rather the outcome, and
2 the critical outcome we're assessing here is does the
3 patient believe that the communication was effective, they
4 knew their options, and that's where we ought to focus our
5 policy attention.

6 DR. NAYLOR: I agree, and there might be other
7 kinds of measures, so let me just -- and I'll say one more.
8 For example, there was a systematic review that looked at
9 people that were engaged in a process of engagement who were
10 able to get more timely access to services that they needed
11 to avoid more costly. I mean, so the evidence is pretty
12 interesting in terms of what could be better adherence,
13 improved efficiency and effectiveness if we support people
14 being able to understand what their opportunities and
15 options and so on are.

16 MR. HACKBARTH: Yeah. Yeah. I have one other
17 thought that I was trying to blurt out, Alice, but I've lost
18 it momentarily, so why don't you go ahead and I'll --

19 DR. COOMBS: So, I want to not be too simplistic
20 about this, and one thing that Kate said earlier was the
21 hemoglobin A1C and how it's measured and we have some gold
22 standards about what's -- how things are done best. And

1 there's also this area where you would discuss options for
2 therapeutic interventions. For instance, you show a video
3 to a family to say, this is what your loved one is going to
4 be exposed to in the ICU if they're intubated. Then the
5 family can make a more educated decision. However, you have
6 to be careful about shared decision making because it's
7 colored by the person who's talking about the options for
8 therapeutic interventions.

9 So I think it's not as simplistic as just outcomes
10 alone, and that's the only point I want to make, and that
11 there are a lot of moving plates at one time. So if you
12 just say just outcomes alone -- when I said outcome, I mean,
13 looking at a population and saying, you have the potential
14 to have these therapeutic interventions, but yet your
15 outcomes are so disparate compared to the general
16 population.

17 MR. HACKBARTH: Just to be clear, I wasn't
18 referring -- when I used the term "outcome," I wasn't
19 referring to the clinical outcome of the care, which, as you
20 say, can be variable based on various things. I was talking
21 about the outcome of the communication with the patient.
22 Does the patient feel like they understood their choices and

1 was a decision made that they felt comfortable with?

2 DR. COOMBS: So what I'm saying is that a patient
3 and a culturally competent -- -incompetent provider on one
4 side can be faced with some choices that are not necessarily
5 fair choices, is what I'm saying.

6 MR. HACKBARTH: Okay. Yeah, I agree with that.

7 DR. CHERNEW: So, first, let me say I agree with
8 Mary and what I think Craig said, which is I'm opposed
9 broadly to either adding more codes or finding some new way
10 to pay something separate.

11 In spirit, I like the basic notion of measuring
12 outcomes one way or another. I think one thing I took from
13 what Bill said in the very beginning is part of the problem
14 is, often, people are shooting for two-tenths of a percent
15 on whether you thought you were excellently informed or just
16 very good, very well informed, and there's differences.

17 So I guess what I would say in terms of going
18 forward is knowing something explicitly about what -- how
19 good the measurement is, what are the pitfalls of that,
20 would be useful of knowing if there's other strategies, and
21 thinking about even additional ways, which is CMS -- like,
22 right now, CMS is doing it, not through the provider system.

1 They have their own programs that they're contracting for
2 separately. So knowing if any of those things might be
3 valuable would be useful for me to know and for us to
4 understand.

5 MR. HACKBARTH: And here, you're talking about the
6 measurement of patient engagement --

7 DR. CHERNEW: Yeah. So, the measurement of
8 patient engagement. How good is it? Is it meaningful able
9 to discriminate between people? And then how well are some
10 of these programs -- separately, how well are some of these
11 programs that CMMI are doing or contracting for outside of
12 the delivery system, separately, do those look successful?
13 Are they things that should be promoted? Maybe we don't
14 need to know that because they'll do them if they seem to
15 think they're successful. But I would be interested in
16 knowing if those things that are being done outside of the
17 delivery system are useful.

18 MR. HACKBARTH: And so I don't disagree with any
19 of that. But my question, as always, is going to be, is
20 this an activity that's high yield for MedPAC, given our
21 limited staff resources and time together.

22 I think we could actually make an important

1 contribution if we said simply what we were talking about.
2 Look, Medicare's role in this isn't huge. It's very
3 important to do, but Medicare has limited levers to pull.
4 The lever we think that ought to be pulled is rewarding
5 effective performance in patient engagement, not prescribing
6 process, not rewarding activities. It's the outcome that
7 Medicare should focus on. Exactly how to measure that
8 outcome is really not the Commission's expertise, but that's
9 where we think the activity should be focused.

10 The reason I think that could be an important
11 contribution is that this is really important stuff and
12 everybody seems to be talking about it and saying, well, we
13 ought to do more, and none of us disagrees with that.
14 That's what we talked about in the spring. Our question,
15 though, is what should Medicare do, and if we can just put a
16 point on that and say, Medicare's role is X, not Y and Z, I
17 think that can be a contribution.

18 One last comment and then we'll have a few other
19 things. I think one reason this was on the agenda at this
20 meeting was that at our July session, there was a fair
21 amount of discussion about what a challenging environment
22 this is for Medicare beneficiaries. Part of it is on the

1 clinical side and the patient engagement and how they get
2 the care they want and need.

3 But another part of it is on the insurance side,
4 where there's this proliferation of new acronyms and new
5 things and they've got to make really complicated choices,
6 and if they don't understand the choices or they feel like
7 the choices are being jammed down their throats, it will
8 spawn a backlash that we all want to avoid. And there,
9 Medicare's in the insurance business. We're not in the
10 clinical business.

11 Our biggest responsibility in terms of patient
12 education is on the insurance side, and we can't spend all
13 of our time talking about shared clinical decision making
14 and then say, oh, we don't have time to do the insurance
15 side, which is really our responsibility. And so I would
16 like to see us spend more time trying to see how the
17 insurance decisions look from the beneficiary perspective
18 and what can we do to work with them on that.

19 Okay. I'm finished talking now. Others will have
20 a few reactions, and then we'll need to move on. I have
21 Scott, Peter, Craig.

22 MR. ARMSTRONG: Okay. So, just I wanted to affirm

1 where you were heading in this conversation around not
2 creating some kind of payment structure for shared decision
3 making conversations. I don't think we want to go there.

4 I think, in many ways, this conversation just put
5 a bright light on the broader discussion we're having about,
6 I think, why is it that my organization makes money by
7 sitting down and having these conversations? It's the
8 overall construct. And so we're just -- that's the
9 frustration we're experiencing.

10 But one other point before we give up on this is
11 that I think it's possible that some kind of special payment
12 for this kind of conversation may have uniquely big impact
13 around end-of-life decisions and that I would be -- I don't
14 know that much about it, but I would be reluctant to give up
15 on that. And if that is maybe some required component part
16 of a bundle or something like that, I think that might be a
17 uniquely financially-driven opportunity for us to apply this
18 in a way we're trying to avoid getting specific about.

19 MR. BUTLER: So, just quickly, again, I think our
20 discussion this summer was more about who's the trusted
21 agent, who's the general contractor, who's the broker if
22 it's an insurance plan, who's guiding the care above and

1 beyond just is the prostate surgery needed or not. I think
2 that's the other part of our dilemma. I don't think that
3 makes answering your question easier, but I think it is in
4 that context that we kind of were really enthusiastic about
5 finding ways to relate in this complicated environment to
6 the beneficiary.

7 DR. SAMITT: The one thing that I would add is,
8 you know, if we're going to go in the direction of
9 encouraging favorable patient engagement measures of some
10 sort, not at the process level but at the outcomes level, we
11 can't forget the role of putting forth supportive tools and
12 guidance on how to exactly do that. I mean, I think, again,
13 with my own organization's experience, Scott's experience
14 aside, this is not a proven science yet. There aren't
15 really good examples of how to do this well.

16 And so the question is, is what role does Medicare
17 play in helping to identify or highlight or promote best
18 practices and to bring forward the tools so that to link to
19 the incentives, there's a method that provider systems can
20 really focus on and adopt. And I don't know whether
21 Medicare ever goes there, CMS ever goes there, but I think
22 that that, you know, when you link incentives with tools,

1 the implementation is much more accelerated.

2 MR. HACKBARTH: [Off microphone.] Other people?

3 MR. GEORGE MILLER: Yes. I'd just like to add
4 that I agree that we should not pay for shared decision
5 making, but I am struck with the comments that both Alice
6 and Rita made, which are real life experiences dealing with
7 the disparity issue. And while I agree with Mary about
8 outcomes, the current system does not work well in a broad
9 sense for minorities in many different ways. I think Alice
10 quoted some statistics and Peter.

11 The problem, from my perspective, is of not only
12 competencies, but willingness to do the right thing. Now, I
13 don't know how you put a price on that or how you direct
14 that, but if you look at outcomes and if folks are in plans
15 where the outcomes are not -- are very clear, because
16 there's enough evidence, at least in my view, on
17 disparities, very well documented, and if they're being paid
18 by Medicare dollars, whether an MA plan or a health plan,
19 there should be some disincentives not to have favorable
20 outcomes. I don't know how to do that, but I think we need
21 to address it.

22 But I believe that shared decision making and

1 other things are tools and everyone should avail themselves
2 of tools, but the Joint Commission has a requirement for
3 competencies, that you must be able to communicate with all
4 levels of folks that you take care of, then I think this is
5 one that we should also at least talk about having some type
6 of requirement that that is part of Medicare, that you have
7 to be competent, be able to communicate.

8 And again, I am struck by -- and I don't mean to
9 make a big issue of this -- I am struck by that we list the
10 problems of communication, but we list the problems of the
11 patient versus a large majority of the problem, at least in
12 my view and listening to my colleagues around the country
13 when I was in the hospital business, and particularly ASCs.
14 ASCs do not see minority populations. They don't see them.
15 We've got quantified documented evidence that they don't see
16 minority populations in large numbers. That's a problem
17 with me and I think this lends itself to the issue I'm
18 describing.

19 MR. HACKBARTH: [Off microphone.] We need to move
20 on for today, but Mike's not here.

21 DR. MARK MILLER: Where is Mike?

22 [Laughter.]

1 MR. HACKBARTH: I'm responsible for watching out
2 for Mike. Okay. Thank you.

3 DR. MARK MILLER: [Off microphone.] -- the guy
4 who said that.

5 MR. HACKBARTH: Okay. So, thank you, Katelyn and
6 Joan, for the presentation, and we'll put together the
7 pieces here and come back with a proposed plan of action. I
8 think I'm a little closer in my own mind, but you may reject
9 it completely when we get there.

10 So, our final session today is on Part D
11 exceptions and appeals. This is enough to warm the heart of
12 a lawyer.

13 [Laughter.]

14 MR. HACKBARTH: I've been waiting all day for
15 exceptions and appeals.

16 [Laughter.]

17 DR. SOKOLOVSKY: Still here. Still me. Today,
18 we're going to look at an area of Part D that's unfamiliar
19 to most of us, the exceptions and appeals process. As
20 you'll see, there are many levels of appeals, but only
21 limited data are available. So, our analysis is limited to
22 the appeals adjudicated by an independent review entity in

1 contract to CMS and to data on grievances supplied by CMS.

2 Beneficiaries continue to be satisfied with Part
3 D. Many plans participate, and premiums have remained
4 relatively stable. So why are we looking at exceptions and
5 appeals, many of you asked, I'm sure.

6 [Laughter.]

7 DR. SOKOLOVSKY: A number of reasons. When the
8 Commission recommended changes in the low-income cost
9 sharing for Part D, it noted that it was important to have a
10 well functioning appeals process to make sure that access to
11 needed medication was not impeded. We found, in fact, that
12 there's very little public information on this issue.
13 However, CMS audits showed that the lowest performance among
14 plan sponsors is in the area of coverage determination
15 appeals and grievances. So we set out to see what we could
16 find.

17 First, we'll quickly go over some of the key
18 concepts. Then we'll examine the perspective of
19 beneficiaries, physicians, and beneficiary counselors and
20 we'll analyze the available data to see how the process is
21 working and present our key findings.

22 Okay. There are a lot of terms on this slide and

1 you'll be happy to know that I'm not going to go over them
2 all, although we'd be happy to discuss them on question.
3 But I do want to point out some key terms.

4 The exceptions process is invoked when a
5 beneficiary needs a prescribed drug that is not on their
6 plan's formulary or the copayment is much higher than they
7 expected. If their physician supports medical necessity of
8 the patient getting that particular drug, the beneficiary
9 may ask the plan for an exception to the formulary to get
10 the drug. The plan makes a coverage determination, meaning
11 they decide whether the reason given warrants an exception.
12 If the plan refuses, the beneficiary can appeal the
13 decision. Then, if the beneficiary exhausts the plan's
14 internal appeals mechanism, they can ask for a
15 reconsideration by an external review entity, and Shinobu is
16 going to present an analysis of the data provided by that
17 entity.

18 Grievances are other kinds of complaints by
19 beneficiaries about their plan, and Lauren is going to
20 present an analysis of the data on grievances.

21 If you found all of these terms confusing, you're
22 not alone. We conducted 12 beneficiary focus groups, eight

1 physician focus groups, and 17 interviews with beneficiary
2 counselors. Most of them were unaware of how the exceptions
3 and appeals process worked and did not distinguish between
4 the different levels of appeals.

5 Beneficiaries were generally satisfied with the
6 drug benefit and the majority didn't know that they could
7 appeal a plan's decision. However, when we asked focus
8 group participants whether they'd ever gone to the pharmacy
9 to pick up a prescription and found that it was either not
10 covered by their plan or the copayment was much higher than
11 they expected, at least a few beneficiaries in every focus
12 group could point to situations where they faced one or both
13 of these situations.

14 Their actions varied. Some just did without the
15 drug, while others worked with their pharmacist, who
16 contacted the physician to get coverage for the drug. If
17 they could afford it, some patients paid out of pocket.

18 In most groups, at least one person had made use
19 of the exceptions and appeals process. Particularly, some
20 of the younger beneficiaries with disabilities who use many
21 medications seemed to be most familiar with their appeals
22 rights. Results were mixed among those who had used the

1 process.

2 Looking at what the physician perspective,
3 appeals, exceptions, and prior authorizations all require
4 physician intervention and physicians often express
5 considerable frustration over coverage denials or prior
6 authorization requests. They did make the point that some
7 plans were much harder to deal with than others. In each
8 group, physicians could point to at least one plan with
9 processes that they found particularly burdensome.

10 One talked about a situation where a patient's
11 chronic condition was under control with a particular
12 medication and they had to change it to something else. The
13 other option was to speak with the plan. But as one
14 physician remarked, "Your nurse may be on the phone for
15 upwards of 30 minutes" -- there's no dedicated line, they
16 have to get on the regular customer service line -- to get
17 the prior authorization. And a lot of companies want to
18 speak to the doctor directly and doctors don't have time for
19 that.

20 Counselors' involvement with the medication
21 appeals and exceptions differed across organizations. They
22 reported that they sometimes assist beneficiaries who have

1 difficulty getting coverage for their drugs, but the
2 majority said that actually going through the appeals
3 process is a rarity and things are usually resolved before
4 that step.

5 Counselors saw the exceptions and appeals process
6 as a last option. If a beneficiary had a problem accessing
7 their drugs, counselors would try to help them switch plans,
8 particularly if they were receiving the low-income subsidy
9 and have the ability to switch plans each month. If they
10 are not eligible to switch outside of the open season,
11 counselors often direct beneficiaries to manufacturers'
12 assistance programs or encourage them to ask their
13 physicians for samples to cover them temporarily. Overall,
14 counselors try to steer beneficiaries from plans that impose
15 any restrictions on the drugs that they're currently taking.

16 Now, Shinobu is going to take you through the
17 appeals process.

18 MS. SUZUKI: As Joan mentioned earlier, there are
19 multiple levels to the appeals process, but the data we have
20 is from the second level of the appeals process where the
21 review of the case is moved from plans to the external
22 review entity. In a few minutes, I'll be showing you how

1 the number of appeals that reach this stage compare to those
2 observed under Medicare Advantage or MA.

3 One thing that I highlighted in the paper is that
4 unlike the MA's appeals process, a coverage request that is
5 denied by a plan at the first level of appeals is not
6 automatically forwarded by the plan to the IRE, or the
7 external review entity. Rather, the enrollee or the
8 prescriber must take the initiative to submit the appeal.

9 To understand how the exceptions and appeals
10 process is working under Part D, we talked to beneficiaries
11 and physicians, which Joan has talked about, and we also
12 looked at data. CMS's audit in 2012 found that plans were
13 struggling the most with Part D's coverage determination
14 appeals and grievances.

15 Examples of the kinds of issues that were
16 identified include failure to make coverage determinations
17 within a specified time frame; failure to notify the
18 beneficiaries or their prescribers of their coverage
19 decisions; and not making sufficient effort to gain
20 additional information they need to make an appropriate
21 clinical decision.

22 One interesting outcome of this audit is that

1 there has been a jump in the number of appeals in 2013. The
2 number of cases for the first six months of 2013 has already
3 exceeded the total number of cases for 2012. A large
4 portion of the increase is attributable to two of the plan
5 sponsors that were audited by CMS in 2012.

6 Here are some key findings from the analysis of
7 the Part D appeals data. The number of cases that reached
8 the IRE has ranged from about 11,000 to slightly over 20,000
9 cases between 2006 and 2013. That translates to less than
10 one case per 1,000 in any given year, which is a much lower
11 rate compared to MA, where the number of cases have ranged
12 from three to eight cases per 1,000.

13 We found that the share of appeals that are sent
14 to the IRE because plans fail to make a coverage decision in
15 a timely manner has generally been decreasing.

16 We have also seen an increase in the share of
17 appeals that are upheld by the IRE, meaning that the
18 external reviewer agreed with plans' coverage decisions. We
19 have also found a wide variation across plans in the share
20 of cases that are upheld by the reviewer. For example, even
21 though a typical plan had between 70 to 80 percent of their
22 cases upheld by the IRE, in about a quarter of plans, less

1 than half of the cases were upheld. That means for these
2 plans, the reviewer disagreed with plans' coverage decisions
3 and reversed those decisions in over 50 percent of the
4 cases.

5 Finally, about a third to 40 percent of appeals
6 are dismissed in any given year. Often, the dismissals are
7 due to technical reasons, such as not filing the appeal
8 within the specified time frame or lacking a required
9 document.

10 In 2013, a policy change removed the requirement
11 to use an official form to designate an authorized
12 representative. Based on the data for the first six months
13 of 2013, that change appears to have reduced the number of
14 appeals that are dismissed for technical reasons.

15 Although we identified aspects of Part D's
16 exceptions and appeals process that appears to have improved
17 over time as well as areas where further improvements may be
18 necessary. It is not clear what the right level of appeals
19 is for Part D.

20 On the one hand, the lower appeals rate compared
21 with MA may reflect differences in the nature of the
22 services provided under Part D compared with MA. Rather

1 than go through the exceptions and appeals process, enrollees
2 may find alternative medications or switch to a plan that
3 covers the medications they need.

4 On the other hand, the low appeals rate may
5 reflect a lack of transparency in the appeals process or
6 excessive administrative burdens imposed on enrollees and
7 prescribers that discourage them from submitting an appeal.
8 An automatic escalation to the next level of appeals may
9 remove some of the administrative burden on the enrollees
10 and prescribers who wish to appeal the coverage decision by
11 plans.

12 Finally, although we did not find many plans that
13 fit this description, a plan with a large number of appeals
14 and a large number of cases that are reversed by the IRE may
15 signal a problem with the exceptions and appeals process and
16 is one of the elements that CMS uses to rate plans.

17 In the next slide, I'm going to switch to talking
18 about a different appeals process that deals with Part D's
19 late enrollment penalty. As you recall, enrollment in Part
20 D is voluntary. However, if you do not enroll in Part D
21 during your initial enrollment period, you are charged a
22 late enrollment penalty. The penalty is based on the number

1 of months a person goes without Part D coverage. The
2 exception is if the person had a coverage that's comparable
3 to the standard benefit under Part D. That's called
4 creditable coverage.

5 For a person who had initially been eligible in
6 2006 with their initial eligibility period ending in
7 December of that year, the penalty to enroll in a plan this
8 year would have been over \$20 per month. This penalty is
9 permanent and it rises with the increase in the base
10 beneficiary premium.

11 For individuals enrolling in Part D outside of the
12 initial eligibility period, plans have to determine whether
13 they will be subject to the late enrollment penalty. To do
14 this, plans will often ask beneficiaries to submit documents
15 showing that they had comparable drug coverage. In every
16 year since 2007, the number of appeals related to the
17 penalty has exceeded the number of coverage-related appeals
18 received by the external review entity.

19 The majority of the cases are reversed by the IRE,
20 meaning that they should not have been charged the penalty.
21 The high reversal rates observed for the LEP-related appeals
22 suggest that the process used by plans to verify creditable

1 coverage status may not be effective in identifying
2 enrollees' prior drug coverage. In addition, given that
3 those enrolling in Part D outside of the initial eligibility
4 period is likely to be a small share of those newly
5 enrolling in Part D, the number of cases observed suggests
6 that this problem is affecting a significant portion of
7 those people.

8 We are also concerned that the resolution of the
9 cases where the penalty is incorrectly applied may be
10 delayed by low awareness among the enrollees about the
11 penalty, and there may be some enrollees who are paying it
12 when they shouldn't because they don't understand the
13 penalty or are not aware of their appeals rights.

14 MS. METAYER: We analyzed grievance data from CMS
15 for the years 2007 to 2012. To remind you, a grievance is
16 any complaint or dispute, other than a coverage
17 determination or a late enrollment penalty determination,
18 expressing dissatisfaction with any aspect of plan
19 operations. Grievances are collected for each plan and
20 factor into the STARS plan rating.

21 We decided to look at grievances since the appeal
22 rate was low. We wanted to see if there is any evidence in

1 the data of issues relating to coverage determinations. We
2 found that most of the grievances filed have been unrelated
3 to coverage determinations, exceptions, and appeals, and
4 accounted for about three percent of grievances each year.
5 Most grievances filed each year, about 62 percent, related
6 to issues of enrollment, a plan's benefits, or access to a
7 pharmacy.

8 At a more general level, among plans with 1,000 or
9 more enrollees, grievances per thousand have been
10 fluctuating over time. Grievances have ranged from about
11 5.6 to 11 per 1,000 enrollees.

12 For the years 2007 to 2012, we compiled a list of
13 the 20 plans with the highest amount of grievances per 1,000
14 enrollees. Among these plans, we found that the number of
15 grievances per year was still low and averaged about 25
16 grievances per 1,000. We found that some plans were among
17 these 20 plans with the highest number of grievances for
18 multiple years. Enrollment averaged about 15,000 enrollees
19 and 82 percent were MAPDs.

20 The plans that continue to have a high number of
21 grievances for multiple years may suggest a lack of
22 improvement in quality or plan operations among these plans.

1 On the other hand, plans with very few grievances,
2 particularly if it persists over time, may indicate a low
3 aware awareness about the grievance process among their
4 enrollees.

5 In summary, while beneficiaries continue to be
6 satisfied with Part D, most are unaware of how the
7 exceptions and appeals process works and many physicians
8 find the process frustrating. CMS's program compliance
9 audits, Part D appeals data, potential issues with the
10 process used by plans to verify an enrollee's prior drug
11 coverage status, and grievance data shows improvements in
12 some areas and potential issues in others.

13 Commissioners may wish to discuss the potential
14 implications of these findings on aspects of coverage
15 determinations, exceptions and appeals, and grievances that
16 may need improvement. Additionally, there may be issues the
17 Commission would like to pursue further, such as the process
18 used to determine which enrollees are subject to the Part D
19 late enrollment penalty.

20 Thank you.

21 MR. HACKBARTH: Thank you. Clarifying questions?

22 Bill and then George.

1 MR. GRADISON: You mentioned the substantial
2 increase in appeals this year, particularly coverage
3 determination issues, and seemed to tie it to the audit of
4 two of the companies. What's the connection? I didn't get
5 that. I would have thought that an audit might have had
6 just the opposite effect.

7 MS. SUZUKI: So, the big increase was seen in the
8 auto-forwarded appeals, which is the kinds of appeals that
9 should have been forwarded to the external entity because
10 the plan did not process it within the specified time frame,
11 and that showed up in the first half of 2013.

12 MR. GRADISON: [Off microphone.]

13 MS. SUZUKI: We think so. I haven't verified
14 that.

15 DR. BAICKER: So, I want to talk with you offline
16 to better understand the metrics in the audits. But to
17 understand this potential causal connection, do we know how
18 CMS chose which plans to audit?

19 MS. SUZUKI: I think they used a couple different
20 criteria. They want to be representative. There might have
21 been performance, past performance type things to make sure
22 that they capture those plans. The audit is conducted at

1 the sponsor level and so they chose about 40 sponsors, which
2 covered about 70 percent of enrollees.

3 MR. HACKBARTH: George, and then Rita.

4 MR. GEORGE MILLER: Do you have demographic
5 information on those who were audited? I'm sorry, of the
6 beneficiaries that were included in the audit? And, number
7 two, do you have a sense if there is regional variation that
8 is similar to what we've seen in other sectors as far as the
9 number of those who had grievances? I should have said not
10 audited, but grievances for the demographic information.

11 MS. METAYER: We do have LIS information for the
12 grievances and we may be able to do it by region if we look
13 at where the plans are operating, but we haven't done that
14 yet.

15 MR. GEORGE MILLER: Okay. Do you follow what I'm
16 saying about the number of grievances, do they mirror or
17 follow the regional variation, especially the high utilized
18 areas of the country for medical care? Do we see more
19 grievances from that area of the country, as well? Does it
20 parallel or mirror that?

21 MS. METAYER: We haven't done that yet, so we
22 don't know --

1 MR. GEORGE MILLER: Okay.

2 MS. METAYER: -- but we could look into it.

3 DR. MARK MILLER: Also, I think your question,
4 even though you said "audit," you corrected yourself. I
5 think he's asking the same question for what we know about
6 coverage determination appeals. And so I think our answer
7 is we'll look at what we can do by demographics and
8 geography. Everybody squared away? Okay.

9 DR. REDBERG: Is it publicly available for each
10 plan what their rate is of grievances and exceptions?

11 MS. SUZUKI: I'm not sure how public it is. There
12 are some public information. When CMS produces plan STAR
13 rating, and three of the 18 elements that plans get rated on
14 are related to coverage -- the appeals and grievances. And
15 so that information is available at the, I would say, plan
16 level, but it's actually at the contract -- well, no,
17 actually, that is at the plan level.

18 DR. MARK MILLER: So, for example, I think one of
19 the things that goes into the STAR rating is the percentage
20 of appeals overturned, right?

21 MS. SUZUKI: The other way, the upheld.

22 DR. MARK MILLER: Okay. Upheld. Sorry. So

1 there's things like that. But I think one take-away from
2 this is whether that's sufficient or whether, in the end,
3 we're beginning to think that maybe an indicator would be
4 lots of appeals and lots of overturned, which means the plan
5 was overruled, would be an indication that you might have a
6 problem.

7 MR. HACKBARTH: [Off microphone.] Other
8 clarifying questions? Jack, what do you make of this?

9 DR. HOADLEY: Well, I'm really glad to have this,
10 because this is really a pretty important area, even though
11 it feels like it's way obscured down in the weeds. But it's
12 an important area of concern for beneficiaries, or maybe
13 more accurately said, their advocates, since a lot of
14 beneficiaries aren't that familiar with this whole part of
15 the process, and it's an area where we really have very
16 little information. So even the little bits that we've
17 started to get here, I think, move us forward.

18 And I think it's important because, you know,
19 really, in a sense, one of the logics in the design of Part
20 D was providing, first of all, a privately-based benefit,
21 but doing it in a way that gave plans quite a bit of
22 flexibility on their formulary designs and their use of

1 tiers and their use of prior authorization and all these
2 kinds of things.

3 One of the things that was always stated, every
4 time you'd say, well, the plans have that flexibility, but
5 everybody always has the right to get the drug they need on
6 exception provided it meets whatever kinds of standards.
7 And so we've never been able to say, and we really still
8 can't say, is that promise fulfilled? Are people really
9 able to get exceptions?

10 And I think, you know, we've been asking on
11 several presentations today, what are the policy levers?
12 Why are we doing this from a policy lever perspective? And
13 I think already in some of the things we've heard here,
14 there are issues like, well, maybe we need better notices
15 going to beneficiaries so they understand their rights.

16 On this one that I was not aware of was an issue,
17 this late enrollment penalty issue, the idea that people
18 don't understand that penalty and what they need to do to,
19 perhaps for many people who really don't need to pay it, to
20 justify that they don't need to pay it, so is that a
21 question of notice? Is that a question of really changing
22 the process by which that verification is done so it's not

1 in the plans' hands or whatever? I don't know what the
2 right answer is on a lot of these questions.

3 The value of the audits, we have some initial
4 evidence that there's -- first of all, they're finding
5 problems and that there's some, perhaps, sentinel effect by
6 doing the audits, and then getting into what are some of the
7 issues that the audits raise that are being done and seeing
8 whether there are ways to address some of those.

9 And another one on the kind of the focus group
10 findings is the burden that's placed on the physician and
11 the difference that I think you pointed out -- it certainly
12 was in the paper -- that whereas a lot of services in Part A
13 and Part B it's a matter of whether the provider is
14 ultimately going to get paid, so they have their own
15 justification for going out and helping to pursue the
16 appeal, in this case, the physician is the one who has most
17 of the burden for saying, oh, this is a justified drug.
18 It's not the physician whose payment is at stake for this.
19 In fact, it's adding work to them that they aren't getting
20 paid for and it's the manufacturer or the plan where the
21 payment issue really resides. So there are some questions.
22 Are there ways to address that physician burden, or what's

1 the standard of proof on that?

2 And then the one sort of technical issue of this
3 issue of auto-forwarding some of the adverse decisions,
4 which is done in Part C but not in Part D, was there a
5 reason for that? Should that be changed?

6 So I think there are a bunch of policy things that
7 we could do. We may not be ready to figure out which are
8 the right ones or even to know what the answers are yet.

9 I've got a lot of sort of specific comments that I
10 won't take the group's time on, but it did strike me there
11 was a couple of larger sort of analytical things that could
12 be put on the table. One is that CMS has been collecting
13 since the start of the program on a quarterly basis a set of
14 measures from the plans. It requires the plans to submit
15 these with fairly specific and well designed criteria. And
16 they are things like how many exceptions were requested by
17 your enrollees? How many of those were granted? So that's
18 just one example of a number of measures.

19 These are reported by the plans to CMS every
20 quarter. They are not made public. I have said in the past
21 they should be made public and it appears -- you know, we
22 looked into this at one point -- it appears that CMS is

1 using them for various kinds of internal things, and one of
2 the reasons that may be cited, or two reasons that may be
3 cited for not putting these public is, one, these are plan
4 reported and so there's a question of are they reported
5 consistently from one plan to another, although in some
6 cases, like the exception request counts, it's a pretty well
7 defined measure. And the other is that they're -- and this
8 was raised in the presentation -- there is really no right
9 answer. I mean, is it -- are you better to have more
10 exceptions or are you better to have fewer exceptions? You
11 can see tracks by which you get the good results either way.
12 But it's still useful, I think, to have a sense of how much
13 this goes on. So that's something that I think, pushing on
14 CMS to make those data publicly available.

15 And the other thing, and this is not a small
16 request and so I don't know whether it's a good use of time
17 to do this, but there are things that could be done with the
18 claims data because there are -- you can look at the claims
19 data, for example, for off-formulary drugs that are, in
20 fact, paid for by a given plan, and the only way you can get
21 to that result is do it under an exception. So there's no
22 flag on the claims data that says "exception," but you can

1 deduce from the data that that had to be done on an
2 exception. So there's some way to look at these -- there's
3 obviously not a way to look at exceptions requested and not
4 granted. There's not a way to look at drugs people paid for
5 out of pocket because they weren't allowed. And, again,
6 this will be also quite hard to do, but it is possible to
7 look at drugs that are provided at a lower tier with a lower
8 cost sharing than the stated tier for that drug. Those are
9 not easy analytical tasks, but --

10 DR. MARK MILLER: I just want to be clear. Those
11 analyses would require passing claims data through some
12 separate quantified version of the formulary and the rules
13 for the formulary for every plan.

14 DR. HOADLEY: It turns out that the public -- the
15 researcher-available files of the claims data actually have
16 some additional processing that isn't provided in the files
17 that CMS gives to you guys.

18 DR. MARK MILLER: [Off microphone.] Then Shinobu
19 is going to leave --

20 DR. HOADLEY: Right.

21 [Laughter.]

22 DR. HOADLEY: I'm being careful how I -- but -- so

1 when I get a claims data file to use, I get a flag on each
2 claim of what tier it was on, what its formulary status is,
3 and when it has no tier, the tier is missing, then that is
4 the equivalent of saying it was done by exception. So that
5 actually does exist in the files as they go through RESDAC
6 and the processor.

7 DR. MARK MILLER: [Off microphone.]

8 DR. HOADLEY: But even with that, it's not an easy
9 process to go through, and I'll stop at that without going
10 into some of my wittier comments.

11 [Pause.]

12 MS. UCCELLO: So, I agreed with most of what Jack
13 said that I could follow.

14 [Laughter.]

15 MS. UCCELLO: I agree that the high rate of
16 reversal on the late enrollment penalty is a concern,
17 especially that -- I mean, it seemed like from the mailing
18 material that a lot of people don't even know that they're
19 paying it. I mean, that's a problem. Is there an -- how
20 does the billing come on this? Is there a line item for
21 that or is it just all rolled up into one rate?

22 MS. SUZUKI: I don't think we know for sure. A

1 lot of people have their premiums deducted from their Social
2 Security check. But I think plans are required to send the
3 enrollee a letter, a notice, saying that there's a late
4 enrollment penalty that's charged to that person.

5 DR. MARK MILLER: And we did talk this through
6 with CMS because, actually, this one kind of fell in our
7 lap. We were doing something else and then this kind of
8 popped up. So we talked to CMS about it. And what their
9 take on it was, the beneficiary is being informed. The plan
10 sends a letter. The beneficiary either chooses to ignore it
11 or doesn't understand what's being said and then it
12 automatically goes to the next level and then overturns the
13 plan. And I think you were hitting it, Jack, is there's
14 some communication process there that's not working between
15 the plan and the beneficiary.

16 MS. UCCELLO: Okay. The other concern that I had
17 was the beneficiary counselors encouraging everyone to
18 enroll in plans without utilization management. The
19 beneficiary counselors, are they mostly for LIS folks or are
20 they for everybody?

21 DR. SOKOLOVSKY: They're for everyone and their
22 job, as they see it, and probably accurately so, is to

1 advocate for the beneficiary. So if a beneficiary has a
2 prescription, the presumption is they need it. It was
3 disturbing to me to realize that not a single one -- you
4 know, you've got 20 drugs. It's going to be hard to find a
5 plan. Nobody thought to say anything about that. But,
6 again, that wasn't -- that's not how they -- they're not
7 clinical people and that's not how they --

8 MS. UCCELLO: Well, does that -- you know, it's
9 not necessarily right for the person to get all of these
10 drugs. First of all, they may have a higher premium to
11 begin with, and they might be getting things that they're
12 not -- that's not appropriate. So, I don't know what to do
13 about that, but it's a problem.

14 DR. BAICKER: So, I think this is a really
15 important discussion even beyond this important silo that
16 we're talking about, because so many of the policies we talk
17 about, we say, well, sure, as long as there's a robust
18 exception process. When it's limits to home health care or
19 outpatient therapy or all sorts of things, we think there
20 are always going to be exceptions and we need a streamlined
21 way to identify those to be able to implement a policy that
22 does a better job of cutting out inappropriate use.

1 So I think this is great, and the low-income
2 determination -- or, sorry, the late enrollment
3 determination, one thing I found interesting about the
4 acronym page was how many of them were repeated.

5 [Laughter.]

6 DR. BAICKER: But the late enrollment penalty is
7 clearly very important, but a little more specific to this.
8 So I wanted to focus for a second on the coverage
9 determination bucket, and all of this vocabulary was very
10 new to me, too. And I thought, well, our goal is to figure
11 out how often the plans are not doing the right thing,
12 without being as judgmental as that sounded like I was
13 being, and there are many different steps along the way and
14 it sounded like some of them are much more readily
15 observable than others. So I wanted to point to the ones
16 that are important that I think were missing and maybe think
17 about places we could get tangential information that might
18 be suggestive about those things that are hard to observe.

19 So, there's a whole group of people who should be
20 requesting a redetermination who aren't because they don't
21 know their rights to do that. They don't realize that they
22 have an option. And that, we just don't observe directly,

1 so I'm going to come back to that as one to think about
2 indirect proxies.

3 Then there are the people who request a
4 redetermination and it's deemed, well, you should have got
5 that drug. That was a mistake. Maybe that's not the plan
6 doing the wrong thing. Maybe that's just the way the
7 process should be working, and we have some measures of
8 that, although not really complete. It sounds like we have
9 some ideas about that.

10 The next step is they are denied the
11 redetermination and they appeal and on appeal it's
12 determined, you should have gotten that drug. So the
13 process failed earlier on, and that's where we focused and
14 we have -- we're not sure whether we want that to be higher
15 or lower based on the steps that have to -- you want people
16 to know they have the right to appeal, so you want the
17 bucket of people who are using the process that's available
18 to them to be high if they need it, but you want the people
19 who need the process to be low, and that creates this
20 tension about what the right rate is.

21 So all of that uncertainty about what we think
22 should be happening in a well performing, well behaving plan

1 makes me wonder if we could look at some correlates or
2 proxies that might give us a sense. And one that Jack
3 mentioned was looking at the tiers of utilization. Look at
4 utilization patterns as way to think, well, if people are
5 roughly similar once we adjust for their health risks in the
6 big bundle of drugs that we think they might be taking and
7 we see exceptions in some plans where they're not getting
8 those medications, that would be one proxy.

9 Another would be satisfaction with their plans,
10 with all the difficulties that those are fraught with. We
11 could have some sense of whether people feel like the
12 process is working for them, or total drug utilization, or
13 consequences of people not having their drugs optimized in
14 terms of other health care that they're using. All that's
15 very squishy, and I realize none of it would be definitive
16 and none of it would let us flag particular plans where we
17 think that's a problem.

18 And that's why I wanted to know more about the CMS
19 audit process, to know whether if they were going into plans
20 that had demonstrated aberrantly low appeals rates in one
21 year and then they reverted to trend. That would be a
22 different story from if they went into plans that were

1 consistently low that suddenly jumped up a year afterwards.
2 That would be a more persuasive piece of evidence.

3 So that audit process seems like a better way to
4 flag individual-level problems, or plan-level problems. But
5 maybe some of these sort of proxy analyses of what the
6 basket of goods utilized by people in different plans, how
7 that correlates to some of the parts of the appeals process
8 that we can observe might give us a sense of how well the
9 system is working to fill in the pieces we don't observe
10 directly.

11 DR. HOADLEY: Just a quick follow-up. The
12 quarterly data that I referred to that CMS collects from the
13 plans do, in fact, collect some of the specific things that
14 you're referring to as unobservable. They're unobservable
15 right now. And so that's really part of my point in trying
16 to get hold of those data, that plans are counting them, CMS
17 is collecting quarterly accounts, so --

18 DR. BAICKER: So we just need to get Shinobu on
19 that.

20 [Off record discussion.]

21 MR. KUHN: Just one quick question on the late
22 enrollment penalty. Like others, those numbers are big. So

1 if the plan rules that there is a penalty for late
2 enrollment, there wasn't creditable coverage, whatever the
3 case may be, does that benefit of that additional penalty,
4 does that go to the Treasury Department? Does it go to the
5 plan? Who is the recipient of those funds?

6 MS. SUZUKI: It does not go to the plan. It
7 basically goes into the Treasury.

8 MR. KUHN: Okay. Thank you.

9 DR. MARK MILLER: And, actually, I shouldn't have
10 joked around immediately following that comment. In order
11 for her -- which she and I tend to do -- but in order for
12 her to get her hands on that data -- and we also have to
13 find out the data that you have, so don't you leave after
14 this -- it may be the Commission does need to say something
15 in order to give some lift to this concept. Let's just bang
16 away. Give us the data. They might do it, but it might
17 take a little lift from this group.

18 DR. BAICKER: We really, really need that data and
19 they should give it to us right now.

20 DR. MARK MILLER: Right. Right.

21 MR. HACKBARTH: That will work.

22 DR. MARK MILLER: We'll work on the language, but

1 --

2 [Laughter.]

3 DR. REDBERG: Are most of the appeals people that
4 wanted brand name drugs and got generics, because the plans
5 are structured so they have drugs of every type, right, in
6 every plan?

7 MS. SUZUKI: We don't have the details of what the
8 actual appeals were, but usually -- so there were two that
9 we discussed with exceptions. One was something that's not
10 on the formulary, or not on the formulary because you have
11 to go through the utilization management before you get that
12 drug. Or you can appeal the cost sharing on a non-preferred
13 brand drug. So non-preferred brand name drugs usually have
14 a high cost sharing, roughly \$90, on average, and preferred
15 tier, \$45, \$50. So you could appeal cost sharing on the
16 non-preferred tier to be lowered to the preferred brand name
17 drug level.

18 DR. HOADLEY: [Off microphone.] So it will be
19 both brands.

20 DR. REDBERG: I guess just one other -- it's
21 really a clarifying question, but I didn't -- you had said
22 in March of 2012, the Commission noted that LIS enrollees

1 were mostly using, or tended to fill more costly brand name,
2 and then there were changes in the cost sharing. Do you
3 know if there have been changes in that trend since -- it
4 was on page one of the mailing material.

5 MS. SUZUKI: So, there was no change in the cost
6 sharing structure for LIS. That was a recommendation.

7 DR. REDBERG: I see. But it didn't happen.

8 MS. SUZUKI: Right.

9 MR. ARMSTRONG: Just a couple of things. First, I
10 wanted to go kind of a ways back. Joan, you started this
11 out by declaring there are a lot of things going really
12 well, but I was trying to remind myself, why did we do this
13 analysis again? Was it we stumbled on the fact that we
14 haven't evaluated this process in a while when we were
15 looking at this issue of the LIS, or were there some other
16 reasons why we pursued this?

17 DR. SOKOLOVSKY: The main reason was because of
18 our LIS recommendations and we heard a lot from the
19 community about what would happen to people who needed drugs
20 if we did this, if they really needed the drugs, and a
21 number of the Commissioners who supported the recommendation
22 were worried about that. And so we said in the text that we

1 needed to make sure that they could get drugs through the
2 exceptions and appeals process, and so we thought -- we
3 waited a year, but we thought we ought to look at it, and
4 that was the main reason. And then we, of course,
5 discovered how little information there was about it. And
6 the late enrollment penalty, we completely stumbled into.

7 MR. ARMSTRONG: Okay. Good. So, looking at the
8 questions up here, I would say, you know, and Jack, I think,
9 was very articulate about -- the answer to the first
10 question, I would say, is yes. There are issues that should
11 be improved.

12 But I would say no, frankly, to the second
13 question, and maybe I'm just out of touch with this, but it
14 seems like this affects a fairly small number of
15 beneficiaries. It seems like, relative to the grievance or
16 appeals processes for other parts of the Medicare program,
17 this is -- you know, people are triggering the process or
18 getting involved in the process at a much lower rate. The
19 rate of reconciliation through this process is incredibly
20 high and fairly fast.

21 And then I relate this issue and the use of our
22 resources to the spectrum of other issues in inpatient acute

1 care or post-acute, hospice, you name it, and it would be
2 very difficult for me to suggest that we haven't
3 sufficiently asked and answered the question.

4 Are there issues here? Yes. Could it be
5 improved? Yes. Is this as important as a lot of other
6 things for us? I would argue it's not.

7 DR. CHRISTIANSON: A question for Jack, really.
8 So, if I understood you right, the data on all the stuff
9 we've been talking about are not publicly available at the
10 individual plan level?

11 DR. HOADLEY: Right.

12 DR. CHRISTIANSON: Okay. So --

13 DR. HOADLEY: Except for the ones that are in the
14 STAR ratings --

15 DR. CHRISTIANSON: Right.

16 DR. HOADLEY: -- that they alluded to.

17 DR. CHRISTIANSON: Is there anything else, I mean,
18 is there anything, if you could proclaim one of these
19 measures that should be available to beneficiaries on a year
20 to year basis at the plan level that isn't now that would
21 really be beneficial to them, what would it be, if any of
22 them?

1 DR. HOADLEY: I'd have to think about any -- I
2 mean, there are about 50 or 60 measures on the list of these
3 what I call the quarterly data. I'd say, the last I looked,
4 maybe a quarter of them relate to the broad area of
5 exceptions and appeals, and I would probably say that -- I
6 mean, some of them are much more routine, you know, some
7 basic quantity measures of things going on in the program
8 that can be measured other ways. But I think the exceptions
9 and appeals is probably at least the domain. Which measure
10 within that domain, I'd have to think about.

11 DR. CHRISTIANSON: That's partly, I mean, it seems
12 to me like that is something we could do which, if it was
13 reasonable. I mean, I would look for you for suggestions
14 that wouldn't be time or staff intensive and so forth. If
15 it could improve things for beneficiaries, why not require
16 that some of these things -- or at least something that has
17 meaning be available to the general public?

18 MR. GEORGE MILLER: Just one comment about Jack's
19 comments. I think they were very well stated and I would
20 somewhat tend to agree except for the fact that we are
21 looking at that issue -- looking at this issue and giving it
22 scrutiny may keep some folks honest, that they know we could

1 be looking. What I'm afraid of, although it's not a large
2 number, we wouldn't want abuse of the situation or for it to
3 get worse. So I think the fact that we at least review it
4 and keep it on the radar screen may mean that some folks may
5 do things right.

6 DR. MARK MILLER: You know, I don't normally try
7 to push you in one direction or another, but I do think what
8 Scott was saying here a second ago of how much effort to put
9 into more of this, and you could imagine a product of this
10 conversation working like this -- and I think this is also
11 consistent with the exchange between Jon and Jack -- we'll
12 have a chapter in December on what's going on in Part D and
13 then that will go into our March report. You could imagine
14 a text box, some portion of that chapter that says, look, we
15 looked at this. This is what we found, and a summary
16 version of this, and there are a few steps that we could
17 take. The call for releasing the data and reserving the
18 right that, after some people look at that, maybe some of
19 that goes into the STAR rating system, number one.

20 Number two, I don't want to forget this one, and
21 I've just lost track of what we said in the presentation.
22 There is this intense frustration on the provider side of

1 trying to get access to the drug plans when these processes
2 are in play. And the notion of simple things, I recall some
3 conversations with you guys, you know, dedicated phone
4 lines, that type of thing, so that people are not hanging on
5 the phone for 20 and 30 minutes. I know this is really
6 small potatoes, but, you know, just a list of things that we
7 could say.

8 And then, finally, I think there's probably some
9 words we can put around this LEP thing. This is a little
10 bit odd and people may be paying for something that they
11 don't need to pay and there's just a bit of a communication
12 thing there.

13 So you could imagine just the text box that sort
14 of says, here are three or four things that we think need to
15 be -- to push the agency on. I'm sorry.

16 DR. BAICKER: So, as one of the culprits in having
17 wildly suggested all sorts of other things that one could
18 do, that point is very well taken and I think suggesting
19 that there are these avenues to explore might be sufficient
20 rather -- the point is well taken that there are a lot of
21 things that might go into this chapter and other chapters
22 and that this might be a fair amount of extra work that's

1 not really warranted.

2 DR. MARK MILLER: [Off microphone.] But I also
3 think the other comments you were making, I don't think you
4 quite understood that a bunch of that other data could have
5 laid to rest.

6 MR. KUHN: I think both Scott and Mark and others
7 have made a good point on this, but also, we've kind of had
8 this conversation in the past, and I think there was one in
9 the spring where we were even tossing around a notion of a
10 de minimis dollar amount before it kind of elevated to the
11 important factor of where we need to kind of be involved.
12 And I understand that and I think Mark's solution is a
13 pretty good one.

14 But, also, we can't underestimate that we're
15 talking about the cost and quality here, but the access
16 issue is absolutely critical and we keep leaving that out of
17 some of these conversations and that is a bit disturbing.
18 When we were talking one time about a rural issue, I can't
19 begin to tell you how important access is in rural areas
20 with distances people drive.

21 Mark made an observation here, as did others, you
22 know, if we don't fix these problems, it undermines the

1 confidence in the system by providers. They lose
2 confidence, and just kind of like the SGR, Glenn has talked
3 about that a lot of times, about if we don't fix that
4 problem, they lose confidence in the system.

5 But, again, it's the access issue. So I'd hate
6 for us to kind of draw a line, a dollar figure or something
7 else. I think we can address this not in a full-blown
8 report, but let's just be real careful of how cavalier we
9 kind of treat some of these issues, because they might be
10 small, but to a certain set of Medicare beneficiaries,
11 they're absolutely critical. They're life and death
12 situations.

13 MR. HACKBARTH: Craig, I apologize. Mike just
14 pointed out that I started with Jack and then didn't get all
15 the way around to you. So you will have the last word.

16 DR. SAMITT: [Off microphone.] It's okay. I
17 pass.

18 [Laughter.]

19 MR. HACKBARTH: That's the last word, then, I
20 guess. Okay. Thank you very much.

21 We will now have our public comment period.

22 Seeing nobody going to the microphone -- yes,

1 please.

2 Please identify yourself and your organization and
3 when the red light comes back on, that signifies the end of
4 your two minutes.

5 MS. SANDERS: My name is Stacy Sanders and I'm the
6 Federal Policy Director with the Medicare Rights Center.

7 My organization operates a national help line for
8 people with Medicare and we field about 15,000 calls per
9 year from Medicare beneficiaries, family caregivers, and
10 service providers.

11 And actually, the second most common call to our
12 help line is for people who are dealing with appeals. They
13 have been denied a service, or they have been denied a
14 prescription drug. And most often, those calls are from
15 people who have left the pharmacy counter without their
16 prescription and they don't know where to turn. They don't
17 know what the process is to ask for an appeal and they
18 really have no good information.

19 I would just say, you know, from the beneficiary
20 perspective, the appeals process really starts at the
21 pharmacy counter and the plan has, essentially, three
22 opportunities to deny a beneficiary a drug that may be a

1 medically necessary drug. They are refused at the pharmacy
2 counter, there is the coverage determination, and then the
3 redetermination.

4 I think we envision an appeals process that's much
5 more manageable for beneficiaries, that has fewer steps,
6 that's more transparent, that provides information about why
7 a drug is being denied at the pharmacy when the person is
8 refused.

9 And I will say, I think it's also very important
10 to consider that because this process is so tedious and
11 because the burden is fully on the beneficiary to navigate
12 this process, there are many people who do not have the
13 wherewithal to actually begin the appeals process.

14 So I think the scope of the problem is really in
15 question. I think we can't rely on the data about coverage
16 determinations and redeterminations because the process
17 really does begin at the pharmacy counter when a person is
18 denied a medication. And I think a more streamlined process
19 would not only help beneficiaries, but would also be of a
20 serious benefit to providers.

21 So thank you.

22 MR. HACKBARTH: [Off microphone.] Okay, we are

1 adjourned until 9:00 a.m. tomorrow.

2 [Whereupon, at 5:02 p.m., the meeting was
3 recessed, to reconvene at 9:00 a.m. on Friday, September 13,
4 2013.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 13, 2013
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
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

PAGE

Update on Medicare's ability to innovate on payment
and delivery system reforms

- John Richardson, Lauren Metayer

3

CMS financial alignment demonstrations for dual
eligible beneficiaries: Status report

- Christine Aguiar, Carlos Zarabozo

73

Public Comment

117

1 P R O C E E D I N G S [9:00 a.m.]

2 MR. HACKBARTH: Okay. Good morning, everybody.
3 We have two sessions today -- one on Medicare's ability to
4 innovate on payment and delivery reforms, and the second on
5 an update on the dual-eligible demonstration projects. So
6 we're going to begin with CMMI, I think. John?

7 MR. RICHARDSON: All right. Thank you. Good
8 morning, everybody. In this session staff will update
9 Commissioners on Medicare's new authority to test and deploy
10 innovations in payment policy and health care delivery,
11 which was substantially expanded in 2010.

12 We also will give a brief overview of the types of
13 models that CMS is testing under this new authority, which
14 are covered much more extensively in your mailing materials.

15 From among the dozens of projects described in the
16 mailing materials, which, in the interest of full
17 disclosure, I should acknowledge are based substantially on
18 CMS' description of these projects, we will take some time
19 to present more detailed information on six State
20 initiatives where CMS is targeting some of its new
21 innovation funding to work in concert with these states to
22 implement their solutions to several of the issues, such as

1 episode-based payment and increasing patient engagement,
2 that the Commission has grappled with.

3 The purpose of this session is to seek your
4 guidance on two things:

5 First, are there any specific innovation models,
6 either that we present today, that are described in the
7 mailing materials, or that you know about from other
8 sources, that you would like us to keep tabs on in
9 particular?

10 Staff are already tracking initiatives in their
11 issue areas, such as the shared decision making grants that
12 we discussed yesterday, the bundled payments for care
13 initiative, pioneer ACOs, and the financial alignment
14 initiative for dual eligibles that Christine will talk about
15 in a moment. But we want to know if there are any others
16 that we should keep track of.

17 Second, we seek your input on issues concerning
18 the process by which CMS and ultimately the Secretary of HHS
19 will implement Medicare's new powers to expand payment and
20 delivery models. Those decisions will involve difficult
21 trade-offs between, on the one hand, policymakers' demand
22 for strong empirical evidence that a model is successful

1 from a cost and quality standpoint, and on the other hand,
2 policymakers' demands that the pace of the diffusion of
3 innovations in Medicare move much faster than it has in the
4 past. We are interested in your views of how to balance
5 that trade-off.

6 In early 2010, the Commission examined Medicare's
7 legal authority and administrative processes to test and
8 implement payment and delivery system reforms. The
9 Commission's three key findings were that:

10 First, funding for Medicare research and
11 demonstration activities was very low relative to the size
12 of the program and not stable from year to year;

13 That the administrative and regulatory processes
14 for conducting and evaluating demonstrations were too
15 inflexible and time-consuming to meet policymakers' needs
16 for the rapid testing of policy innovations;

17 And, third, that the demonstration process would
18 be more effective if there were a clearer locus of
19 accountability for deciding what innovations to test and
20 more transparency in the evaluations of demonstrations.

21 The Congress acted to address many of these issues
22 in the Patient Protection and Affordable Care Act of 2010.

1 That law authorized the establishment of a Center for
2 Medicare & Medicaid Innovation within CMS; streamlined the
3 process of approving and testing innovation models;
4 authorized a \$10 billion multi-year funding stream for the
5 innovation center, which is automatically renewed every
6 decade; and authorized the Secretary to expand payment and
7 delivery system models through the rulemaking process --
8 that is, without further congressional approval -- if
9 certain cost and quality criteria were met. The act also
10 directed the Secretary to submit a comprehensive report to
11 the Congress on the innovation center's activities at least
12 every two years.

13 While the new law and CMS' subsequent
14 implementation of the innovation center have started to
15 address many of the issues that plagued the previous
16 Medicare demonstration process, we think some issues bear
17 continued scrutiny.

18 For instance, we look forward to learning how CMS
19 will evaluate the cost and quality impacts of the dozens of
20 payment and delivery system models that have been launched
21 since 2011, especially in areas where multiple initiatives
22 may be operating at the same time and involving the same

1 providers.

2 As the Secretary prepares to exercise her new
3 authority to expand models that meet the cost and quality
4 criteria, we will be closely watching how that process
5 unfolds and how the evaluation process will work and how the
6 perspectives of external stakeholders such as beneficiaries,
7 providers, and private payers will be included?

8 As I noted in the introduction, all of these
9 questions involve complex trade-offs between transparency,
10 accountability, and the speed with which innovations are
11 diffused throughout the program. We discussed these trade-
12 offs in the 2010 report, and we are interested in your views
13 today of how these competing priorities can and should be
14 balanced.

15 Now Lauren will give a high-level overview of the
16 innovation center's activity and then present the
17 particularly interesting payment and care delivery
18 innovations being implemented in six states.

19 MS. METAYER: Currently, the CMMI is testing its
20 innovation models under seven different categories.
21 Participants in each of the models vary from physician group
22 practices, FQHCs, to health plans, to state Medicaid

1 programs.

2 The first category, accountable care, includes
3 pioneer ACOs, which David described to you yesterday.

4 The bundled payments for care improvement category
5 includes bundled payment episodes for acute and post-acute
6 services, as the Commission discussed in the spring.

7 The primary care transformation category includes
8 the federally qualified health center demonstration as well
9 as other models which seek to increase access to primary
10 care services.

11 Initiatives focused on the Medicaid and CHIP
12 population are initiatives which are administered by the
13 states but are jointly funded by the federal government and
14 the states.

15 The initiatives focused on Medicare-Medicaid
16 enrollees category includes the financial alignment
17 demonstration for dual eligibles which Christine and Carlos
18 will present information on later this morning.

19 Initiatives to speed the adoption of best
20 practices includes, among other models, the community-based
21 care transitions program which aims to reduce readmissions
22 to the hospital, of which the Commission discussed this past

1 spring.

2 Lastly, while we would be happy to answer any
3 questions regarding the previous six categories, we would
4 like to focus the remainder of this presentation on the last
5 category: Initiatives to Accelerate the Development and
6 Testing of New Payment and Service Delivery Models.

7 The models within this category include innovation
8 awards, which are part of the Innovation Challenge CMS
9 launched in November of 2011. Under this challenge, CMS
10 accepted applications from innovators to test new service
11 delivery and payment models for Medicare, Medicaid, and
12 CHIP. Innovation award winners include, among other things,
13 models aimed at reducing unnecessary imaging services and
14 models to prevent readmissions to the hospital. Currently
15 there are 107 different participants in this model, and
16 award totals have varied from \$1 to \$30 million, totaling \$1
17 billion. The CMMI has recently announced round two of the
18 innovation challenge and will award another \$1 billion.

19 One point to note here is that this is an area
20 where the new CMMI is innovating in a fundamentally
21 different way than CMS used to. Rather than the CMS
22 creating demonstrations to test out across the country in a

1 top-down approach, this innovation challenge utilizes a
2 ground-up approach where innovation is coming from those in
3 the environment.

4 We'd now like to turn your attention to another
5 aspect of this innovation category, which are the models run
6 at the state level. These awards are given to the states to
7 help fund state-based models for multiple payers. So far,
8 state models have been given to six states who are currently
9 implementing their models. The CMMI has also given funds to
10 19 other states who are in the pretesting and design phases
11 of implementation in their states.

12 The state models seek to address several of the
13 issues the Commission has been interested in. Specifically,
14 in the next few slides we will give examples of the ways in
15 which the state models have addressed the topics of episode-
16 based payment, care coordination, patient engagement,
17 expanding primary care, and disparities.

18 The states that we will be talking about today are
19 those that have received funding from the CMMI and currently
20 in the implementation phase of the model. These states are
21 Arkansas, Maine, Massachusetts, Minnesota, Vermont, and
22 Oregon.

1 All of the state models have some aspects of
2 episode-based or alternative payment models. One state,
3 Arkansas, has implemented an episode-based payment model
4 which includes conditions such as upper respiratory
5 infections, ADHD, and colonoscopy. A key issue which the
6 Commission has grappled with is attribution or who is
7 responsible for the episode of care. In Arkansas, they have
8 a designated a principal accountable provider -- or PAP --
9 for each episode of care. Each PAP's average cost per
10 episode will be calculated. If the average cost is above a
11 certain threshold, the provider will pay a portion of the
12 excess costs. If the PAP average costs are lower than a
13 certain threshold, they are eligible to share in savings
14 with the payer.

15 The state models also seek to better coordinate
16 care. With its funding, Oregon's model has created
17 coordinated care organizations, or CCOs. CCOs focus on
18 coordinating physical, behavioral, and oral health care.
19 According to Oregon, CCOs differ slightly than ACOs in that
20 they are full risk-bearing entities and the model emphasizes
21 the role of the community. A CCO also operates within a
22 global budget. Within this global budget, CCOs have the

1 flexibility to institute their own payment and delivery
2 reforms which they think would work best for their members.
3 To ensure that cost savings from CCOs are the result of
4 improved care coordination rather than from withholding
5 care, over time payments to CCOs will be based primarily on
6 performance incentives and not capitation.

7 Another issue the Commission has been exploring
8 and that the state models have sought to address is patient
9 engagement. The innovation model in Maine will provide a
10 shared decision making training tool to providers in its
11 state. Maine will use its funding to incorporate shared
12 decision making into the practice work flow for all primary
13 care providers in an effort to better engage patients.

14 Similarly, Vermont is using funds for its
15 innovation model to run a public engagement campaign that
16 promotes preventive services, better information about
17 medical services and testing, and shared decision making
18 between patients and their health care providers. In the
19 spring, the Commission discussed that the best practices of
20 Medicaid-Medicare coordination programs for dual-eligible
21 beneficiaries included the ability to connect beneficiaries
22 to community resources and social supports. In Vermont, to

1 help connect people to these resources, they have made a web
2 portal with a health risk assessment tool to provide people
3 personalized education materials, community-level resources,
4 and social supports.

5 One of the critical aspects of all of the state
6 models that has been a focus is the expansion of primary
7 care. Massachusetts' model seeks to transform and expand
8 the role of primary care in its state. To do this,
9 Massachusetts is allowing participating primary care
10 providers to enter into a shared risk and shared savings
11 arrangement. Under this, providers receive risk-adjusted
12 capitated payments for primary care services as well as
13 additional payments based on their quality of care.

14 Primary care providers may also share in the
15 savings on non-primary care spending. Massachusetts feels
16 that allowing primary care providers to share in these
17 savings is an incentive for them to coordinate those
18 services as well.

19 Another focus of many state models is reducing
20 disparities, a topic which the Commission discussed
21 yesterday. To address the issue, Minnesota is creating 15
22 accountable communities for health, or ACHs. ACHs are

1 accountable for its population's health and have the goal of
2 reducing disparities in its community. ACHs must, among
3 other requirements, include an ACO, demonstrate significant
4 community responsibility, and prioritize care for people
5 with complex conditions and needs. ACHs must also seek to
6 integrate medical care with behavioral and mental health,
7 public health, long-term care, and social services. To
8 measure its improvements in reducing disparities, Minnesota
9 is planning on monitoring its performance of 14 population-
10 based measures which will be tracked by race and ethnicity
11 whenever possible. Measures include, but are not limited
12 to, the percentage of adults with good or excellent health,
13 heart disease mortality, and the percentage of adults with a
14 usual source of care. Minnesota has set its baseline for
15 these measures and has also set targets for the years 2016
16 and 2020. Minnesota hopes that the integration of all these
17 services will also help to reduce silos in health care.

18 To recap, this presentation has given you a sense
19 of the innovation that is currently happening at the state
20 level through the innovation center. The mailing materials
21 also included some additional information on other models
22 which are running. We are looking for your guidance on any

1 issues or models which should be monitored going forward,
2 guidance on any information about the coordination of
3 multiple initiatives from the provider perspective, as well
4 as Commissioner input on ensuring transparency and
5 evaluations and the desire to move and expand models as
6 quickly as possible.

7 Thank you.

8 MR. HACKBARTH: Okay. Thank you, Lauren and John.
9 Well done. Do we have any round one clarifying questions?

10 MR. GEORGE MILLER: Excellent report. Thank you
11 very much for the information.

12 As you were analyzing the different programs, did
13 any of them deal with dental health? In our organization
14 we're finding that many of our patients have some problems
15 because of dental health, you know, eating and some of the
16 other issues. So any of these demonstrations deal with
17 dental health at all?

18 MS. METAYER: Yeah, I think a lot of them include
19 a lot of different aspects, and I think Oregon for sure
20 includes the integration of oral health care services. But
21 we can get back to you on any other programs.

22 MR. RICHARDSON: One other clarification, not

1 exactly related to that question, but it is that Medicare so
2 far is not participating in any of these programs. The
3 states are very interested in having Medicare be a
4 participant, but by and large, they involve the Medicaid and
5 CHIP populations and in some cases private payers as well.
6 I guess the relationship to your question, why I thought of
7 it, was that it being a Medicaid benefit in many states,
8 that's why it's integrated, but obviously also for the
9 public health aspects of that.

10 MR. GRADISON: I hope this question won't be
11 viewed as too parochial. I noticed on page 15 of the
12 mailing that my home town of Cincinnati had 31 different
13 initiatives. My interest may be a little more than average
14 since I was mayor of Cincinnati in an earlier life, and I
15 remember very well Mark Twain's comment about Cincinnati.
16 He knew the river cities pretty well. He said, "When the
17 world ends, I want to be in Cincinnati because everything
18 happens there 20 years late."

19 [Laughter.]

20 MR. GRADISON: Which I took to be a compliment, to
21 be frank. And it sounds like that has changed completely.
22 But, offline, I would appreciate any additional information

1 you may have about Cincinnati or the source from which you
2 got that number. And, more specifically, I -- it's sort of
3 a theoretical quantitative that only time will be able to
4 answer, but is it possible that a community of less than
5 400,000 people could have 31 different initiatives and still
6 be able to evaluate these separately without -- I use a
7 technical word -- the "contamination" -- I don't like that
8 word. It has health -- it has a double meaning. But,
9 anyway, technically, I think it's the right word to describe
10 my concern.

11 MR. RICHARDSON: We can certainly get you the
12 information about what's going on in Cincinnati, and I think
13 you just put your finger on one of our concerns about places
14 like Cincinnati where there are a lot of projects running at
15 the same time. To the extent that CMS is trying to evaluate
16 and isolate the impact of an intervention, it is going to
17 need to identify a control group as well as a treatment
18 group or have some -- or at a minimum have pre- and post-
19 analyses of what happened. But even in that case, when
20 you've got multiple initiatives, trying to have causality
21 attributed to a particular intervention, we think it is
22 going to be challenging, and we'll see how CMS sorts that

1 out. That's one of the things we want to follow up with
2 them on.

3 MR. GRADISON: Can I assume from your response
4 that, in the awarding of these grants, it was all done just
5 on a separate basis without relationship to, let's say, the
6 number of grants in a community and things like that?

7 MR. RICHARDSON: I don't know that for a fact.
8 Lauren, do you want to weigh in on that?

9 MS. METAYER: I think they do give consideration
10 to how many other things are running within the city. But
11 just in Chicago, there are 59 different initiatives running,
12 so, I mean, I don't know how much they do that.

13 MR. GRADISON: Well, there was a time when
14 Cincinnati was bigger than Chicago. That has long since
15 past. Thank you.

16 DR. NAYLOR: Is there an overall evaluation
17 framework for these, meaning have we -- have a common set of
18 core metrics been defined? One. And, secondly, could you
19 clarify the role of the rapid cycle evaluation team?

20 MR. RICHARDSON: Let's see. In terms of the
21 metrics, there is a broad framework which is laid out in the
22 law, which is that the evaluation has to find that, on both

1 cost and quality, the following things happen: costs were
2 not increased, or were decreased but at a minimum were not
3 increased relative to a baseline; and, of course, there's a
4 lot of art that goes into figure out what would have
5 happened in the absence of the intervention. But that's the
6 cost component. Costs didn't increase or were decreased.
7 And quality was either improved or was not worsened.

8 On the cost side of that, the Chief Actuary at CMS
9 needs to certify that the cost estimate or the cost part of
10 the analysis is sound, you know, basically make a public
11 certification.

12 As I noted, this is, as far as we can tell from
13 what's in the law, going to be done through the rulemaking
14 process, and so there will be some public process presumably
15 with notice and comment, and by virtue of that process there
16 will be some public scrutiny of what the decisions are.

17 I don't have very specific answers for you about
18 each project. I do know that certainly for the ones that
19 are more like initiatives and models as opposed to, let's
20 say, the award, the grant awards, there is an evaluation
21 that's being planned for each of those projects. The
22 actuaries are involved in the design of the evaluation. You

1 know, and there's an evaluation contractor that's similar to
2 the old model that's going to be involved in that. But in
3 terms of the specific criteria for each individual model, I
4 don't have that information.

5 And then the rapid cycle question, I don't have a
6 lot of information about that either, but we can certainly
7 dig into that for you.

8 DR. NAYLOR: Thank you.

9 MR. HACKBARTH: I don't mean for this to sound
10 snarky, but it probably will. I don't see anything rapid
11 about any part of this process, which is sort of my concern
12 with all of this, is that one of the goals, original goals,
13 was to speed the innovation process, and that's what I'm
14 searching for. Consider this a rhetorical question. You
15 don't have to respond to it. But I don't see enough
16 emphasis on speeding the innovation cycle. Lots more
17 activity, lots more money, but I'm looking for more speed.

18 MR. BUTLER: We've talked previously about CMS'
19 resources and ability to do all their work. I'm clear about
20 what's being funded. I'm not clear about what staff
21 resources are added on, if any, in CMS to be able to do all
22 this work.

1 MR. RICHARDSON: When they created the innovation
2 center, that was staffed with some new folks from outside
3 CMS, and they also absorbed the old Office of Research
4 Demonstrations and Information. So some of the initiatives
5 that are described in the mailing materials are actually
6 pre-CMMI projects, and the staff that were responsible for
7 that process came over to CMMI. And then when -- Dr.
8 Berwick was heavily involved in the set-up of the innovation
9 center; he created it to bring in new people from outside.
10 For instance, Dr. Mai Pham, who was at the Center for
11 Studying Health System change, is heavily involved in the
12 accountable care organizations, which, as David reminded us
13 yesterday, are also partly in the Center for Medicare, is a
14 Medicare fee-for-service program, but components of it are
15 being done through the innovation center. And I'll have to
16 get back to you with specific details, but as far as the
17 administrative structure goes, there is a physician in
18 charge of each of the broader issue areas into which they've
19 sorted these programs. And I think that was done
20 intentionally to try and make sure that there was a clinical
21 aspect to each of the projects as well.

22 MR. BUTLER: I'm just trying to get a sense. Are

1 there 10 people? Are there 100 people? Are there 200
2 people that --

3 MR. RICHARDSON: I'll have to get back to you with
4 a specific number.

5 DR. MARK MILLER: We can give you the specific
6 number. I think the perception is that given the way the
7 funding worked, its stability and the amount, if there are
8 parts of CMS that are struggling, at this point anyway, I
9 don't think there's a big perception that this is where the
10 problem lies. It's more on the appropriated side.

11 DR. CHERNEW: They've also contracted out with
12 some very good people to help them think through, so even if
13 you knew the number of people that were in the office,
14 they've gotten a lot of outside advice from really top-notch
15 people about how to solve some problems that actually might
16 be unsolvable, but nevertheless, the people that are not
17 solving them are really good.

18 [Laughter.]

19 MR. HACKBARTH: So I have a question about the
20 Secretary's authority to extend successful projects. Let's
21 take an example. Let's assume that the bundling -- some
22 facet of the bundling around hospital admissions proves to

1 be successful. Is the Secretary's authority to say that for
2 all Medicare admissions we are now going to move to this
3 bundle? Or is it that this is no longer a pilot but it's
4 still voluntary, this is a new voluntary option for
5 providers nationally, much like the MSSP program?

6 MR. RICHARDSON: I'm just looking at the plain
7 language of the statute. She could expand it nationwide
8 through the entire program. And I think that that's one of
9 the key issues that will get litigated one way or the -- you
10 know, either in the formal meaning of that word or through
11 the regulatory process. But, you know, just look at the
12 words in the statute. My interpretation of it is that she
13 could push it out to the entire program, the entire country.

14 MR. HACKBARTH: Okay.

15 DR. MARK MILLER: And it would be non-voluntary
16 [off microphone].

17 MR. RICHARDSON: And it would be -- you know, if
18 you want to participate in Medicare, this is what you're
19 going to do.

20 MR. HACKBARTH: Yes.

21 MR. KUHN: Just one other thing in terms of this
22 authority being tested of what they could push out. So, for

1 example, there are things that are in the statute now. So,
2 for example, market basket update, that's set by Congress.
3 And say a demonstration tested some things but also they
4 thought the payment rate was not right. Does she also have
5 the authority, absent Congress, to adjust payment rates as
6 part of that in the future as well?

7 MR. RICHARDSON: Yeah, the only restriction is
8 changing the benefits. There was a specific prohibition on,
9 you know, changing the benefits to which beneficiaries are
10 entitled. But as far as payment, the conditions under which
11 services are delivered, I think like a lot of things in the
12 statute, there's flexibility. So, you know, depending on
13 the administration's discretion or aggressiveness -- and I
14 think, you know, that will be balanced by what they try to
15 do and then the response from the legislative branch.

16 MR. KUHN: And then per your response to Mary's
17 question, the regulations for acting on those have not yet
18 been promulgated or --

19 MR. RICHARDSON: That's correct.

20 MR. KUHN: Thank you.

21 MR. HACKBARTH: Okay. Let's move to round two,
22 and I would urge people to take note of the questions that

1 Lauren mentioned. One objective for this presentation was
2 just sort of a general update on what's happening with this
3 important part of the program. But a second is: Are there
4 particular models that you want to dig into in further
5 detail, learn more about? Potentially, you know, we could
6 say we want to go off and make recommendations about those
7 independent of what's going on here, so as you formulate
8 your round two comments. Kate, do you want to kick off?
9 You don't? Kate respectfully declines.

10 DR. BAICKER: I'm saying I'm good for this round
11 [off microphone].

12 MR. HACKBARTH: Okay.

13 DR. NERENZ: I'm just curious what your thoughts
14 are about the general approach to evaluation in any of these
15 domains that you wish to speak to.

16 A little more specifically, I'm thinking that in
17 some of the past CMS programs, there has been a particular
18 concept or model identified, and then it's performed in 10,
19 15, 20 different locations. And when you evaluate, you draw
20 some conclusions about the performance of the whole as well
21 as the individual ones.

22 It seems to me in some of these programs there are

1 a lot of one-off, unique, implemented in one place or in one
2 state programs which, from one perspective, is just fine. I
3 mean, that's sort of consistent with the concept of
4 innovation. That part's okay. But it's a case study for
5 evaluation.

6 What's your sense of how this is going to play out
7 in terms of drawing broader policy conclusions about this
8 portfolio?

9 MR. RICHARDSON: That's an easy one.

10 [Laughter.]

11 MR. RICHARDSON: Oh, boy. I mean, that's really
12 the nut of the issue. I'm going to give you, you know, a
13 classic Washington answer. I'm going to avoid answering it
14 by talking a lot.

15 [Laughter.]

16 MR. HACKBARTH: You don't need to do that [off
17 microphone].

18 MR. RICHARDSON: Okay. Thank you, Glenn.

19 DR. NERENZ: A real answer is okay.

20 MR. RICHARDSON: Well, I mean, I think that that's
21 really the problem that they're going to have in a lot of
22 cases, is this something -- and it's ultimately going to

1 come down to is this something that we can expand across the
2 program? Is it something we're going to do regionally? You
3 know, Medicare as a national program always has this problem
4 with trying to come up with national policies that reflect
5 the local market idiosyncracies of what they're doing. And
6 you see that playing out in this particular initiative, too,
7 because some of these things are going to tell them, you
8 know, the bundled payment example, you know, maybe it makes
9 sense to bundle some amount of post-acute care up to 30 days
10 afterwards. But in other places, it's going to be, well,
11 you know, we don't have a lot of physician groups here, so
12 how are we going to organize this vast array of small
13 practices that we have? That's not going to be national
14 necessarily.

15 MR. HACKBARTH: During her presentation I think
16 Lauren used the expression that some of these are top down
17 and some of these are bottom up, the bottom up being in
18 particular the innovation grants. I think the problem that
19 you mentioned is particularly true in the case of the
20 innovation grants, which are almost by definition, you know,
21 the outgrowth of unique local circumstances. It's a
22 challenge, I think.

1 DR. NERENZ: Well, and just the part of the kind
2 of answer I was looking to explore is that if you structure
3 a demonstration around a big concept and you do it in
4 multiple places, and let's just say it succeeds wildly,
5 there's a fairly straightforward path to making that
6 national policy. You decide that on the basis of all this
7 evidence this is a good thing and you move in that
8 direction.

9 But in the case of a successful one-off project,
10 the direction might conceivably be just to say this will now
11 be open in the future for any entity or any state who wishes
12 to do it. But now the direction is that Medicare, CMS, is
13 supporting a whole number of different variations and models
14 and what-not as opposed to a more simple, less varied set of
15 options. I'm just curious about how this carries forward.

16 MR. RICHARDSON: Well, just to pick up on that
17 point, I think part of the diffusion will be if they do some
18 of these one-offs and they come up with a good idea. Say
19 Arkansas thinks episode-based payment is going to work and
20 they have a very diffuse provider network. One of the
21 reasons they wanted to do it is that they don't have a lot
22 of big groups there, and they have a lot of rural providers.

1 Maybe somebody in Maine or Colorado says, "Oh, that could
2 work here," and that's part of the transparency and
3 diffusion of the ideas, is back out from these local
4 programs into other local areas. They may not turn into
5 national programs necessarily. But one of the functions of
6 the innovation center and one of the reasons I think the
7 Congress wanted to keep the funding stream going is to
8 perpetuate some of these ideas out of the local areas.

9 DR. NERENZ: Again, I was trying to anticipate
10 back to some of our discussions. Would we be in a position
11 then four or five years from now to say this is a good way
12 for CMS to go in Arkansas, Maine, Wyoming, and Idaho, but
13 not a good way to go elsewhere? We typically have not done
14 that in the past.

15 DR. NAYLOR: Well, I mean, the other end of that
16 coin is the 59 efforts going on in Chicago or 31 in
17 Cincinnati that, absent a framework that helps you to think
18 about the interactions of those options, these thousands
19 flowers blooming will not, you know -- if you don't have a
20 deliberate set of ways of thinking about not just what did a
21 one-off accomplish but, rather, what are the interactions,
22 that one example you provided of a site that said it's only

1 because we had both an ACO and a community-based care
2 transition initiative operating simultaneously that we were
3 able to achieve goals.

4 And so I think that the other end of this is how
5 are we going to know what works or what are the sets of
6 interactions that work, because for many it may not be just
7 one of these. And, of course, all of the evaluation
8 problems that you've outlined in terms of getting a robust
9 comparison group and being able to disentangle, these are
10 real issues, and it seems like going forward we should --
11 you know, it's not project by project, effort by effort,
12 innovation by innovation. We should have a big-picture
13 framework about how we're going to use the rest of the
14 resources.

15 DR. BAICKER: So I absolutely agree with all of
16 the emphasis on evaluation, and I think the challenge that
17 you're highlighting is that what works in one area may not
18 work in another -- you both said that -- and the strategy
19 might be here's the set of tools that are available to you,
20 and the way that could in theory be canonized, regulated,
21 is, you know, here are the parameters under which you get
22 flexibility, and that flexibility continues only as long as

1 you demonstrate results. So the outcomes we care about or
2 the quality of care for beneficiaries, the costs with which
3 that high-quality care is delivered, et cetera, and you can
4 be much more flexible about the inputs into that process if
5 you're well measuring the outputs and say you've got an
6 innovative idea, great, give it a try. But we're yanking
7 the plug if -- pulling the plug if it doesn't meet these
8 endpoints within some reasonable time period to get up and
9 running.

10 MR. RICHARDSON: Sorry, Kate. Can I just tease
11 out? Would that be an ongoing evaluation process or a one-
12 time? Because that's another issue, you know, you have a
13 model that works, it's national policy, and, you know, you
14 never necessarily come back and evaluate it again. Or you
15 could --

16 DR. BAICKER: Well, I would think of it as an
17 ongoing thing the same way, you know, it's not like if you
18 get a five-star quality rating you're done.

19 MR. RICHARDSON: Right.

20 DR. BAICKER: That keeps getting re-evaluated. So
21 I would think --

22 MR. RICHARDSON: Or the ACOs have three-year

1 contracts, so every cycle --

2 DR. BAICKER: Right, so that I would think that
3 there would be -- you could free yourself up from
4 micromanaging the mechanisms if you were well monitoring
5 deviations from acceptable outcomes.

6 DR. CHERNEW: I think there's two very different
7 types of interventions going on. One of them is sort of
8 broad, like, say, Arkansas or Oregon, which they're big
9 payment initiatives. And you can envision holding that
10 payment initiative accountable for quality and cost broadly
11 that you could monitor as you normally would.

12 A lot of these are very micro provider specific
13 things where one organization is doing an intervention on
14 how to get people to comply with medications or how to deal
15 with ER observation days or things that are very micro.

16 My personal opinion is eventually you're going to
17 pull the funding for those micro things and have to fold
18 those organizations -- if they've learned, great, if others
19 want to emulate them, great -- into a broader accountability
20 framework, which is a different than a broader evaluation
21 framework. I think the innovation center is meant to help
22 organizations learn from each other in part, and whatever

1 works in different organizations will have to be put into a
2 broader accountability framework, which I think would be
3 useful.

4 And for that reason, I'm not worried that we know
5 exactly how every little thing worked in all that level of
6 precision.

7 One of my concerns, though -- and you might want
8 to speak to this -- is the openness of all the evaluations
9 about what's going on in CMMI. How confident are we that
10 the data going in is going to be reported back and others --
11 I'm not even sure who others are -- will be able to come up
12 with sort of some sense of what went on collectively in that
13 process?

14 MR. RICHARDSON: I don't know the answer to that.
15 I remember you raising that three years ago when we talked
16 about the old process. I mean, it's still an open question.
17 The evaluations they described as independent evaluations,
18 but, of course, they're contractors to CMS. I think you
19 mean even other external --

20 DR. CHERNEW: Yeah, but are the contractors
21 allowed to publish them, or do they have to get it approved
22 through the normal channels?

1 MR. RICHARDSON: I don't know the answer to that,
2 but --

3 DR. CHERNEW: Is it forced to go through peer
4 review, or is it going to come out in a CMMI report about
5 how well they did, or not?

6 MR. RICHARDSON: All the statute says about it is
7 that the evaluations have to published in a timely fashion,
8 but there's obviously a lot of details that need to be
9 ironed about that. But that's one of the things we can ask
10 about.

11 DR. CHERNEW: What you mean by published might be
12 different than what I mean by published.

13 MR. RICHARDSON: I do not mean peer reviewed. The
14 statute certainly doesn't speak to that.

15 DR. COOMBS: So you asked the question about which
16 of the projects and demonstrations that -- I'd be interested
17 in specifically the physician-hospital collaboration. And
18 looking at this particular demonstration in terms of
19 coordination of care across settings and the quality
20 initiatives, Kate and I guess your associate wrote an
21 excellent piece on coordinated care and conflict with
22 competition. And in essence, many physicians are trying to

1 get in an integrated health care delivery system, and under
2 that there's this massive urgency to merge and consolidate
3 health care systems. And I'm wondering if we can learn
4 something specifically about this in terms of gainsharing.
5 Mount Auburn, MACIPA, has been a poster child for
6 collaboration between physicians and hospitals, and they've
7 done very well at this in terms of being able to both bear
8 risk. They also have a more preferable population in terms
9 of patients. And it would be interesting to learn the type
10 of patient demographics that are under the umbrella of this
11 specific system. And going forward, if there are other
12 physician-hospital collaborations, I'd be very interested in
13 -- because I would love to learn from these kind of
14 demonstrations. I think they speak volumes, and because
15 we've always had this competition between physicians and
16 hospitals in terms of one may have more emphasis on building
17 capacitance and the other have more interest in terms of the
18 overhead and the cost of doing business. And I think this
19 is the kind of demonstration that really moves the meter in
20 terms of patient care.

21 MR. KUHN: Like others, I'm a bit concerned about
22 the number out there and the overlap that we see going on.

1 I just am really wondering how you're going to have enough
2 evaluation contractors, let alone enough technical expert
3 panels to be able to manage a couple thousand initiatives
4 that are out there right now.

5 Having said that, I would just say that I remember
6 when I was at CMS and when we launched the Acute Care
7 Episode, or the ACE demo, we looked all across the country
8 of where we could put that demonstration so that it wouldn't
9 overlap with other activities. And ultimately that's why it
10 wound up in Texas and Oklahoma and New Mexico, just a few
11 states where they were eligible for that particular
12 demonstration, because you wanted to make sure that you had
13 the right control and intervention groups to manage that.
14 When you have 50 or so running just in an individual city, I
15 just do worry about the evaluation, how we're really going
16 to learn from this as we go forward.

17 Having said that, I'm curious. Now that we've got
18 a couple thousand things up and running, have they shut down
19 any since they have been up and running? Or are all of them
20 still going forward?

21 MR. RICHARDSON: Not that I know of, not that we
22 have -- they moved over, some of the ones that had been

1 started before under previous laws. In fact, there was --
2 one of the demonstrations I talked about three years ago,
3 the Medicare coordinated care demonstration was down to one
4 site. It started with 15, I believe.

5 MR. KUHN: Right.

6 MR. RICHARDSON: And there was one site left in
7 Pennsylvania, and that recently got another extension. So,
8 you know, it's --

9 MR. KUHN: Well, and that's--

10 MR. RICHARDSON: Anyway.

11 MR. KUHN: And the thing is that I worry that when
12 you've got that many, the ability for an agency to have the
13 proper oversight, whereas the ones that aren't working,
14 whether it's the integrity of the entities that are involved
15 in it or whatever, there might be issues there. And I don't
16 know about that particular one that you talked about, but
17 what I do worry is the perpetuation of these things being
18 reauthorized over and over again, and they almost become
19 then a permanent kind of adjunct kind of one-off part of the
20 program on a go-forward basis. And you could have --
21 instead of one national program, you have now thousands of
22 little mini program operating around the country under the

1 guise of demonstrations. And so they've got to have some
2 way to kind of end these things and wind some of these
3 things down.

4 MR. HACKBARTH: Given your operational experience,
5 Herb, at CMS, could you just sort of take that comment a
6 little bit further? One of the concerns that I have with
7 this approach of so many different models is that I think if
8 these things work and we implement them, there are huge
9 operational implications for the agency --

10 MR. KUHN: Exactly.

11 MR. HACKBARTH: -- an agency that's already
12 struggling with an operational budget that is way too small.

13 MR. KUHN: You're absolutely right, Glenn, and so
14 the question is, if you find -- you've got, again, a couple
15 thousand out there, but even maybe operationalize five of
16 them would be a huge undertaking. There would be major
17 rulemaking. It would be putting together the contractors to
18 manage it, changing with now the Medicare administrative
19 contractors to help manage them. It would be a big
20 undertaking.

21 So the criteria that they ultimately select the
22 really good ones on a go-forward basis, these things really

1 have got to be stand-out stars as part of this thing,
2 because you can't put together an apparatus like that for, I
3 would think, just incremental gains. So I still don't know
4 how they're going to do that evaluation process.

5 MR. HACKBARTH: Yes.

6 MR. KUHN: One other just comment just on the top
7 dot point up there in terms of specific models of interest
8 in the future. Obviously the ones that deal with
9 coordinated care, bundling the pioneer, shared savings, and
10 even some of the gain-sharing ones I would be interested in
11 us continuing to look at.

12 MR. HACKBARTH: And so, Rita, before we go to you,
13 I just want to pick up on that last comment and analysis and
14 invite people to react to this. So Alice focused in on
15 gain-sharing. It's Page 13 of the paper. We recommended
16 gain-sharing, I think it was 2008-2009, actually I think the
17 same time as the readmissions penalty and the bundling
18 pilot. That was all apiece.

19 And part of the appeal of physician hospital gain-
20 sharing to us at that point was, this was something
21 relatively easy to do, at least I think -- I'm willing to be
22 proven wrong on that -- as opposed to major changes in both

1 payment and organization of care delivery. This may be
2 relatively low-hanging fruit, but here we are six years
3 later and very little has been done on this.

4 I know there was some litigation about whether
5 this could be done in New Jersey. I'm with Alice. You
6 know, I'd like to learn more about this, and potentially
7 this is something that we could recommend that could be done
8 quickly. I use that term advisedly. So I invite others to
9 react to that and see if there's some interest in pushing on
10 that. Rita.

11 DR. REDBERG: Thanks for that excellent report. I
12 think -- I just want to highlight, I think it's really
13 important to be testing these care and delivery models. We
14 have a huge health care system and it's very hard to
15 innovate, obviously, nationally. And, you know, I am
16 concerned about resources.

17 Just to sort of put it in context, you know, when
18 you think about how much Medicare spends on health care
19 delivery and we're now talking about ways that we could
20 increase value and increase the quality of patient care, I
21 mean, we spend billions, for example, on a lot of medical
22 devices, you know, things that haven't been tested nearly

1 like we were talking about here. They haven't been
2 evaluated, haven't been looked at, you know, metal-on-metal
3 hip implants, we have lots of knees and hips, and Medicare
4 routinely spends billions without asking for data and
5 looking at it and going back and saying, How's this working?
6 How is it working here? How is it working in this
7 population?

8 And so, I think the \$2 billion is probably not
9 nearly enough, and especially in context of what we spend
10 overall in the health care to look at it. I was really
11 struck that they got almost 3,000 applications, and how to
12 choose just a hundred? I mean, I think the idea that there
13 are so many groups and organizations that are interested in
14 innovating in care and delivery is fantastic and that I wish
15 they had more money to fund more of them and that we could
16 look at them.

17 I do think, of course, it's really important for
18 us to look at them, but I think it's really important for us
19 to keep in mind that it's a great innovator and really, I
20 hope, can help us improve the quality of care as well as
21 value for Medicare beneficiaries by things we're going to
22 learn from CMMI, and that we need to still realize that as

1 they're learning and growing, they're still probably better
2 ahead of a lot of our more traditional Medicare that we
3 spend a lot more money on.

4 So having said that, I'm just curious, the
5 Secretary had to report to Congress last year, and do we
6 know anything about what that report said?

7 MR. RICHARDSON: It was a very, I guess you could
8 say, preliminary report since the CMMI hadn't been up and
9 running very long. It was a deadline for the initial report
10 that was probably one of the ones that made more sense when
11 the bill was drafted, and then by the time it's enacted, you
12 know, there wasn't a lot of time between when that happened
13 and when the report was due.

14 I expect the next one to be significantly more
15 informative. It was essentially a recitation of, these are
16 the things that we're doing, did not address the issues that
17 we're grappling with here, which is how evaluations are
18 going to work, whether the expansions would be program-wide
19 or local and those kinds of things.

20 I think some of that will only get -- I'm sorry --
21 only get figured out or, again, litigated -- I don't
22 necessarily mean that in the legal sense -- but as the

1 Secretary starts to make actual decisions about those
2 things, they may not telegraph much of that ahead of time.

3 DR. REDBERG: My other question, Section 30.21
4 allowed a waiver of, whatever it was, Title 18, the fee-for-
5 service requirement. Did any of the innovation models --
6 because it seemed like most of them were built within the
7 traditional Medicare fee-for-service model, which, of
8 course, those give them some limitations in terms of what
9 they can do because -- were any of them taking advantage of
10 that or not using a fee-for-service model?

11 MR. RICHARDSON: I'll have to get back to you on
12 that in terms of the explicit payment. For example, the
13 bundled payment for care initiative which they're actually
14 doing under the Innovation Center involves a miniature
15 episode payment to the entities that have agreed to
16 participate in that. So that's different than the
17 traditional fee-for-service approach. And I'll have to see
18 if there are some other examples where they're diverging
19 from that.

20 MR. ARMSTRONG: Two general points. First, it's
21 hard for me to be too specific about where I would focus in
22 on these initiatives. Frankly, I would pull out MEDPAC's

1 agenda and look at the blue and purple items and ask, This
2 is what we think is important of this world of initiatives
3 going on, which speak to those items that we care about and
4 we're going to focus on and how can they help us be smarter
5 about that as we go forward?

6 The second point I would make would be, I think,
7 just to the anxiety about this being, you know, big and
8 crazy and unmanaged and a lot going on, and this anxiety
9 about, well, how is it that we're contributors to a process
10 of reforming our industry? Can we do the best job of
11 capitalizing on what we learn and translating it into, you
12 know, faster improvement?

13 Well, I don't know the answer to that, but I would
14 just say, I think it's actually much bigger than we've even
15 identified. We're just talking about investments through
16 either the Federal Government or the Medicare program in
17 innovations, which I would argue is, frankly, a fairly small
18 percentage of the innovation that's unfolding.

19 And the fast work and the work that I know I spend
20 much of my time focused on is not supported by any of these
21 initiatives. It's innovation that's unfolding in the local
22 markets because people think, organizations think that it's

1 going to achieve better results.

2 So I would just say that I wish there was a grand
3 plan, you know, where someone knows how Federal reforms
4 through the ACA, CMMI grants, the work we do here around
5 payment for the Medicare program, innovations sponsored at
6 local markets or elsewhere, and all the change taking place
7 just through the private sector, all kind of contributed
8 their part to a big plan.

9 If someone knows kind of how that's supposed to
10 work, I'd love to hear it. I just kind of trust that it
11 will and that here at MedPAC we need to just be attentive to
12 doing the best job we can of contributing in our way to
13 something that's kind of big.

14 DR. CHRISTIANSON: One sort of general comment or
15 contribution to the discussion about the messiness of all of
16 this for evaluation, I think what we haven't talked about
17 is, it's very messy for implementation, too, in the sense
18 that, at least my experience with some of these groups that
19 have the innovation grants, is that the same people are
20 involved in multiple grants.

21 So I worry about the capabilities on the ground of
22 actually doing what people are saying they're going to do.

1 So part of the evaluation is going to have to be a very
2 close look at the fidelity, by that I mean is what's getting
3 done actually what was promised. You know, we don't want to
4 -- it would be a shame if the people evaluated what people
5 said they were going to do instead of what they actually
6 did. So that's a general comment.

7 In terms of the discussion points, the models that
8 are most intriguing to me are the ones that try to -- in
9 Oregon's case, coordinate, in Minnesota's case, maybe manage
10 care or cost, what the grants are saying are silos, long-
11 term care, dental health, behavioral health, and acute care,
12 and I think our delivery system is not currently structured
13 to do that very well, and I think there are big potential
14 gains for this.

15 Although I would ask Lauren and John, these are
16 Medicaid program efforts and so, is one of the things we
17 should be thinking about in answering your question, you
18 know, is there a lot to be learned from Medicare while
19 looking at these things, and I guess I would just ask you
20 how that should rank in terms of our -- that consideration
21 should rank in terms of our recommendations to you?

22 MR. RICHARDSON: I think that's definitely on the

1 table as a high priority, and bearing in mind that if
2 something is skewed toward a particular part of the Medicaid
3 population, like pregnant women or children, it may not be
4 as applicable. But if there are things that could be
5 applicable to a broader patient population, definitely.

6 DR. CHRISTIANSON: Do you see the Oregon and
7 Minnesota cross-silo efforts as being directly applicable to
8 Medicare? I guess being direct about my question.

9 MR. RICHARDSON: I think that they -- yes, I think
10 they should be.

11 MS. METAYER: And I think a lot of the states --
12 their plan is for it to be applicable to Medicare in the
13 long term. I think Oregon's is going to move to dual
14 eligibles, the CCO, soon.

15 DR. MARK MILLER: And that's what I was going to
16 also add here. In the next session, they'll talk --
17 Christine will talk about the dual eligibles demonstrations,
18 but she will also -- there are a couple of states, Minnesota
19 is one of them, where they're moving to a dual eligible
20 approach on a different platform than the demonstration.
21 It's on a D-SNP basis.

22 And so, what I would say in response to that

1 comment is, I think we should be thinking about the state
2 innovations in two or three ways. One is, if they have
3 something going and they have Medicare -- sorry -- Medicaid
4 in the private sector and we there's -- and again, given the
5 lack of information and all the rest of it, but if for some
6 reason we thought there was a good reason to get even more
7 lift by Medicare's involvement in it, that's something that
8 we could speak to.

9 Then I think there's John's point, if I understand
10 it, which is, if there's something from the Medicaid side --
11 and part of the reason that I wanted the state stuff put in
12 here, and this is just my own failing -- is, I wasn't paying
13 attention to what was going on out in the states and sort of
14 felt like there's some interesting things going on out there
15 and I wanted to bring it in front.

16 If there's something to learn from it, I thought
17 the Arkansas episode thing was very interesting. We've been
18 tying ourselves -- and I mean we in Washington 20 years type
19 of thing -- tying ourselves in knots with this concept and
20 those guys just kind of did it. That was kind of
21 interesting to me.

22 And then I think the third thing is, there are

1 populations that overlap specifically in Medicare, the duals
2 and the social services with medical. We have been talking
3 about, we will be talking about and it comes up to bat next
4 session.

5 MR. GRADISON: When Medicare and Medicaid were
6 legislated in 1965, the compromise, basically, was that
7 Medicaid would operate on a Federal/state basis, but with
8 the states not necessarily doing things exactly in the same
9 way. Medicare was intended to be a uniform national
10 program. I don't think either one has exactly worked out
11 that way.

12 In the case of Medicaid, there's been pulling and
13 hauling in terms of what the states should be required to
14 do, and I think that it's very interesting to me to watch
15 the deal-making, which I think is taking place as CMS
16 attempts to negotiate with states that are hesitant about
17 taking advantage of the expansion opportunities that the ACA
18 provides in the Medicaid program.

19 In other words, those programs, the extension of
20 those programs may not look the same in every state. My
21 first awareness of the fact that Medicare wasn't exactly
22 uniform is, a kind of pedestrian example, was finding out

1 when I was involved in the legislative side of these things
2 that colostomy bags, the frequency of changing them varied
3 from one part of the country to another. What's that all
4 about in the national program?

5 And as time has gone by, I've become more and more
6 aware of not only the fact that there are variations, but
7 that that's a healthy sign, in spite of the intentions that
8 there were initially. My own personal view is that this is
9 way too big and complicated a country and there are too many
10 variations to really stake the future of the program on
11 making everything or even attempting to make everything
12 uniform.

13 Or to say it in a more specific way, I think part
14 of our job in the interest of the program is to make the
15 Medicare world a safer diversity. I mention that because I
16 think what's going on here through these experiments is
17 fully consistent with that idea. And therefore, I don't
18 look upon these so much as a question of should it be
19 imposed everywhere? If something seems workable, it perhaps
20 then should be made available everywhere, but not
21 necessarily as a requirement.

22 That isn't necessarily the automatic way some

1 folks think about Medicare. So I just raise it here sort of
2 as something that's in the back of my mind we might want to
3 think about as a general principle one way or the other in
4 the future.

5 DR. HALL: I'm wondering if there's something that
6 we can do as Commissioner's that might help reap the benefit
7 of this, irrespective of whether we think the program is
8 coordinated or not. Two billion dollars being put into
9 research on health care reform is nothing to wink our eye
10 about. There are a lot of good people around the country
11 who are doing good things, and as a group, we probably know
12 a lot of those people, and also we probably know some that
13 are perhaps not doing the best work.

14 Not that I'm suggesting we do more work, but I
15 think we should keep our eye on this program, but also not
16 just in terms of evaluating what staff are doing, but maybe
17 to bring back ideas of things that would seem to be highly
18 compatible with a lot of our goals here that we've talked
19 about over the next couple of days. I think we could help
20 reap the maximum benefit for Medicare recipients that way.

21 DR. CHERNEW: I want to ask a clarifying question
22 of Bill's question, comment, if I can. Bill talked about

1 money going in, \$2 billion, whatever it is, for evaluation.
2 Of the money you've talked about, how much is actually for
3 things like evaluation and how much is actually just paying
4 the extra fees? How much of this is just a fee increase for
5 doing whatever it is they say that they're ultimately doing?

6 MR. RICHARDSON: I don't know the amount of money
7 that's going to evaluation. I mean, Peter asked about what
8 the administrative infrastructure is here and we can add
9 that fact to that analysis. But I think implicit in your
10 question is, is some of the funding for CMMI going to extra
11 payments or actually affecting the amount of money received
12 by the --

13 DR. CHERNEW: Yeah, basically the operations that
14 are giving money out to providers.

15 MR. RICHARDSON: Right. The grants -- so that the
16 award programs, which are more, I view, as traditional
17 grants where I would say that those are going to the
18 providers for the purposes of whatever administrative
19 changes they're going to make in their delivery system. And
20 then there are the models where, as part of the program, the
21 providers are agreeing to get paid differently and perhaps
22 have some gain-sharing or whatever the aspect of that would

1 be.

2 I think in the latter case, though, where the
3 models -- so basically you're putting a model on top of this
4 flow of Medicare benefit dollars, I don't think that there's
5 extra money, quote-unquote, from the Innovation Center going
6 to those providers, as opposed to the grants, the awards,
7 through the grant programs that are -- that's what the money
8 is intended for, is the operation of the programs.

9 DR. BAICKER: I thought some of the state level
10 things actually required, after a certain amount of time,
11 demonstrating that you were saving the program money in
12 terms of what was going to providers. Is that --

13 DR. MARK MILLER: Just for one second, okay, and
14 if I could, I think what we're saying here is when you're
15 talking about how the provider is paid, that's a benefit
16 dollar. That's under the flows of dollars that go out on a
17 regular basis. Then to the extent that there is money that
18 we're talking about here, it's to help generate the idea,
19 administer the idea, and evaluate the idea.

20 But if there's an extra payment or some incentive,
21 that that's running more through the benefit dollars that go
22 out of the trust fund on a --

1 DR. CHERNEW: So things like the primary care
2 demonstration where they pay primary care providers an extra
3 amount of money, that's not part of the CMMI-type budget?
4 That's coming from some other place?

5 MR. RICHARDSON: I don't know. I'll have to find
6 out.

7 DR. MARK MILLER: I'll check that fact
8 specifically, but generally, yes, that's the way I think it
9 works.

10 MR. KUHN: But, Mark, isn't it also true, on
11 previous demonstrations had to be budget-neutral going
12 forward?

13 DR. MARK MILLER: And then you get into Kate's
14 question.

15 MR. KUHN: Right. They're giving them money up
16 front in order to implement. And so, is that actually -- is
17 that coming through CMMI or is that through trust fund --

18 DR. MARK MILLER: My sense of that is, in general,
19 it comes through the trust funds, but we can check whether
20 there's a specific difference here.

21 MR. RICHARDSON: For a given project, yeah.

22 MR. GEORGE MILLER: Yes, just a brief comment on -

1 - I agree with John that we should look at what the states
2 are doing and private sector to learn from them as well, and
3 as Bill talked about, there's a diversity of the country and
4 diversity of ideas and the fact that we would look at all of
5 these models and try to learn from them, I think would be
6 helpful. At least it would be to me.

7 But this last discussion was very interesting to
8 know where the dollars are really coming from, so I'd love
9 to hear that answer as well.

10 MR. HACKBARTH: Any particular models, again, that
11 folks want to dig deeper on? So keep that in mind as a
12 question. George, is there anyone that you want --

13 MR. GEORGE MILLER: Well, the disparity in the
14 Minnesota model I'm very interested in and will follow very,
15 very closely.

16 MR. HACKBARTH: Okay, good. Great.

17 DR. SAMITT: So, with the risk that it may appear
18 that I'm pandering to the Chairman, I'd put my money on
19 Oregon and Massachusetts as the models that I'd be
20 interested in for different reasons.

21 Oregon, mainly because the focus is on bigger
22 bundles, and I'm a believer in bigger bundles because I

1 think my experience is that innovation occurs more commonly
2 across silos and when you've got greater room to move. And
3 I think that Oregon is also very much the next generation of
4 ACO-like that we referenced yesterday as opposed to it being
5 too fee-for-service-like or, you know, and not close enough
6 to Medicare Advantage. The question is, does that create a
7 scenario that's middle of the road?

8 Massachusetts is intriguing to me because of the
9 primary care focus. It didn't go unnoticed in the materials
10 from yesterday that 12 percent of spending goes to the
11 Physician Fee Schedule, and I would imagine the component of
12 that 12 percent that is primary care is even less. The Dean
13 experience is about six percent. And other research clearly
14 shows that physicians generate a lot of the balance of the
15 remaining costs, and so I think if we can garner a clearer
16 sense of innovation and incentive at the physician level, at
17 the primary care level, I would imagine that we will reap
18 quality improvement and savings downstream.

19 So if I were to pick the two models that I'd be
20 curious to monitor, it would be Oregon and Massachusetts.

21 In terms of the multiple initiatives, I'm actually
22 less concerned about the thousand flowers blooming. I think

1 we should let them bloom. I think we should see what folks
2 can come up with when they innovate. I don't think we've
3 done enough of that in the industry or within organizations
4 and we should not suppress that. The whole notion of this
5 initiative is to encourage innovation.

6 And then I guess the bulk of my contribution
7 probably is really more in the spread category, because my
8 personal experience is very deep there. You know, we've
9 innovated in our organizations and the comments about
10 framework are very important. I think CMS should develop a
11 very sophisticated framework to evaluate these programs.

12 The way that we've gone about it is step one is
13 obviously, does the innovation work? We need some clarity
14 about how we're going to measure whether it works and we
15 need to bless and say, this grouping works.

16 But then the next step that we've followed,
17 particularly on the Dean side, is for the innovations that
18 work, which ones of them go into a tool kit that's published
19 and is available for anyone to use? So this whole voluntary
20 notion. But the other bucket are innovations that work that
21 go into a category that are mandated for everyone to use.

22 And we did the same thing. We said, these

1 innovations need to be open labeled and spread to everyone
2 and every site in our system must do it. But these are
3 very, you know, culturally sensitive or geographically
4 sensitive and they may be voluntary. But we must do a
5 better job assuring that they do work in certain settings,
6 and making sure those who would be amenable to it know that
7 it exists.

8 It's something that I referenced yesterday when we
9 talked about shared decision making. Do we know what models
10 work and have we done an effective job from CMS, Medicare,
11 or anyone else, that ensures that we spread those
12 innovations to anyone who would benefit from it?

13 So, I would encourage a more clear framework for
14 evaluating these as well as a methodology to assure that
15 spread doesn't take 17 years if we're going to share some of
16 these best practices throughout the system.

17 DR. HOADLEY: So, in your basic question about
18 sort of what the priorities might be, I kind of resonate
19 with Scott's comment, I mean, to the extent that some of
20 these can be looked at as ones that seem to fit into some of
21 the issues that staff overall thinks or we've already
22 expressed as a group that are priorities, sort of do that,

1 which is a little bit of bucking the question, but --

2 But I also think, particularly on the set of State
3 initiatives, we really should look carefully at whether some
4 of them are less applicable to Medicare and the nature of
5 how they're done, if they're much more tied into some aspect
6 of how Medicaid operates or how the State is otherwise
7 envisioning the ones that go beyond Medicaid to private
8 sector. Maybe you've already really made that cut and these
9 are ones that seem like they have applicability, but we
10 should make sure that some of them -- that they all do in
11 the ones that we might want to pursue.

12 On some of the evaluation questions, it seems to
13 me, and without knowing more detail on all the things on
14 this list, it's hard to do this, figure out what exactly
15 this cut means, but there's a difference, and several people
16 have expressed versions of this, between things that are
17 more fundamental and to disseminate further would require
18 legislation or under this authority really changing
19 something about how Medicare payment works versus things
20 that are really more kind of like we were just saying,
21 things that could be in the tool kit.

22 Mike was mentioning things that might have to do

1 with medication adherence or imaging or whatever, you know,
2 things that are smaller that aren't so much, okay, we have
3 to change based on this how Medicare does things. They just
4 may be ideas that are out there for providers or the ways to
5 address shared decision making or any of these kinds of
6 things. They're just things that providers, in general,
7 with their Medicare dollars could do, and it isn't
8 necessarily -- and so those, you know, some kind of this
9 softer evaluation that says, first of all, are they not
10 doing harm and they look like they're making more
11 information available and making the ability to disseminate
12 them is useful.

13 The ones that are kind of a step more complex or
14 more fundamental to how the rules of Medicare work, those
15 are the ones that kind of need to be treated differently.
16 So if there's some kind of a slice that can kind of divide
17 things that way, that might be helpful.

18 And I guess my only other observation is, over the
19 years under this sort of older way of doing demos, we, in
20 theory, at least, did really systematic evaluations of a lot
21 of these things and it seems to me that an awful lot of the
22 evaluations of these things, A, weren't all that timely. I

1 mean, we criticized over the years things like that. But
2 also, findings often were pretty ambiguous and we'd get
3 through and we'd say, well, you know, it feels like it does
4 some good things. It doesn't -- there's no clear evidence
5 that it saved money.

6 And so I don't know that expectations should be
7 that -- particularly with all these additional complications
8 of overlapping projects and things -- that even if we could
9 sort of line that up, we necessarily are going to get clean
10 scientific results that we all could say, okay, that's the
11 final proof we need to just change Medicare once and for
12 all. So our level of expectations has to be realistic.

13 MR. HACKBARTH: Yeah. I almost bet against being
14 clear, definitive results given all of the confounding
15 variables and size of the cells and --

16 DR. HOADLEY: So, a sense of softer kind of
17 evaluation, you know, making sure that it doesn't do harm,
18 that it feels like a good thing, and then just -- but also
19 with a transparency of all that and to the extent that it
20 can be quick gives us the ability to say, okay, here's a
21 bunch of things that have this amount of information about
22 them and let, to some extent, the world figure out which

1 ones --

2 MR. HACKBARTH: And ultimately, the success of so
3 many of the innovations is contextually dependent. It'll
4 work some places and not other places. When you do the
5 national evaluation, you average it out, the likelihood, if
6 not probability, that there's going to be nationally no
7 statistically significant effect is pretty high.

8 Peter.

9 MR. BUTLER: Four points relative to priorities,
10 the first on the gain sharing. Historically, I think this
11 is viewed as private physicians partnering with hospitals to
12 kind of make improvements and share in the results and the
13 skeptical side -- well, first of all, I think there's such a
14 decreasing number of private physicians with which to do
15 this, it's probably not a long-term scenario.

16 And, second, the ones that are still at it are
17 kind of the specialty groups that want a piece of the
18 technical component, and surgery center and imaging, and
19 their idea of gain sharing is give me some of the money that
20 you're making, and particularly for my, as George would
21 frequently say, for my commercially insured patients.

22 Now, where I think gain sharing can work, though,

1 and ought to be focused is on clinically integrated
2 physician-hospital organizations that have private employed
3 and hospitals that are truly clinically integrated and, as a
4 result, can accommodate the payment models that are the
5 higher level than the lower level gain sharing. They can be
6 an ACO. They can handle bundled payments. They have the
7 data. So that level of gain sharing, I think, is something
8 that is extremely important and going on successfully in
9 some areas.

10 Second point is I always favor Statewide
11 demonstrations versus anything that is at a lower level.
12 DRGs, I think, were successful because it was tested in New
13 Jersey, not in Hoboken or something like that. And so I
14 think, politically and otherwise, whether, Bill, it's
15 mandatory or voluntary, Statewide takes into account a
16 political unit and a diversity of applications that are more
17 likely to result in sustainable policy changes.

18 My third point is on which ones to do. Scott, you
19 mentioned blue line, purple line, and Mark, you mentioned
20 episode. So, episode is, to me, the journey from fee-for-
21 service. We've got plenty of activity on ACOs and MAs. So
22 the episode, I would reinforce as one, well, why not?

1 Nobody else is really -- maybe Arkansas isn't the right
2 exact place, but why not?

3 And, finally, the last one, on the disparities, I
4 like, not just because it's disparities but because of the
5 population health focus. So, most people think population
6 health is like ACOs or something like that, which really is
7 just managing the continuum of care for those that have
8 illness. This is the only one that I can see that actually
9 is looking at the community health measures. And when we
10 start at the beginning point and say we spend twice as much
11 in this country and we have lower life expectancy, you know,
12 this is one that gets at social determinants and the entire
13 community in a way that none of the other demonstrations do
14 because they're most -- not none, but most of the other ones
15 on payment models for those that are sick, not how do you
16 collectively improve measurement of the health of the
17 community you're serving.

18 MS. UCCELLO: In terms of where we should focus, I
19 think if we step back and think about some of the
20 overarching themes that we're interested in, two of them are
21 the ability of providers to bear risk and the ability of
22 beneficiaries to understand and respond to different

1 incentives. And I think if we -- we may be able to look
2 across these different programs and make use of the
3 variation across them to maybe provide some insights into
4 those two things.

5 DR. BAICKER: Just to follow up briefly, just
6 emphasizing what Cori was saying and what Jack and Peter
7 were saying, I'd add to Cori's list integration of payments,
8 which goes along with providers bearing risk, and those
9 things are sort of the obvious bridges to what we work on
10 regularly, and for goodness sakes, let's get as much
11 information from the States as we can.

12 But then that doesn't mean ignore all the other
13 ones. There are lots of interesting other buckets. We had
14 a discussion yesterday about shared decision making and
15 thought, like, yes, that's a really important thing, but
16 it's not something that we can necessarily generate with the
17 insurance program levers at our disposal. Maybe some State
18 figures out how to do it and we say, wow, that demonstration
19 that's promoting shared decision making actually has
20 components that we want to build into Medicare. I have no
21 reason to think that it will or won't work, but those other
22 things suggest levers that we're not looking at.

1 So there's the levers we look at in figuring out
2 how they work and there's the potential for new levers to
3 emerge.

4 MR. HACKBARTH: Just to pursue the shared decision
5 making example, so yesterday, I said what I believed, which
6 is I think Medicare has relatively limited levers to make
7 that very good thing happen. Having said that, I think it's
8 a good idea to fund local level innovations with it for the
9 reasons that Craig and others have described. It's a good
10 thing if people can learn from one another, or care delivery
11 systems can learn some ways of doing that work better than
12 others. I think it's an appropriate thing for the Federal
13 Government to fund that sort of cross-delivery system
14 learning, even if it doesn't mean that there's going to be a
15 Medicare payment policy that results from the research.

16 Mike, and then Mary.

17 DR. CHERNEW: So, my sense of this is that at the
18 big level, our job -- I apologize for this analogy -- is to
19 make the soil of Medicare fertile and hopefully the seeds
20 will grow in that without constantly being fertilized. So
21 I'm a little worried that they're constantly -- they're
22 constantly putting these things out and they only work

1 because they're paying extra, they're doing something extra.

2 It needs to grow in -- I'll be more concrete. Sorry. I've

3 had a lot of Froot Loops.

4 [Laughter.]

5 DR. MARK MILLER: You should have a flag or

6 something --

7 DR. CHERNEW: Yes, exactly. This is what you need

8 to do, Glenn. The question is, many of these will grow well

9 in an ACO, and so you learn about shared decision making.

10 You already have the structure that something will work.

11 The same is true for a vast number of these things.

12 The question is, are there things that are really

13 good that our existing big picture Medicare structures just

14 won't accommodate? And then we have to think about how to

15 change the broad big picture Medicare structures.

16 But if many of these of the thousands -- many of

17 them will do just great in the existing structures we're

18 building, and then I think we're probably going to be okay.

19 DR. NAYLOR: So, continuing the analogy -- no, I

20 won't say that.

21 [Laughter.]

22 DR. NAYLOR: I totally, totally am -- the seed has

1 been planted now.

2 DR. REDBERG: [Off microphone.]

3 DR. NAYLOR: Yeah. I think, reflecting on this
4 conversation, the extent to which the Medicare policies can
5 promote a very common theme here, which is around
6 transparency and a learning health system model. So not
7 saying what needs to happen, but making sure that people
8 know, when they get to better, that they have an
9 accountability -- maybe that is the accountability framework
10 earlier -- to share with others. And so that has been a
11 pretty -- I mean, we're trying to figure out how to be --
12 create the soil. So I think that's a really important thing
13 for us.

14 MR. HACKBARTH: Let me go sort of narrow again,
15 answering my own question about which of these things I'd
16 like to learn more about. Primary care medical home is one
17 that I'd like to learn more about. Is there any more a
18 Medicare-only medical home project, or has it all been
19 folded into the multipayer comprehensive initiative?

20 MR. RICHARDSON: I think it's been folded in, but
21 I'm -- we'll find out.

22 MR. HACKBARTH: What did you say, Mary?

1 DR. NAYLOR: [Off microphone.] I thought the
2 advanced primary care included -- are you talking about
3 Medicare-only?

4 MR. HACKBARTH: Only, yes. And the reason that I
5 asked that is that under this rubric that's been created,
6 where we test things and the Secretary has the authority to
7 make them happen if they work, if there's not a Medicare-
8 only, you know, what's being tested is what happens when
9 multiple payers do it, so how does the Secretary and the
10 actuary estimate the effect of Medicare alone doing it? So
11 that's a question that I have.

12 A second aspect of this for me is that my hunch,
13 and I may be wrong, but my hunch is that it's unlikely that
14 medical home will be found to have a significant cost
15 reducing effect. I hope I'm wrong about that, but that
16 would be my guess. And in part, I think it's for what we
17 were discussing with Jack. It'll work some places and it
18 won't work others, and when you average it all together,
19 you'll find no significant effect.

20 So you do medical home at Puget Sound, or you do
21 medical home in Geisinger, you have one set of impacts. You
22 drop medical home down into America's most fragmented care

1 delivery system with a real extreme imbalance of providers,
2 you'll get a completely different set of effects. And mush
3 those together and do an average and say, oh, it works or it
4 doesn't, I think is just a conceptually flawed approach to
5 trying to figure out whether this is good policy or not.

6 And I think even if medical home does not save
7 money when you mush all this stuff together and average it
8 out, it still may be good policy if it's successful in
9 improving care coordination for beneficiaries, if it manages
10 to extend further our limited primary care resources by
11 providing more supports to those practices so they can
12 handle more patients. We need to do that, given the
13 imbalance that we have in primary care. So it may be
14 wonderful policy even if it does not meet that cost test.
15 And, oh, by the way, if we're doing all multipayer demos, we
16 may not know the answer to the cost test for Medicare alone.

17 The bottom line is my fear, and I'm willing to be
18 corrected, we're on the fast track to nowhere in terms of
19 making a decision about whether medical home is a good idea
20 for Medicare alone. And this sort of goes with my tirade
21 about bundling around missions. We dump things into CMMI.
22 We don't think about what we're trying to find out, what

1 we're trying to do, and it becomes sort of the death loop.
2 You go onto the demo track, never to appear again, and that
3 troubles me.

4 Any final --

5 MR. BUTLER: One comment. If the purpose of this
6 is to develop demonstrations that ultimately end up in
7 policy, I understand the value. If it, as you said, also
8 has this benefit of providers and others sharing with each
9 other so they can improve, I wouldn't spend Federal dollars
10 doing that. We don't have the time, nor would we go to
11 these projects as a source of -- because, like your medical
12 home, it's going to be three years from now. We go to -- if
13 you've got money to burn, let's go with Institute for Health
14 Care Improvement or let's go with -- or let's we create our
15 own networks to do real-time stuff and find out what's
16 working now, not two years from now when these things may
17 limp along. So do it for policy, but don't do it just as a
18 way for us to learn from each other so we can improve. I
19 don't think that that's a good purpose of this, my own
20 feeling.

21 DR. SAMITT: The only other thing I would is that,
22 you know, we shouldn't just look at CMMI demonstration

1 projects to find innovation. We need to cross the transom
2 and look on the commercial side and say, maybe there are
3 examples where private industry is innovating in its own
4 right, a lot of which of these innovations are applicable to
5 Medicare and Medicaid, as well. And so instead of investing
6 a lot in new demonstrations that are Medicare-specific or
7 just government payer, let's broaden our acceptance and view
8 of innovation to many other sectors and see if some of those
9 are also applicable to go into the tool kits we described
10 earlier.

11 MR. HACKBARTH: At a minimum, maybe it would be
12 useful for CMMI to say, you know, here are the projects that
13 are aimed at changes in Medicare, testing changes in
14 Medicare policy, here are others that are designed to
15 promote innovation in care delivery, and say, what is the
16 appropriate allocation of resources between these two broad
17 purposes? And maybe that second category of those designed
18 to spawn innovation in care delivery, we ought to think
19 about having established partners like IHI and others to
20 work with as opposed to going off on their own and trying to
21 reinvent that wheel.

22 Okay. Thank you, John and Lauren. Well done.

1 [Pause.]

2 MR. HACKBARTH: Christine, you can start whenever
3 you're ready.

4 MS. AGUIAR: Good morning. Today, Carlos and I
5 will update you on the CMS financial alignment demonstration
6 for dual eligible beneficiaries. As a reminder, the
7 Commission last discussed the demonstration in April 2012
8 and submitted a comment letter to CMS regarding the
9 demonstration in July 2012.

10 Today's presentation will start with background on
11 the demonstration, followed by an overview of the states
12 that are progressing towards implementation. Next, I will
13 discuss how elements of the demonstration align with the
14 Commission's comment letter. Then I'll go over the main
15 reasons why some states have decided to no longer
16 participate in the demonstration and why there is renewed
17 interest among states in dual eligible special needs plans,
18 or D-SNPs. Finally, Carlos will discuss the main
19 similarities and differences between the demonstration and
20 the Medicare Advantage program.

21 Let's begin with some background information. As
22 you know, dual eligibles are a diverse population and

1 require a mix of medical care, long-term care services and
2 supports, and behavioral health services. This is a
3 population that can benefit from coordination of care, and
4 the Commission has been assessing ways to improve care
5 coordination for these beneficiaries over the past few
6 years.

7 From the perspective of improving care
8 coordination for dual eligibles, the Medicare and Medicaid
9 Coordination Office at CMS announced the financial alignment
10 demonstration in 2011. The purpose is for states to develop
11 integrated care programs for full-benefit, dual-eligible
12 beneficiaries. States can implement a capitated model, a
13 managed Fee-for-Service model or both.

14 Under the capitated model, a health plan receives
15 Medicare and Medicaid capitation payments. The plan payment
16 rates will be set below expected Medicare and Medicaid
17 spending in order to provide for up-front savings to both
18 programs.

19 The managed Fee-for-Service model maintains
20 Medicare Fee-for-Service. States finance a care
21 coordination program and can receive a retrospective payment
22 if the program meets quality thresholds and results in

1 Medicare savings.

2 This slide describes the states that are
3 implementing the demonstration. I apologize for the small
4 font on the slide, but this is important information we
5 wanted to share with you all.

6 In order to participate in the demonstration,
7 states first had to submit a proposal to CMS. Twenty-six
8 states submitted proposals.

9 The next stage is for CMS and the state to sign a
10 memorandum of understanding, or MOU. The states on this
11 slide are the seven states that, to date, have signed an
12 MOU.

13 As you can see in the second column on the table,
14 six of these states are implementing the capitated model
15 while Washington is the only state with an MOU for the
16 managed Fee-for-Service model.

17 As you see in the last column on the slide,
18 Washington's program began on July 1st, 2013. The other
19 demonstrations are expected to begin in Fall 2013 or 2014.

20 Most demonstrations will begin with a three-month
21 opt-in enrollment period that is followed by a period of
22 passive enrollment. During opt-in enrollment, eligible

1 beneficiaries can choose to enroll in the demonstration.
2 During passive enrollment, eligible beneficiaries that have
3 not yet enrolled will be automatically enrolled into the
4 demonstration and assigned to a plan.

5 The start dates for some of the demonstrations
6 have been delayed. For example, California's MOU stated an
7 October 1st, 2013 start date, but the demonstration is
8 delayed until April 2014.

9 In the July 2012 comment letter to CMS, the
10 Commission commented on the 5 aspects of the demonstration
11 that are listed on this slide. Over the next few slides, I
12 will describe how the MOUs align with the Commission's
13 comments on these aspects.

14 We'll start with the scope of the demonstration.
15 Most of the 26 states proposals included enrollment of the
16 majority or entire subgroups of dual eligibles in the state
17 into the demonstration.

18 The Commission commented that the scope of the
19 demonstration was too broad and represented a program change
20 because approximately three million dual eligibles would be
21 enrolled in the demonstration if CMS approved every state's
22 proposal. The Commission encouraged CMS to reduce the

1 scope.

2 As you can see on this slide, estimated enrollment
3 across the seven states could reach over one million. Note
4 that California had initially proposed to enroll up to one
5 million dual eligibles but reduced the scope to about
6 456,000.

7 There are still 12 active state proposals that
8 have not yet progressed to a signed MOU. As you see in the
9 last row on the table, close to 900,000 beneficiaries are
10 eligible to enroll across these 12 states.

11 If every state with an active proposal proceeds to
12 implementation without reducing its scope, total enrollment
13 in the demonstration could reach close to two million.

14 With respect to passive enrollment, CMS's proposed
15 design for the capitated model included a passive enrollment
16 strategy with opt-out. The Commission expressed support for
17 the use of passive enrollment as long as certain beneficiary
18 protections were included.

19 There is precedence for passive enrollment in the
20 Medicare program because it is already used for the low-
21 income subsidy population under Part D. The passive
22 enrollment features, which are listed on this slide, are

1 consistent across all MOUs and align well with the
2 Commission's comments. For example, beneficiaries will be
3 notified of the demonstration 60 or 90 days prior to passive
4 enrollment and can opt out both before and after enrollment.

5 Moving on now to plan requirements, the Commission
6 suggested that MA, or Medicare Advantage, requirements
7 represent the minimum standard in order to provide a
8 baseline standard of requirements for the demonstration
9 plans. Consistent with the Commission's suggestion, the
10 MOUs indicate the MA requirements do represent a minimum
11 standard for most plan requirements.

12 The Commission also raised concerns about the
13 potential destabilization of the Part D market, given that a
14 large number of dual eligibles will be enrolled in the
15 demonstration and demonstration plans will not submit Part D
16 bids. CMS indicated that it does not expect treatment of
17 Part D under the demonstration to have a major effect on
18 beneficiaries but that it will closely monitor any effects.

19 For monitoring and evaluation, the Commission
20 emphasized the importance of collecting consistent quality
21 measures across all demonstrations in order to evaluate and
22 monitor the demonstration. The MOUs were largely in

1 agreement with these comments. CMS will collect a core set
2 of quality measures across all demonstrations and will fund
3 an external evaluation of the demonstration.

4 Turning now to program costs and savings, there is
5 more detail on this topic in your mailing materials, but in
6 the interest of time I will focus on the methodology for
7 estimating savings on this side and the methodology for
8 developing baseline spending on the next slide.

9 With respect to estimating savings, the Commission
10 stated that CMS should estimate savings separately from
11 Medicare and Medicaid and then adjust each program's
12 capitation rates based on these estimates. This would be an
13 equitable way to allocate savings since savings are more
14 likely to come from one program or the other.

15 The Commission also encouraged CMS to develop
16 realistic savings estimates so that plan capitation rates
17 neither exceed nor are below the cost of care.

18 The methodology for estimating savings in the MOUs
19 is largely unchanged from CMS's original proposal. CMS will
20 develop a combined Medicare and Medicaid savings estimate,
21 and both Medicare and Medicaid capitation rates will be
22 reduced by the same savings estimate.

1 The savings estimates for each state are listed on
2 this slide. Note that the savings estimates are generally 1
3 percent for the first year of the demonstration and increase
4 each year.

5 With respect to estimating Medicare and Medicaid
6 spending absent the demonstration, the Medicare baseline
7 will be a mix of Fee-for-Service and MA spending based on
8 CMS's assumptions of whether beneficiaries would have been
9 enrolled in Fee-for-Service or MA absent the demonstration.

10 The Commission commented that the quality bonus
11 payments made to MA plans below four stars under CMS's
12 demonstration authority should not be included in the
13 baseline. The Commission has strongly objected to CMS's use
14 of its demonstration authority to make unilateral changes in
15 payment rates, and including the bonus payments in the
16 baseline would institutionalize these payments. However, as
17 we understand, the bonus payments will be included in the
18 baseline in addition to the statutory bonus payments made to
19 four and five-star plans.

20 Moving on now, a number of states are no longer
21 participating in the demonstration. Three states --
22 Arizona, New Mexico and Tennessee -- formally withdrew.

1 Three other states -- Minnesota, Wisconsin and Oregon -- are
2 still working with CMS on programs for dual eligibles but
3 under different demonstration authority. Hawaii is no
4 longer working on the demonstration but may do so after
5 2014. All of these states had submitted proposals to
6 implement the capitated model.

7 We interviewed state representatives, health plan
8 representatives and other stakeholders to better understand
9 why some states decided not to participate. The main
10 reasons the stakeholders cited are listed on this slide.

11 For one, up-front savings may not be achievable in
12 every state, and the removal of the up-front savings and the
13 quality withholds may not leave plans with enough funding to
14 address unmet need.

15 Second, if D-SNPs are paid higher than
16 demonstration plans because up-front savings and quality
17 withholds are not removed from the D-SNP rates, D-SNPs could
18 compete with demonstration plans for enrollees by offering
19 more attractive supplemental benefits.

20 Third, the demonstration focuses solely on dual
21 eligibles, and states may prefer to make delivery system
22 changes for the entire long-term care population.

1 Fourth, there has been less flexibility than
2 originally thought for states to customize the demonstration
3 to align with their individual Medicaid programs.

4 Finally, the timing of the demonstration can
5 conflict with other state priorities and changes to their
6 Medicaid programs.

7 Recently, momentum has developed among some states
8 to pursue integration through D-SNPs. The stakeholders we
9 interviewed stated that the D-SNP program may be preferable
10 to states because, unlike the financial alignment
11 demonstration, up-front savings and quality withholds are
12 not removed from D-SNP payment rates. They also reported
13 that there is more uncertainty among some stakeholders over
14 the future of the demonstration than over the
15 reauthorization of D-SNPs.

16 The stakeholders we interviewed generally agreed
17 with the Commission's 2013 recommendations to Congress on D-
18 SNPs. Changes that extend beyond the Commission's
19 recommendations include consolidating Medicare and Medicaid
20 reporting requirements, giving states a greater role in the
21 D-SNP selection process and implementing a transition period
22 to enable states to work with D-SNPs to incrementally become

1 more integrated.

2 The National Association of Medicaid Directors is
3 currently working with states to identify legislative and
4 regulatory changes to D-SNPs that would improve Medicare and
5 Medicaid integration.

6 Carlos will now compare the requirements for the
7 demonstration and the MA program.

8 MR. ZARABOZO: In the next two slides, we will
9 review the major differences and similarities between the
10 demonstration plans and contracts under the Medicare
11 Advantage, or MA, program. The major differences are in the
12 area of plan payments, how enrollment generally occurs and
13 what additional requirements are being imposed.

14 With regard to payment, the demonstration plans
15 will not submit bids for Medicare Part A and Part B
16 benefits. In MA, plans bid against an area benchmark, and
17 the bids determine how much a plan will be paid, any premium
18 the plan would charge and the extra benefits the plans are
19 able to offer.

20 In the demonstrations, plans will receive a
21 capitated per-member per-month payment based on the cost
22 that CMS projects that the Medicare program would have

1 incurred absent the demonstration.

2 So it would be a combination of projected Fee-
3 for-Service expenditures and all projected MA payments, as
4 Christine discussed.

5 Once the basic capitation rate is set, the savings
6 percentage is then deducted up front, and there is an
7 additional withhold of payments that can be returned to
8 plans if they meet quality targets.

9 Some states are also including risk corridor
10 arrangements whereby Medicare and Medicaid will share in the
11 losses and gains of plans.

12 The demonstration plans will not have Part D bids
13 but will be paid the national average bid amount plus a
14 monthly estimated payment for the low-income cost-sharing
15 and reinsurance subsidy amounts. As Christine discussed,
16 the Commission expressed concern over the possible
17 destabilization effect in the Part D market by the absence
18 of bids.

19 In addition to the Medicare capitation payments,
20 Medicaid will be making capitation payments to the plans
21 which will cover the costs of Medicaid services as well as
22 providing revenue for cost-sharing associated with Medicare-

1 covered services. Some states will also require plans to
2 offer additional benefits not covered by Medicaid.

3 The two other major aspects of the demonstration
4 that differ from MA are enrollment rules and reporting
5 requirements.

6 Although it is common for MA plans to obtain
7 enrollment through insurance agents and brokers who receive
8 commissions, some states will require that all enrollment be
9 through an independent third party.

10 Another difference is that the demonstration plans
11 will be meeting some additional requirements, including the
12 need to report additional quality data that will determine
13 whether or not they are entitled to receive quality withhold
14 amounts. The measures that must be reported for this
15 purpose will vary from state to state.

16 There are a number of features that are common to
17 both the demonstration plans and Medicare Advantage though
18 some of the features are common only up to a point.

19 Plan payments will be risk-adjusted based on the
20 risk scores of individual enrollees as in MA and in Part D.

21 It is currently the case that in MA low-income
22 beneficiaries can enroll in or drop out of plans on a

1 monthly basis. This is also the case for demonstration
2 plans.

3 In any Medicare Advantage plan, the plan is
4 prohibited from charging cost-sharing for Medicare-covered
5 services to dually eligible beneficiaries or qualified
6 Medicare beneficiaries or who otherwise have Medicare cost-
7 sharing covered under Medicaid.

8 MA plans can have premiums which beneficiaries
9 would be expected to pay. The demonstration plans are not
10 permitted to charge any premium for the Medicare Part A and
11 Part B benefit package or for Part D.

12 In MA, beneficiaries may pay Part D premiums that
13 vary depending on where the plan's bid is in relation to the
14 national average bid and whether the beneficiary can receive
15 the low-income premium subsidy.

16 We should also note that in 2013 the vast majority
17 of Medicare beneficiaries have access to an MA plan with no
18 premium that includes Part D drug coverage because plans are
19 using the Part A and Part B rebate dollars to reduce the
20 Part D premium.

21 As Christine mentioned, demonstration plans will
22 generally be required to comply with all MA contract rules,

1 which includes the reporting of encounter data and
2 compliance with the new minimum medical loss ratio
3 requirements, except that CMS has informed us that the loss
4 ratio requirements will not be applied in the two states
5 that have risk corridors -- Massachusetts and California.

6 In summary, the purpose of today's presentation
7 was to update you on the status of the financial alignment
8 demonstration.

9 In terms of next steps and additional work on the
10 subject of dual eligibles, possible work would include
11 exploring additional ways of improving the care for dual-
12 eligible beneficiaries through special needs plans or D-
13 SNPs.

14 Related to the discussion the Commission had
15 yesterday about a level playing field between ACOs, Fee-for-
16 Service and Medicare Advantage, the financial alignment
17 model is another capitated model with payment benchmarks and
18 payment rules that differ from the existing Medicare
19 Advantage capitated model.

20 Also related to this work is an issue that arises
21 in connection with the Commission's discussions of
22 redesigning the Medicare benefit package. If a redesigned

1 benefit package includes an out-of-pocket maximum for
2 beneficiary cost-sharing but with a higher initial
3 deductible, then such a design raises a concern as to
4 whether there should be additional financial support for
5 low-income individuals beyond what currently exists in the
6 Medicare savings program.

7 Thank you, and we look forward to your discussion.

8 MR. HACKBARTH: Okay. Thank you, Christine and
9 Carlos.

10 Any clarifying questions?

11 MS. UCCELLO: In the mailing materials, it was
12 mentioned -- Massachusetts's high-cost risk pool. Is that a
13 reinsurance program?

14 MR. ZARABOZO: They have a high-cost risk pool for
15 two Medicaid categories. They have the people who are
16 institutionalized and high-cost community dwelling. And
17 what happens there is that there's a withhold from the
18 capitation, and then it is distributed among the plans.

19 So it's sort of internal just to those two
20 particular risk categories. Within the plan, there's a
21 redistribution of the dollars based on the cost for those
22 two categories of people.

1 DR. HOADLEY: You said on slide 13 that there's
2 uncertainty about the future of the demonstration, more so
3 than the reauthorization of D-SNPs, but I just wanted to
4 remember. The D-SNPs currently will expire; is that right?

5 MS. AGUIAR: Yes, by the end of 2014.

6 And I would -- you know, in the paper, I believe
7 that we caveated this section with saying this is what we
8 heard from the stakeholders --

9 DR. HOADLEY: Right, right.

10 MS. AGUIAR: -- that were involved in states that
11 decided not to pursue but that there obviously are states
12 that are going ahead with it that don't have these concerns.

13 One of the issues we did hear from those
14 stakeholders that were involved in the states that decided
15 not to pursue the demonstration was that there was a sense,
16 a growing sense, that D-SNPs will continue to be
17 reauthorized, whether permanently -- certain ones,
18 permanently -- as the Commission recommended. And there was
19 more uncertainty about the future of the demonstration.

20 But, again, we just caution that that is among the
21 few stakeholders that we spoke with.

22 DR. HOADLEY: Okay.

1 DR. NERENZ: On slide 3, just to clarify, when you
2 distinguish the two models -- the capitated and the Fee-for-
3 Service -- the capitated means that the payment from CMS
4 goes to a qualified managed care plan in the form of
5 capitation. But, just to clarify, it does not mean that
6 payment from the plan to providers is capitated. Is that
7 correct?

8 MR. ZARABOZO: That's correct. Internally, within
9 the plan, they can have whatever payment arrangements they
10 wish to have.

11 DR. NERENZ: And of those that are active or have
12 MOUs signed, do you know anything about what the pattern of
13 those payment arrangements looks like, or is there no
14 pattern?

15 MS. AGUIAR: What we have learned -- and we
16 haven't spoken to all of them to see whether or not there
17 was a pattern. The way that the demonstration was rolled
18 out is that what we heard from the plans that wanted to
19 participate in the demonstration; they had to build their
20 provider networks and negotiate their provider rates with
21 those networks before the plans themselves knew what the
22 final rates they would be getting from Medicare and Medicaid

1 were.

2 So, from the plans that we spoke with, they were
3 planning to pay Medicare payment rates for Medicare
4 services.

5 DR. NERENZ: Okay. Well, that was actually going
6 to be one of my specific questions because, theoretically,
7 if you're blending two payment streams and you ask about how
8 plans are going to pay providers, they could pay Medicare
9 rates or they could pay Medicaid rates or they could do
10 something else.

11 MS. AGUIAR: Right. Again, from the plans that we
12 had spoken with that were involved in the demonstration
13 starting up, at least for the first year, their plan was to
14 get their networks and to pay the Medicare providers based
15 on the Medicare rates.

16 MR. HACKBARTH: But my understanding from the
17 written material was that only Massachusetts, of the states
18 using the capitated model, has gone far enough to really
19 find out how many plans will actually participate. And what
20 they found is that some of the ones who previously expressed
21 interest backed out, and they only have three plans
22 statewide. Is that right?

1 MS. AGUIAR: Yes, that is correct. Massachusetts
2 is the only state.

3 So, as I believe I had explained earlier, the
4 steps are the proposal which was 26 states, then the MOUs
5 which are 7 states and then the 3-way contract which is
6 signed between the state, CMS and the health plans.

7 Massachusetts is the only state so far that has
8 progressed to the three-way contract. And when that
9 contract was signed, three of the states -- three plans --
10 that originally were going to participate in the
11 demonstration withdrew.

12 MR. HACKBARTH: Right. Okay.

13 Other clarifying questions?

14 [No response.]

15 MR. HACKBARTH: Who wants to go first? Alice, do
16 you want to go first?

17 DR. COOMBS: Thank you very much. I found this
18 very interesting.

19 One of the things that you talked about just in
20 the paper specifically was dealing with a deterrent for why
21 some of the states withdrew and some of the states lost
22 interest. And you mentioned the advent of the ACA and how

1 that would influence states' decisions whether or not to
2 engage in the demonstrations. And I was looking at the ones
3 that whittled down to the seven, and can you say something
4 about the federal matching and whether or not the percentage
5 of the Medicaid penetration in the various states based on
6 the benchmark of the federal poverty level had an influence
7 on the decisions in these states.

8 MS. AGUIAR: I can't say whether or not that was a
9 reason. From our conversation with the State reports and
10 also from the letters that the states that formally withdrew
11 that they had sent to CMS. What they indicated is that
12 between, you know, preparing themselves for health care
13 reform and also for other state priorities, they had too
14 many resources, and they were unable to devote that to this
15 demonstration. But that level of detail was not in any of
16 our research.

17 DR. COOMBS: So early on Massachusetts was very
18 concerned about the cost shifting as to Medicaid and
19 Medicare -- the dual eligible and how that would work out.
20 And, conceivably, the formula based on the baseline from
21 what we read in the paper will justify both entities since
22 it would be -- you would incentivize the network to continue

1 to care for these patients in terms of that agreement. And
2 how they work the baseline I guess is really the important
3 piece of this.

4 MS. AGUIAR: Yes, I think so. And to use
5 Massachusetts as an example, that is my understanding.
6 Massachusetts does already have an integrated care program.
7 It's called the Senior Care Options, the SCO program. It's
8 very well known, and that is for the 65-plus dual eligibles.
9 They didn't have a program for the under-65, which is what
10 this demonstration would be for. And so, you know, my sense
11 was they worked very closely with CMS to really try to
12 determine what the baseline was, what the expected savings
13 could be off that baseline, and then what the plan rates
14 could be.

15 You know, as we talked about earlier with Glenn,
16 obviously there were three health plans that felt that they
17 weren't able to continue to pursue within this
18 demonstration.

19 DR. COOMBS: And I guess, lastly, we probably
20 should look and see if we can draw some conclusions about
21 the penetration of D-SNPs and correlation with the
22 demonstration states.

1 MS. AGUIAR: Yes, I guess we can answer that
2 somewhat informally. Again, the states that -- and, again,
3 I keep caveat'ing with this is what we heard from the
4 stakeholders that we spoke with, so I don't want to say this
5 is exactly the rationale from every single state, but from
6 what we heard. You know, when you think about it, three of
7 the states that formally withdrew -- so Arizona, again, has
8 had an integrated care program for duals for years, has high
9 Medicaid managed care and MA penetration there. The same
10 thing with Minnesota, and the same thing with New Mexico.
11 And so it does -- from what we heard, that was one of the
12 concerns about those states because if you were starting
13 this demonstration and the payment rates to the plans have
14 up-front savings and quality withholds removed from them and
15 most of your enrollees are likely to come from a D-SNP, an
16 MA plan, or from a Medicaid managed care plan, that means
17 that those health plans will be operating under payment
18 rates that are less than what they receive now.

19 In the instance of Massachusetts, with the under-
20 65, most of those beneficiaries are expected to come from
21 fee-for-service. So there was less of that concern.

22 So that was, again, one of the concerns that we

1 heard from the stakeholders.

2 MR. HACKBARTH: Are you at liberty to say which
3 three plans in Massachusetts are participating?

4 MS. AGUIAR: We are at liberty. I think it is
5 public. I don't have all of them off the top of my head. I
6 believe one is Network Health or Fallon? Do you remember?

7 MR. ZARABOZO: [off microphone].

8 MS. AGUIAR: One of them I believe is Network
9 Health, but we could get back to you with that.

10 MR. HACKBARTH: Okay. As we go through round two,
11 would you put your questions, your final slide up? So the
12 principal purpose here was to provide an update on an issue
13 that we've spent a lot of time on in the last several years.
14 But I would like Commissioner input on whether we should go
15 back into the D-SNP issue. You'll recall that we looked at
16 this as part of a congressional mandate, whether to
17 reauthorize or not in the last cycle. And so the question
18 is: Should we revisit? There are always issues, new
19 issues, new opportunities that come up, but where does this
20 fit on your register of things for us to do? It is not on
21 the work plan that we've discussed with you for the year to
22 this point, so this would be a new addition to that.

1 MR. ARMSTRONG: I don't have a question, though to
2 your question on our work plan, I don't have a strong
3 opinion. But this has always been a population that we
4 really struggle with, and they need a lot of care. They
5 consume a lot of our resources, and we could do a better job
6 of, you know, creating the kind of alignment we're trying to
7 create through this work.

8 Having said all that, though, I think we've put
9 into motion a lot we should be paying attention to, and I'm
10 not sure that I would prioritize teeing up much more work on
11 this beyond what otherwise would be the role we planned,
12 which is monitoring the progress of these demonstrations.

13 MR. HACKBARTH: I should mention that the last
14 item, related work, which is sort of tangentially related to
15 this, may be more closely related to benefit redesign. That
16 is on our current work plan, to look more at the low-income
17 supports.

18 MR. GRADISON: I agree with Scott. I don't see
19 that this changes anything in terms of the input to our
20 earlier recommendations. Others may feel differently and
21 could talk me out of that, but I don't see anything from
22 what we are learning here that, had we known it, would have

1 changed what we recommended. At least that's my read.

2 DR. HALL: I was looking for some evidence that
3 this might shed light on better ways of patient engagement.
4 Do you have any information on that as one saving feature of
5 this?

6 MS. AGUIAR: On whether or not the demonstrations
7 might shed light on it?

8 DR. HALL: Yes.

9 MS. AGUIAR: The demonstrations are still so much
10 in the beginning implementation phase, and, again,
11 Washington's managed fee-for-service program began in July.
12 Massachusetts' program is beginning enrollment now. So we
13 don't yet have, I believe, enough experience.

14 I know that in the MOUs and then in the three-way
15 contracts, there are information and the expectations of
16 patient involvement. But whether or not -- how those are
17 actually functioning, it's too early to tell.

18 DR. HALL: So it sounds like it's passive
19 enrollment, but there is some notification a month or two
20 ahead of time.

21 MS. AGUIAR: Yes, exactly.

22 DR. HALL: And that notification says, by the way,

1 we'd like to put you into this plan, or --

2 MS. AGUIAR: No, so all of the demonstrations are
3 beginning with an opt-in or voluntary phase-in portion.

4 DR. HALL: Yeah, right.

5 MS. AGUIAR: And I believe that the notifications
6 say, you know, here's this demonstration, if you care to --
7 if you want to enroll, you know, you are able to do so. And
8 then that there's -- I'm not sure if it's an exact same
9 document or if there's a subsequent document that comes out
10 about 60 days before passive enrollment that says we will
11 passively enroll you into this demonstration plan unless you
12 choose a plan or unless you opt out.

13 DR. HALL: Okay. Thank you.

14 MR. GEORGE MILLER: Very briefly, great chapter.
15 I really appreciate the information, and it helped me
16 understand this population better, something we have a
17 strong interest in. However, with the Chairman's statement,
18 I believe we have enough to say grace over, and I would not
19 suggest we do anything more.

20 DR. SAMITT: Thanks for the presentation. Very
21 clear.

22 It strikes me that the demonstration projects and

1 the D-SNPs are actually complementary. It goes back to our
2 discussion about ACO, that it encourages different avenues
3 to develop a coordinated care model for duals, and so I
4 would echo what others have said. I don't see a reason to
5 re-evaluate D-SNPs. I think we should let them flourish,
6 both they and the demonstration projects, and see where it
7 brings us.

8 DR. HOADLEY: I, too, would say I don't think we
9 need to sort of revisit what we did on the D-SNPs. And I
10 think overall we're sort of at the right level of attention
11 here. I mean, I think this was really useful, and, you
12 know, if we anticipated another kind of an update like that
13 -- you know, I don't know if it's a year from now or when,
14 but you guys can figure that part out. And I think, you
15 know, the monitoring -- and I don't know on some of these --
16 a couple of these things I'll mention, I'm probably really
17 saying what CMS should be monitoring and we should be
18 monitoring to make sure they're monitoring. But, I mean,
19 some of the things that you raised that are not down at the
20 level of the program evaluation but sort of the shorter
21 term, you know, as the states move forward from the MOUs to
22 the contracts, you know, where do they suddenly make little

1 changes. And you noted the one example that Massachusetts
2 had not provided details on how they were going to do their
3 intelligent assignment approach that was supposed to have
4 come in that next step.

5 You know, I think the issues that I'm concerned
6 about is similar to the comments I made on the ACOs
7 yesterday and a couple of other people just have mentioned.
8 Are beneficiaries aware? How do they understand and process
9 that initial letter that says they have a choice to opt in?
10 And how many really do opt in? You know, when it gets to
11 passive enrollment, you know, do they understand what's
12 going on, or are there problems because of that? To the
13 extent that intelligent assignment is used, you know, how is
14 it used? When is it used? And how does that work? That
15 would be something we could take some examples from for
16 potential use in Part D assignment issues.

17 So, I mean, I think there are just some
18 interesting things that hopefully CMS will be monitoring and
19 we can continue to keep track of.

20 MR. BUTLER: We talk about CMS' ability to handle
21 all they have. We haven't talked as much about the states
22 and what's on their agenda. So, George, I think you

1 mentioned enough to say grace over. I think a lot of states
2 are -- Illinois has already bitten off more than they can
3 chew. They're into their meal. And you've got state
4 exchanges. You've got Medicaid expansion overall. And then
5 you layer on these things. So analysis, no. Monitoring
6 with a capital M, yes.

7 MS. UCCELLO: I agree with what others have said.
8 I just want to touch base with you again about the
9 Massachusetts risk corridor. If you just happen to find out
10 any information about why those corridors were structured
11 the way they were, which is in a way that I would not define
12 as risk corridors, just I would appreciate you letting me
13 know.

14 And just to explicitly confirm support for looking
15 into more cost-sharing assistance for near-poor, not only in
16 the context of benefit redesign but also the ACO cost-
17 sharing discussion we had yesterday.

18 DR. NERENZ: In Michigan, as this program gets
19 discussed, I would -- my own impression is that most of the
20 concerns being expressed have to do with the Medicaid side
21 of this, not the Medicare side of this, and that is, what
22 will happen to long-term care services, community support

1 services, in a model where entities that have been more
2 familiar with Medicare payment step in and become
3 responsible?

4 With that in mind, has there been activity on this
5 program from our counterpart commission focusing on Medicaid
6 issues? Have they issued a report? Are you in touch with
7 them? Because conceivably this is an area where both
8 commissions would have perhaps converging interest.

9 MR. HACKBARTH: So let me address part of that,
10 and then I'll defer to you folks for more detail. We have,
11 in fact, talked with MACPAC, the Medicaid/Chip Commission.
12 I think I've gone on two separate occasions to meet with
13 them on this topic, and I don't know, have you done it
14 separately as well?

15 DR. MARK MILLER: I've been with you [off
16 microphone].

17 MR. HACKBARTH: Yeah, okay. He's been with me.
18 Funny, I didn't see you there. I kept looking.

19 [Laughter.]

20 MR. HACKBARTH: So we have had both that sort of
21 formal interaction, and there has been considerable
22 interaction at the staff level as well.

1 DR. MARK MILLER: Apparently I didn't make much of
2 an impression when I went.

3 [Laughter.]

4 DR. MARK MILLER: That's okay. So we talk to the
5 other commission on issues frequently, and we always talk
6 before our respective meetings on what issues are going on.
7 So on the dual eligibles, generally we've been talking about
8 -- talking to them, and as Jim mentioned yesterday, we have
9 data set work going with them on duals.

10 On this, my understanding is that they're also
11 keeping track of it, but they haven't come out and said I am
12 going to, you know, speak to it at this point. That's my
13 sense.

14 MS. AGUIAR: I will just add, when -- so our
15 Commission, we first discussed this issue in April of 2012,
16 and MACPAC also had one, if not at least two sessions, I
17 believe, of their commission sessions on the demonstrations
18 as well, and then as Mark said, that they're continually
19 updating their Commissioners on it.

20 MR. HACKBARTH: I'm at least tentatively scheduled
21 to go to the MACPAC Commission meeting on October 18th, and
22 I'm sure this will be a subject for discussion.

1 DR. MARK MILLER: Did you want me to go with you
2 [off microphone]?

3 [Laughter.]

4 DR. NAYLOR: I'm always following these comments.
5 I am struck -- beautiful report, and I'm struck by the
6 common-ground challenges and evaluation especially as these
7 states are deciding to take all comers in the demos. And I
8 would echo all that my colleagues ahead have said. To the
9 extent that any of the existing demos focus specifically on
10 dual eligibles and especially the diversity among the dual-
11 eligible populations, to the extent that they can help us in
12 understanding what are really common-ground issues that you
13 brought up so beautifully in earlier work around beneficiary
14 engagement and critical importance of care coordination,
15 financial integration. That I think could be helpful. So I
16 don't know if it's just monitoring or really, really helping
17 us to target those demos. I think -- because I do recall
18 that one of the challenges is building the capacity of the
19 health plans to be able to take on more and more through a
20 D-SNP process.

21 So I think that we could learn a great deal
22 because I do know that some of these demos, either in

1 advanced primary care or some of the demo issues themselves
2 or the innovations are focused on this population. And I
3 think it's really important for us to continue to grow in
4 our capacity to understand how to do that better.

5 DR. CHERNEW: I have a few points.

6 The first one is we've had a lot of sessions about
7 the in efficiencies that arise because of a lack of
8 coordination between Medicare and Medicaid. So, broadly
9 speaking, I'm thrilled to see this type of activity going
10 on.

11 My first sort of answer to the question is I agree
12 with everyone, I wouldn't go back and revisit D-SNPs. I do
13 think it's worth spending some time trying to look at sort
14 of what I'll call broadly the level playing field question,
15 but really I'm interested in how it fits in with some of the
16 other programs, how these demos fit in with things like
17 ACOs. My understanding of the question, if I know from --
18 if I remember from the mailing materials, if you're in an
19 ACO, you can't be in this.

20 MS. AGUIAR: If beneficiaries have already been
21 assigned or attributed to an ACO, they will not be removed
22 from that ACO in order to be assigned or attributed to this

1 demonstration.

2 DR. CHERNEW: And so in Massachusetts there's a
3 lot of ACOs. Do we know things, for example, like how many
4 people are going to be pulled out of this demonstration and
5 put in the ACO?

6 MS. AGUIAR: Well, no, the way that I believe it
7 works is if the ACO in Massachusetts are already in
8 existence and they already have some dual eligibles --
9 again, this is just the under-65 population -- attributed to
10 them, those beneficiaries stay with that ACO. All other
11 dual-eligible -- all of the other eligible population can
12 either voluntarily enroll, and if they don't they will be
13 passively enrolled into the demonstration.

14 DR. CHERNEW: And so I almost understand that, and
15 that's useful. But understanding more broadly how this fits
16 in -- Massachusetts, I think, has a unique position of being
17 in both presentations this morning, and so understanding how
18 the morning presentation, the first one, fits into this one
19 and whether we want, first, understanding, and then asking
20 the question: Do we want to segment the population the way
21 it's segmented and segment the programs? I'm not asking you
22 that question. I'm saying as a topic for the Commission to

1 understand where the seams are, and I think it's
2 particularly interesting because of the things from this
3 morning, I believe all the states have made different
4 decisions about which populations to put in different types
5 of things. And so learning about that would be interesting
6 to me.

7 My last point is when we had those earlier
8 discussions about the inefficiencies, there are always some
9 sentinel things that we look at. The one that always sticks
10 in my mind is the hospital admission and nursing home
11 churning that would go on. That's something -- if you
12 understand what I mean by that, people going to hospital,
13 then coming back to the nursing home. Finding some measures
14 of whether or not we see those inefficiencies going down
15 would be useful because it would help me answer our broader
16 question, and I'd be interested in other people's views,
17 which is: Is this the -- ultimately I think we want to
18 know, Is this the way forward, ultimately the way forward
19 for dealing with the coordination between the programs? Or
20 is there some other alternative that I'm not aware of?

21 MS. AGUIAR: What I would just add to that is
22 there is also -- again, from the Medicare-Medicaid

1 coordination office at CMS -- another demonstration that I
2 do not believe we've updated you on too much. But that is
3 getting at -- trying to get at this issue of the churning.
4 And basically I think what that model is trying to do is to
5 take the Evercare model, which is a capitated I-SNP model,
6 and bring it within fee-for-service. So that is still in
7 the implementation phase, but I don't know if you have
8 interest in that. We could add that to something that we
9 monitor and report on.

10 DR. CHERNEW: [off microphone] for me, but I'd
11 love other people's views. I'm interested in all of the
12 issues of how these different programs aimed at similar
13 goals are relating to one another, and ultimately if I think
14 of the Medicare program in 2020 or pick some other point in
15 time, I hope -- and maybe I'm crazy, but I hope that we
16 don't have 12 different demonstrations with very similar
17 goals working in a whole bunch of different places that get
18 in each other's way and -- you know. I would hope that we
19 could somehow streamline a model for the program overall,
20 even if it gets operationalized differently. But I'm not
21 sure that's feasible.

22 MR. ZARABOZO: On the churning point, we should

1 mention that under MA there is not a three-day hospital stay
2 requirement for a SNF to be covered as a Medicare-covered
3 service. So you wouldn't necessarily have churning going on
4 within the MA program. And when Craig looks at the
5 encounter data, he can tell us to what extent --

6 [Laughter.]

7 MR. HACKBARTH: Although the churning that we
8 usually talk about in this context is between the long-term
9 care facility and the hospital trigger Medicare payment for
10 skilled nursing facilities.

11 MS. AGUIAR: Yes, and within fee-for-service.
12 Yes.

13 MR. HACKBARTH: So I thought I understood the ACO
14 assignment issue and the interaction with Massachusetts, but
15 now I don't think I do. So let me just take an example.

16 Massachusetts has a flock of ACOs, Pioneer and
17 other. Let's take an under-65 Medicare beneficiary
18 qualified by virtue of disability --

19 MS. AGUIAR: Yes.

20 MR. HACKBARTH: -- that receives her primary care
21 service from one of the organizations, many organizations in
22 Massachusetts that is an ACO. Is that beneficiary eligible

1 for the Massachusetts demonstration?

2 MS. AGUIAR: Yes, that beneficiary can participate
3 in the duals demonstration if she actively disenrolls from
4 the ACO and re-enrolls -- and enrolls into the Massachusetts
5 demonstration. But she will not be passively enrolled, so
6 she will not be taken out of the ACO and placed in the
7 demonstration.

8 MR. HACKBARTH: But she was passively enrolled in
9 the ACO. It's not like --

10 MS. AGUIAR: Yeah.

11 MR. HACKBARTH: -- she's made a choice and we'd be
12 taking it away.

13 DR. CHERNEW: Would she need to switch providers
14 to passively -- I didn't realize you could passively -- or
15 actively disenroll from an ACO.

16 MR. HACKBARTH: There's no enrollment at all.

17 MS. AGUIAR: Right. What I would say to this is
18 that I think this is -- how this -- what we know is what has
19 been written in the MOUs and three-way contracts, and it's
20 sort of very -- not very detailed information about who's
21 eligible, who won't be passively enrolled, and things like
22 that. I think you're getting to really good questions on

1 how in practice this is going to work, and we just don't
2 know yet. But I think that is something we will follow up
3 on.

4 DR. NERENZ: This may be back to a clarifying
5 point. In your example just now and a couple of other
6 places, we picked up specifically under 65. I had not
7 previously formed the impression that either this program or
8 the ACOs were uniquely about under 65. Am I incorrect?

9 MR. HACKBARTH: The Massachusetts demo actually
10 focuses on the Medicare-eligible population under age 65.

11 DR. NERENZ: That one state.

12 MR. HACKBARTH: Right.

13 DR. NERENZ: But not the whole program.

14 MS. AGUIAR: No. For the financial alignment
15 demonstrations, each state sets their eligibility criteria.
16 Massachusetts is for the under-6.

17 DR. NERENZ: Okay. That had been my impression.
18 I just wanted to make sure wasn't missing something that it
19 was broader than that.

20 MR. KUHN: And on the issue of the terms -- or the
21 MOU, won't there be a subsequent detailed terms and
22 conditions between the state and CMS?

1 MS. AGUIAR: Yes, that is --

2 MR. KUHN: Probably all that will be detailed out
3 in --

4 MS. AGUIAR: Right. So that is the three-way
5 contract, and to date, as we said before, Massachusetts is
6 the only one that has gone that far. That does give some
7 more detail, but not on everything.

8 DR. HOADLEY: Mike's comments reminded me, you
9 know, there are also states that are doing waiver programs
10 in Medicaid for their dual eligibles that are not -- where
11 there's no Medicare involvement. Florida is an example
12 that's implementing right now. Are you following those at
13 all? Because, I mean, there's obviously implications for
14 Medicare, at least indirectly if not directly.

15 MS. AGUIAR: Right. We're following it in the
16 sense that the financial alignment demonstration -- so every
17 state has obviously the eligible population, but then also
18 populations are excluded. And so I would say in general --
19 again, it depends by state, but some states do exclude some
20 HCBS waiver populations, particularly if it's for the ID/DD
21 population. Florida has not yet progressed to an MOU, so
22 I'm not quite sure how they would -- how that waiver

1 initiative going on there would align with this
2 demonstration.

3 DR. HOADLEY: Because they're putting all of their
4 -- pretty much all of their dual eligibles into initially
5 the long-term care -- ones that are in long-term care into
6 the long-term managed care program, managed long-term care
7 program, and then starting in 2014 they'll be putting all of
8 them into the managed acute care --

9 MS. AGUIAR: Oh, right. I'm sorry. I
10 misunderstood what you meant by the waiver.

11 DR. HOADLEY: Yeah, I'm talking about the --

12 MS. AGUIAR: Yeah, the mandatory Medicaid managed
13 care enrollment, yes.

14 DR. HOADLEY: Right.

15 MS. AGUIAR: So that did happen in New York, and I
16 believe also in California, and the way that it worked in
17 New York was that moving the duals into mandatory managed
18 care for the Medicaid services happened first before the
19 demonstration was implemented, and I believe that that's the
20 same way that it happened in California, at least for some
21 of their population, if not all. So they are, I think, to
22 the extent that's possible, trying to align the

1 demonstration, the timings of the demonstration, with their
2 other Medicaid initiatives, particularly around mandatory
3 Medicaid managed care enrollment.

4 MR. HACKBARTH: Anybody else?

5 [No response.]

6 MR. HACKBARTH: Okay. I'm ready to call it. Let
7 me just sort of sum up where I think we are here.

8 We've spent a lot of time on this issue over the
9 last several years because it's a really important one.
10 We're talking about a population of beneficiaries that, yes,
11 is very expensive, but even more important than that is very
12 vulnerable, the most vulnerable portion of the population we
13 serve. And, you know, we helped encouraged in a small way
14 this idea that there are ways to integrate Medicare and
15 Medicaid and the associated care delivery to better serve
16 this population. And so that's a good thing.

17 We made comments on the CMS proposal for the
18 demos, most of which have been accepted in one form or
19 another. A couple have not. At this point I think mostly
20 we're in the watching phase now to see how these things
21 actually work in practice.

22 We made, I think, an explicit decision here,

1 despite the growing interest in some states in D-SNPs as an
2 option, not to revisit that again. Our position is that
3 they ought to continue, be reauthorized indefinitely where
4 they truly integrate Medicare and Medicaid, and it sounds
5 like there is some interest at the state level in that.

6 The other issue that we touched on today that we
7 will pursue further is the low-income issue, the Medicare
8 savings programs, and whether they need to be modified or
9 extended beyond what they are today as part of benefit
10 redesign or as part of other initiatives as well.

11 I think that's where we are. Agreed? Anything
12 you want to add?

13 DR. MARK MILLER: No. You got it.

14 MR. HACKBARTH: I think we're done. Thanks,
15 Christine and Carlos.

16 We'll have our public comment period now.

17 You know the ground rules but I need to repeat
18 them anyhow. Please begin by identifying yourself and your
19 organization. When the red light comes back on, that's the
20 end of your two minutes.

21 As always, I will repeat for the audience that
22 this is not your only, or even your best, opportunity to

1 influence the work of the Commission. The most important
2 opportunity is to interact with the staff or to communicate
3 with Commissioners by letter, or by putting comments on our
4 website.

5 DR. CONROY: My name is Joanne Conroy and I'm from
6 the Association of American Medical colleges, which supports
7 and represents our nation's teaching hospitals and medical
8 schools.

9 We appreciate that MedPAC spent the morning
10 talking about alternative payment models. Our academic
11 medical centers, and the broader community, agrees that
12 there's actually an urgent need to implement payment and
13 care delivery innovations. And many of our members are
14 actually leaders in the initiatives you discuss this
15 morning.

16 The AAMC itself is a convenor of 10 teaching
17 hospitals in the Bundled Payments for Care Improvement
18 Initiative, and it looks like we may actually have a few
19 more institutions joining us over the next few months.

20 The alternative payment methodologies you've been
21 discussing all become very successful because we continue to
22 shift care to a different and probably more appropriate

1 setting. We'd like to remind you, however, that this shift
2 from inpatient to outpatient and post-acute settings does,
3 however, have an effect on the amount of support to the
4 Medicare program that provides for graduate medical
5 education because the Medicare GME payments are a very
6 direct tie between inpatient admissions.

7 We urge the Commission to monitor the effect of
8 these payments as these alternative payment methodologies
9 roll out across the country in order to not only ensure that
10 there's an adequate number of physicians but certainly to
11 ensure sufficient access for the growing number of Medicare
12 patients.

13 Thank you.

14 MS. McILRATH: Sharon McIlrath with the AMA.

15 I just wanted to also suggest that there might be
16 some areas that CMMI has not addressed yet or had done so
17 only minimally.

18 One of those is in the area of specialty models.
19 I think they just have a contract that they are starting to
20 look at that, but there are a number of specialties that we
21 have talked to and consulted with that are developing and
22 have models that are fairly well developed and that could be

1 plugged in and looked at.

2 A lot of these are episode-based. And so, if you
3 wanted to think about what you could easily drop into
4 something that was broader, they seem to fit that. They
5 would be, probably, tested in more than one area so you
6 would get around, a little bit, the issue of does it work
7 across sites.

8 You also know, sort of, going in -- assuming that
9 you've designed the bundle right -- what the payments are
10 going to be and you have some assurance that you're not
11 going to be paying more. You'd have the technical expertise
12 of the specialties doing that. Some of these, it's more
13 than one specialty looking at it.

14 So just, as you go forward, to think about aren't
15 there some ways that the specialty input and those kinds of
16 models are also tested.

17 MR. HACKBARTH: Okay, we are adjourned.

18 [Whereupon, at 1:26 a.m., the meeting was
19 adjourned.]

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21

22