

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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9:51 a.m.

COMMISSIONERS PRESENT:

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1 P R O C E E D I N G S [9:51 a.m.]

2 MR. HACKBARTH: Good morning. Thanks for coming.

3 We have two sessions this morning, the first on ACOs and
4 then one on low-income beneficiaries and competitively
5 determined plan contributions. So on ACOs, David, are you
6 leading the way?

7 MR. GLASS: I will start out.

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

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

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

19 Very briefly, policymakers wanted something like
20 ACOs because Medicare volume growth is thought to be
21 unsustainable, quality in Medicare is uneven, and there is a
22 lack of care coordination.

1 They wanted to create an MA-like incentive to
2 control volume without requiring an entity that could accept
3 full capitated payment and the risk that goes with it, that
4 does not lock the beneficiary into a limited network, and
5 that does not require an entity to create contracts with
6 providers and pay claims.

7 There are two Medicare ACO models:

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

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

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

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

20 In pure (or unaccountable) fee-for-service,
21 payment is by service, it's silo-based; there is some
22 quality incentive as in the VBP program, and no provider is

1 at risk for the total cost of care.

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

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

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

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

21 ACOs have to have primary care physicians as
22 members because they are the key to beneficiary assignment.

1 Hospitals or specialists can be members but are not
2 required.

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

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

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

21 Primary care physicians are the key to assignment
22 of beneficiaries as they are in the Pioneer program, and

1 performance data is provided by CMS quarterly.

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

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

10 To quickly review:

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

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

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

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

22 And remember, ACOs' patients are still free to use

1 providers outside of the ACO. And if they choose to go to a
2 specialist or hospital outside of the ACO, the ACO remains
3 responsible for this spending.

4 There are some differences between Pioneer and
5 Shared Savings ACOs.

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

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

16 If the savings in year one and year two are both
17 greater than 2 percent of total spending, then the ACO can
18 transition to what CMS calls a more population-based payment
19 in year three. In that design the ACO gets a capitated
20 payment for the share of Part B or Part A&B spending,
21 depending on the design, that it provides, but it is still
22 responsible for the total spending, including that provided

1 by providers outside of the ACO.

2 Payments in the Medicare Shared Savings Plan ACOs
3 can also vary based on whether the ACO is in a one-sided
4 risk design, or bonus-only, or a two-sided risk design.
5 Note that almost all the ACOs, 212 of them, are in Column 1
6 -- that is, one-sided risk or bonus-only design. Here if
7 spending is lower than the benchmark, the ACO shares in the
8 savings. If spending is higher than the benchmark, the ACO
9 does not share in the loss.

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

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

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

21 The Commission has been involved in the
22 development of the ACO concept for many years. We wrote two

1 comment letters to CMS -- one preliminary to and one in
2 response to the proposed rule for the Medicare Shared
3 Savings Program. Although we raised a number of issues,
4 including risk adjustment and quality metrics, I will only
5 discuss the three on this slide.

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

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

20 And, finally, we proposed assessing benchmark
21 spending and savings with standardized prices to approximate
22 service use. This helps establish congruence between

1 targets and performance across the country and avoids
2 problems when things like the wage index change or the
3 sequester hits.

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

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

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

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

20 But this advantage of not processing claims is
21 also associated with their weakness of having fewer tools to
22 control utilization. First, ACOs cannot limit networks.

1 This means they cannot restrict access to fraudulent or
2 inefficient providers, although some ACOs are talking to CMS
3 about ways they can help CMS identify fraud and stop it.
4 They also are not able to require prior authorization before
5 certain services are provided. The most important
6 limitation may be that ACOs can not affect beneficiary cost
7 sharing. This is especially problematic because fee-for-
8 service beneficiaries with first dollar coverage under
9 Medigap have little incentive to consider cost when setting
10 their treatment plan. One option to address this would be
11 for Medigap plans to offer lower cost sharing for ACO
12 physicians, just like some Medicare Select Medigap plans
13 offer lower cost sharing for in-network hospitals. To the
14 extent differential cost sharing keeps patients within the
15 ACO and results in lower costs, those savings could be
16 shared as lower premiums for those Medigap plans.

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

20 The purpose of this slide is to show the amount of
21 savings an ACO or MA plan can generate and how that is a
22 function of how much excess service use there is in the

1 market.

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

20 Next, let's add a line representing MA plans.
21 This is the pink line. Based on data from MA bids, in this
22 model we assume MA plan's overhead is 10 percent higher than

1 fee-for-service. So MA plans start with a deficit of 10
2 percent and must overcome that overhead by reducing
3 inefficient service use. In this graph, the pink line
4 assumes that for every 10 percent increase in identifiable
5 excess service use, the MA plan can eliminate 6 percent of
6 that service use. So at the left-hand side, if the MA plan
7 does nothing, it has 10 percent higher costs than fee-for-
8 service. But on the right-hand side, if it moves to a
9 market with 50 percent inefficiency, they may be able to
10 have 20 percent lower costs than pure fee-for-service due to
11 eliminating some of that inefficiency. The general idea I'm
12 trying to illustrate with this hypothetical is that the more
13 inefficiency there is in a market, the more opportunities
14 there are for both MA plans and ACOs to save money relative
15 to fee-for-service.

16 An example may help. In Orlando, Florida, MA
17 plans bid on average 15 percent below fee-for-service. This
18 suggests there is significant excess service use that can be
19 eliminated, enough to generate those 15-percent savings and
20 cover their overhead. So we would also expect ACOs to form
21 in Orlando with the expectation that they could use some of
22 those same physician tools and lower service use. The

1 savings may not be as large as MA plans, but they should be
2 enough to cover the ACO's overhead.

3 Now let's shift to some actual data.

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

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

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

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

18 The third column is markets where MA bid 5 percent
19 or more above fee-for-service. MA plans can bid above fee-
20 for-service in these markets because the benchmark is often
21 set above fee-for-service costs. As you know, the
22 Commission has recommended against this in the past.

1 So let's walk down the information in the first
2 column. This first column represents where MA plans have
3 shown they can reduce cost. These markets have 44 percent
4 of all beneficiaries. They have 61 percent of ACO
5 beneficiaries and 54 percent of ACOs. I say here potential
6 ACO beneficiaries, and by that I mean fee-for-service
7 beneficiaries that live in a market with an ACO. So the
8 bottom line is the first column tells us that ACOs are more
9 likely to be in markets where MA plans have shown they can
10 reduce spending.

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

19 So, in summary, we see rapid growth in ACOs. All
20 the ones we've talked to hope they can generate savings by
21 reducing excess service use. However, they're somewhat
22 limited in their ability to do this relative to MA plans

1 because they do have all the tools MA plans have to reduce
2 service use, but they do have the advantage of lower
3 overhead. In general, we see the ACOs forming in markets
4 where MA plans have already shown service use can be
5 reduced. And as we illustrated in your mailings, ACOs with
6 2 percent overhead should be able to be profitable if they
7 can generate at least 4 percent reductions in service use.
8 However, this 4 percent reduction will be much easier in
9 some markets than in others.

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

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

21 The third issue we have up there is a way to
22 address the issue of cost sharing. One potential is to have

1 a new type of Medigap plan, a Medigap Select that could
2 offer lower cost sharing for physicians in the ACO or lower
3 cost sharing simply for using a certain set of physicians.

4 And the other short-term issue we have up there is
5 measuring performance use, and one way to do this is right
6 now we're measuring performance based on costs, and that has
7 some problems because prices can go up and down. An
8 alternative would be to measure performance based on service
9 use as opposed to spending, and that would remove issues
10 such as wage index shifts or distortions due to SGR or
11 sequester and things like that.

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

19 I'll open it up for discussion.

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

21 We'll do two rounds -- a round of clarifying and
22 then a round of more open comments and questions. I propose

1 that we use the modified version of Round 1, by which I mean
2 I'll just ask people to raise their hands if they have a
3 clarifying question as opposed to going around the table.
4 And in Round 1, please limit it to clarifying questions, you
5 know, "What does Slide 14, Row 2 mean?" That sort of thing.

6 So, with that, Round 1 is open.

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

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

13 DR. STENSLAND: That's right.

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

21 DR. STENSLAND: Right.

22 DR. NERENZ: Okay. Thanks.

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

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

11 MR. GRADISON: Yes.

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

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

17 MR. GLASS: Right.

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

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

22 DR. MARK MILLER: Unless you take them from a

1 hospital to an ACO or -- I mean an ASC or something like
2 that.

3 MR. GLASS: Yes.

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

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

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

19 MR. GRADISON: Thank you.

20 MR. BUTLER: On Slide 11, please. So I want to
21 understand -- you made the point only eight have picked
22 shared risk. Maybe the 60 percent versus 50 was not a

1 strong enough incentive to get people on the right-hand
2 side. But the bottom right-hand corner, I want to
3 understand that. In year three, so where it says there's 10
4 percent sharing, does this mean that if they're 10 percent
5 over expected or the target spending, they will have to eat
6 60 percent of the loss? How does that work?

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

8 MR. BUTLER: So let's say-- because it's a
9 two-sided risk, now you're all the way up to year three.
10 And it says the maximum -- limited to 5 percent year one,
11 7.5 year two, 10 percent year three. Explain what that
12 means if you were to have your spending -- you know, how
13 much risk then is being swallowed? Is it the 60 percent of
14 the 10 percent?

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

21 MR. BUTLER: Okay. So then maybe I'm looking at
22 the wrong line, even performance payment limit. How many

1 dollars are at risk as a percent if you perform -- you blow
2 the -- you know, you're way off the mark in your spending in
3 year three in the double-sided --

4 MR. GLASS: Well, the most you can lose is 10
5 percent of the total spend.

6 MR. BUTLER: Yeah, okay.

7 MR. GLASS: Yeah.

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

14 MR. GLASS: Right. Well, that --

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

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

20 MR. HACKBARTH: So at this stage --

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

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

5 MR. BUTLER: 60 percent versus 50 percent.

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

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

16 MR. HACKBARTH: Yeah.

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

21 MR. HACKBARTH: Yes.

22 MR. BUTLER: I think you get the gist of what I'm

1 trying to anticipate.

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

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

8 MR. GLASS: Right.

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

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

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

18 MR. GLASS: Yeah.

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

21 MR. HACKBARTH: Yeah, and, Peter, you're
22 absolutely right that that happened in the 1990s. People

1 took on risk that they really didn't know how to manage, and
2 there were blow-ups because of that.

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

6 MR. HACKBARTH: Right.

7 MR. GEORGE MILLER: Yeah. Two quick ones on Slide
8 10, please. I thought I heard in the presentation, in the
9 last bullet, that after year three, they could go to a
10 capitated rate. Did I understand that correctly?

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

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

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

16 MR. GEORGE MILLER: Okay.

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

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

21 MR. GLASS: Right, yeah, depending on which model
22 it is, yeah.

1 MR. GEORGE MILLER: Okay.

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

5 MR. GEORGE MILLER: Right.

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

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

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

17 DR. STENSLAND: So this is mostly nurse
18 practitioners, physician assistants. So somebody might go -
19 -

20 MR. GEORGE MILLER: Yeah. I understand.

21 DR. STENSLAND: And that might be their primary
22 care source of care.

1 MR. GEORGE MILLER: Right.

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

8 MR. GEORGE MILLER: Right.

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

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

15 DR. STENSLAND: Yeah.

16 MR. GLASS: It gets complicated, because --

17 MR. GEORGE MILLER: Yeah. Yeah.

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

1 MR. GEORGE MILLER: After the triggering visit.

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

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

9 DR. STENSLAND: Right.

10 MR. GEORGE MILLER: Yeah. Okay.

11 MR. HACKBARTH: Okay. Clarifying questions?
12 Further clarifying questions? Alice, then Herb.

13 DR. COOMBS: So, Slide 11. In the eight who
14 elected to take the two-sided risk, do we know anything else
15 about the eight in terms of suburban, what they looked like
16 --

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

20 DR. COOMBS: Oh, okay.

21 MR. GLASS: -- told the story. Maybe they made
22 the mistake. I don't know.

1 MR. HACKBARTH: Just got in the wrong line?

2 [Laughter.]

3 MR. GLASS: Just filled out the wrong form.

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

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

8 [Laughter.]

9 MR. HACKBARTH: Herb.

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

17 MR. GLASS: I don't think we're absolutely sure
18 where it stands. They apparently called a truce and they're
19 figuring it out, I think. They had some kind of meeting
20 about it. But I'm not sure what the final status is. The
21 issue had to do with quality, moving from the quality
22 reporting to judging performance on quality, and it had to

1 do with how you set the thresholds or not and whether there
2 was enough experience to do that.

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

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

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

22 DR. STENSLAND: They are just starting to develop

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

11 [Off microphone discussion.]

12 DR. STENSLAND: Okay, Main Street.

13 [Laughter.]

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

21 DR. DEAN: It's probably too early to answer this
22 question, but it always seemed to me that the fact that ACOs

1 could not limit in any way where the beneficiaries actually
2 received care -- do we have any information as to how often
3 that's actually been a problem and what percentage of their
4 costs are outside their own organizations? Like you say, it
5 may be too early to answer that.

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

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

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

17 [Laughter.]

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

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

21 MS. UCCELLO: So, the text box in the chapter
22 talked about the opt out of the data sharing. Is there any

1 even anecdotal evidence about other beneficiary negative
2 reactions and whether people have decided just to go to
3 different primary care providers altogether?

4 MR. GLASS: Well --

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

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

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

22 MR. GLASS: I think -- well, we'll try to pursue

1 that, because we looked and it's about 50 percent seem to be
2 physician only, or physician-based, if you will. But what
3 markets they're in, we haven't analyzed yet.

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

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

21 MR. HACKBARTH: But the precise parameters of the
22 second three-year cycle are not clear yet at this point.

1 There will be some downside risk, is what CMS has suggested,
2 but exactly how it will work is not clear, is that correct?

3 Rita.

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

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

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

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

21 DR. REDBERG: Thank you.

22 MR. ARMSTRONG: My apologies if this question is

1 redundant to questions asked already, but I'm on Slide 10
2 and I'm not quite getting how the risk is defined. And my
3 sense is that what the ACOs are doing is identifying a
4 subset of the total costs for a population of patients and
5 going at risk for that, or is for the total per member, per
6 month, for that population, regardless of where those
7 patients actually experienced their care?

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

10 MR. ARMSTRONG: Okay.

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

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

1 MR. HACKBARTH: So, let me kick off round two. As
2 you reported in both the presentation and in the written
3 material, one of the issues that we raised about the
4 proposed rules, or even before the formal publication of the
5 proposed rule, had to do with how beneficiaries are notified
6 of ACO participation. And our concern, my concern at the
7 time was that this could be unsettling to beneficiaries.
8 They get a letter saying that you've been assigned to
9 something that they're unfamiliar with, and to the extent
10 that they understand it at all, it may be, well, they
11 understand that the payment rules are changing and that
12 their physician and hospital are going to be paid
13 differently and they're going to share in savings and the
14 government is going to share in savings, but oh, I, as the
15 patient, I don't get anything out of this.

16 Do we know how this process has worked in practice
17 and how beneficiaries are reacting to these notifications?
18 And is CMS doing anything to try to understand in a
19 systematic, as opposed to anecdotal, way how this is going
20 down with Medicare beneficiaries?

21 MR. GLASS: I'm not sure about the latter, about
22 CMS's, but we can look into that, how CMS is collecting data

1 on it. From talking to some of the ACOs, it does get the
2 beneficiaries' attention and they do get a lot of telephone
3 calls. So they've had to put in extra resources to make
4 sure that there's someone to answer the phone who knows the
5 answer to the question and can reassure the patients what's
6 going on.

7 MR. HACKBARTH: Mm-hmm.

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

13 MR. HACKBARTH: Right.

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

19 [Laughter.]

20 DR. STENSLAND: And some of them opt out, just
21 saying, you know, because I think a lot of it is about data
22 sharing. You know, you're going to share your data, and

1 some people might just have a negative reaction to people
2 seeing their data. And, generally, we have a small sample,
3 you know, whatever, ten different ACOs that we've talked to,
4 but generally, they're saying, maybe five percent say that
5 they don't want their data shared. Now, we've also heard
6 that in some cases, after they talk to their doctor, some of
7 them go back and contact CMS and say, okay, go ahead and
8 share my data because now I understand what this is all
9 about.

10 MR. HACKBARTH: So my concern about this, and I'm
11 old enough to have lived through the managed care backlash
12 of the 1990s and came away with some, I think, hard-earned,
13 learned, lessons about that, and one of them that I think I
14 learned was that patients are uneasy about their providers
15 having a reason to reduce care and save money, particularly
16 if they have no choice in the matter and the savings are all
17 going to somebody else. And I'm afraid the ACOs, as
18 currently structured, tick all those boxes. They don't have
19 any choice. They don't share in the savings. And my fear
20 is that this is sort of ripe for -- especially if the
21 communication is kludgy -- really ripe for, over time,
22 creating a backlash.

1 And I fear that, much as in the 1990s, there will
2 be people who have a reason to foment a backlash, because if
3 an ACO is going to work, it is going to take income from
4 some people and redistribute it to other people, and the
5 people who are losing income -- subspecialists,
6 radiologists, interventional cardiologists, whoever -- are
7 going to have every reason to whisper in their patients'
8 ear, this isn't in your interest. They're saving money at
9 your expense. You don't have any choice, and you're not
10 even getting part of the savings.

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

16 Round two. David.

17 DR. NERENZ: I would be interested in your
18 thoughts on where this goes a few years down the road, to
19 the extent you can see that. I start with what's on Slide
20 11, but actually it's in a few other places, just in how the
21 savings are calculated, because the core through financial
22 appeal element or incentive is this shared savings

1 component.

2 It is correct, I think -- but it's in the text --
3 that this two to four percent is calculated against the year
4 prior spending of the group of people assigned to the ACO.
5 So you're not competing against market. You're not
6 competing against the national number. You're competing
7 against yourself, basically.

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

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

18 So now, finally, the question. If those general
19 observations are so, it would seem like this is a mechanism
20 that would incentivize a certain type of integration,
21 meaning perhaps centered on primary care but not including
22 everything, and it would incentivize integration for a

1 while, up to a point. But then it would sort of cease being
2 attractive because of these components I mentioned earlier.
3 Is all that reasonable, or is there some way which this
4 continues to be attractive several years down the road after
5 the initial low-hanging fruit, so to speak, has been
6 harvested?

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

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

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

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

17 MR. GLASS: Right.

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

20 MR. GLASS: Correct.

21 DR. NERENZ: So they would have to actually create
22 --

1 MR. GLASS: That's right.

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

4 MR. GLASS: Correct.

5 DR. NERENZ: Okay.

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

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

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

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

21 MR. GLASS: Right.

22 DR. NERENZ: -- into --

1 MR. GLASS: Yes.

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

4 MR. GLASS: Yes, that's correct.

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

13 MR. HACKBARTH: I think, David, you've raised some
14 really key issues, and one that I focus on is how this
15 relates to Medicare Advantage. To me, one of the principal
16 potential strengths of Medicare Advantage is that plans have
17 the ability to steer patients to high-performing providers
18 by using limited networks or differential cost sharing,
19 whatever. And I think to get where we want to go in terms
20 of elevating delivery system effectiveness, that steering
21 patients to high performers and away from low performers is
22 a very important thing to do.

1 Now, switch over to ACO. As you say, the payment
2 structure here is built on historical costs, and as opposed
3 to the efficient providers being differentially rewarded,
4 either in payment or volume, we don't have either of those
5 mechanisms that work. They're not getting rewarded for
6 their past efficiency nor are they getting any volume
7 because the patients aren't rewarded for going to high-
8 performing providers.

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

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

1 readmissions from those facilities.

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

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

10 Bill, round two -- or Jack.

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

18 The other point I wanted to make really, I guess,
19 picks up off of Glenn's point on the beneficiary
20 involvement, and I know from conversations in the focus
21 groups I've been in over the years talking to beneficiaries,
22 beneficiaries have trouble telling us when they're in a

1 Medicare Advantage plan, which is an entity that means they
2 have an ID card and a bunch of other things, and they have
3 trouble knowing that they're in MA versus their Medigap or
4 whatever. And so with whatever, I mean, you're relying with
5 something like the point is trying to make sure that they
6 know that they're in it and what it means and that's a
7 pretty steep ask, I think, and could lend to some of the
8 things Glenn was raising, or could just lend to general
9 confusion. And I don't know the answer beyond that.

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

17 I guess another thing that is -- what can we learn
18 as you look forward, and that's one of the questions you
19 asked, and I guess it strikes me that there's enough
20 variation in the types of entities that are out there that
21 we ought to be able to pick up some things. I was struck by
22 a couple of examples that were in the chapter that weren't

1 otherwise mentioned, but you had said there were a set of
2 ACOs that had a -- Universal American had a Medicare
3 Advantage plan company that was involved, and sort of what
4 are they doing differently? Does that create a different
5 kind of dynamic going on? There's a couple that involved a
6 pharmacy as part of the unit. What does that involve?

7 And on the broader group is sort of the questions
8 that we've talked about over time, is the payment
9 relationships between, especially where there's hospitals
10 and doctors involved, how is that all being organized and
11 what opportunities do we have, or what is CMS doing to sort
12 of really study these varieties of models and understand
13 that when you do something, that one is not going to work,
14 and so in the future, we should say that's not a good model.
15 This is a model that works better. So, yeah, we ought to
16 encourage that kind of model, or it would work only if we
17 made this adjustment.

18 I gather you've done some interviews of some of
19 the ACOs. I don't know whether you have more plans to do
20 sort of more systematic interviews or whether CMS has any
21 plans, but it seems like those are directions that would be
22 really helpful.

1 MR. GRADISON: Three quick points.

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

9 The second thing that bothers me, again, I'm just
10 trying to think this through. If I am being measured
11 against my performance year by year and to get any kind of a
12 chance for making money out of this deal, I've got to
13 achieve savings of at least 2 percent year after year after
14 year, I don't get it. Isn't there some point -- I think the
15 same thing, frankly, about hospital readmissions. Isn't
16 there some point where maybe it can still go lower but it
17 kind of levels out? Just thinking that through into the
18 second and three-year cycle, again, I don't exactly get it.

19 And my final point is that, as I think about when
20 will we have enough data to be able to really understand
21 what's going on here and what it may be for policy, it may
22 be so far off as a practical, realistic matter, that the

1 pressures for major changes within the program will overcome
2 our ability to interpret what we've already done through
3 very well intended and hopefully very effective initiatives
4 such as this.

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

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

15 MR. GRADISON: [off microphone].

16 MR. GLASS: Okay.

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

19 MR. GRADISON: Yes [off microphone].

20 MR. HACKBARTH: Okay.

21 DR. HALL: I think this was a very well done
22 chapter for us to look at, and I think continuing to look at

1 the development of ACOs as it affects Medicare patients is
2 going to be really, really important. I was recently at a
3 meeting of some of my colleagues, professional colleagues in
4 geriatrics, the field of taking care of older people, and
5 there's virtually no major medical center around the country
6 now where they're not engaged in an ACO formation or having
7 discussions about ACOs.

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

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

19 But out of that, almost in a parallel universe,
20 there's a lot of activity going on in terms of trying to
21 understand a little better what kind of differences would be
22 important if you were structuring a health system that was

1 Accountable Care-oid or -- what would it really look like?
2 And part of that are things that we've talked about, but I
3 think it's going to be very important for us to keep a focus
4 on this. This would be such things as a tremendous surge in
5 interest in interprofessional -- at the present time,
6 interprofessional education, but interprofessional dialogue
7 in any part of a health care system, a lot more interest, as
8 you all know, on transitions of care. One very interesting
9 marker is 30-day readmissions rates. And there's a lot of
10 very, very good information based on not just singular
11 trials in one hospital but in many, many hospitals that are
12 almost totally irrelevant to the below-65 population but are
13 quite relevant for older people.

14 Just to give one example that's getting a lot of
15 attention lately, a number of health systems have decided to
16 take a look at how they are repairing hip fractures in older
17 adults. Perhaps sort of the paradigm of an event, a single
18 event that can make things go wrong in every aspect, not
19 only in terms of life but the morbidity and maybe, and more
20 importantly, the cost to the health care system. And it
21 becomes abundantly clear that with relatively simple things
22 of health care personnel talking to one another, agreed-upon

1 quality indicators that would be totally irrelevant to a 25-
2 year-old, that you can reduce costs in half, you can reduce
3 complications, sometimes by 90 percent.

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

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

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

16 So why do people do this? I'd say first it's not
17 because they view a market that is ripe. I think they look
18 at their own base. These are all providers or physician
19 groups that are saying, "I can do better than I'm doing
20 now." And, ironically, they're almost looking for those
21 chronic illness -- they're looking through the sick patients
22 that they see not being managed well, which, by the way, if

1 you get to the Medicare Advantage, those are the very ones
2 you're going to want to maybe not have in your plan. So
3 suddenly the ones you're trying to attract in the early days
4 of ACOs are the very ones that you're going to want to stay
5 away from later on. So there's kind of a perverse
6 incentive. But I think it's provider-specific. It happens
7 to be in markets where there's higher fee-for-service
8 utilization, but I think the motivation is from the
9 individual proprietor's perspective.

10 Second, as Bill said, the economics don't really
11 work, particularly if a hospital is in this. So they don't
12 look at this and say, "What an opportunity." Your example
13 in the chapter doesn't do the revenue loss on the provider
14 side. It shows the, you know -- it's more of a physician
15 group perspective on it. But the economics don't work. And
16 I think the other side of that is it's not just the money
17 for the infrastructure. It's the competing management time.
18 This is a subtlety, but the hospital world has got
19 value-based purchasing increasing in numbers. They've got
20 the readmissions rates penalties going from 1 percent to 2
21 percent. They've got meaningful use. They've got hospital-
22 acquired conditions, also a whole series of metrics that

1 they're trying to hit on one side of their management
2 ledger, and at the same time trying to get 33 quality
3 indicators and an infrastructure for managing an ACO
4 together, and it literally not only can be kind of
5 confusing, just an opportunity -- a management time
6 opportunity and energy. Where do you want to put the real
7 efforts, and trying to do both, but it's tough.

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

18 Fourth, I think people are saying, hey, this is a
19 way to -- the training wheels, it gets me started, and if I
20 punch the Medicare ACO ticket, I have much -- I need that as
21 credibility with the commercial insurers. Because you could
22 say you're not even in a Medicare ACO, why should I talk to

1 you on the commercial side? Or if you have experience there
2 -- and this is a positive thing because it creates a --
3 Medicare is creating a catalyst and, frankly, a legally-
4 easier-to-comply-with structure to get started than the
5 commercial world has provided up so far. So you're getting
6 a big push of jumping not just to Medicare ACO as, oh, by
7 the way, we're doing this, but good entré into the
8 commercial world.

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

21 MR. GEORGE MILLER: Yes, also let me echo that
22 this is an excellent chapter, and I appreciate the work that

1 staff has done, and it really crystallized, at least in my
2 mind, where we are with ACOs.

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

1 Medicare beneficiary first.

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

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

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

22 I really thought Dave's comments about

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

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

22 And, finally, I think we have all been talking

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

8 DR. BAICKER: There are obviously a lot of first-
9 order issues in terms of how the pricing is structured, how
10 the incentives are structured, and I just wanted to pick up
11 on the really important point you raised about communication
12 with beneficiaries, and that's obviously important to convey
13 what the program is trying to do and to reassure people,
14 like it could be described in very scary terms that are not
15 warranted, and avoiding that seems important not only for
16 beneficiaries to understand what is going on, but also to
17 avoid undermining the integrity of the program by selective
18 disenrollment and selective opting out, and that would
19 really -- no matter how well we try to risk-adjust things,
20 that could really undermine the financial stability of that
21 arm. And I don't know how much of the beneficiary --
22 individual level beneficiary information is really crucial

1 to the operating of the ACO versus what parts could be
2 reported in aggregated ways that would give them a base of
3 information to work on that might be less -- whether there's
4 an intermediate step between opting out and opting to
5 withhold all of your data and fully participating, is there
6 some way to mask or aggregate sensitive data and communicate
7 that in a way that's not even more confusing for the set of
8 options available to people. But I think having --
9 adequately conveying the upside of this to beneficiaries,
10 which is not dollars in hand necessarily but the higher
11 quality and devoting the resources that are spent on them to
12 the highest-value care seems like a message one ought to be
13 able to convey, and to the extent that we can remove
14 whatever little parts might disincentivize or scare people
15 away from participating, that seems important.

16 DR. CHERNEW: So first let me say I get this
17 feeling that as we redesign the health care system, we're
18 building different pieces of it in different workshops. And
19 I worry that what's happening in some of those workshops
20 isn't going to be consistent with what's happening in
21 others, and when it comes together it's not going to look
22 all that good. And so I really commend this chapter as at

1 least a first step to beginning to think about how to
2 harmonize all of these pieces, not for 2014 but for 2020 and
3 beyond, or whatever it is. And I think this is just great
4 for that reason.

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

17 The other thing that I think is really crucially
18 important to me is to understand the interaction between the
19 competition between ACOs and MA plans, and one point that
20 hasn't come up much is you mentioned in your presentation
21 that the negotiation with providers that MA plans have to do
22 as kind of an administrative overhead thing, and that's

1 certainly the case. But in the grand scheme of things, I
2 think the bigger issue is that providers get to charge MA
3 plans rates that they negotiate, but in the ACOs, you're
4 getting paid fee-for-service rates. And if I'm an ACO and
5 I'm competing with an MA plan but I get to control how I
6 negotiate with that MA plan in a variety of ways, there's
7 interactions that might have significant effects that I'm
8 not sure we've completely thought through, not to mention
9 how ACOs and the formulation of them influences what happens
10 in the commercial market in a variety of ways.

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

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

21 One thing that struck me that was very interesting
22 is being able to say that what is the representation of the

1 ACOs that are now on the books, what do they look like? And
2 what does the rest of the Medicare population look like in
3 terms of parity? Whether it's parity in terms of the income
4 levels, parity in terms of racial composition, what does --
5 I mean, how does the 250 look like? Does it look like the
6 Medicare population, the 49 million, or not? And I think
7 that's really important in terms of lessons that are
8 learned.

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

17 There are internal portions of the ACO that, being
18 in Massachusetts, we had to deal with, and there are
19 external parts of the ACO. One of the internal components
20 of the ACO is when you have geographic isolation of
21 providers and how those providers see themselves as being
22 either eliminated from certain groups or in the inside of

1 the ACO family within their geographic region. I think that
2 creates new paradigms that we haven't seen before.

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

16 So there are internal dynamics within the ACO that
17 changes the paradigm for Medicare beneficiaries, and we've
18 actually talked about this. I mean, they're very complex
19 contractual agreements, and there's some new thoughts as to
20 some of the specialists having a capitated agreement with
21 some ACOs, say an ENT surgical group might decide that they
22 would like to have this kind of permanent arrangement for

1 this defined population, whereas the manager of the ACO
2 knows that they're very limited with, say, orthopedic
3 surgery or neurosurgery. They may have a different defined
4 relationship with specialties under the umbrella of ACOs.
5 So there's a lot of versatility on what an ACO can look
6 like. It doesn't have to be all fee-for-service. It can
7 have components that are hybrids of any mixture based on the
8 geographic availability of resources.

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

18 And then there's the whole notion of mental health
19 services. How do we address mental health services within
20 ACOs? And that's a factor because a lot of mental health
21 services have not been incorporated within the structure of
22 the ACOs.

1 I'm concerned about selection. I am also
2 concerned -- what Glenn said was very true -- about how this
3 message gets to beneficiaries, because that's really huge.
4 If you impair access to physicians based on the design of
5 the process for them being incorporated in the ACO, it can
6 result in adverse events and delay of care or, you know,
7 challenges with access.

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

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

20 MR. GLASS: Well, as I remember it, the risk score
21 of new patients comes with them, so that would increase the
22 payment. I don't think the historical spending of new

1 patients comes with them, so it doesn't change that part.

2 MR. HACKBARTH: So they have a dollar value on a
3 base year, but that is adjusted for risk over time.

4 MR. GLASS: Yeah. So we had suggested that a new
5 patient bring his or her historical spending and risk score.

6 MR. HACKBARTH: Yeah.

7 MR. GLASS: And I think they made it -- they bring
8 their risk score.

9 DR. COOMBS: But in the case of new enrollees, you
10 may not have that history.

11 MR. GLASS: Oh, you mean someone just turning 65,
12 aging in, yeah, right.

13 MR. KUHN: I'd like to kind of speak a little bit
14 to something that Mike raised as well as, I think, Glenn and
15 George, and it's captured up here on Slide 16 that's up on
16 the longer-term issues, and that really is kind of this
17 alignment with ACOs, MA, fee-for-service, on a go-forward
18 basis. I think it's been talked about here as the fact that
19 we've got a unique opportunity. We've got these three-year
20 contracts. We know in three years that we're going to have
21 a set of policy questions to deal with on kind of the next
22 generation of these programs and how we get this kind of

1 alignment on a go-forward basis. So whether it's setting
2 common benchmarks, whether it's setting common performance
3 goals, I think some good work for the Commission in the
4 future will be to look at those set of questions that are
5 appropriate that CMS, Congress, and other policy and law
6 makers could be thinking about, but also maybe even go far
7 enough to start thinking about making specific policy
8 recommendations in this area as we prepare for three years
9 from now. Let's stay ahead of this game and be kind of
10 advancing the common goals that we have.

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

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

21 [Laughter.]

22 DR. SAMITT: So it's good to know that. It's very

1 helpful information. I'll have to go back and do something
2 about that.

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

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

22 And so I think we're going to learn a lot. I

1 think there are going to be some very high-performing
2 systems. I think there are already high-performing systems
3 in Medicare Advantage that we should be studying more
4 carefully. And there will be some very high-performing
5 systems -- hopefully we will be one of them -- in the ACO
6 space that the rest of the market will learn from and will
7 adopt over time.

8 I also think that ACOs are a way station that, you
9 know, even organizations like ours, you know, we're a track
10 2 ACO right now, but ultimately, you know, where we really
11 want to be is in Medicare Advantage, you know, that that's
12 the ultimate end state and we'll get there eventually.

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

22 A couple other things that -- you know, there's a

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

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

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

20 In terms of these issues, I think there's actually
21 some synergy between the beneficiary notification issue and
22 the cost-sharing issue. If we think part of -- I mean,

1 aside from the notification confusion or whatever, but
2 providing more incentives for beneficiaries to participate
3 can be preferential cost sharing when they stay in the ACO.
4 That's one of the flaws of this, the inability maybe to use
5 cost sharing as a way to steer patients into the more cost-
6 efficient providers. But it could also be a way now for the
7 beneficiaries to see a way that they can share in some of
8 the savings, that it's not all just going either the
9 government or to the providers.

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

20 So I think we -- and as well, looking at service
21 use rather than costs, all these things I think we should
22 pursue aggressively to see how much of that we can

1 incorporate into this next round.

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

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

22 [Laughter.]

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

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

22 The last point I would make is that it may be

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

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

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

16 [Pause.]

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

21 We talked about CPC in our examination of benefit
22 redesign issues in Medicare. What we'll be specifically

1 talking about today is what the rules might be for low-
2 income individuals who would need financial assistance in
3 paying premiums and cost sharing in a CPC system.

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

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

20 We'll also look at the status of dually eligible
21 beneficiaries in the current fee-for-service and MA programs
22 to highlight some issues that need to be considered.

1 We are using Part D for our discussions, but there
2 are other options that we will not be discussing today that
3 have been proposed, such as block grants to the States to
4 cover dually eligible populations or having Medicare and
5 Medicaid dual eligibles covered in exchanges and not through
6 the current Medicare and Medicaid system.

7 To remind you of what a competitively-determined
8 plan contribution system, or CPC system is, it would be an
9 approach whereby the government would determine a set dollar
10 contribution level for Medicare coverage. Medicare
11 beneficiaries would choose among different plan options in
12 the person's geographic area. The plan options would
13 include traditional fee-for-service Medicare and private
14 plans, where such plans were available. A bidding process
15 would determine the government contribution in each area.
16 Some plans will be more costly than others, requiring an
17 added premium payment from the beneficiary. The
18 beneficiary's current plan might be one that requires an
19 additional payment, and the relative cost of a given plan
20 can change from one year to the next. Such a system would
21 have consequences for dually eligible beneficiaries in terms
22 of which options might be fully subsidized, and States would

1 also see changes in their financial obligations, depending
2 on how the system was designed.

3 This graphic illustrates a CPC system where the
4 government contribution is set at the weighted average of
5 four bids in a geographic area, with each plan assumed to
6 have an equal level of enrollment. In this example, two
7 plans are at or below the government contribution level of
8 \$650, while the two plans on the right side of the slide,
9 Plans 3 and 4, are above the threshold. For low-income
10 individuals, Plans 1 and 2 would be the plans they could
11 enroll in without a premium, but like any other beneficiary,
12 they could enroll in Plan 3 or 4 by paying a premium out of
13 pocket.

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

20 As you will recall from last month's presentation
21 by Julie Lee and Scott, the CPC approach may involve
22 significant movement from current options as well as

1 movement from year to year, in particular for low-income
2 beneficiaries when only some options are fully subsidized.
3 If a limited number of options are fully subsidized, there
4 also may be issues with a plan's capacity to enroll a large
5 number of low-income individuals.

6 To state a basic principle of a CPC is that
7 through the bidding process, the lowest-cost plans can be
8 identified. As in the current Medicare program, under CPC,
9 all beneficiaries would have a portion of the cost of
10 coverage subsidized in the sense that today, for example,
11 the Part B premium that beneficiaries pay is intended to
12 cover 25 percent of the program costs, while the remainder
13 is subsidized for all beneficiaries. For low-income
14 individuals, there are additional subsidies for premiums and
15 cost sharing and the costs of care that Medicare does not
16 cover is also subsidized for many beneficiaries. Arguably,
17 when trying to determine what is the least costly option for
18 low-income individuals, all program costs should be taken
19 into account: The Medicare Part A and Part B benefit, the
20 drug benefit, and the cost sharing for each of these
21 benefits as well as costs of services, such as long-term
22 care services and supports.

1 In a CPC system, one way to try to ensure that the
2 least costly option is identified is to have all plans bid
3 on the full package of benefits. As we will discuss, there
4 are a number of issues to consider if CPC is designed in
5 that way.

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

17 I should also mention that another difference
18 between the Part D model and the CPC system that we have
19 been talking about is that Part D plans bid for geographic
20 regions that consist of entire States or multi-State
21 regions. We have been talking about smaller geographic
22 areas for CPC bidding, consisting of metropolitan areas and

1 units known as Health Service Areas within States. In
2 addition, plans are not at full risk under Part D, but MA
3 plans bear full risk for the Part A and Part B benefits.

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

21 With regard to cost sharing and out-of-pocket
22 costs that can be subsidized for low-income individuals,

1 here's a listing of those items that could be subsidized.
2 Some dually eligible beneficiaries only have their Part B
3 premium paid, as in the case of the category we refer to as
4 qualified individuals, or QIs. Other beneficiaries have, in
5 addition to premium assistance, cost sharing protections
6 under A and B, as I mentioned.

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

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

18 As I mentioned, there is a lack of uniformity in
19 Medicaid payments for cost sharing under Medicare Parts A
20 and B, and the Medicaid program often pays less than
21 Medicare allows in cost sharing. The consequence of this in
22 the current system is that in fee-for-service Medicare,

1 providers can decline to accept dually eligible
2 beneficiaries, and in MA, plans may have to pay higher
3 amounts to providers to ensure access to care through the
4 plan's network. Non-dual enrollees may also end up
5 subsidizing cost sharing for dually eligible beneficiaries
6 in MA plans.

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

15 A potential remedy for this in CPC is to level the
16 playing field by "federalizing" cost sharing at a uniform
17 level, as was done in Part D. This would apply to both
18 private plans and to fee-for-service, which is a bidding
19 plan in a CPC system. It would be costly to raise cost
20 sharing to Medicare-allowed levels across the States and
21 policy makers would have to deal with the question of how to
22 finance such an approach. In Part D, the federalization of

1 the drug benefit included a maintenance of effort provision
2 whereby States contributed to the cost based on their
3 historical costs. Other possible options include having the
4 States share in the actual incurred cost. Different options
5 would have different States paying relatively more,
6 depending on how generous they had been in the payment of
7 Medicare cost sharing historically.

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

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

1 assigned low-income enrollees.

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

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

21 If all plans are to bid on the Medicaid benefits
22 for dually eligibles, then a risk adjustment model for the

1 combined set of benefits may be easier to develop if there
2 is a standardized benefit package. However, coming up with
3 a standardized benefit package is not like standardizing
4 cost sharing for A and B benefits. There is wide variation
5 in what States cover under Medicaid and there are many
6 reasons why there is variation across the States, including
7 greater or less reliance on institutional care. Thus, it
8 would be difficult to devise a standardized benefit.

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

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

20 Part D was an expansion of the Medicare benefit,
21 but it is unlikely that the Medicare benefit would be
22 expanded to cover what are now Medicaid benefits.

1 Presumably, therefore, plans would bid on the Medicaid
2 benefit to serve only the dual population, though it is
3 possible that the benefit could be offered to non-duals as
4 an optional benefit. Even in that case, though, the option
5 would be very expensive and there would be pricing issues
6 that would have to be addressed to avoid adverse selection.

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

22 So I'll close by restating the opening question,

1 which is, is it feasible to use Part D as the model for
2 dealing with low-income beneficiaries in a CPC system, or
3 should the CPC system be limited to the Medicare A and B
4 benefits with other benefits dealt with separately? We have
5 looked at several issues that complicate the situation for
6 low-income beneficiaries within CPC, including the lack of
7 uniformity in cost sharing and the lack of uniformity in
8 benefits that make it difficult to have combined bidding in
9 CPC. We also looked at different ways combined bidding
10 might be implemented and discussed whether all beneficiaries
11 might have access to an expanded benefit and whether all
12 plans should bid on a combined benefit. We have also
13 touched on the question of whether there should be standards
14 for plans to ensure that dually eligible beneficiaries and
15 the under-65 in particular are adequately served, which is a
16 point that Christine and Lauren will discuss in their
17 presentation this afternoon.

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

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

22 So, let's see, we're going to do round one

1 beginning with Scott again, because I'm a sensitive kind of
2 guy and I know he's feeling a little put upon.

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

5 MR. HACKBARTH: Right. Right.

6 MR. ARMSTRONG: Think about it a little bit.

7 MR. HACKBARTH: And, actually, let me modify what
8 I said, Scott, especially given our late time right now.
9 Let me ask for a show of hands. You may not have a
10 clarifying question that you want to ask. So we have Cori.
11 Anybody else on this side? Okay. Cori, you go ahead.

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

16 MR. ZARABOZO: What that was doing was there was a
17 situation where one area had four plans, and then I was
18 saying, well, let's look at two other areas and use the same
19 plan bids to see what happens. So one of them, for example,
20 was \$500 and \$600 were the two bids, so the weighted average
21 would be \$550. The other example was \$600 and \$700, so the
22 weighted average would be a different number.

1 MS. UCCELLO: So I guess my confusion was, well, I
2 thought these were going to be based on national averages,
3 but it was actually done looking more regionally or --

4 MR. ZARABOZO: Yes.

5 MS. UCCELLO: Okay.

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

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

10 MR. ZARABOZO: Right.

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

13 Clarifying questions? I have Kate and then Mary.

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

21 MR. ZARABOZO: That's a good question.

22 [Laughter.]

1 MR. ZARABOZO: Umm --

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

4 [Laughter.]

5 DR. BAICKER: [Off microphone.]

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

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

15 MR. ZARABOZO: And the State could have --

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

18 MR. ZARABOZO: Yes, that --

19 DR. MARK MILLER: -- in my head.

20 MR. ZARABOZO: Yeah.

21 DR. MARK MILLER: Does that get close?

22 DR. BAICKER: [Off microphone.]

1 DR. MARK MILLER: It's a way.

2 MR. HACKBARTH: Mary.

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

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

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

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

20 MR. HACKBARTH: There isn't here, I think, a
21 really important question to which I don't know the answer.
22 This model would tend to -- do all plans need to be prepared

1 to serve duals as opposed to what is happening in the demos,
2 which may mean that select plans build the necessary
3 clinical infrastructure to deal with dually eligible
4 patients, especially the really complicated ones that have
5 severe physical disabilities or cognitive issues. So are
6 those generalized capabilities that every health plan ought
7 to have, or are they really more appropriately found in
8 specialized organizations? A question. I don't know the
9 answer.

10 MR. GEORGE MILLER: Yes. I'd like to ask a
11 different type of question for our discussion and that is,
12 notwithstanding that I -- well, first of all, I thought the
13 chapter was very well done and certainly liked the
14 discussion of CPC. But for this population, for these low-
15 income beneficiaries, is the CPC model the right model then
16 to put in things like Part D in, versus the other way
17 around. Is Part D the right model for subsidizing low-
18 income beneficiaries in the CPC? Is there another model
19 that may work better, particularly because of the complexity
20 -- I mean, the extraordinary work that was done in putting
21 this chapter together, I almost felt I needed a Philadelphia
22 lawyer to read it with me to help explain everything that

1 went through in the chapter. And as a result, for this
2 vulnerable population and all the different things that they
3 need, especially the care coordination, the mental health
4 and all those services, it's just a wonder how they can
5 migrate through all this, the different options and the
6 different things that they would need to do. Is this the
7 best model to help them to do that? That's my question.

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

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

14 MR. HACKBARTH: No assumptions.

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

20 MR. HACKBARTH: Yeah. So what I meant to say,
21 George, at two levels. First of all, whether CPC is the
22 right model for anybody is an open question. You know,

1 we're just trying to think through it systematically. And
2 then as we try -- we've done this in a series of meetings
3 now and taken off pieces of it. Now, we've looked at this
4 particular challenge of the dually eligible Medicare
5 beneficiaries and it's sort of a second-level question.
6 Even if you were to do CPC, how do you bring this
7 particularly challenging population that exists now in this
8 dual Federal-State structure into a CPC model? Should you
9 try to do it using Part D, that model as the foundation, or
10 do it the way we do it in Medicare Advantage, which is you
11 have the plans bid and then the State Medicaid programs fill
12 in in different ways, State by State, in accordance with
13 their own rules. Really complicated stuff to think through,
14 and we're just trying to begin the process of thinking
15 through these issues.

16 Clarifying questions? Peter and then Bill.

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

18 [Laughter.]

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

22 MR. HACKBARTH: Well, we spent a fair amount of

1 time with MACPAC on the CMS demos, and so we do recognize
2 that this has implications for both organizations. We
3 haven't tried to synchronize positions on things, but we've
4 shared information, shared perspectives and the like.

5 You know, if, in fact, we decide to move toward
6 some recommendations on CPC, this would be an issue that
7 would be implicated and we would go through a similar
8 process of talking to MACPAC about our thinking on it. But
9 in my mind, we're still quite a distance upstream from that.
10 We're still thinking at a very conceptual level about the
11 overall issues raised by CPC, and I think it's premature to
12 go to MACPAC on any particular issue at this time.

13 Bill.

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

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

1 ahead of each other.

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

16 DR. HALL: Just a clarifying point, for what it's
17 worth. CPC is an acronym that's already been taken in the
18 medical world that refers to a specific kind of conference
19 that looks at the sequence of events that led to a
20 misadventure and to a death. Every week, the New England
21 Journal has a CPC conference on the front cover. So you
22 might want to reconsider the acronym.

1 [Off microphone discussion.]

2 MR. ZARABOZO: We've actually trademarked CPC
3 here, so you're going to have to stop using it.

4 [Laughter.]

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

7 On to round two. Scott.

8 MR. ARMSTRONG: Just a couple of points.

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

13 [Laughter.]

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

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

1 particularly complicated part of this, given the
2 coordination issues and so forth.

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

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

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

17 That's all.

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

21 [Laughter.]

22 MR. ZARABOZO: Is that a compliment or --

1 [Laughter.]

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

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

16 And in terms of pooling and segmentation and, you
17 know, how -- do we have different rates for one group than
18 another, I generally favor as much pooling as possible. And
19 when we think about potentially offering some of these long-
20 term-care benefits for the non-duals, the actuary in me, you
21 know, I'm screaming, "Oh, my God, oh, my God." This is, you
22 know, adverse selection galore here. So, I mean, I think

1 we'd have to be very careful with that kind of thing

2 So just generally, you know, I look forward to us
3 thinking through this more, but, again, fantastic job in
4 just showing how many questions need to be addressed if we
5 move forward on this.

6 DR. SAMITT: So great job with the chapter.

7 Thanks.

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

19 Likewise, for the second part about segmentation,
20 for me that depends because it will -- how will the plans
21 respond, and how will the providers respond? And, you know,
22 caring for the dually eligible population has great

1 opportunities for systems that are successful, and care
2 coordination and value-based care delivery. And so will we
3 see a lot of desirability of dual eligibles? And if so, I
4 don't think we should segment them. We should keep them
5 together. But if we are concerned that this population will
6 be less attractive to some plans, then maybe we sort of need
7 a bidding process for Medicare-only and a separate bidding
8 process for Medicare or Medicaid duals. And I don't -- and
9 whether there's some kind of variation on the theme, that it
10 really should be a separate segmented process just to make
11 sure that folks have an opportunity to bid separately, look
12 at the populations separately, and that we have ample
13 participants in both sets of plans.

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

19 My first reaction was: Why not have the bidding
20 as a uniform bidding for everyone? But I know that there
21 are some selection issues and there are some issues of
22 overall cost. And the payment-to-cost ratio changes

1 tremendously in terms of managing these specific patients.
2 So I would say that the demonstration projects that are
3 going on right now are going to be invaluable. I know that
4 Massachusetts has one, and some of the strategies they are
5 employing I think are very helpful for the rest of the
6 states to kind of look at. But Massachusetts in and of
7 itself is very unique with -- it wouldn't be translated to
8 some other states in terms of their challenges.

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

14 DR. CHERNEW: I agree with all that has been said,
15 explicitly the extent to which you've laid out an
16 exceptionally complex topic, and I think it's just a broader
17 illustration of how hard it is to figure out how to deal
18 with aspects of the duals and cost sharing in different ways
19 in the Medicare program. And my general feeling is we deal
20 with this issue -- even apart from the CPC, we have to deal
21 with this issue for the reasons that Alice said and how we
22 deal with different -- where Medicare and Medicaid rub

1 together, and when that doesn't work very well, how we might
2 deal with it.

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

1 -- to really enunciate exactly what the clear answer should
2 be, and that's certainly where I am.

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

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

17 [Laughter.]

18 PARTICIPANT: [off microphone].

19 DR. NAYLOR: Not at all. Great, amazing job. I
20 do think that this conversation represents an opportunity,
21 and the conversation that we'll have later, to really
22 highlight both the complexity and vulnerability and multiple

1 dimensions of a challenge of the dual eligibles and maybe
2 some potential solutions. So I don't see it exactly in the
3 same way.

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

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

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

1 complexity of the care needs.

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

8 I hope that made sense.

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

12 [Laughter.]

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

1 charged one that you need to think through.

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

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

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

1 this that will come up in the afternoon.

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

11 Not next month. Next year [off microphone].

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

22 Peter raised a point that I was going to raise,

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

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

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

22 So, in conclusion -- and please don't throw

1 something at me for this. I'm just trying to indicate my
2 uncertainty about what to move. I think our premise ought
3 to be subject to a lot more discussion than we've had so
4 far, the premise that this division should be resolved on
5 the Federal side rather than on the state side. Or to be
6 more specific, the question comes to me, comes in my mind:
7 What about trying to figure out a way in which Medicare
8 makes a payment to the states to assure that the states can
9 provide the Medicare level of benefits to the dual eligibles
10 rather than trying to figure it out the other way around?

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

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

22 But having said that, I think when that was done

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

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

1 to impose a bidding system on top of it. So I think
2 separating out the issues around trying to do a bidding
3 system from just what it means to deliver care in a better
4 way to this population is a good separation. I think
5 obviously we'll have to intersect at times.

6 You know, from what I've looked at on the Part D
7 program, there are two comments I want to make about how it
8 relates.

9 One is that even though Part D is set up to be a
10 bidding system where everybody bids on the entire
11 population, there is a fair amount of effective segmentation
12 that actually occurs within Part D. For an awful lot of the
13 plan sponsors, but not all of them, their basic plan is
14 sometimes 80 to 90 to 95 percent low-income subsidy
15 patients, enrollees; and their enhanced plan is the
16 opposite. So for at least some of those -- it's not true of
17 every sponsor, but for probably a majority of the sponsors,
18 there really has been a segmentation, and we've had
19 scenarios where sponsors, you know, seem like they want to
20 get that population, and other years where they seem like
21 they don't want to get it. But there's definitely a kind of
22 a segmentation that occurs even in a structure that wasn't

1 supposed to be segmented. So I think that's something to
2 bear in mind.

3 The other goes to this whole thing on choices and
4 constraints on choices and the idea that -- there's a couple
5 ideas here. One is there's this churning because every year
6 when different plans qualify as the benchmark plans for
7 which there will be no premium, there's a whole set of
8 people reassigned, auto-reassigned every year, and so
9 there's a lot of churning and disruption for that population
10 in order to try to maintain choice but keep them in the
11 cheap plans. But we also the phenomenon where we have as
12 many as a quarter of all the LIS patients actually not
13 ending up in a benchmark plan and paying premiums. If that
14 were because they're making informed choices that it's worth
15 paying another \$5 or \$10 or \$20 or \$30 a month to get the
16 kind of plan they're in, that would suggest that system is
17 working well. But I think we think that that's probably
18 just, you know, at one point they made a choice and now
19 people are sticking -- they don't do their research, and
20 they're kind of sticking to those plans even though
21 sometimes those premiums start to creep up fairly high.
22 Unfortunately, we don't understand very well why that

1 happens, but it says that even though you're trying to make
2 sure you create a system that keeps people fully subsidized,
3 that seems -- there seems to be a limit to which that works
4 in Part D. And so thinking about how that would play a
5 level of benefits that's potentially quite a bit more
6 expensive, even than the ones that were in expensive plans,
7 they may be paying, you know, \$30 or \$40 a month, which is a
8 lot of money for a low-income person, but in a full A, B and
9 D kind of world, that's going to be more dollars if they end
10 up in the "wrong" plan, the non-subsidized, the non-low-
11 option plan. And because people tend to be pretty sticky
12 and don't do their research, there's a fair expectation that
13 that could happen.

14 So I guess I'll stop with those points.

15 DR. NERENZ: Well, as others have pointed out,
16 there's a lot of very much complexity and detail in the
17 chapter, and it took a lot of thought to lay that all out
18 for us. And so in reading it, I was trying to sort out for
19 myself how much of that complexity is absolutely essential
20 and really must, must be addressed to go down this general
21 path at all. And how much of it is based on certain like
22 intermediary choices where you choose a certain branch path,

1 and then once you've done that, now no problem?

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

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

21 All right. Now, then I go to page 12 in the
22 report. Sorry to keep flipping back and forth, but I think

1 this hangs together. There was a very surprising sentence
2 there that I marked when I read it. It says, "In the
3 majority of states, Medicaid payments are limited to the
4 total amount provider receives, which includes Medicare
5 payment and any cost sharing, cannot exceed what Medicaid
6 would have paid."

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

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

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

22 MR. ZARABOZO: To answer the question whether or

1 not we will pay any cost sharing, we will look at the
2 Medicare payment and see if it's more than we, Medicaid,
3 would pay. We will not pay cost sharing.

4 DR. NERENZ: Okay.

5 DR. MARK MILLER: [off microphone].

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

14 [Off-microphone discussion.]

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

19 DR. NERENZ: Okay. But at least up to that
20 question -- I'm sorry. I then misinterpreted that sentence.
21 The fundamental problem in this that the rest of the
22 complexity would try to solve would be basically the problem

1 with provider level access, providers being willing to
2 accept patients -- duals as the prime example -- who would
3 come through this program. Okay.

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

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

21 MR. ZARABOZO: That's the point about -- yeah, it
22 would be to raise it to the Medicare level, yeah

1 MR. HACKBARTH: Okay. Two comments -- one
2 specific to the duals issue and then one more broadly about
3 competitively determined contributions, not CPC. And the
4 second comment is more for the audience than for the
5 Commissioners.

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

1 population or these populations?

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

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

19 For the audience, on the broader question of what
20 we're up to, it occurs to me that not everybody has been
21 here for all of our serial conversations on this broad topic
22 of competitively determined plan contributions. What we're

1 trying to do here is take an idea, sometimes referred to as
2 "premium support" by some people, "vouchers" by other
3 people, "defined contributions" by still other people, and
4 there's a lot of heated, emotional, political rhetoric about
5 it, and break it down into pieces and try to think through
6 systematically what the issues are that need to be addressed
7 if Medicare were to go this way.

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

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

19 We'll now have our public comment period.

20 I know you know the rules very well, but let me
21 just quickly repeat them for other people. Identify
22 yourself and your organization, and please limit your

1 comments to no more than a couple of minutes. When the red
2 light comes back on, that signifies the end of the two
3 minutes.

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

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

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

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

20 That is quintessentially not the case for the
21 dually eligible population because they're certified not to
22 be able to do so.

1 So perhaps it would be a good Federal policy to
2 treat the bad debts created by state repricing, which was
3 permitted by Congress on a different basis.

4 Thank you.

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

7 [Whereupon, at 12:25 p.m., the meeting was
8 recessed, to reconvene at 1:25 p.m., this same day.]

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1 the Commission recently recommended that D-SNPs that are
2 MMCPs be made permanent and that the authority for all other
3 D-SNPs be allowed to expire.

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

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

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

1 use affect spending.

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

7 Now I'll turn it over to Lauren.

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

15 Individuals under 65 and age 65 and older may also
16 qualify for Medicaid if their income and assets are low
17 enough to meet Medicaid eligibility. Or if they incur high
18 medical expenses, they can deduct the cost of the medical
19 care from their income and spend down in order to qualify
20 for Medicaid. The spend-down population is referred to as
21 the "medically needy" pathway. However, the medically needy
22 pathway is an optional Medicaid eligibility category --

1 meaning that states may decide to cover or not to cover this
2 group of individuals.

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

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

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

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

1 remainder are partial benefit.

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

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

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

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

19 Lastly, Medicare and Medicaid covers behavioral
20 health services for dual eligibles, which include mental
21 health and substance abuse services. In general, Medicare
22 covers partial hospitalizations and visits to behavioral

1 health providers, while Medicaid services generally include
2 social work, personal care, rehabilitation, and preventative
3 services.

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

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

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

22 For all dual eligibles, Medicare accounted for

1 more than half of combined Medicare and Medicaid spending.
2 Assuming an average federal match of 60 percent, total
3 federal spending on dual eligibles was an estimated \$141
4 billion in 2009.

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

13 Lastly, we also analyzed spending on dual
14 eligibles with a severe and persistent mental illness, or
15 SPMI, which we define as schizophrenia, schizoaffective
16 disorder, bipolar disorder, major depressive disorder, and
17 paranoid disorder. The SPMI population is a subset of the
18 behavioral health population. In 2009, about 16 percent of
19 dual eligibles had at least one SPMI condition. There was a
20 higher prevalence of SPMI among dual eligibles under the age
21 of 65. This is expected because having a disabling mental
22 health condition can qualify an individual for SSDI, which,

1 as I explained earlier, is the main pathway to dual-eligible
2 status for individuals under age 65. Medicare accounted for
3 more than half of combined spending on the SPMI population.

4 The literature suggests that Medicare and Medicaid
5 Coordination Programs, or MMCPs, can reduce utilization of
6 certain high-cost services, such as hospital and nursing
7 home utilization, but the Medicare and Medicaid programs may
8 not realize savings from the reduced utilization.

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

18 With respect to Medicaid, savings may be possible
19 by shifting beneficiaries that use LTSS services out of
20 nursing homes and into community-based settings. This is
21 referred to as state's rebalancing their long-term-care
22 system. This shift out of nursing homes and into community-

1 based settings can occur through MMCPs or through state
2 initiatives that are independent of MMCPs. Much of the
3 literature on the shift of LTSS services out of nursing
4 homes and into the community shows that it can result in
5 Medicaid savings. However, much of this literature looks at
6 per user savings rather than aggregate Medicaid savings.
7 For instance, on a per user basis, Medicaid expenditures can
8 decline if it is cheaper to provide LTSS services in the
9 community rather than in a nursing home. However, total
10 Medicaid expenditures can increase if the nursing home beds
11 of the beneficiaries that shifted to the community are
12 filled by other Medicaid beneficiaries.

13 Christine will now review the findings of the
14 qualitative analysis.

15 MS. AGUIAR: Moving on to now to our findings
16 about MMCPs from structured interviews, our June 2011 report
17 described key MMCP activities that are listed on this slide.
18 For the analysis I'll discuss today, we interviewed mostly
19 providers and care managers. We learned more about barriers
20 to care coordination, such as the complex physical and non-
21 physical needs that affect dual eligibles' medical care and
22 dual eligibles' many providers that operate in silos of

1 care. We also learned more details on the key practices
2 that MMCPs use to overcome these barriers. As I'm reviewing
3 the key practices over the next few slides, please keep in
4 mind that one possible strategy to prepare MA plans for dual
5 eligibles is for MA plans to adopt these key strategies.

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

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

21 One is providing high-contact, in-person care that
22 is not limited to a few visits. For example, some MMCP care

1 managers attend doctor appointments with dual eligibles.

2 Conducting home visits to assess dual eligibles'
3 living situations is another key practice. One care manager
4 described visiting a beneficiary's home to identify why the
5 individual kept missing medical appointments. The care
6 manager realized that the individual was physically
7 disabled, lived on the second floor of a building without an
8 elevator, and could only make the medical appointments if
9 someone carried this individual down the stairs.

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

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

22 Interviewees consistently described dual

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

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

18 This slide also presents yet another key practice
19 of the MMCPs. In many states, there are care management
20 resources in the community. Some state or county-based
21 organizations and aging services agencies provide care
22 management to dual eligibles or administer or refer dual

1 eligibles to Medicaid or social services. Some behavioral
2 health providers and FQHCs employ care managers. The MMCPs
3 in our analysis generally leverage these resources by either
4 directly contracting with them for care management or by
5 coordinating with these organizations.

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

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

20 As you can see on this slide, the first option is
21 to adopt the MMCP key practices we just discussed into all
22 MA plans. The goal of this strategy is to support MA plans

1 in offering better care delivery for these beneficiaries
2 than is currently available through fee-for-service. Note
3 that the motivation here is to improve care coordination
4 rather than to achieve Medicare savings. As Lauren
5 discussed earlier, although the literature shows that key
6 activities of MMCPs reduce utilization, there is no evidence
7 of Medicare savings because of the way MA capitation rates
8 are set relative to fee-for-service.

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

16 The second strategy is to financially align
17 Medicare and Medicaid benefits. The separate Medicare and
18 Medicaid financing streams complicate care coordination, as
19 the Commission has said over the past few years, and they
20 result in cost shifting between the two programs.
21 Unfortunately, the MMCP key activities that we have been
22 discussing today alone do not fix the conflicting

1 incentives. One strategy is to financially align Medicare
2 and Medicaid benefits under current law. A second strategy
3 is to financially align those benefits in the context of a
4 CPC system, as you were discussing this morning in Carlos'
5 presentation.

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

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

22 On this slide, we also list options for which

1 Medicaid benefits could be federalized. The options are to
2 federalize all Medicaid benefits for dual eligibles, only
3 payment of Medicare cost sharing, or only the Medicaid
4 benefits for a particular dual-eligible subgroup. Given the
5 Commission's concern about the readiness of MA plans to
6 manage all dual eligibles' benefits, federalizing Medicaid
7 benefits for a subgroup of dual eligibles could be a way for
8 MA plans to gain experience with that subpopulation before
9 all Medicaid benefits are federalized.

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

14 MR. HACKBARTH: Okay, thank you.

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

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

22 And then my second question to that, who is going

1 to be their evaluation contractor, that's going to look at
2 this work and give a report on it?

3 MS. AGUIAR: I will answer the second one first.

4 I believe that it's RTI, but I will confirm that.
5 And Cori is agreeing, yes. But I will confirm that and get
6 back to you, but I do believe it is RTI.

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

13 The MOUs really do differ in the amount of
14 specificity about the care model that is written in the MOU.

15 Part of that, I think, like for example in
16 Massachusetts, that population is specifically the under-65
17 disabled. So the care management strategies for there may
18 be a little different than California where they're dealing
19 with a much more broader population.

20 We have not -- we've been tracking the MOUs but we
21 have not gone to look to sort of see -- done a count of are
22 these -- whether those key strategies are listed. And they

1 are sort of also sometimes listed in -- I don't want to say
2 -- perhaps a little more general terms than we're able to
3 really able to determine whether or not the plans are going
4 to be asked to do those key care management activities and
5 how it will be measured or regulated.

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

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

15 MR. KUHN: [off microphone] Thank you.

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

18 MR. GEORGE MILLER: Yes, please, on slide seven.

19 I greatly appreciate the demographic information.
20 One thing, in the reading, if I remember correctly, even
21 though minorities are more likely to be dual eligible but
22 whites make up the larger block of that. But do we have

1 defining characteristics of each one of the segments of the
2 population that drives them being dual eligible and the type
3 of care? Is the type of care, is it across the board? Is
4 it specific to any one particular bucket of folks? Or it
5 just hits all segments of the populations?

6 Any learning that we could derive from it?

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

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

12 MR. GEORGE MILLER: That's correct. Thank you.
13 You worded it better than I did. Thank you.

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

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

22 I'm not 100 percent sure, but I want to see if we

1 could tease out the demographics of the people that
2 participate in those programs.

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

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

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

16 MR. GEORGE MILLER: Right.

17 MS. AGUIAR: North Carolina, Massachusetts,
18 Minnesota, Wisconsin and Florida. They all have these
19 Medicare/Medicaid coordination programs. What I personally
20 found to be very striking finding from that was the
21 limitations and the barriers -- because again, we were
22 speaking to people on the ground, so providers on the

1 ground, care management on the ground -- were really the
2 same across all of those states.

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

7 MR. GEORGE MILLER: Right.

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

10 MR. GEORGE MILLER: Thank you.

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

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

20 In the past, when we've looked at kind of pilot
21 coordination programs in CMS, it didn't look like they were
22 showing much results. So this one you say does work. Can

1 you cite any kind of numbers, in terms of the amount of the
2 impact of the program? Because it's kind of fundamental to
3 whether this is a good idea or not.

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

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

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

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

19 MS. AGUIAR: Sure.

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

22 MS. AGUIAR: Exactly, that addressed both. Right.

1 And so what we have seen from the literature is there
2 definitely has been evidence that these programs -- as Mary
3 said, PACE, which we include in our previous reports, more
4 literature review of PACE -- really does reduce more of the
5 expensive, high cost hospitalization, nursing home use, ER
6 visits.

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

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

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

20 MR. HACKBARTH: Okay, other clarifying questions?

21 MR. GRADISON: Is there any information that
22 you've looked at or that's available at the state level

1 about how managed care plans that they run entirely on their
2 own deal with these same issues for people who just don't
3 happen to qualify for Medicare? It could be a 64-year-old
4 non-disabled person or something like that.

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

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

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

18 So we wanted to talk with them really just to sort
19 of see from the other side, they have the Medicaid side but
20 they don't have the Medicare side. So we did speak with
21 them, and again it was really just a lot of the same issues
22 about silos of care and just the need of intense care

1 management, the need of someone minding the shop across the
2 multiple providers.

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

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

15 MR. GRADISON: Thank you.

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

20 MS. AGUIAR: oh, that's good.

21 DR. HOADLEY: On Slide 2, when you define the term
22 MMCP, is that a term with an official, sort of CMS meaning?

1 Or is it more of a term of art you're using, as you've
2 described it here?

3 MS. AGUIAR: Yeah. It's a term we invented.

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

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

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

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

21 MS. AGUIAR: Right. No, they really weren't. We
22 really tried to go into markets where we knew that there was

1 at least an MMCP operating, and then to talk with providers.
2 What we didn't know really, in selecting the providers,
3 whether or not they were working, you know, basically some
4 of them were working with duals that were in these MMCPs.
5 Some of them were working with duals that were in regular
6 MA. Some were working with duals that were just in fee-for-
7 service.

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

10 DR. HOADLEY: Good, thank you.

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

13 Bottom of 6, the bullet of behavioral services.
14 What exactly is the defining line between what Medicaid pays
15 and what Medicare pays?

16 MS. AGUIAR: Oh for behavioral health?

17 DR. NERENZ: In that domain, yes.

18 MS. AGUIAR: In that domain.

19 I'm going to give you a preliminary answer and
20 then I'm going to check with Dana, who is our inpatient
21 psych specialist.

22 Lauren, do you have that in front of you?

1 MS. METAYER: I don't.

2 MS. AGUIAR: Pull that up.

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

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

11 MS. AGUIAR: I believe Medicare pays that.

12 DR. HOADLEY: Because it's a psychiatrist?

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

22 DR. HOADLEY: I am just curious, since there is

1 that divide, is that an area of coordination that we should
2 be paying some unique attention to just because of how there
3 might be some hair split distinction?

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

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

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

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

19 This is a -- if you look at slide 17, where you
20 talk about the two different strategies, whether it's an MA
21 plan of activities, or whether you financially align the
22 two, I think it's pretty clear what our objective is, what

1 we're trying to achieve. And that is both benefit
2 coordination and care coordination of a very difficult
3 population, in some cases a very difficult population.

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

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

15 I think there's too much at stake here, too many
16 dollars at stake, too many opportunities when you look at
17 this, to not continue to pursue this pretty aggressively but
18 I'd like to hear more about both of these strategies and see
19 which one aligns best and which one might make sense. And
20 also, learn a little bit more about what some of the states
21 are doing as they start to launch some of these particular
22 demonstrations that are out there.

1 DR. DEAN: To sort of follow-up on what Herb just
2 said, and maybe this was more a round one type question.
3 But the experience with supporting care coordination
4 programs in the past has been pretty disappointing. And
5 yet, it appears that at least some of these have been
6 somewhat more effective, although whether there's an
7 aggregate cost savings I guess is the question.

8 Do you have any sense about why these programs
9 were more effective? Was it because they were more
10 intensive? Was it because of a more select population that
11 really had a lot more needs and therefore were more
12 vulnerable to the fragmentation problems and so forth?

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

20 And from what we've heard again from plans through
21 this research, their ability to be able to manage the full
22 spectrum of benefits, particularly the home and community-

1 based service benefits, really helps them we've heard
2 anecdotally to keep beneficiaries in the community rather
3 than go to the nursing home.

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

9 PACE has the additional benefit of being able to
10 really merge the funding, since it is a very small program
11 and it is basically a provider-based program rather than an
12 insurance-based program. And so they are, I think -- I
13 won't say they're at a more of an advantage than an MCO but
14 I think why there's a lot of literature on PACE that shows
15 the positive outcomes is because they're able to blend these
16 financing streams. They're able to provide not only the
17 long-term care long-term services and supports in the
18 community that the beneficiaries need but they have
19 flexibility to provide other things that beneficiaries need,
20 as well. And because they function out of a daycare center,
21 there's a lot of focus on keeping a daily eye on these
22 beneficiaries.

1 MR. HACKBARTH: So let me ask a question,
2 Christine, about the nature of the evidence we have. So we
3 look at organizations with certain characteristics and there
4 are studies that show that they produce savings or improve
5 quality. How much variation is there around those averages?

6 The reason I ask that is it's sort of alluring to
7 say there's magic in a particular structure, whether it's a
8 financial or a type of care delivery program. But my
9 experience suggests that structures really -- they help.
10 They can facilitate. But execution accounts for a whole
11 lot.

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

16 Could you just characterize the evidence a little
17 bit more?

18 MS. AGUIAR: Sure. I would say, and again this
19 goes back to Peter's question. I would like to go back,
20 because when we looked at the evidence, it was sort of to
21 see -- we wanted to come with aggregate conclusions about
22 whether or not, in general, these programs are reducing

1 hospitalizations, nursing home visits. But we weren't
2 categorizing the magnitude of that yet. We have the
3 evidence, so we could go back to that.

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

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

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

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

1 MS. AGUIAR: Right.

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

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

16 [Laughter.]

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

19 DR. SAMITT: So I am exactly where you are on
20 this, Glenn. I think going back to Slide 15, you know, I'm
21 very skeptical about a regulatory solution to adopt
22 methodologies. It presumes that there's a one-size-fits-all

1 solution, which isn't really the case -- how do you know
2 which tools apply where, and the populations are different.

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

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

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

21 MS. UCCELLO: I have a clarifying question first.
22 On Slide 12, when we talk about this barrier, is this a

1 barrier even for -- the silo issue. Is this a barrier even
2 for duals who are already in MA plans? Or are you talking
3 more generally?

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

13 MS. UCCELLO: All right. Thank you.

14 I agree with financial -- the need for better,
15 more financial alignment, but we do need to think more about
16 these kind of coordination issues because I think they apply
17 not just to the duals, but for non-duals who happen to be
18 high-cost and may need the services that Medicaid provides
19 under duals, but they are paying for other ways to pay. So
20 I think that we need to think about this not just in the
21 dual environment but more generally for those with, you
22 know, high-cost, chronic, or long-term-care needs or things

1 like that, especially because one of the barriers here is
2 that it's not just -- the coordination isn't just between
3 the Medicare and the Medicaid services and providers, but
4 it's within those. And so, you know, more needs to be done
5 even just within those kinds of services and the transitions
6 between those that are covered by one payer in addition to
7 across payers. So I think that's just something we need to
8 keep in mind as we move forward.

9 DR. REDBERG: So actually picking up on that
10 theme, dual eligibles are obviously a very disparate
11 population because of the under-65/over-65, the mentally
12 ill. But some of those themes Cori was just picking up on I
13 think are not just true for duals but for all patients, you
14 know, that we have a lack of care coordination. It's
15 certainly true in the Medicare fee-for-service system and
16 perhaps more so because, I mean, I see a lot of patients who
17 then tell me, "Well, my other cardiologist gave me this,"
18 and, you know, I mean, I don't even know who these other --
19 because you can see as many doctors as you want under
20 Medicare, and a lot of patients see many, many doctors, and
21 it's very -- there's no coordination at all, and they don't
22 have a primary care physician who's coordinating.

1 So I think care coordination, it looked like a lot
2 of the -- or some of the FQHCs that you talk to are moving
3 towards patient-centered medical homes, and that would be an
4 interesting group to look at and see how they're handling
5 the care coordination. Is it going better than those? But
6 certainly the silos issue is important, and communication.

7 But the other thing, you know, I think it's a very
8 difficult group, and I don't know what the answers are, but
9 part of it is these are -- I mean, the patient example you
10 gave, I mean, these aren't health care. These are big
11 social problems. I mean, in San Francisco, the homeless
12 population know that if they come to our emergency room and
13 they say they have chest pain, it's likely they'll have a
14 warm bed for the night. And you know it's a very expensive
15 way to give someone a warm bed, and you would like to be
16 able to do something else. But they can get admitted to the
17 hospital and stay for several thousand dollars, you know,
18 because they said they had chest pain or, you know, the drug
19 abusers come in and allege pain and get a lot of narcotics.
20 And it's very difficult social problems, and they're very
21 expensive ways to deal with it. But the city doesn't have
22 the same social services readily available for people, you

1 know, where they really need it and where it would really
2 help them. So it's an incredibly expensive way that really
3 doesn't treat, but you have all of the poverty and
4 depression and substance abuse all kind of rolled into, and
5 a lot of them are in the dual-eligible population.

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

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

22 I would just also, you know, in arguing against

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

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

20 I think it's more the first two than the latter,
21 to be frank. If there is some way that we could convince
22 ourselves solving for that population of patients health

1 care, actually applied and defined solutions that were much
2 broader to a much bigger swath of our Medicare program, our
3 health care system, might be a path for us to figure out how
4 do we, you know, find the wherewithal to really solve this
5 one. But it's hard.

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

19 At that level of description, it seems like that
20 would be a way to think about particularly the under-65
21 disabled. Now the low-income over-65 might actually just be
22 a more natural fit into Medicare Advantage as we currently

1 see it. But it would, I think, be worth thinking a bit more
2 about a PACE-like structure perhaps in a direct contracting
3 environment where you don't even go through a plan structure
4 to get there.

5 DR. HOADLEY: This really was a good paper and I
6 think really sets up a lot of interesting issues, and I find
7 myself resonating with a lot of the comments I'm hearing,
8 including this notion that a lot of the issues we're really
9 talking about are not particular to the dual-eligible
10 population, but they're broader issues about how to
11 encourage more care coordination and the example of the
12 physical health/behavioral health coordination, you know,
13 which I'm seeing in the project I'm doing on Medicaid-only
14 situations, and clearly there are plenty of examples where
15 it would apply in Medicare-only. And I think what we get is
16 that the dual just adds the extra layer of complication, so
17 it is something additional where there may be policy levers
18 that we can address, and that's why it's worth focusing on,
19 because where is it that the two streams of money or the two
20 sets of rules get in the way, but there are a lot of other
21 things that get in the way regardless. And the couple of
22 things that I think about are a lot of the kinds of services

1 you talk about from the examples you use on the care
2 coordination are the things that aren't necessarily paid for
3 by anybody, and that's where, you know, the capitation model
4 offers promise, because they can figure out it's worth our
5 spending X dollars here to save money there even though X
6 wouldn't have been paid for under either of the separate
7 rules. So that's a sort of good thought, and that's both
8 the time spent, the cost of the actual coordinators, but
9 also the things they want to coordinate to when they're --
10 about housing and nutrition and things that are kind of out
11 of the scope of programs like Medicare and Medicaid.

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

21 And, you know, my last comment really goes to this
22 leadership thing and some of the other ways we've

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

19 DR. HALL: I agree with the discussion that has
20 gone forward, and, you know, the term "duals" implies that
21 there's some homogeneity in a population, and that's the
22 antithesis of what this population looks like.

1 So I think at some point we're going to have to
2 figure out some way of subdividing the duals in terms of
3 their needs and -- their medical needs and their social
4 needs. So it's very different if someone has end-stage
5 renal disease and is 50 years of age or someone who is
6 demented at age 85. I don't know how you would say let's
7 develop a health system that will solve their problems.
8 It's too impossibly heterogeneous. It would be like saying
9 let's take everybody with the letter H and see if we could
10 develop a health care system for them.

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

14 MR. BUTLER: Okay. So I'll get to one precise
15 recommendation. I usually am concise, and I'll try to be,
16 but I can't -- I want to make one comment. You know, 150
17 years ago, these kinds of very sick people would often go to
18 the hospital, or the rich would stay home, and you would
19 have a doctor, a nurse, and maybe a spiritual leader, and
20 those were the three people that took care of all of it.
21 And if you did a family tree of, like, nurses and doctors
22 and what they have spawned in terms of a workforce to

1 coordinate these things, specialists and case managers and
2 hospice and nocturnists, you name it, physical therapists,
3 you have an army of people that now have lost sight of, you
4 know, what you're trying to do. That's just on the hospital
5 side.

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

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

1 these kinds of patients.

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

14 MR. GEORGE MILLER: Yes, very briefly, because
15 many of my colleagues have said and we're all around the
16 same issue, and primarily what is best for this population,
17 and then the broader population of Medicare beneficiaries,
18 whatever that model is. But I just want to echo that even
19 though we're addressing the health care issue, so many of
20 the social issues manifest itself to become a health care
21 issue. And wherever we end up, we have got to clearly
22 understand -- I liked listening to Peter talk about what we

1 used to have 150 years ago, and those who are now there -- I
2 won't let him forget this. Sometimes they're Philadelphia
3 lawyers who are there as well. But the ultimate goal is to
4 find the best solution for the patient, whatever model. And
5 sometimes we drive processes because of cost, and that
6 certainly is a consideration, as we look at this segment of
7 this population of people trying to develop and evolve the
8 best solution. And, you know, I'm not sure I've heard that
9 yet and certainly look to hear more information. MA plans
10 may be one solution, but the question is: Do they have all
11 of the coordinating efforts and all the resources necessary
12 to deliver the best care for the best patient at the best
13 time at the best place?

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

19 I don't have any answers here. I think that the
20 one thing that we know -- and this is apropos of Scott's
21 comment -- is we know right now that the differences in
22 eligibility requirements, the differences in benefits in

1 Medicare and Medicaid create unbelievable structural and
2 unnatural barriers for promoting the kind of seamless care
3 that this population needs. And so at least, at the very
4 least, we should be exploring the capacity to use financial
5 policies to eliminate or at least drive down some of those
6 barriers.

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

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

20 The last thing I'd say is that we've worked with
21 some of these groups, and they're different subgroups. So
22 the younger disabled and the kinds of incentives that would

1 help us to get to better integration of mental health,
2 behavioral health, and physical health for the young
3 disabled are quite different than those for the frail, older
4 adults. And I think -- so at least one way, as Bill has
5 already suggested, is really let's think about these not as
6 duals but as complex people at different points in the
7 trajectory, and we need a different care delivery system.
8 We need a whole system redesign, but different approaches to
9 match their needs.

10 DR. CHERNEW: Thanks. A lot of this is motivated
11 by the observation that private plans in general don't have
12 a lot of experience with this population, which is certainly
13 true. But I think I'd be remiss if I didn't note that the
14 fee-for-service system, which I guess has been handling them
15 by default for ages, so has a lot of experience, hasn't done
16 all that well. So, you know, the bar we're comparing things
17 to matters, and doing better in these plans is really
18 important. But we're comparing them to a fee-for-service
19 system. And in that context, there's a lot of focus on the
20 coordination potential, gains potentially from coordination,
21 particularly across things like the Medicaid and Medicare
22 services and adding other services in. And I think that

1 that's wonderful. But I think it hasn't really been
2 emphasized much, not to forget that a lot of this type of
3 system coordination can prevent just flat-out abuses.

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

10 In the spirit of some of the comments that were
11 made earlier, I'm interested not just sort of in the average
12 effect of these programs, but also the heterogeneity of
13 their effects. I'm very much in many ways with what Glenn
14 said, which is I tend to really dislike detailed
15 requirements for plans to do very specific things. Some of
16 it is because sort of flat-out execution things, but also
17 the environments differ. So, broadly speaking, just because
18 some organizations are successful with a particular strategy
19 doesn't mean making the other organizations pursue that
20 strategy will lead to their success. They're different
21 people, they're in different environments, and there's just
22 probably a lot of heterogeneity.

1 So in response to sort of what Mary's saying about
2 what we need, there's a real question about who the "we" is
3 in that, and the extent to which the "we" is we need to
4 segment a bunch of things out and we need to change the
5 incentives in the systems and a bunch of things versus allow
6 the organizations with the right incentives and the right
7 setup to then figure out how to segment their own
8 populations for their own environment. And I think that
9 there's a lot of regulatory changes and efficiencies we
10 could probably make, but I tend to be on the side of being
11 less prescriptive and less regulatory about how they have to
12 treat the various populations. And I think --

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

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

21 I should say just in response to something Dave
22 said, and others, about PACE, we had -- I mean, Jennie Chin

1 Hansen was here, but we had some chapters and work we did on
2 PACE the tone of which was typically how come these things
3 haven't diffused and could they diffuse if they didn't have
4 walls or I don't know how the roof would hold up. But,
5 anyway, the point is other aspects of how they would work.
6 And I think what I took from some of that discussion is
7 exactly this point that organizations that you believe are
8 actually really, really good tend not to be as replicable as
9 one would necessarily like, suggesting that it remains a
10 challenge to figure out how to do a good job. And I think
11 the reason why this chapter is so important is, of the
12 populations that we deal with -- and, of course, there's a
13 lot of populations -- this is a population where there's a
14 lot of money generally speaking, a lot of need for, you
15 know, good care, good coordination, and there's just a lot
16 of -- it's an important population because of the financial
17 and clinical implications, and I don't think we're serving
18 them particularly well now. So I think that is great. And
19 the more we can add suggestion-wise, the more we can set up
20 a system that will enable excellence to succeed, I think the
21 better. But I do tend to come down on the side of being
22 less prescriptive when possible.

1 DR. COOMBS: So I think that one of the things I'm
2 grappling with is that the quantity of labor and what's
3 necessary to do the best product or the perfect product that
4 everyone is talking about around the table is enormous. And
5 I don't want us to get it twisted in the sense that if there
6 is a need or a disparity in terms of access, in terms of
7 plans coming to the forefront to say, well, you know what,
8 this is an area we really want to focus in. If there's a
9 deficit in that area, it speaks to the fact that whatever
10 incentive out there is not good enough. And at some point
11 you have to say what does the incentive do if you're having
12 such a problem with having providers in the area? I mean,
13 that's like basic in terms of just reimbursements or
14 whatever's necessary to get to the next level.

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

19 And in terms of the social issues, I think when
20 you think about the social issues, sometimes they can be
21 overwhelming, and sometimes there's overutilization with
22 some of the social challenges. But, you know, I'm reminded

1 of something someone said in my psychiatry rotation in
2 medical school: "Just because you're paranoid and you think
3 they're out to get you, it doesn't mean that they're not out
4 to get you."

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

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

1 the spectrum.

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

18 MR. HACKBARTH: So this is the Medicare Payment
19 Advisory Commission, and I for one wouldn't be here if I
20 didn't think that payment wasn't important. But I don't
21 think it's the only thing that matters. You know, I think
22 that it's important to try to improve payment policy because

1 it can encourage and reward good things or it can remove
2 barriers to doing good things, and those are really
3 important. But in and of themselves, in and of itself,
4 changing payment policy doesn't guarantee you good results,
5 would be my thesis.

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

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

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

18 Something that Alice said resonates with me. You
19 know, when you're working within a care delivery system and
20 trying to solve a difficult problem -- and certainly dealing
21 with the unique needs of these patients would qualify --
22 there are barriers that you face that have nothing to do

1 with incentives, that are, you know, inherent in the
2 organizations that exist or don't exist and social
3 conditions and other things. And, you know, we need to be
4 realistic that, you know, no matter what we do, even if we
5 could envision a perfect policy and snap our fingers and
6 have Congress enact it, those things aren't going to go away
7 overnight.

8 One of the -- now I'm going to sort of "new
9 paragraph" and approach this from a different direction.
10 One of the things that always has frustrated me about health
11 care in general is that I think -- I can't prove this, but I
12 think there is maybe less aggressive effort to identify best
13 practices and import them than there may be in some other
14 industries. And, you know, I sort of wonder why that's
15 true. You know, we talk about good models, and I don't want
16 to regulate them for reasons that I said earlier. But, boy,
17 I wish people would be actively talking to one another and
18 trying to figure out what works and learn from it and import
19 it. Yet that seems to happen at a very slow pace within
20 health care. And, boy, I wish I knew what the key was to
21 accelerating that. That might be a real useful contribution
22 if we could figure out how to solve that problem.

1 DR. NAYLOR: I think that -- a couple of us were
2 on the IOM Learning Health System Study Committee and spent
3 18 months looking at this, and I do think that there is an
4 opportunity in terms of the kind of payment policy that
5 would accelerate a learning health system, meaning make it
6 an expectation if investments are made, and you show the
7 answer, and even if you can't adopt it directly in your
8 community, you can look at what it does contribute in terms
9 of advancing.

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

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

15 For now we need to move ahead to hospice.

16 [Pause.]

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

22 Over the years, the Commission has been very

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

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

18 One other item of note. While it's not on today's
19 agenda, we plan to have additional discussion in the future
20 about ways to facilitate hospice use among patients for whom
21 hospice fits with their preferences, exploring things like
22 shared decision making, concurrent care, and other

1 approaches that you discussed at the January meeting.

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

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

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

22 We also had information from a panel of hospice

1 physicians and executives that suggested that the benefit
2 needed stronger oversight. Panelists gave reports of lax
3 admission practices and recertification practices, and some
4 expressed concern about questionable financial arrangements
5 between some hospices and some nursing homes. At the
6 extreme, we heard anecdotal reports of some hospices engaged
7 in aggressive marketing tactics toward nursing home
8 patients.

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

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

21 The Commission also recommended several steps to
22 increase accountability of the hospice benefit, including a

1 physician narrative requirement and a face-to-face
2 recertification visit requirement. Both types of measures
3 have since been implemented.

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

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

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

16 This next slide shows the substantial amount of
17 Medicare hospice spending that's devoted to stays greater
18 than 180 days. In 2011, Medicare spent nearly \$8 billion on
19 hospice care for beneficiaries with stays exceeding 180
20 days, more than half of all hospice expenditures that year.
21 The Commission made a recommendation that CMS conduct
22 medical review of all stays exceeding 180 days for hospices

1 with an unusually large share of their patients with very
2 long stays. PPACA adopted a similar requirement, but CMS
3 has not implemented it. These data underscore the
4 importance of implementing the PPACA medical review
5 provision.

6 These data also show that Medicare spent about
7 \$2.7 billion in 2011 on additional hospice services for
8 patients who had already received at least one year of
9 hospice care. This raises a question of whether there
10 should be a policy where beyond a certain length of stay,
11 providers would be required to demonstrate a patient's
12 hospice eligibility to Medicare before additional payments
13 are made.

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

21 Since then, PPACA gave the Secretary of HHS the
22 authority to revise the hospice payment system as she

1 determines appropriate in fiscal year 2014 or later. To
2 date, no regulatory action on payment reform has been taken,
3 but CMS has a research contract underway to study the issue
4 and is getting input from an industry technical expert
5 panel. CMS has also sought comment from the industry on
6 potentially collecting data on non-labor costs like drugs,
7 supplies, DME, and also has indicated it is in the process
8 of considering cost report revisions.

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

18 So on this next slide, we have a picture of what
19 the average labor cost of visits per day looks like
20 throughout a hospice episode. What we have here is the data
21 for all hospice patients who were discharged deceased with a
22 length of stay of exactly 30 days. The blue line shows for

1 each day in the 30-day episode the average labor cost of
2 visits per day, and as you can see, it's U-shaped, higher at
3 the beginning and end, lower in the middle.

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

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

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

18 So, with the labor cost of visits data that you've
19 just seen, it's possible to take an initial step on payment
20 reform. Industry stakeholders point out that these data do
21 not include non-labor costs like drugs, DME, and supplies,
22 and they also do not include chaplain visits. But the six

1 type of staff for which we have visit data account for about
2 68 percent of hospices' direct costs. Therefore, we can use
3 the visit data initially to adjust a portion, specifically
4 68 percent, of the hospice payment rate for the U-shaped
5 curve and keep the remaining 32 percent of the payment rate
6 flat.

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

14 So here is what our example payment system looks
15 like. There is a per diem payment that starts higher and
16 declines over the course of the episode and then increases
17 in the last seven days of life. The first column lays out
18 the structure. We've created four different payment rate
19 groups, days one to seven, days eight to 14, days 15 to 30,
20 and days 31 and beyond. There's an extra payment for each
21 of the last seven days of life on top of the rate that
22 normally would apply for those seven days.

1 And in the second column, you can see the relative
2 rates for the different days in the episode based on the
3 labor cost of visits data you just saw.

4 And then the third column shows the payment rates
5 that result when we use the relative weights to adjust 60
6 percent of the base rate. Note these rate changes have been
7 calculated to be budget neutral in the aggregate. And the
8 resulting payment rates that you see in that third column
9 range from about \$255 per day for the first seven days to
10 \$139 per day for days 31 and beyond. The last seven days of
11 life would receive an additional \$120 per day on top of the
12 regular rate for those seven days.

13 And then you can look in the very far right
14 column. You can see how these rates compare to the current
15 flat \$153 per day. The rate for days one to seven increases
16 66 percent. The rate for days eight to 14 increases one
17 percent. The rate for days 15 to 30 declines four percent.
18 And the rate for days 31-plus declines ten percent.

19 So this next slide shows you the impact of the
20 illustrative payment system. As you can see here in the
21 first column of numbers on the left, the 20 percent of
22 hospices with the fewest patients staying more than 180 days

1 see an increase in payments of about 6.7 percent. In
2 contrast, the 20 percent of hospices with the most patients
3 staying more than 180 days see an decrease in payments of
4 about 3.7 percent.

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

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

19 So, to summarize, the effects of the illustrative
20 payment model are in the expected direction, but modest.
21 Larger changes might be needed to eliminate the higher
22 profitability of long stays, but a first step in that

1 direction is possible now with current data. Additional
2 changes could be considered later if additional data on non-
3 labor costs or chaplain visits become available.

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

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

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

17 However, unusually high rates of patients
18 discharged alive among some providers raise concerns about
19 questionable business practices. We heard industry concerns
20 about some providers that seek patients likely to have very
21 long stays, even if they may not meet the hospice
22 eligibility criteria of having a life expectancy of six

1 months or less. Higher rates of live discharge are one
2 indication of this practice, as providers often discharge
3 these long-stay patients when the hospice incurs liabilities
4 towards the payment cap.

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

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

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

19 Given our concern with some providers enrolling
20 patients who may not meet the eligibility criteria and then
21 discharging them, we wanted to look at patients with long
22 lengths of stay and their trajectories post-discharge. We

1 found that long lengths of stay were a key driver of live
2 discharge. Almost one-third of all patients discharged
3 alive in 2010 had spent at least 180 days in hospice before
4 they were discharged.

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

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

15 Again, we found a particular relationship with
16 above-cap hospices. Patients discharge from above-cap
17 hospices were over 20 percent more likely to still be alive
18 180 days after discharge, compared to patients discharged
19 from hospices below the cap.

20 While these results underscore the need to ensure
21 patients meet the hospice eligibility criteria before they
22 are admitted, some patients with long stays and stable

1 conditions will remain. We wanted to examine Medicare
2 spending outside hospice for these patients if they were
3 discharged compared to the payments Medicare would make to
4 hospice if they continued to remain there.

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

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

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

22 These results emphasize the need to ensure that

1 beneficiaries continue to be appropriate candidates for
2 hospice throughout long episodes.

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

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

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

21 This issue is motivated in part by a recent OIG
22 study. OIG examined hospices that focus on nursing facility

1 patients and found that these hospices tend to be for-profit
2 and treat patients with diagnoses that tend to have long
3 stays and require a less complex service mix. The OIG
4 recommended CMS monitor these hospices and that CMS reduce
5 the payment rate for hospice care in nursing facilities.

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

17 When we look at the hospice claims data, we see
18 that hospice staff provide more aide visits in nursing
19 facilities than in patients' homes, and it is not clear why
20 this occurs, since nursing facility residents have access to
21 assistance with their activities of daily living through the
22 facility staff.

1 The provision of hospice aide visits in the
2 nursing home raises questions of duplicate payment, and one
3 question that could be asked is whether the Medicare hospice
4 benefit should include aide visits in the nursing home
5 setting. Or an alternative way to think about this is it
6 seems reasonable to expect that nursing facility residents
7 receive no more aide visits than patients in the home.
8 Currently, we see patients in nursing facilities receive
9 more hospice aide visits and less hospice nurse visits than
10 patients at home. If nursing facility patients receive
11 similar amounts of aide visits to patients at home, the
12 overall labor cost of hospice visits for all types of visits
13 combined would be four to seven percent lower in the nursing
14 facility than in the home.

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

21 In summary, hospice spending on stays exceeding
22 180 days is substantial, accounting for more than half of

1 all Medicare hospice spending. This underscores the
2 importance of CMS implementing the PPACA medical review
3 provision. It also underscores the need to make progress on
4 payment reform, as a substantial amount of resources are
5 devoted to long stays that are favored under the current
6 payment system. As shown with our illustrative payment
7 model, an initial step toward payment reform is possible now
8 with existing data. The issue of high live discharge rates
9 among some hospices may signal questionable admitting
10 practices and bears further monitoring. Finally, the
11 provision of hospice aide visits in nursing facilities
12 raises questions of duplicative payment. A policy option
13 that could be considered is a reduction to the hospice
14 payment rate in nursing facilities.

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

17 MR. HACKBARTH: Thank you.

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

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

21 MR. HACKBARTH: Let me see hands going down this
22 way. Peter and then Bill and Jack.

1 MR. BUTLER: So the OIG study you referenced was
2 actually out of a recommendation we made in 2009, right?

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

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

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

22 MR. BUTLER: I was trying to get to a potentially

1 more aggressive and more specific recommendation than let's
2 just look at what's going on in these areas, because before,
3 I think you said, you asked that -- we asked the OIG the
4 financial relationships between hospices and long-term care
5 facilities. It was mostly related to, still, the nursing
6 home issue.

7 MS. NEUMAN: Yeah.

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

13 [Off microphone discussion.]

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

17 MR. BUTLER: But --

18 [Laughter.]

19 DR. MARK MILLER: No, that's good. On the live
20 discharge thing, of the three things that we have presented
21 here, we did not have more specific direction. On the other
22 two, it's much more clear. We think the data suggests

1 there's a U-shaped curve and then we have brought it to a
2 finer point on the nursing facility.

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

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

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

15 [Off microphone discussion.]

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

18 I would think that we want to not just lead to a
19 payment modification to make sure that this is under
20 control, but perhaps understanding, as you suggest, maybe
21 some fundamental things that are going on that need to be
22 corrected that maybe the payment by itself won't.

1 MS. SADOWNIK: I think it's also worth noting that
2 another panel that we had convened on hospice quality
3 experts had suggested monitoring providers with high rates
4 as something that would warrant looking at as a quality
5 measure in and of itself.

6 MR. HACKBARTH: Do you have any real --

7 MR. GRADISON: Yes, a quick question about nursing
8 home reimbursement. Could you please explain to me how the
9 80/20 rule applies? My recollection is that one of the
10 definitions of a hospice for Medicare purposes is that 80
11 percent of the patient days have to be outside of an
12 institution, and I want to -- I never really thought about
13 how that's defined. Would nursing homes as well as
14 hospitals be, or hospice physical facilities all be part of
15 the 20 percent?

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

19 MR. GRADISON: Yes.

20 MS. NEUMAN: So it's -- Medicare will only pay up
21 to 20 percent of the days to a particular hospice at the
22 higher inpatient level of care, and anything above that gets

1 paid at the regular home care rate. That's a little bit
2 different from the vast majority of care that's going on in
3 the nursing facility setting. Most of the nursing facility
4 hospice care is at the routine home care level. So it is
5 already at that home care level. It's not in that 20
6 percent and --

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

9 DR. HOADLEY: Yeah, two quick questions. On Slide
10 12, I think you said that the rates you have set up here are
11 done on a budget neutral basis, and I assume that when you
12 look at the percent change from the current rate, which on
13 the surface doesn't look very budget neutral, it's because
14 there are so many days in that 31-plus category.

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

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

19 And then on Slide 18, when you make a comparison
20 like this, \$156 per day for the hospice rate, is that the
21 rate paid to the hospice specifically and are there other
22 Medicare payments being made for those patients during the

1 period they're in the hospice that are not reflected on
2 this?

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

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

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

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

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

20 DR. REDBERG: I'm just trying to understand better
21 what particular services, if someone is in a nursing home
22 and is in hospice, are there different services, because it

1 seems like there's almost total overlap between what the
2 nursing home staff aides and nurses could do and what
3 hospice aides and nurses can do. Is there anything --
4 except for kind of a philosophy, is there anything that
5 differentiates them?

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

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

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

22 DR. REDBERG: Sure. It just seems like there is

1 potential for a kind of even cross-training or dual and
2 reduction in payment because it could be more efficiently
3 coordinated and collaborated between nursing home and
4 hospice. Thank you.

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

17 MS. NEUMAN: I think that there are certain niche
18 services, specialty services, that can be high cost that a
19 small portion of the hospice population might be candidates
20 for. So I think of things like palliative radiation for
21 bone metastases as being something that can be expensive and
22 that a small segment of the population would have need for.

1 And I think that that is what is the source of the things
2 that you're seeing articles about. And hospices are not --
3 like, for example, with palliative radiation, they're not
4 required to provide it. They need to tell the patients
5 ahead of time what services they offer and the patients can
6 decide whether or not to go with that hospice.

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

10 MS. NEUMAN: That's true. Exactly.

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

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

19 So I didn't quite understand. If we already take
20 68 percent of the costs, which represent the majority of the
21 labor costs, why is that methodology not consistent to say,
22 we want to go a whole lot further than just an initial step?

1 Is that a clear question?

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

4 DR. SAMITT: Please reword it for me.

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

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

19 DR. SAMITT: I'm not sure.

20 [Laughter.]

21 DR. SAMITT: No --

22 DR. MARK MILLER: And I'm sorry if I took you way

1 off. I thought your point was, you've got 68 percent of it
2 --

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

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

12 DR. SAMITT: Exactly.

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

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

15 MR. HACKBARTH: Put up 15, Kim.

16 MS. NEUMAN: Yes. This one?

17 MR. HACKBARTH: Oops, 13.

18 MS. NEUMAN: Yes.

19 DR. SAMITT: Right. So the difference between the
20 4.2 and the 13.8, you know, we say that the data is
21 sufficient for an interim step, but we still have quite a
22 bit of a gap. So I guess what I'm questioning is will full

1 data offer any additional information as to whether we
2 should skip over an initial step and just go all the way.

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

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

20 MR. HACKBARTH: So, Craig asked what I was going
21 to ask. So we've adjusted 58 percent and we get this amount
22 of compression. I don't hear any reason to think the last

1 32 percent would have a disproportionate impact, or is there
2 a reason why the last 32 percent would achieve relatively
3 more compression than the first 68 percent?

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

7 MR. HACKBARTH: Okay.

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

11 MR. HACKBARTH: Okay.

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

21 MR. HACKBARTH: Yeah. Well, let's frame that as a
22 question. So we're talking about making payment

1 adjustments. We're using as a barometer of success this
2 sort of analysis.

3 DR. CHERNEW: That's right.

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

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

7 MR. HACKBARTH: Yeah.

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

13 DR. CHERNEW: Mm-hmm.

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

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

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

22 DR. CHERNEW: And there's behavioral changes in

1 various ways. So I think it would be harder to make this
2 flat anyway. This is done without big behavioral changes.

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

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

22 MR. HACKBARTH: I think we're still on round one -

1 -

2 DR. CHERNEW: But it's a good round.

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

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

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

20 MS. NEUMAN: Well, there are certain specialized
21 high-cost things like palliative chemotherapy, palliative
22 radiation, and those are the two right now that come to mind

1 but I feel like there are a couple of others, where they
2 have the option of covering it if it's consistent with their
3 philosophy of care but they do not have to. They need to
4 notify the beneficiaries ahead of time of what they do and
5 don't cover and they need to treat all beneficiaries equally
6 with regard to those services.

7 MS. SADOWNIK: Also, in terms --

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

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

11 DR. DEAN: The same base rate.

12 MS. NEUMAN: Right. Yeah.

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

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

21 MS. SADOWNIK: We actually found, though, in terms
22 of live discharge, that -- because both of those,

1 chemotherapy and radiation, would be Part B services, and we
2 actually found that in terms of live discharge to go on and
3 use a service immediately after, that that was not -- it was
4 really emergency services that were driving the ship and
5 patient stays and mostly and to some extent ER outpatient
6 visits, and the spending on Part B was a fraction of one
7 percent, so --

8 MR. HACKBARTH: Herb.

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

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

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

19 MR. KUHN: Because as I read this, I was thinking
20 -- you know, what came to my mind was the multiple procedure
21 reduction for imaging, that you can only gown the patient
22 once. You greet them once. You know, these people travel

1 to a nursing facility once and there's a certain fixed cost
2 that one person incurs. I was wondering if they had
3 specified one way or the other. So they didn't. Okay.

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

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

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

1 changing the payment system?

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

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

8 MS. NEUMAN: Yes. Yes.

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

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

15 MR. HACKBARTH: Okay. Clarifying questions?
16 Alice.

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

1 of patients in there?

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

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

9 [Pause.]

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

17 On the hospice in nursing homes, I really think
18 that this is a very important area for continued inquiry.
19 The thing that I was -- your Table 6 that looked at aides,
20 nurse visits, and then total hospice visits in nursing home
21 versus not suggests, overall, there's more visits going on,
22 but it's not clear to me how much in some cases aides might

1 be substituting for other. I don't know if that's the case
2 or not. So the nurse visits at some of these time periods,
3 hospice nurse visit looks a little less, but the total any
4 hospice visit looks higher for nursing home versus not. So
5 I was just wondering, you know, to make sure that aides
6 weren't substituting in some cases for a professional.

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

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

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

22 But that being said, I think this is a very

1 important area of continued inquiry, and that's it.

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

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

16 And the other thing I think that is critically
17 important, if I remember correctly from the last report,
18 that you got some of these recommendations from the field,
19 which is an important ally that they recognize these things
20 in the -- behavior that takes place in the marketplace,
21 because, again, I think it's a very good program and the
22 fact that there could be tremendous savings in the overall

1 Medicare program by dealing with palliative care versus
2 heroic efforts to try to extend life when it's just not
3 going to be appropriate to do so. But at the same time,
4 we're responsible for the entire Medicare program and when
5 we see these issues, we certainly need to address them and I
6 think that the staff has done an excellent job of addressing
7 those issues.

8 [Off microphone discussion.]

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

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

20 MS. NEUMAN: Do you mean the --

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

1 MS. NEUMAN: Right.

2 DR. HALL: -- twice for 90-day periods, 30 days,
3 and then, unfortunately, the fourth one is indefinite, which
4 probably should disappear.

5 So another area of this we might look at is that
6 there may already be some controls put on this, that a
7 professional is looking at this pattern, but somehow it
8 isn't really being -- no one takes it seriously, quite
9 frankly.

10 MS. NEUMAN: So when someone is recertified for
11 hospice, it's the hospice physician --

12 DR. HALL: Right.

13 MS. NEUMAN: -- who does the recertification. And
14 we have not done analysis, like looking at the provider
15 number of that physician to see if there's different
16 patterns across different providers, or different
17 physicians, but it's something that could be looked at.

18 DR. HALL: So if you looked at those long stays
19 and you find that it concentrated on a relatively small
20 number of hospice physicians, one might say -- although we
21 hope that doesn't happen -- that the sign-off may not have
22 taken into consideration all of the implications of another

1 length of stay.

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

4 DR. HALL: Right.

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

7 MS. NEUMAN: Yes.

8 MR. HACKBARTH: And before, there was no
9 requirement for that. So that was one thing we added.

10 We also proposed -- recommended a requirement for
11 a face-to-face visit, which was also added in PPACA, right?

12 MS. NEUMAN: Correct. Yes.

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

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

21 DR. MARK MILLER: Well, and this goes back to --
22 and George mentioned this recently, so I think this must

1 have been before you showed up -- and so this was one of the
2 things -- I'm sorry, before you were appointed as a
3 Commissioner --

4 [Laughter.]

5 DR. MARK MILLER: Maybe a little too familiar.

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

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

14 And, actually, we had some medical directors from
15 around the country and there were some pretty surprised
16 responses when it went around the table and said, yes, there
17 are people in our marketplaces who are behaving this way.
18 And some of, I think, what's happening here, and your group
19 may be different than this, is that new actors were entering
20 the market and behaving differently, and I think some of the
21 people who had been around the block for a longer period of
22 time were saying, this is a very loose way to run the

1 railroad, that type of thing. And so that's what led to the
2 recommendations that these two were just talking about.

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

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

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

1 any discussion of since you began your excellent
2 presentation.

3 DR. MARK MILLER: No --

4 MS. NEUMAN: No, you go.

5 DR. MARK MILLER: After you.

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

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

18 On the long stay stuff, this provision in PPACA
19 about the medical review and the 180-day, you know, a lot of
20 180-day stays, you said has not been implemented. Do we
21 know anything about what's going on there? Are there some
22 issues with it?

1 MS. NEUMAN: We've asked a number of times and we
2 don't have any information as to why it hasn't been
3 implemented.

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

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

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

21 DR. HOADLEY: It may not be worth it. I don't
22 know. It just was a thought I had, because I do hear people

1 talk about nursing facilities that will do different kinds
2 of things and whether it could relate to this at all.

3 MS. NEUMAN: Yeah.

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

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

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

21 MS. NEUMAN: Exactly. So we have an issue on both
22 ends. We have the very long stays and some patients who are

1 probably of questionable eligibility. And then on the other
2 end, we have people coming in one, two, three, four days
3 before the end of their life and not getting the full
4 benefit that they might get if they had entered earlier.

5 And some of the stuff I mentioned at the
6 beginning, trying to facilitate hospice use among patients
7 who would be interested, like the shared decision making,
8 concurrent care kinds of stuff that we've talked about
9 exploring, that could be worked to sort of look further at
10 that issue.

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

16 MR. HACKBARTH: Our initial chapters on this
17 emphasized, as Kim said, that there are issues at both ends,
18 too late admission as well as very long stays. But my sense
19 from that earlier conversation several years ago was the
20 problem of people being admitted to hospice too late, we
21 didn't think was really amenable to a change in hospice
22 payment policy, that there were other factors that needed to

1 be worked on to fix that, whereas the long stay issue, we
2 thought was more a function of incentives created by the
3 payment policy. Is that fair, Kim?

4 MS. NEUMAN: [Nodding affirmatively.]

5 MR. HACKBARTH: Okay. Scott.

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

13 MR. ARMSTRONG: Yeah. I just would amplify a
14 couple of points. This really is an investment in a good
15 thing, hospice, in that I think we should expect to see a
16 return on this. If I remember correctly, ten, 12 years ago,
17 20 percent of patients dying on Medicare were dying in the
18 hospice program, and it's up to 45 percent now. I would
19 argue that's still far from where we should get this to, and
20 so there's still work to be done on that.

21 Nonetheless, we're not talking about that right
22 now, necessarily. We're talking about the per diem payment,

1 structure changes, and I support the direction that you're
2 going and I think it's smart.

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

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

16 MR. HACKBARTH: Rita.

17 DR. REDBERG: I just wanted to add, also, that I
18 support the changes that you suggest making to address the U
19 curve, but that also, although coverage can't really be a
20 mechanism for getting more patients into hospice, I notice
21 in particular in my field, I think we under-utilize hospice
22 care. I think it's most -- or cancer patients are most

1 likely to be referred to hospice. I couldn't really tell --
2 you gave the dollar amounts for how much goes into heart
3 disease and I forgot the other categories, you know, for
4 heart failure and other.

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

18 It's very gratifying that there's an increase in
19 use in hospice, except for perhaps people that don't
20 qualify, but that we could, perhaps, through increased
21 coverage for shared decision making or other non-coverage
22 mechanisms be increasing it, particularly for non-cancer

1 patients who would benefit.

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

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

18 MR. HACKBARTH: [Off microphone.]

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

22 One thing that -- there was one sentence in the

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

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

16 MS. NEUMAN: The patients would be --

17 MR. HACKBARTH: Residential?

18 MS. NEUMAN: Not in a Medicare SNF stay.

19 MR. HACKBARTH: A residential facility.

20 MS. NEUMAN: Yeah. They'd be a residential,
21 exactly. And to follow up on that, Medicaid does pay --
22 typically will pay 95 percent of the room and board for a

1 hospice patient rather than 100 percent.

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

10 The only thing that I'd love to see more of is the
11 fact that, on the one hand, we say that we're using hospice
12 -- we're considering hospice too late, and on the other
13 hand, there are some instances where we are probably using
14 hospice too long or too much. And it begs the question
15 about whether there's an accountability problem. So who
16 upstream should be more accountable for the under-
17 utilization or the excessive length of hospice? You would
18 imagine that ACOs should pay attention to this and MA would
19 pay attention to this, I would imagine, if it's all
20 included. But I'm wondering if there is some payment policy
21 that shines some light on accountability further upstream so
22 that whomever is suggesting hospice, referring hospice, or

1 should, has more effective incentives to follow best
2 practices this way. And I'm not quite sure how to structure
3 that.

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

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

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

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

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

22 MR. HACKBARTH: Right.

1 MS. NEUMAN: -- considering whether it should be
2 in Medicare Advantage.

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

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

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

14 [Laughter.]

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

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

22 DR. CHERNEW: Can I ask a clarifying question now?

1 MR. HACKBARTH: If you want.

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

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

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

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

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

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

20 But beyond that, I think that one of the concerns,
21 I think, and I don't know exactly how potent this is, but
22 one of the things that I've experienced is that people are

1 very reluctant to sign onto hospice because they're afraid
2 of giving up conventional curative services. And I just
3 wonder if there is a way to blend some of those payments, or
4 to provide some support -- I mean, we've talked about
5 eliminating that requirement altogether, which may well make
6 sense, but I wonder if there's sort of a halfway step ahead
7 of that that might encourage at least people to become aware
8 of the advantages and take away some of the fear that exists
9 that they're never going to be able to go to the hospital
10 again or whatever it might be.

11 MR. HACKBARTH: What is -- PPACA mandated a
12 demonstration on this issue of patients being allowed to
13 continue curative care even after electing hospice. What is
14 the status of that at this point?

15 MS. NEUMAN: So there was no funding appropriated
16 for it, so it's unclear if it will occur.

17 DR. DEAN: One other question. You know, we've
18 talked a lot about eligibility and appropriateness of people
19 entering into hospice and all that, and we've also talked
20 about how unsatisfactory the criteria of six months of
21 expected lifespan or less really is. Have any of your
22 consultants or your experts talked about ways to make those

1 criteria better and a little easier to -- I mean, for those
2 of us that have to make that judgment, I mean, it's --
3 that's part of the reason, of course, that you only --
4 people come too late, because maybe some of these changes,
5 people are pretty stable, and then when they start on a
6 downhill course, sometimes that's pretty fast. And also, if
7 someone has a severe chronic disease, you say, well, yeah,
8 probably they won't make it for six months, but on the other
9 hand, they may well live much longer than that.

10 I guess the question is, we haven't talked much
11 about that particular criteria, and to me, it's a very
12 unsatisfactory criteria. We need a better threshold, a
13 better measure. And I just wonder if any of your experts
14 have -- I don't have one, but I wonder if they've brought
15 that up or have ideas.

16 MS. NEUMAN: So when we did the industry panel
17 leading up to the 2009 recommendations, one of the things we
18 did talk about was the local coverage determinations that
19 the CMS contractors have that sort of spell out the criteria
20 for when someone's eligible versus not, and we had some
21 discussion about whether there was some need to fine tune
22 those. And by and large, the folks -- the hospice folks

1 that we talked to didn't see gigantic room for changes.

2 They did do some tweaks themselves in places where
3 they thought that if they thought about it one way, it would
4 make it more precise. But that was not an area where they
5 felt that big changes were needed.

6 Now, that said, we're a few years past that now
7 and it's something that we could go back and do some more
8 talking and thinking about.

9 DR. DEAN: For all the problems it's caused, I
10 think that might be worthwhile, to try and see if there's a
11 better way to decide about eligibility.

12 MR. HACKBARTH: So let me go back to Tom's first
13 issue about patients having to forego other therapy to opt
14 for hospice. So my recollection, correct me if I'm wrong,
15 is that there have been some non-Medicare demos on that. I
16 recall one done by Aetna, and there may have been more than
17 one. And my vague recollection is that what they found was
18 that it did not increase cost and was actually -- it got
19 more patients to opt into hospice. Am I even remotely
20 close?

21 MS. NEUMAN: That's correct, and the -- there are
22 some differences, though, about their population --

1 MR. HACKBARTH: Right.

2 MS. NEUMAN: -- versus the Medicare population
3 that raises questions about what would happen in Medicare.
4 They have a much -- it's a younger population who elect
5 hospice even later than the older population does --

6 MR. HACKBARTH: Yeah.

7 MS. NEUMAN: -- and it's mostly cancer in that age
8 group. And so the question is, what would happen in
9 Medicare, and in the fee-for-service environment.

10 MR. HACKBARTH: And I thought that those reasons
11 for questioning whether the Aetna and other private demos
12 accurately predict what would happen in Medicare made sense
13 to me, you know, and so I thought it was a good idea to do a
14 demo of this. But now we're in a situation where, if we're
15 not going to do a demo, the issue won't go away. What do we
16 do in the face of a lack of Medicare-specific evidence on an
17 issue that I think is pretty important? I don't have an
18 answer. That's a rhetorical question. I don't have an
19 answer to it right now, but I think that's something we need
20 to come back to. Just to say, well, we've always required
21 patients to forego curative care and we'll just mindlessly
22 continue that, may be a significant barrier to appropriate

1 use of hospice care.

2 Herb.

3 MR. KUHN: Although we've spent most of this time
4 talking about payment changes, the fact that the issue of
5 program integrity continues to crop up and be part of this
6 conversation, I think that's useful and instructive.

7 The second thing is, I've listened thoughtfully to
8 the comments that have been made that while we're able to
9 adjust 68 percent based on the data we have, we might want
10 to have stronger incentives. But I think back to past
11 things that we've seen in the Medicare program that
12 sometimes even small tweaks to the system can bring about
13 big changes. And the one I think about is the one on
14 therapy distribution and home health. And prior to 2008,
15 CMS would pay so much up to ten therapy services, and then
16 over ten, it would change, and guess what, we had a lot of
17 clustering between 11, 12, and 13. Then in 2008, CMS made a
18 change. Now, we had some other clustering that occurred as
19 a result of that, but in that one single year, that first
20 year, we had the swiftest change we had ever seen in that
21 program as a result of the payment changes. So it can have
22 a big impact very quickly as part of the process and we

1 can't lose sight of that as we go forward.

2 And then the final thing I would make, Glenn, not
3 as a suggestion but just as -- well, a suggestion, perhaps,
4 to you as Chairman -- is that this is really some terrific
5 work that they've done here. And if, indeed, CMS is right
6 now working with a technical expert panel to work on this
7 issue, would it make sense somehow that we formally
8 communicate this work to them as part of that process,
9 whether it be a letter from the Chairman to the Secretary,
10 whether it is a staff conversation, whatever the case may
11 be. But I want to make sure that this body of work is part
12 of that conversation and it's fully shared with the agency
13 as they continue to go forward.

14 MR. HACKBARTH: [Off microphone.] Have we been in
15 touch, Kim, with the --

16 MS. NEUMAN: Yeah, we do communicate with them.
17 In fact, part of PPACA's requirement was that they consult
18 with us on the process, so we're in communication.

19 MR. HACKBARTH: Okay. Alice.

20 DR. COOMBS: One of the things -- we talked about
21 this whole notion of bundling the hospice service, but I'm
22 concerned that it might result in some thinking that service

1 is becoming a part of the general budget of an ACO. I think
2 the stratified approach to the reimbursements in terms of
3 the fee-for-service is the way to go, and you might be able
4 to tailor it once you find out what the under-utilization is
5 in terms of up-front robust build-up versus a cliff at some
6 point that's yet to be defined in terms of over-utilization.
7 The way it is now, it's just a gradual heel, but you might
8 even have a medical cliff at some point if you see that the
9 services, once you include the 32 percent that's not
10 included. So I think there's a lot of room for tailoring
11 this stratified approach, but I like it.

12 DR. CHERNEW: So, I like this a lot, too, in
13 general and in specifics, and one of the specifics that I
14 like the most is instead of just coming up with a U-shaped
15 payment rate by day, you have a declining rate, essentially,
16 with a spike upon discharge to capture the way that the data
17 has shown, and I think that is exactly the way to fit the
18 data. I like that aspect a lot, so I think it's good.

19 Just in response to the comment about we should be
20 more aggressive, we have another mechanism, the update
21 factor, to be aggressive, and I think if we thought the
22 margins were generally too high, we would deal with that

1 through the conversion factor kind of approach as opposed to
2 tweaking this. That's different than trying to flatten out
3 the quartile margins that was discussed here. And I guess
4 my view is, I don't know what the optimal slope of the
5 quartile margins is because of issues that we don't have all
6 the data, there's case mix issues, there's behavioral
7 changes we don't know.

8 So all that leads me to think that I'm basically
9 very comfortable that this is a step in the right direction
10 and that other issues about over-generosity, or if we think
11 that's true, we should deal with that in another process for
12 which we have recommendations on the table. And I think,
13 although, again, I'm not sure, this reflects existing
14 payment policies, not what would happen if our
15 recommendations for hospice updates were put in place. Is
16 that --

17 MR. HACKBARTH: So our existing recommendation is
18 a freeze in the rates. This reflects current rates.

19 DR. CHERNEW: Oh, so it's basically the same, but
20 --

21 MR. HACKBARTH: Yeah, basically.

22 DR. CHERNEW: But, of course, there would be

1 inflation in some sense, so the margins might go down
2 anyway. But, anyway, that --

3 DR. MARK MILLER: Just in case anyone is confused,
4 would you put up 13 so as they refer to the quartiles,
5 they're referring --

6 DR. CHERNEW: Yeah. Well, I'm going to move off
7 that now anyway.

8 [Laughter.]

9 DR. CHERNEW: So I think this issue of how it fits
10 into ACOs and MA is really important and worthy of a lot
11 more attention, and I would say part of what I think is
12 going on, and we've had other presentations on hospice, is
13 over time, the mix of diseases that hospice beneficiaries
14 have had has changed, which you show and you've shown in the
15 past. That not only affects, say, what you think the length
16 of stay might be, the sort of mean, if you will, it affects
17 the potential variance and predictability. So we're
18 inherently going to run into a problem with predictability
19 when we move to certain diseases relative to other diseases,
20 and that doesn't mean we would just -- if you knew who
21 shouldn't be in, that would be great. But even the best,
22 well-meaning, well-trained physician will have a hard time

1 predicting someone's length of stay in a hospice program
2 with a lot of diseases.

3 And so I'm not advocating this strongly now, but
4 one of the things that we thought about in some other work
5 that we had done was that everybody should have access to
6 good palliative care, even if you can't figure out that this
7 person is likely to die with some probability within some
8 window of time, and that every person, particularly people
9 who are nursing home residents, should have someone
10 accountable for their entire spectrum of care, not segmented
11 out to the nursing home portion and the hospice portion.

12 And so I think thinking about how to -- we, for
13 example, have automatic assignment to people who would get
14 palliative benefits based on some modeling. You're going to
15 get some over- and under-assignment, but the point is,
16 everybody would get access to good palliative care and they
17 wouldn't have to forego other things. They wouldn't have to
18 forego curative care, because I do think what happened, I
19 think, in the Aetna example was they didn't say they would
20 forego curative care, but as they moved to the hospice
21 process and the palliative care process, their choices about
22 care just generally changed in ways that I believe were

1 better for the patient, ignoring any of the financial
2 things, which is actually probably the less -- I think it's
3 important that we don't -- the reason I like the budget
4 neutrality of this, I think it's important to understand
5 that the motivation here primarily is, I think, better
6 access to care for people at this stage of their life. And
7 if we have monetary issues, we can deal with that through
8 other mechanisms. But I think this is more about accurate
9 payment and access to important care. And I think that
10 requires some accountability, some honoring of quality, and
11 I think this is really a step in the right direction.

12 DR. BAICKER: My comment was really much along the
13 same lines as Mike's. I would just add one sentence to
14 that. The goal, I think, is to be neutral about how long
15 patients should be in hospice, except it should be as long
16 as they should be in hospice based on their preferences and
17 their individual health, and the U-shaped curve seems to map
18 to that neutrality, that we're not trying to push people
19 there longer or put them there less time because that
20 captures the real way that costs accrue. And so if that's
21 our goal, we don't have strong views about how margins
22 should look across these quartiles or quintiles. They

1 should be -- we don't think that it should be related to how
2 long you keep the patients. It should be related to running
3 an efficient operation and providing high-quality care that
4 makes people want to use those services, et cetera.

5 And so the fact that this flattens the margins, we
6 think is probably good, because we suspect that those
7 original margins were not in line with that neutrality of
8 length, and this looks more in line, but if we got those
9 payments right, it might or might not result in flat
10 margins, and that's okay as long as we think that we've
11 created the incentives for the patients who need access to
12 hospice care to get exactly as much as they need.

13 MR. HACKBARTH: Okay. Thank you, Kim and Sara.
14 Very nice work.

15 We're now to our last session on bundling post-
16 acute care services.

17 [Pause.]

18 MR. CHRISTMAN: Good afternoon. Next, we will
19 talk about bundling post-acute care. I would like to thank
20 Craig Lisk and John Richardson for their contributions to
21 this work.

22 The Commission has been examining bundling as

1 another possible approach to payment reform. Today's
2 presentation provides a review of material we have presented
3 previously and provides additional information about how
4 Medicare could implement a policy. We are going to review
5 the reasons bundling could be beneficial and discuss an
6 illustrative example of a bundling policy based on
7 Commissioner input from prior meetings. Then we will
8 discuss issues in setting payment for the bundle, including
9 how to set the bundled amount, creating incentives for
10 quality, and policies for addressing beneficiary incentives
11 in a bundle.

12 The Commission has been interested in bundling of
13 acute and post-acute services because it has the potential
14 to move Medicare away from its fragmented fee-for-service
15 payment systems, particularly for post-acute care.
16 Establishing bundling would provide incentives for better
17 coordinated care, which is particularly important for
18 beneficiaries that are making the transition from the
19 hospital to another site of care. Poorly executed
20 transitions can place beneficiaries at risk for a
21 rehospitalization that is undesirable for both the
22 beneficiary and the program.

1 Bundles would encourage providers to consider the
2 costs of care over an entire episode and not just for their
3 silo. There is no incentive to encourage placing a
4 beneficiary in the lowest-cost PAC setting that meets their
5 needs under current policies, even though there is overlap
6 in the type of patients served and services provided among
7 PAC facilities. Bundling could also help narrow the
8 considerable geographic variation in PAC spending, which is
9 greater than the variation observed for other Medicare
10 services, by creating incentives for the more efficient use
11 of PAC.

12 For this presentation, we have developed an
13 illustrative approach to bundling. At our prior meetings,
14 Commissioners expressed a preference for longer 90-day
15 bundles that included all of the acute, post-acute, and
16 physician care associated with a hospitalization. Under
17 this approach, Medicare would continue to pay individual
18 providers under the current fee-for-service systems with a
19 small portion of each fee-for-service payment withheld.
20 Medicare would set an episode benchmark or spending level
21 for the episode based on a beneficiary's diagnosis and
22 comorbidities.

1 Our illustrative bundle is based on current fee-
2 for-service payment systems. Using fee-for-service
3 minimizes the incentive to stint. Providers would still be
4 paid on a fee-for-service basis. If they do not provide a
5 service, they do not get paid. Fee-for-service is also
6 simpler to implement. Such an approach does not require
7 that providers make side payments to each other, as would
8 become necessary if Medicare were to pay for bundling in a
9 single global payment to a group of providers. Our approach
10 does not require that a hospital or other lead provider
11 operate like an insurer that negotiates rates and makes
12 payments to the other providers in the bundle.

13 A small portion of each fee-for-service payment
14 would be withheld and tied to performance in the bundle.
15 Providers that failed to meet the episode spending benchmark
16 would not get their withhold back. Holding providers to a
17 spending benchmark would also capture some dimensions of
18 quality, as costly readmissions are a significant portion of
19 cost for some episodes. Lowering readmissions would improve
20 care and make it easier for providers to keep below a
21 spending benchmark.

22 Using a withhold provides some guarantee of

1 savings even if providers do not meet the episode
2 benchmarks, and using a withhold also means that Medicare
3 does not have to chase providers for a return of funds after
4 the episode is over.

5 The withhold also limits the financial risk for
6 providers as it places only a portion of their payments at
7 risk. If spending exceeded the benchmark amount by more
8 than the amount withheld, the provider would not be
9 responsible for repaying the excess amounts beyond the
10 withhold.

11 The return of the withhold could also be tied to
12 quality metrics so that providers would have to maintain
13 quality in addition to meeting spending targets.

14 Examples of measures that could be used to watch
15 for stinting during a bundle include readmission or
16 emergency department use and change in functional status at
17 the end of an episode. Medicare will also need to be
18 vigilant for other changes that could represent a gaming of
19 the bundling incentives. Other signs of providers
20 responding inappropriately to the bundle could include
21 delaying services outside the bundle window or providing a
22 greater number of bundled episodes. Medicare could develop

1 measures to watch for these trends and adjust its policies
2 if they appear to be an issue.

3 Effective risk adjustment would be an important
4 element of setting the episode benchmark for a bundle. Risk
5 adjustment guards against patient selection and facilitates
6 fair comparison across providers. Our review of existing
7 risk adjustment methods suggests that they can explain a
8 significant share of resource use in the illustrative
9 bundles.

10 Using MS-DRGs to adjust for severity, our model
11 was able to explain 31 percent of the variation in charges.
12 We also added in chronic conditions and functional status,
13 and this increased to 36 percent. These results suggest
14 that all three of these elements should be include when
15 setting episode benchmarks. I would note that the
16 explanatory power of these risk adjustment methods are even
17 higher when they are used to explain Medicare spending for
18 the bundle at the facility level.

19 Determining the level at which to set the episode
20 benchmarks will be a critical decision. Since the point of
21 bundling is to provide better incentives than current fee-
22 for-service silos, the episode benchmark should be set in a

1 manner that minimizes or avoids the problems of Medicare's
2 current payment systems. The benchmark should be based on
3 patient characteristics, such as the risk adjusted factors
4 listed previously, and they should not be tied to the
5 specific PAC setting a patient receives care at.

6 The benchmarks should also keep in mind that
7 current average spending levels may be excessive, as there
8 are many areas with very high PAC use. Benchmarks could be
9 set at levels that are less influenced by areas with
10 unusually high utilization.

11 Finally, the performance against a benchmark
12 should be computed as an average for all bundles over a
13 period of time. This softens the incentives for patient
14 selection as it averages the high-cost cases in a period
15 with other lower-cost episodes.

16 DR. CARTER: To incentivize the efficient
17 provision of care, CMS could establish the benchmarks in a
18 couple of different ways. These include basing the
19 benchmark on lower spending on post-acute care and
20 readmissions or basing the benchmark on spending in
21 geographic areas with low resource use, and I'm going to say
22 a little bit more about each one of those.

1 One way to establish --

2 [Lights turn off.]

3 [Laughter.]

4 DR. CARTER: Somebody in the back, did they lean
5 against the -- there we go. Okay.

6 One way to establish benchmarks would be to base
7 them on lower spending on post-acute care and readmissions.
8 The wide range in whether beneficiaries use PAC, what PAC
9 they use, and high Medicare margins for home health and SNF
10 all suggest that spending on post-acute care could be lower
11 without necessarily compromising quality. The variation in
12 the level and the rate of readmissions suggests that
13 spending on them could also be lower.

14 Just as an illustration, the benchmark could be
15 based on spending on readmissions and post-acute care that
16 is ten percent lower and this would establish benchmarks for
17 the whole episode that are five percent less than current
18 fee-for-service spending.

19 Another way to establish the benchmarks would be
20 to base them on the practice patterns of geographic areas
21 with low resource use. Per capita spending on PAC that was
22 wage and risk adjusted found a two-fold difference between

1 the tenth and 90th percentiles in MSAs, and an eight-fold
2 difference between the highest and lowest areas. So, for
3 example, benchmarks could be set using some portion of the
4 difference between high- and low-spending areas.

5 We are also exploring the idea of using practice
6 patterns in managed care plans to establish the benchmarks.
7 With encounter data hopefully available later this year, we
8 can pursue this option, as well.

9 Regardless of how they're established, the
10 benchmarks would work in the following way. Here, we show
11 an episode benchmark of \$43,000 for the episode with two
12 scenarios, one where providers keep their total average
13 spending below the benchmark, which is on the left, and one
14 where they don't, which is on the right.

15 Providers would bill Medicare just as they do now
16 under fee-for-service, with their average bill amount shown
17 on the first row. With a four percent withhold, the
18 withheld amounts are shown in the second row. In the case
19 where actual average spending is below the benchmark, the
20 \$1,600 is withheld from payments going to the provider, with
21 net immediate payments going to the provider of \$39,000.

22 At the end of the performance period, actual

1 spending is compared to the benchmark. In this case,
2 average spending was below the benchmark, so CMS would pay
3 the providers the withheld amount and the total program
4 payments to the provider are \$41,000.

5 In the second column, we see the case where the
6 actual spending, \$47,000, was above the benchmark. Here,
7 the withheld amount, the \$1,880, is retained by the program.
8 The program limited its risk for the amount above the
9 benchmark. It paid out in total the \$45,000 instead of the
10 full \$47,000 for the episode.

11 Now, we want to talk about what bundling can mean
12 for beneficiaries and their families. Because providers are
13 at risk for total spending over the period of time, bundling
14 is likely to mean more coordinated care. There will be
15 fewer and more successful transitions between settings and
16 fewer avoidable readmissions.

17 For example, a family or caregiver is likely to
18 receive more extensive follow-up care and to be given one
19 telephone number with a contact person to ask questions and
20 to have their concerns addressed. Less time would elapse
21 between discharge from the hospital and admission to post-
22 acute care and until the beneficiary receives follow-up

1 physician care.

2 Other quality measures could track the patient
3 experience, for example, how well their pain is managed or
4 how well they felt their providers listened to them, or
5 their involvement in making their decisions about their
6 care.

7 While beneficiaries' choice of providers needs to
8 be protected, there are advantages to aligning beneficiary
9 incentives with the purposes of bundling. Providers may use
10 several approaches to do this. First, they may give
11 beneficiaries information about quality differences across
12 providers being considered for placement after discharge.
13 This could shift some beneficiaries away from poor-quality
14 providers.

15 Providers may also furnish services to better
16 manage the beneficiary's care after discharge, such as
17 having a care manager assigned to them to oversee their
18 care, someone who would conduct medication reconciliation
19 and give focused instruction on managing the condition at
20 home.

21 As Evan mentioned before, tying withholds to
22 quality performance could reinforce the importance of

1 furnishing high-quality, well coordinated care to
2 beneficiaries.

3 Once bundled payments have been implemented, down
4 the road, Medicare could create stronger incentives for
5 beneficiaries and providers to encourage high-quality, low-
6 cost bundles. Medicare could influence beneficiary choice
7 of post-acute care providers by structuring beneficiary cost
8 sharing so that cost sharing is higher when a beneficiary
9 decides not to use recommended providers. Beneficiaries
10 would retain a choice about where to receive care, but their
11 choices could cost them more. I think we talked a little
12 bit about this during the ACO presentation this morning.
13 Medicare could also send stronger signals to providers by
14 revising its Conditions of Participation to include high
15 quality standards. In setting higher standards, it could,
16 for example, exclude the poorest quality providers from the
17 program.

18 Bundled payments will require providers to make
19 many changes to their practices, both internally and between
20 providers. To ease the transition, CMS could consider
21 adopting this reform for select conditions and expand the
22 number over time as providers gain experience with managing

1 the care across a spectrum of providers and settings.

2 Another transition element could be to establish
3 benchmarks that represent small reductions from current fee-
4 for-service spending, with larger reductions phased in over
5 time. Likewise, the withholds could start out being a small
6 share of payments and get larger over time. For example,
7 they could start at two percent and grow to five percent
8 over time.

9 At the last Commission meeting, Peter mentioned
10 the Medicare spending per beneficiary concept as an
11 alternative way to think about bundling, and we've included
12 a short description of this in the paper. In brief, the
13 MSPB establishes a spending target for groups of conditions,
14 such as a major diagnostic group. The bundle spans 30 days
15 and includes hospital, PAC, the physician services, and
16 readmissions. The MSPB is a measure of hospital efficiency
17 and would hold the hospitals responsible for total spending.
18 Eventually, the plan is to use this value-based purchasing
19 with hospitals at risk for spending above the targets and
20 sharing in savings if they are below it.

21 The big difference between this and the bundling
22 approach we've been talking about is at the MSPB, the

1 hospital is fully responsible for spending during the
2 episode. In the bundling approach, all providers share in
3 the risk and reward for keeping spending below the targets
4 or benchmarks, and in this sense, all of the providers'
5 incentives are aligned. But you may want to discuss this
6 alternative approach we've outlined.

7 Other items you may wish to discuss are preferred
8 ways to establish the episode benchmarks and the withholds;
9 ways to influence beneficiaries' selection of providers and
10 settings while preserving choice; the need for a transition
11 and possible approaches; and, once we've agreed on an
12 approach to bundling, we can conduct impact analysis to
13 begin to model the alternative ways to establish benchmarks
14 and withholds.

15 And with that, we look forward to your discussion.

16 MR. HACKBARTH: Thank you very much, Carol and
17 Evan.

18 Who looks ready? Mary.

19 DR. NAYLOR: Just because I wasn't ready the last
20 time. So thank you. Just a couple of questions.

21 First, this was framed as bundling post-acute, but
22 it's bundling the entire acute care episode, is that -- I

1 mean, meaning it's inpatient, post-acute, et cetera.

2 DR. CARTER: And readmissions, right.

3 DR. NAYLOR: And readmission.

4 DR. CARTER: Right.

5 DR. NAYLOR: And so I'm wondering how you would
6 frame it as different from Model 2, which includes and
7 allows for up to 90 days. This one, I think, says all
8 condition readmissions, and Model 2, I think, has only
9 related. Is that the distinguishing characteristic? I'm
10 talking about the demo --

11 DR. CARTER: I think you're right in terms of
12 related readmissions being included in the bundle, and I'd
13 have to double-check on that. My understanding of Model 2
14 is that providers could propose length of their bundle --

15 DR. NAYLOR: Right.

16 DR. CARTER: -- and so there's some variation
17 there. Providers also were given choices about conditions
18 that they could bundle. They were actually given many
19 choices to include in their proposal to CMS, and now that
20 CMS has approved a set number of conveners and participants
21 and providers, they're working out those arrangements,
22 including things like gain sharing arrangements and what

1 risk adjustment model and what quality measures to include
2 and things like that. And our understanding is that, you
3 know, at this point, those haven't been locked down and the
4 providers that are in the mix may not end up in the end
5 actually moving forward, so --

6 DR. NAYLOR: And one last question. Is there any
7 thought that having this approach could actually increase
8 referrals to post-acute care among those that might have
9 just benefitted from community services? So is there a
10 sense that one of the things you would have to watch for is
11 maybe increased referrals for people that may not need those
12 services?

13 DR. CARTER: I mean, it's true that the benchmark
14 will reflect sort of the average mix in utilization. So to
15 the extent that you use post-acute care more, you may exceed
16 the benchmark. But it is something -- you know, in our
17 proposal, we've tried to balance the incentive for stinting
18 with trying to encourage the right setting to be used. But
19 we appreciate that concern, and we're also concerned that it
20 might generate bundles, and so we've tried to put proposed
21 policies to counter that, as well.

22 MR. CHRISTMAN: I guess I would just add that it

1 may increase the frequency of post-acute referral for some
2 patients, but I think in that, one would hope there might be
3 a drop in readmission. So you might see what -- when you're
4 monitoring performance against a benchmark, you may see the
5 post-acute dollars rise, but hopefully, you'd see the
6 readmission dollars drop, and so --

7 DR. NAYLOR: But you could also see hospital
8 lengths of stay drop as people get moved more quickly to a
9 different setting.

10 DR. CHERNEW: I'm sorry. I have a clarifying
11 question on your clarifying question. So the original
12 admission is included. So, for example, if somebody has a
13 stroke, that first admission is included, and then all of
14 the subsequent post-acute admissions and all that other
15 stuff is also included. And so if you decided just to send
16 someone to the community, that first admission would avoid -
17 - would get their whole withhold back. So you wouldn't have
18 the --

19 DR. NAYLOR: That is -- I misunderstood --

20 DR. CARTER: Well, they'd only get the -- they'd
21 get the withhold associated with the hospital spending,
22 right, because there is no full up-front bundled payment.

1 DR. CHERNEW: [Off microphone.] Their proportion
2 of the withhold -- so they wouldn't have an incentive to
3 send someone to post-acute, because the extent to which that
4 ramped-up spending, it would reduce the likelihood that that
5 original hospital for the original admission would get its
6 portion of the withhold -- the withhold on its payment --
7 back. That's what I think you said.

8 DR. CARTER: Right, because we're not fronting the
9 whole bundled amount.

10 DR. CHERNEW: Right.

11 DR. CARTER: Right.

12 DR. COOMBS: Before I put anything in my mouth,
13 Table 3. I had a question about these with any PAC versus
14 without any PAC, and I remember that during the LTCH
15 presentation, we had an average cost of \$17,000 per
16 admission or something like that. This doesn't seem like a
17 -- I mean, it's a savings, but it's not like a tremendous
18 savings. So I'm wondering if this is additive or
19 synergistic or just in terms of additional savings when you
20 bundle it.

21 MR. HACKBARTH: Say again, Alice, where you are --

22 DR. COOMBS: So when you bundle -- the bundle with

1 PAC on Table 3 --

2 MR. HACKBARTH: This is in the paper.

3 DR. COOMBS: It's in the paper, page 16. The
4 average cost per episode spending is \$30,000. So are you
5 proposing that with the bundle, you're going to go much less
6 than that?

7 DR. CARTER: We didn't propose any specific
8 amount, but so that right now is the average spending.

9 DR. COOMBS: Right. So you would propose
10 potentially that if you were going to use the services here,
11 it would be much less, because there's no difference between
12 the separated fee-for-service that exists right now.

13 DR. CARTER: I'm sorry, I --

14 DR. MARK MILLER: No, go ahead.

15 DR. CARTER: No, I'm actually just not
16 understanding your question.

17 DR. COOMBS: Okay. Go ahead.

18 DR. MARK MILLER: All right. Table 3 talks about
19 average spending for selected diagnoses with and without the
20 post-acute care services, so it's just reporting that. In
21 the presentation, if you're tracking on the \$43,000 number,
22 that was just an illustration of one, you know, episode, and

1 it was completely illustrative.

2 DR. COOMBS: Okay.

3 DR. CARTER: Oh, yeah. That doesn't tie to any of
4 these conditions.

5 DR. MARK MILLER: And it wouldn't tie to any of
6 this here. So maybe I don't understand your question.

7 DR. COOMBS: So if you go to that slide, which it
8 was the difference between the two costs, one was \$41,000
9 and the other was \$47,000 --

10 DR. MARK MILLER: [Off microphone.] It's just an
11 illustration.

12 DR. COOMBS: Yeah. So for the illustration, for
13 costs, the withhold of four percent still results in the
14 same services being rendered and there's a gradient between
15 the two. One goes over the benchmark, gets four percent
16 withheld, but still, at the bottom line, still gets \$45,000
17 versus the \$41,000. So the four percent doesn't seem to be
18 enough to make that much of a difference for the --

19 DR. MARK MILLER: [Off microphone.] And I think I
20 now see what you're saying. You're saying, in that
21 instance, even though actor number two on the far right ran
22 over the benchmark and didn't get their withhold back,

1 because that row is zero, they still got paid more.

2 DR. COOMBS: Exactly. So --

3 DR. CHERNEW: [Off microphone.] Their costs were
4 higher.

5 DR. MARK MILLER: And it's absolutely correct. I
6 mean, this is an attempt to illustrate how the policy would
7 work and you have raised a good point because maybe that
8 isn't strong enough incentive and you would have to think
9 about a larger withhold. But, of course, you'd also have to
10 think about whether you're giving enough money to get the
11 care done and all that, as well.

12 DR. COOMBS: Right. So what I was doing is
13 actually looking at the chart that shows a stroke plus VACU
14 [phonetic] care at 30 grand, and looking at the data that we
15 had before and just comparing basically a higher benchmark -
16 - the same benchmark but higher billing in terms of the
17 bottom line, what you get from the four percent withhold
18 with both cases.

19 MR. HACKBARTH: You know, this, too, is an
20 illustration, but you put your finger on a key design issue.
21 How strong do you want this incentive to be to be efficient
22 without making it so strong that it encourages stinting on

1 needed care. So there's a balancing to be done.

2 MR. KUHN: Another question kind of on the
3 benchmarks but maybe from a little bit different angle -- so
4 we've talked a lot around this table in the past about the
5 different assessment tools that are used for post-acute care
6 and the development now of the care tool, which is step in
7 the direction towards kind of a site-neutral payment system
8 which, to a degree, bundling takes us towards more of a
9 site-neutral, hopefully, system as we move forward.

10 So, if the care tool was fully deployed, would
11 that have any impact in terms of benchmark calculation, or
12 is the benchmark total devoid of kind of the assessment
13 tools and kind of what goes on in the post-acute care area.

14 MS. CARTER: Well, I think it would help in terms
15 of setting a risk-adjusted benchmark because right now we
16 don't have assessment data for folks who use long-term care
17 and, maybe more importantly, we don't really know the
18 functional status and cognitive status of patients at
19 discharge from the hospital. If we had all of that
20 information, I think you'd have a better way of establishing
21 accurate -- more accurate -- benchmarks.

22 MR. KUHN: Thank you.

1 MR. HACKBARTH: In the absence of a really good
2 tool like this, this sort of accepts the world as it is with
3 its imperfections and says, well, how can we create some
4 incentive at the margin to try to improve it, whereas the
5 care tool takes sort of a fundamental reform approach.
6 That's the way I think of it.

7 MR. KUHN: I think that's a fair way, and that's
8 kind of what I was trying to think about. Is it an
9 either/or, or is there a blend of the two as we go forward?

10 MS. UCCELLO: I'm afraid this might be a blend,
11 but I'm going to go for it now. For slide 13, I'm just
12 trying to understand the incentives between the different
13 providers.

14 So, if you have a hospital and you have the PAC
15 providers, and now -- so the hospital sends somebody to a
16 SNF.

17 Now the SNF could say, well, I don't care. I'm
18 going to be paid fee-for-service. I'm going to just bill
19 high. And so what? The hospital doesn't get its withhold
20 back? I don't care.

21 MS. CARTER: These would be withheld 4 percent
22 from every provider.

1 MS. UCCELLO: From everybody.

2 MS. CARTER: Right.

3 MS. UCCELLO: But looking at the right-hand
4 column, in a sense, they're paid more.

5 But my question then is, does this still provide
6 incentives for the quasi-partnerships?

7 Can the hospitals say, well, no, I'm not going to
8 send somebody there anymore because I see that they're just
9 acting totally in their interest rather than kind of across
10 -- I mean, is that what we hope is kind of going on here to
11 prevent one of the actors from saying, well, I don't really
12 care about this thing on the whole; I'm going to maximize
13 what I can get?

14 MR. HACKBARTH: Although your initial point is one
15 of the basic design issues with withhold-based systems, at
16 the first level of analysis, every individual player's
17 incentive is still to maximize their fee-for-service payment
18 and do that enough so that the loss that we share
19 collectively doesn't hurt too bad. And so, withhold
20 arrangements by themselves do not create really strong
21 incentives for joint action.

22 Now it may well be, though, that if the SNF in

1 your example behaves that way the hospital and/or other
2 participants say I'm not going to send anymore patients to
3 them. So you exclude them, and that's the punishment for
4 inappropriate behavior -- is exclusion from the referral
5 network.

6 MR. ARMSTRONG: So just building on that for a
7 moment, we've looked at various ways of constructing bundled
8 payments for post-acute and for other kinds of services in
9 the past. This whole idea of withhold as a mechanism for
10 bundling payments -- have we ever tried an alternative
11 that's sort of a sub-cap kind of a payment for

12 a set of services, which would create a totally
13 different dynamic but also some infrastructure issues too, I
14 suppose?

15 MR. HACKBARTH: Yeah. Well, I think the tradeoff.

16 MR. ARMSTRONG: Have we ever examined that other
17 alternative? Is that work we've done?

18 MR. HACKBARTH: Carol?

19 MS. CARTER: We have not, no.

20 MR. HACKBARTH: So, to me, all other things being
21 equal, setting aside all the organizational issues, which is
22 a big set-aside --

1 MR. ARMSTRONG: It is, yeah.

2 MR. HACKBARTH: -- moving to a true capitated
3 payment is preferable to this sort of withhold mechanism
4 with fee-for-service payment for two reasons. One, the
5 incentives are much stronger, both on total cost and for
6 collaborative behavior, and second, because by getting out
7 of fee-for-service payment you allow a free flow of dollars
8 within the system to where they can do the most good for
9 patients.

10 The problem is that it requires fundamental change
11 in provider organization and relationships. That's the
12 tradeoff.

13 MR. ARMSTRONG: So that was what I was thinking
14 about, and I think this is a round one question.

15 So on the one end we have fee-for-service, and I
16 know how that works, and you're paying on a real micro level
17 for services.

18 And on the other hand you have Medicare
19 Advantage, and that's 100 percent prepaid. So we're in this
20 middle space.

21 And when you look at the total spend, we're
22 carving out what we're calling post-acute care services,

1 right?

2 And I'm wondering, first of all, if we have a
3 sense for of the total spend how much are we trying to
4 package into this bundling idea?

5 And then, second, is it possible that we could
6 actually reduce payments to post-acute services through our
7 proposal but, in fact, increase the overall PMPM that we're
8 spending because costs end up going somewhere else?

9 MR. CHRISTMAN: Well, I think there's a few pieces
10 to your question, and so to just give you a frame of
11 reference, if I recall correctly, just the post-acute
12 dollars in fee-for-service are about \$50 billion a year.
13 Also, remember we've also included acute care in our bundle.
14 So it's a pretty big piece of the fee-for-service spending.

15 And, if I follow your second concern, you know,
16 one of the things that we have talked about as a problem is
17 that providers would have an -- if you pay them based on a
18 bundle, they have an incentive to generate more bundles.

19 I don't think -- you know, we've talked about it a
20 little bit in this paper, that the volume of bundles is
21 something you would have to watch if you were to implement
22 this.

1 But in terms of what you would do in the next step
2 if you started to see some different trends that raise
3 concerns, I suppose Nancy and Sara have been looking at
4 potentially preventable admissions and potentially
5 preventable visits. And I think -- and I'm not that
6 familiar with that project, but I think you start to go down
7 that alley to sort of address the concern you're raising.

8 MS. CARTER: Do you remember the chart that Jeff
9 showed this morning where he had fee-for-service on one side
10 and then ACOs and then MA?

11 MR. ARMSTRONG: Yeah.

12 MS. CARTER: Well, this is kind of to the left of
13 ACOs, right?

14 MR. ARMSTRONG: Yeah.

15 MS. CARTER: Okay.

16 MR. ARMSTRONG: I've got ACOs in my little chart
17 here, too.

18 MS. CARTER: Yeah.

19 MR. ARMSTRONG: This probably is taking my second
20 round question, but if you actually combine acute care and
21 post-acute care spend, you're bundling a huge percentage
22 then of our overall spend into this proposal. And it just

1 might be worthwhile as we're going forward, kind of putting
2 it into the context of that overall spend and how we're in
3 that middle territory where we're trying to do something in
4 between Medicare Advantage and fee-for-service by bunching
5 big chunks of the spend.

6 Anyway, that's kind of clicking up a couple file
7 folders, but it would be good for us to look at that.

8 DR. NERENZ: Yeah, a couple of related questions,
9 and this may end up being sort of a sharper version of
10 Cori's question.

11 Let me preface, I'm a fan of bundled payments.

12 MS. UCCELLO: Are you saying I'm not sharp?

13 DR. NERENZ: No, no, this is -- I'm going to be --

14 DR. MARK MILLER: I'm pretty sure that's what I
15 heard.

16 DR. MARK MILLER: That's what I heard.

17 DR. NERENZ: No, no, no.

18 [Laughter.]

19 DR. NERENZ: No, that has to do with the tone of
20 the question coming. You're fine.

21 And I preface, I'm a fan of bundled payment, but
22 I'm a little worried about some of this.

1 It occurs to me in looking at this slide in
2 particular that I see no positive financial incentives for
3 any individual providers or any collection of providers
4 relative to just doing nothing; status quo. If this were a
5 voluntary demonstration project, I don't know who would step
6 forward to participate.

7 So, I guess, first, am I missing something?

8 MS. CARTER: We're not talking about something
9 voluntary.

10 DR. NERENZ: Okay. That was going to be part of
11 the --

12 MS. CARTER: And we're talking about some kind of
13 benchmark that's lower than fee-for-service, and we're
14 talking about some withhold that you would not get back. If
15 you don't pay attention and do nothing, you may not get your
16 withhold back.

17 So that just depends on -- those are the moving
18 parts, and depending on how you perform relative to the
19 benchmark that would be what's at risk.

20 DR. NERENZ: Okay. I just wanted to make sure I
21 understood.

22 MS. CARTER: Yeah.

1 DR. NERENZ: Heavy stick, little carrot, I think
2 it looks to me.

3 Okay. Now just when I look at the column down the
4 middle, when I compare that, for example, to the ACO shared
5 savings model, that kind of approach gives the organizations
6 at least some option to recover the difference between 41
7 and 43, but I see that you haven't illustrated that here.
8 Is there a reason why that's not built in here?

9 MS. CARTER: Well, they've covered -- the payments
10 covered the services that they billed for. That 41 was what
11 they billed out, and that's what they got paid for.

12 DR. NERENZ: Right, but just let's make sure. I
13 mean that there is no shared savings element here that is
14 providing some of the current attraction in the ACO model.

15 MS. CARTER: I see what you're saying.

16 DR. NERENZ: In the ACO shared savings, you get
17 some money back for having gone from 43 to 41. Here, you
18 don't. Okay.

19 MR. HACKBARTH: So why do it that way, Carol?

20 MS. CARTER: I'm sorry?

21 MR. HACKBARTH: Why do it with an approach where
22 there's no positive shared savings; there's only a stick?

1 MS. CARTER: I guess we were thinking just if you
2 build out those services, would the payments cover that, and
3 the answer was yes.

4 So are you saying, so then we should pay them more
5 than their payments that they billed as sort of a reward for
6 having --

7 DR. NERENZ: Yes, actually, because it costs you
8 money to go from 43 to 41. You have to do medication
9 reconciliation. In fact, you listed some of the things.
10 You have to incur costs to do things differently, to go from
11 43 to 1.

12 In a shared savings model, you recoup some of
13 those costs.

14 And in some of the illustrations, it's even
15 debatable on the ACo side how long it takes you to get
16 there. We looked this morning. You have to achieve a
17 substantial target savings just to recoup the incurred costs
18 of doing the work. And just here, there's none of that.

19 DR. MARK MILLER: What I would say is that if you
20 -- we're trying to start off with key -- what we've moved
21 away from -- and this was some of Scott's questions and some
22 of the things that Bill Gradison was saying earlier this

1 morning.

2 How much weight could a hospital carry if you were
3 to just give them a dollar amount, say, for example, and
4 then let them manage everything from there? That becomes
5 probably a difficult proposition.

6 So this stays in the fee-for-service world, and so
7 the change isn't as dramatic.

8 So, if you set all of this at averages -- you
9 know, average episode spending -- and engaged in the
10 behavior that you're talking about, you essentially end up
11 spending money in all likelihood.

12 Now, if you wanted to pursue your approach and say
13 I want a shared savings approach for this, one thing you
14 could consider here is to set the episode bar below the
15 average and then discuss sharing savings off of that lower
16 average.

17 So my only caution in the exchange there would be
18 this could be a different conversation depending on where
19 you wanted to set the bar.

20 DR. NERENZ: Right. And this guy really was
21 trying to stay consistent with this round one. I was just
22 trying to clarify the thinking that led to this layout.

1 That was all.

2 DR. MARK MILLER: I think it's Cori you're going
3 to have to deal with after the meeting.

4 [Laughter.]

5 DR. NERENZ: I'm just going to ask a meaner
6 question. That was it.

7 DR. HOADLEY: [Off microphone.] I have nothing.

8 MR. GRADISON: I'm still trying to understand 13.
9 Going into this, it's my understanding that the
10 post-acute care settings -- the very settings. They would
11 bill separately as they do today, right? Okay.

12 I assume to make this work -- I think it's in here
13 -- the payment would be for a particular condition, risk-
14 adjusted and so forth, but not based upon the site of care.
15 So we got that.

16 So we develop a benchmark -- I'm looking at table
17 13 -- of \$43,000. Now you've shown what happens if the
18 spending is at 41 and 47. What if you build 43, do you get
19 43?

20 MS. CARTER: Oh, I'm sorry. If you -- yeah.

21 MR. GRADISON: You get 43. So why would you build
22 41?

1 If you know the benchmark is 43, you build 43,
2 right?

3 You don't build 43?

4 I'm having a lot of trouble with this 13. And
5 I'll come to some related questions in a minute, but I've
6 got to understand, though.

7 You've given the 41 and 47 examples. I'm just
8 asking, what about 43, which is what you say is the
9 benchmark?

10 MR. HACKBARTH: I think the answer to Bill's
11 question is, yeah, you get back your withhold --

12 MS. CARTER: You get the withhold back.

13 MR. HACKBARTH: -- and you pay 43. If that's not
14 right, somebody needs to explain to me why it is right.

15 MS. CARTER: At or below the benchmark.

16 MR. GRADISON: Okay. If you build a benchmark and
17 -- okay.

18 Now what --

19 MR. CHRISTMAN: I guess one thing I would just
20 add, though, is that we're talking about setting that
21 benchmark at less than the national average for the rate
22 now. So in some sense, if the provider was significantly

1 below the average, perhaps they could go up and still be at
2 that 43. But I think by setting the benchmark below the
3 average many providers would still have to change their
4 behavior to get there.

5 MR. GRADISON: Now to do this wouldn't you just
6 have to -- for a given condition, regardless of site of
7 service -- set whether it's called a DRG or a RUG or
8 something, that this is the benchmark for a particular type
9 of post-acute care, item by item?

10 I presume you'd want to do it a few at a time. So
11 you'd pick some particular conditions.

12 DR. MARK MILLER: No.

13 MR. GRADISON: No?

14 DR. MARK MILLER: Bill, let me pick up there.

15 So what's going on here is that the underlying
16 payment systems largely remain unchanged. Okay.

17 So, if you use a service, Medicare fees -- you
18 know, Medicare payment rates as they exist stay in place.

19 The episode benchmark was more conceptual in the
20 sense of saying, okay, for a 90-day episode that's triggered
21 by a hospital for these particular services -- and this is
22 just again, for the public, just an example. In this

1 particular instance, it's 43.

2 So the providers engage in their behavior, and
3 that dollar figure, whether it comes out at 47 or 41, is a
4 function of both what Medicare is paying and how many
5 services are used. And then whether they hit that 43 or
6 not, above it or below it, is a function of whether they
7 used more or less services and how each of those services
8 was priced in the regular fee-for-service system.

9 MR. GRADISON: Now I'm really confused. I
10 understood from the discussion a few minutes ago that the
11 hospital was not at risk if the post-acute care setting
12 turns out to be more expensive than we would like it to be.

13 DR. MARK MILLER: Everybody -- hospital, post-
14 acute care provider. They're both at risk.

15 MR. GRADISON: Then I have to circle back to my
16 fundamental question here. How is that going to work in a
17 system where under current law the choice of where you go if
18 you have to go to a nursing home, to a SNF, is not the
19 hospitals?

20 And, in fact, they've got to be very careful what
21 they say or what they do because the choice under statute,
22 as I understand it, has to be preserved.

1 And it may well be that the patient or the
2 physician, for reasons that the hospital doesn't even agree
3 to, wants the nursing home to be a mile from the home of the
4 family rather than the better one 10 miles from the home of
5 the family.

6 I don't quite understand how this system can
7 really work the way we want to and still maintain the
8 current rules of choice. But that's, I guess, a part two
9 comment. I didn't mean it to be, but I didn't understand.

10 The hospital then is at risk. It may not be at
11 risk for \$50 billion, but it's at risk for a significant
12 amount.

13 And just to go a little step further from what I
14 was saying earlier in the day, that may be the way we want
15 to go, ultimately, but to do it really is saying we're going
16 to turn the world over to the insurers because they're the
17 ones who are going to have the capital, the experience and
18 the wherewithal to make this work.

19 It can't possibly work with the hospital because
20 they're not sufficient as -- because they -- it has no
21 reflection upon their capabilities as providing health care,
22 but in terms of providing capital and accepting risk, \$50

1 billion may just be a little high.

2 MR. HACKBARTH: So I think you put your finger on
3 what's a really important dilemma for Medicare that pops up
4 in various places. I'm not sure I would agree with all of
5 the last part of your statement.

6 We do have this issue where traditional Medicare
7 is a free-choice-of-provider system. Indeed, it is in the
8 second section of the Medicare law that Medicare shall not
9 infringe on the patient's free choice of provider. That
10 design feature, which is at the core of traditional
11 Medicare, is always a potential hurdle when it comes to
12 establishing accountability for total cost of care.

13 This is an issue with ACOs. The design is no
14 infringement of free choice but accountability for total
15 costs over a period of time for a defined population. So
16 this is an issue that we're always tugging at.

17 Now here it pops up in a much narrower form than
18 on ACOs. The only infringement on free choice is the
19 potential use of different post-acute providers. That's not
20 to diminish its significance, but in some ways the ACO
21 problem is bigger than this one, at least when you have
22 downside risk --

1 DR. CHERNEW: Yeah.

2 MR. HACKBARTH: -- on the ACOs.

3 Now having said all of that, one of the reasons I
4 thought you could still maybe have ACOs work is free choice
5 is influenced heavily. The patient's choice is heavily
6 influenced by provider advice. And so it may be that in
7 fact you can hold somebody accountable -- a provider or
8 group of providers responsible -- still given the
9 beneficiary free choice, and providers will use their
10 relationships to influence where the beneficiary goes.

11 But all of that is not to deny for a second that
12 there is some friction between establishing accountability
13 and a free choice system. The two at some level are at odds
14 with one another.

15 DR. MARK MILLER: And the only thing I would add -
16 - and I think this made its way into the paper, Carol, but
17 I'm forgetting now.

18 There was some discussion, at least among
19 ourselves and in some of our other meetings, of whether you
20 start to think about changing those rules so that if a
21 provider decides, like Cori's example, that there's a SNF
22 that is really a bad actor and makes referrals, that you

1 allow those rules to be somewhat relaxed. It's a decision,
2 but I thought there was some discussion of that in the
3 paper.

4 The other thing I'd like to do is just maybe
5 offline talk to you a little bit about the hospital risk
6 because we specifically -- and this is to some of your
7 comments from previous meetings. We specifically think that
8 this mitigates a lot of the risk for a hospital.

9 Ultimately, the hospital is at risk for its
10 withhold, whereas if you go a full blown bundle and hand
11 them the dollars, they're at risk for the entire post-acute
12 care episode, however defined. So, in some ways, we felt
13 like we were dealing with some of your concerns about the
14 hospitals being put in the cross-hairs.

15 MR. GRADISON: Well, let's talk about it
16 separately.

17 My understanding is in addition to hospitals
18 you're talking about physicians here. The physician's bill
19 might exceed the hospital's bill for very complex
20 procedures, and that raises a whole series of other
21 questions about what role they play, what influence they can
22 have other than a wink and a nod, which is kind of what you

1 were saying. It might influence them a little, but they
2 still have free choice.

3 We'll talk about it separately. I don't want to
4 take an undue amount of time, but I see some things that
5 seem to be in conflict.

6 And I kind of wonder whether we wouldn't be better
7 off long-term, as an interim step, to get away from this
8 differential in payment for identical conditions based upon
9 the site of service and take that step first, but I
10 appreciate that's pretty modest.

11 MR. HACKBARTH: I guess what we're -- as I hear
12 the discussion around the room, we're not necessarily using
13 this as a cost containment method, I think. Aren't we
14 saying what we're trying to do is improve the overall
15 quality of health care for our Medicare recipients? That's
16 an important distinction.

17 DR. MARK MILLER: And again, I think that would
18 depend on how deep or shallow you wanted to go on a
19 benchmark and the withhold. I think our first and most
20 important objective is to try and create some incentive to
21 coordinate.

22 So perhaps Cori's point ends up being that there's

1 an actor who says I'm going to maximize my own revenue, the
2 hell with everyone else, but at least under a system like
3 this, you would start to want to reach out to your community
4 to figure out whether there is a way to stay underneath the
5 benchmark.

6 MR. HACKBARTH: Right. So I guess you can't
7 always control for the extreme exception, but it seems to me
8 that no physician works in a vacuum now. You may be an
9 independent entrepreneur, but you have to depend on certain
10 systems, use facilities that are out there, whether it's a
11 hospital or a nursing home, and they have their own quality
12 standards, which most human beings would say are meritorious
13 if they're set up the right way.

14 So I think basically what this is, is an attempt
15 to gradually move as many other initiatives we're taking, to
16 point out that the fee-for-service system may not be viable
17 for a long period of time in the modern health care system.

18 MR. GRADISON: I agree with you.

19 MR. HACKBARTH: And, to me, that's -- and I think
20 maybe they can't be giant steps, but I think bundling is not
21 a bad place to dip our feet in the waters here.

22 MR. BUTLER: [Off microphone.] Where are we?

1 MR. GRADISON: This is round one.

2 MR. BUTLER: Come on, don't blame me. I didn't
3 say anything yet.

4 MR. HACKBARTH: [Off microphone.] Look at it this
5 way; you had the last word in round two.

6 MR. BUTLER: Okay. Okay, so I just have one round
7 one question.

8 These are examples in the text. You have actual
9 kind of bundles with and without post-acute care. Do those
10 adjust for -- to do this thing right, you have to pull out
11 things like the add-on payments. You've got to adjust for
12 wages. You've got to adjust for all kinds of things that
13 basically make it so that you're looking at utilization
14 differences as opposed to a pricing and add-on payments
15 difference.

16 And that, technically, either you've done or you
17 feel pretty confident can be done because when I look into
18 our own medical spending per beneficiary that's not a simple
19 thing, but that's what you're trying to do.

20 MS. CARTER: Right, and these are standardized
21 payments. So we took all of the add-ons and the outlier
22 payments out.

1 MR. BUTLER: Okay.

2 MS. CARTER: So it's to exactly get at that.

3 We're trying to show utilization differences.

4 MR. BUTLER: I'm not sure your outliers belong
5 out, but, okay.

6 MR. HACKBARTH: So let me begin round two with a
7 question that I invite people to react to. If Medicare were
8 to go down a path like this, one of the questions that would
9 arise is how this relates to some other ongoing activities.
10 In fact, I think we alluded to this in an earlier
11 discussion.

12 Does it make sense to do this bundling around an
13 admission if you want to move to ACOs, if that's the
14 comprehensive model is your long-term objective?

15 How does this fit?

16 Does it make sense to do this as, as some people
17 have said, a halfway house that allows people who aren't
18 quite ready for the full ACO thing to sort of do it on a
19 smaller scale, and it's a way to move into the
20 accountability world in a small way?

21 So that's a question.

22 Another activity that we have in current law now

1 is the readmission penalty. How would this fit with the
2 readmission penalty?

3 Do you do the readmission penalty in this, or does
4 this supplant the readmission penalty?

5 And then the third question is in the paper Evan
6 and Carol describe the ongoing CMS bundling demos, which
7 take still different approaches to trying to establish
8 accountability for total cost and quality around admissions
9 and post-acute care. How would this fit with those?

10 Are we saying stop the demos; do this?

11 Or, what's the division there?

12 So it would be easy for us to focus on all of the
13 details of how this might work, and that is an important
14 conversation to have at some point. But maybe the first
15 conversation is, if we want to do anything like this, how
16 does it fit with the other initiatives that we've talked
17 about that are now underway?

18 So I invite comments on that in round two.

19 DR. NAYLOR: So I, conceptually, think this is an
20 area we should pursue because it is unique and different
21 from ongoing initiatives and adds a very important
22 perspective.

1 I do think that -- to answer your three questions
2 -- one is that we would carefully, as Evan has suggested,
3 need to monitor hospital admissions to make sure that the
4 opportunities and availability of bundles, especially these
5 kinds of bundles, don't create incentives for the index
6 hospitalizations to grow.

7 I think in terms of the readmission policies the
8 opportunity here is to look longer-term, the 90-day look,
9 whereas the readmission program is looking at 30 days. It's
10 a really important one because it forces the building of
11 collaborations and partnerships between hospitals and post-
12 acute providers.

13 I think the focus on all condition readmission for
14 the Medicare beneficiary is exceedingly important and is not
15 the focal point of the CMS demos. They focus on hospital-
16 related.

17 The thing that I really do want to ask is a very
18 fundamental question in design. When I read this a couple
19 of times, I missed it.

20 So is this a bundled -- I'm Mr. Smith. I come in
21 for an acute episode of heart failure. Is this a bundled
22 payment for heart failure admission and whatever happens in

1 90 days, or is it a combined heart failure plus home health
2 or skilled nursing or LTCH or whatever?

3 In other words, fundamentally is this -- I thought
4 the design issue here was hospital plus post-acute rather
5 than just hospital and whatever happens in the 90 days.
6 That gets back to your question.

7 MS. CARTER: So this is a bundle that spans 90
8 days, and the 90 days starts at hospital discharge. But the
9 bundle episode benchmark -- so let's say in this example the
10 43 -- includes the initial hospitalization, what you term
11 the trigger hospitalization. It would include any post-
12 acute care.

13 DR. NAYLOR: But it doesn't require post-acute
14 care. That is what --

15 MS. CARTER: Well, because it's a fee-for-service-
16 based model, the post-acute care providers get paid if
17 they're used, but --

18 DR. NAYLOR: Honestly, I kept reading it as a
19 combined post-acute plus, which I thought also distinguished
20 it. Okay.

21 [Off microphone.] So, it doesn't require it,
22 okay.

1 DR. BAICKER: I think this is a very promising
2 direction to go, in part because a lot of the big-picture
3 things that we are talking about are phase in slowly, have
4 very low powered incentives involved and are a step towards
5 a broader system reform, whereas the counterbalance to that
6 is doing what you can in the system you have now. And this
7 has, I think, a greater potential to have higher powered
8 incentives in the short run even though it's still within
9 this architecture that we're trying to move away from in the
10 long run.

11 I wouldn't want to throw out reforms like this
12 because they don't move us as far away from that
13 infrastructure because they may be more effective in the
14 short to medium term and don't run counter to those other
15 things we're trying to do.

16 MR. HACKBARTH: So, if I understand you correctly,
17 you're saying that you think it's appropriate to do this and
18 ACOs, that this can be a useful sort of interim step.

19 What about this versus readmission penalties? How
20 do you see those relating to one another?

21 DR. BAICKER: I think that there's a downside to
22 having too many different policy levers trying to be

1 deployed at the same time, that the incentives may be not
2 orthogonal but not exactly parallel.

3 And I think the more different -- slightly
4 different -- pulls there are, that can undermine the
5 effectiveness of each, but I don't feel well enough informed
6 yet to say this versus that.

7 So I've a strong sense that they should be
8 harmonized, but I'm not clear on the space of how well they
9 might actually work in conjunction, together.

10 DR. CHERNEW: I think that the word, bundle, is a
11 little confusing in this discussion because bundle has this
12 notion that there's a fixed amount of money that someone is
13 going to get no matter what happens, and that's not really
14 what's happening here. This is basically a withhold
15 program.

16 So, if I understand correctly -- I'm still in my
17 first round one question -- say the initial index admission
18 was \$20,000. The hospital will get paid that minus 4
19 percent of that. If nothing else happens, they get that 4
20 percent back, all said and done.

21 If they send someone to a post-acute setting, that
22 begins to move up towards this budget. And as soon as it

1 exceeds -- as soon as all the post-acute stuff, any
2 readmissions, exceed what that original budget is, then all
3 the organizations that have provided that care -- the
4 original hospitalization, all the other post-acute -- they
5 begin to not get their full fee. They get their full fee
6 less, basically, 4 percent.

7 And there's this weird range before you get to the
8 sort of max withhold reduction where they get a portion of
9 it but not the full thing.

10 That's how I think that this is set up, just
11 mathematically.

12 Then the question is, is that design good or bad?

13 And the question, of course, for any good and bad
14 is, relative to what?

15 I think if we have nothing else running around I
16 think it's better than the status quo.

17 Relative to readmissions policies, I actually am
18 not a big fan of the readmission penalty as a general rule
19 versus things that I've learned relatively recently, in part
20 because a lot of concern that there are issues related to
21 socioeconomic factors. And we've had a lot of discussion
22 about that. So I would have to look at the exact version of

1 this compared to the exact version of that and the
2 magnitudes and a bunch of things.

3 I prefer broader things like ACO, personally, ACO-
4 type models, but I agree it's not clear how quickly we are
5 going to get to those types of models.

6 This is an area where I think there are such clear
7 problems in the use of post-acute, that anything we can move
8 in this direction probably gets me over the hurdle to
9 support it, but I am admittedly worried about how it fits in
10 both with all the other procedures and, frankly, the
11 political lift and intellectual distraction of trying to
12 sort -- even if I didn't worry about it, just if we spent
13 all of our time trying to figure out how to perfect this
14 version for all of the legitimate things that Bill talked
15 about with this, I think that might distract us from moving
16 in a direction, just emotionally.

17 So, in the end, I guess it remains to be seen.
18 The concern, of course, is that the incentives for the
19 hospital is not to do post-acute care. Everyone,
20 incrementally, is responding to these incentives, and I
21 haven't mapped out how that choice is being affected at each
22 point in the choice phase.

1 So I think it's worth us exploring a little bit
2 more, but I think we have a way to do, to figure out how to
3 answer Glenn's questions.

4 DR. BAICKER: Just to make sure that I understand
5 the relationship between this bucket of policies and the
6 readmissions penalty, I'm sort of thinking of that as nested
7 in this, if we think about the withhold flexibly in terms of
8 functional form. Really, that's a form of bundling where
9 you're getting a clawback that's just not one for one.

10 And so, the question is, is that what's -- then
11 the question reduces to, what's the right clawback and
12 what's the window over which it should be implemented?

13 And if you think of that framework, then the --

14 DR. CHERNEW: [Off microphone.] And who pays it.

15 DR. BAICKER: Right. Then the readmission thing
16 would be part of that whole question. It's not a separate
17 thing. It just has to be harmonized in terms of the
18 parameters.

19 DR. MARK MILLER: And this may be way too
20 simplistic, but the way I was thinking about it is if you
21 had -- you know, we've been talking about in the
22 readmissions penalty to move to a potentially-avoidable-but-

1 all condition.

2 So then let's say somebody began to say, you know,
3 I think we're ready to move forward on this. Somebody. And
4 then they started off with five DRGs. So, for those five
5 DRGs, they're no longer in the penalty because readmissions
6 now have been dealt with here for those DRGs.

7 MR. HACKBARTH: So you see this as supplanting --

8 DR. MARK MILLER: I see you could do it that way.

9 DR. CHERNEW: This is going to put a lot of burden
10 on the actuaries. Who's facing the incentives under this
11 and how much incentives they're facing is very different
12 than the readmission policy, which is coming -- basically,
13 the way we have it now, it's coming out of the hospital but
14 not the post-acute setting, and the magnitude there is a
15 different percentage relative to this magnitude, but it's
16 off of a different base.

17 MR. HACKBARTH: [Off microphone.] Let's continue
18 around.

19 DR. COOMBS: So I agree with Mike.

20 My issue is one of the notion of readmission for
21 any cause. Say you have a hip, and you come back for
22 something else -- pneumonia. And that 90-day period is

1 extraordinarily long.

2 And just on first blush, looking at the slide here
3 in consideration with some of the other factors, it would be
4 a real disincentive to do a CABG on a diabetic who has a
5 high incidence of a wound infection and has to come back and
6 have multiple interventions, may go to an intermediate care
7 facility and bounce back on multiple occasions for which the
8 cardiac surgeon will be responsible for that patient.

9 Why would you consider this risky patient where
10 there's so much time investment? You'd have to be a
11 missionary.

12 So my concern really is this 90-day window where
13 you're really on the hook for people who -- you may be
14 having a region of the country where you have these patients
15 that are just sick. You know, they're just very, very sick.

16 You can't be responsible for something you cannot
17 predict. I mean, you just can't be responsible for that.
18 It's not like you planned that they were going to have these
19 other comorbid conditions for which there are exacerbations.
20 And so, for me, I'm looking on that side of it.

21 And I think it's a good idea to do something where
22 it forces coordination with the people in the village, but

1 you have to watch what you do because the unanticipated
2 negative effects will be that it will steer people away from
3 this table 3.

4 I'm just going down through the table 3 and
5 looking at some of the diagnoses: Septicemia with
6 ventilator, 96 plus hours and the cost of that, and the
7 patient bounces to a place that's really good with
8 ventilators, and all of a sudden you have another problem.
9 You know.

10 The whole notion of bowel resections -- some
11 patients actually go to these facilities with wound vacs in,
12 and if they have some problem with the wound vac and they
13 bounce back for problems -- mechanical problems -- with the
14 wound vac or, say for instance, they develop some kind of
15 super infection -- I know it's one of those things that
16 should never, ever happen, but it does happen.

17 And so, I'm not sure that this 90-day period is
18 one of those things that makes people want to run toward
19 these patients in table 3. That would be one of my
20 concerns.

21 I'm going to sit down and think a little bit more
22 about this. It gives me warning signs. The hairs on the

1 back of my neck just kind of stand up because if I was
2 trying to manipulate the system or gain the system I clearly
3 see there's a way in which I could do that.

4 And I think just to put a form out there to say we
5 force coordination -- there's no cost-sharing. There are a
6 lot of things that are really missing from this puzzle.

7 I would favor the ACO plan more so than just
8 something that just kind of makes us kind of come together
9 in terms of coordination between providers. I like the
10 idea, but I'm not sure this is -- I like the idea of
11 bringing us together, but I'm not sure this is ready for
12 primetime.

13 MR. KUHN: Well, for the last subject on a long
14 day -- and Carol and Evan, you've given us plenty to think
15 about -- it stimulated some interesting conversation.

16 Glenn, kind of responding a little bit to your
17 questions, how they relate to one another -- and I'm glad
18 you framed it that way because to a degree, when I read the
19 paper and as I listened to the earlier conversation, I kept
20 thinking in those ways. So kind of three tiers come up in
21 my mind.

22 One, if we're really thinking about proper post-

1 acute care placement, is that already in the works in terms
2 of the care tool or better assessment?

3 So is that work already ongoing as we move forward
4 versus is this really looking at readmission?

5 And right now we know we have a 30-day policy.
6 This looks at -- to a degree, one way you can think about it
7 is this is kind of a 90-day readmission policy for all --
8 you know, one way to kind of look at this.

9 But there already is a readmission policy that's
10 just kind of getting up and running. It just started last
11 October.

12 Versus a third thing is the issue of care
13 coordination, whether it's ACO -- also readmission policy
14 gets into care coordination as well.

15 So what I was thinking as I kept looking at all of
16 this -- are we really layering on?

17 I think Mark's point made a good observation -- is
18 that, well, do you just carve out those certain areas as
19 part of that? You know.

20 So, again, I think there are a lot of things going
21 on in all these spaces. How do they kind of all interrelate
22 with another so you don't have the layering-on effect?

1 Bottom line for me is I think there's been a lot
2 of good questions raised. I think this is something worthy
3 for further conversation. I'm not sure which way I want to
4 go with it right now, but I think we ought to at least
5 continue the conversation and look at additional policy
6 options here.

7 DR. DEAN: In general, I find the bundling idea
8 appealing although, as Mike points out, this isn't exactly
9 bundling in the way we've talked about it before.

10 I guess my concern would be we need to stop and
11 think, what are the incentives for any individual provider
12 within this structure, and I fear that they're not the same
13 as what we're trying to get to overall.

14 And it even has -- some of the aspects of it make
15 me think of the SGR and the fact that any of us can be
16 perfectly responsible and yet still be penalized because of
17 somebody else's actions. I think we really need to be
18 careful about that.

19 DR. SAMITT: So I'll go directly to the questions
20 that you asked because I think it frames the opportunity
21 well.

22 Yes, I think it makes sense to do this. Even with

1 everything else going on with ACOS, I think it's
2 complementary because I think it appeals to a different
3 provider population that may not be in ACOs today but is yet
4 another means to promote a value-based care delivery model.
5 And now, again, we're getting at another sector that needs
6 to think in this direction.

7 So I think it's complementary.

8 I think it will help in transition, which was one
9 of the discussion questions, by focusing on a select set of
10 conditions, and I think this is what Mark alluded to.

11 I think when it's done that way it supplants the
12 readmission penalty. I would agree that that's what we do,
13 that we don't double-count that way for those conditions,
14 that it's inclusive of those conditions for readmission, but
15 the readmission penalty methodology still applies for the
16 conditions that are not part of this global post-acute
17 bundle.

18 So I think that, too, is potentially
19 complementary.

20 I'm not sure what to say about the demos. In the
21 paper it talked about the fact that the demo phase is a no-
22 risk phase right now. So it just feels like it will take

1 too long to see if this will work, and I'd rather see some
2 potential results sooner. So maybe they can still happen in
3 concert.

4 And then I'd rethink the methodology because while
5 we don't have to do traditional bundling I don't see much
6 incentive to change behavior in this. I mean, the way that
7 I envisioned it would happen is that if you're below the
8 benchmark, you're trued up to the benchmark; if you're above
9 the benchmark, you're trued up down to the benchmark.

10 It's really more of a methodology that you don't
11 have to subcapitate. You can still do a shadow pricing
12 methodology like this, but I think you've got to create an
13 incentive for the right stuff to happen and a disincentive
14 for the wrong stuff to happen.

15 And then one other comment, the alternative
16 bundling strategy that was referenced -- you know, that's
17 intriguing to me because it seems to include physicians as
18 well, and then it's not just the hospitals that are on the
19 hook for the total bundle, but it's the doctors that will
20 potentially influence some of those decisions as well.

21 So I don't quite know how that would work, but I
22 kind of like that alternative strategy, and I'd be

1 interested in learning more about it.

2 MS. UCCELLO: So, despite the questions and the
3 downward spiral they caused in the first round, I am
4 supportive of further consideration of this. And I think if
5 we look back to the first session and that continuum of fee-
6 for-service to MA plan, this moves us to the right of fee-
7 for-service.

8 And, if we think about making sure we do it in a
9 way that -- this may or may not be the perfect way to do it,
10 but does it help start to -- help create incentives for the
11 coordination and discussion across providers, and I think
12 this does have the potential to do that. The details
13 matter, but I think this is worth pursuing.

14 DR. REDBERG: So I am certainly supportive of the
15 concept of bundling and how it could help ensure care
16 coordination and not paying for the same services at
17 different places differently.

18 But I have to say maybe it's the hour, but I'm a
19 little confused now on how this actually will work in terms
20 of the bundle because when I look at that I thought, well,
21 the people that are spending too much are still going to get
22 more. So it's not really an incentive to do less. They

1 just will lose the 4 percent withhold, but overall they're
2 coming out still ahead.

3 And plus, I guess, you could talk about what the
4 benchmark should be.

5 And then there's always -- you know, just because
6 -- and we started talking about, well, this would fit sort
7 of between ACO, and I feel like it's already so complicated.
8 I guess it's just hard working within our system, and I can
9 see if we want to do something more quickly or shorter-term,
10 then that's what we have to do, but my sort of ideal scheme
11 of things gets simpler instead of more complicated.

12 And then we would always have to watch for is it
13 post-bundle expenditures shifting to outside bundles, and
14 that would take a little while to actually determine if this
15 would actually work or just shift.

16 And then the last sort of thing that now I'm
17 confused about is how the bundle would work in terms of
18 where you chose your site of service because we know that
19 some post-acute care is less expensive than others although
20 what I got from the demo was that the outcomes seem the
21 same. Presumably, the benchmark would be different, or
22 those more expensive sites of post-acute care would still be

1 getting paid more because it's still a fee-for-service
2 system.

3 So how would that change then the use of more
4 expensive post-acute care when less expensive would give you
5 the same outcomes? How would this address that?

6 MS. CARTER: Well, you would be more likely to
7 reach the benchmark if you used a more expensive mix of
8 services.

9 DR. REDBERG: Less likely to reach the benchmark -
10 -

11 MR. HACKBARTH: People doing the referring would
12 have a reason to say, does this patient really need to go to
13 an LTCH versus a nursing home?

14 DR. REDBERG: Well, I guess it depends if the
15 benchmark was set according to the IRFs or the SNFs or
16 whatever.

17 MS. CARTER: Right. Presumably, it would
18 represent some mix.

19 DR. REDBERG: Overall, I'm supportive.

20 MR. ARMSTRONG: So, despite the fact we're kind of
21 at the end of a mind-numbing day, I actually think this is
22 one of the best discussions this group has had in a while.

1 I really love this proposal that you put together. It's
2 what we asked for, but it's a level of specificity. So it
3 really describes how it might work, and it gives us
4 something to react to and ask, I think, really productive
5 questions around.

6 I think as it is it's worthy of, and needs more,
7 discussion and so forth, but I think it's an excellent,
8 really concrete idea that's consistent with the things we've
9 been asking for.

10 And then to kind of move from the concreteness and
11 specificity of the proposal to this conversation more
12 broadly about, wow, how does this fit within all the other
13 things we're trying to do -- and I really like -- you know,
14 we do -- I don't know if this is the right way of framing
15 it, but my hope is this is part of our agenda at the
16 retreat.

17 We've got all this work going on in fee-for-
18 service. We want to get the payment right. We want to --
19 you know, and whatever.

20 And then we've got MA, and we want to make sure
21 that's doing what we expect of it and how hospice fits or
22 doesn't, or whatever.

1 And then you've got all this stuff in the middle
2 that we're working on, and we're trying to make sure that
3 the different initiatives that we're pushing forward
4 actually kind of hold together and make sense and don't
5 conflict with one another or build on one another.

6 And I think with some time we could get clear
7 about the criteria we use to judge those things too:

8 Are they trying to solve a cost problem that's an
9 obvious problem?

10 Are they trying to deal with margins that are
11 inappropriate?

12 Are we trying to do something that improves
13 quality and coordination because we know those are things we
14 are really concerned about?

15 Or, are we investing in a pilot or a policy change
16 or payment change that we think will help advance industry's
17 reform to a future that we think would be different?

18 I think those are different criteria, different
19 outcomes. Right now, we're kind of laying them all out. I
20 think we could be a little bit more structured about how we
21 evaluate that, and I think that would be really great work
22 for us to do.

1 DR. NERENZ: I agree with Scott. Thank you very
2 much for putting something with this level of specificity in
3 front of us so we could really discuss it and sink our teeth
4 into it. It's a really nice job.

5 Within this particular framework, just a couple of
6 things -- I would encourage thinking a little bit more about
7 adding some carrot elements, including possibly a shared
8 savings component because of issues people have raised about
9 problems with incentives.

10 I'd also encourage considering more about some of
11 the regulations and rules embedded in fee-for-service that
12 perhaps could be relaxed or eliminated in this model to make
13 it easier to do some coordination of things like steering
14 people to good and efficient rather than other places. I
15 understand the difficulty, but I think we look at it.

16 Even with that, I share Tom's concern about there
17 being some SGR dynamics in this. It looks a lot like that.
18 With that in mind then, the discussion might be extended to
19 say, what about a true, real bundled alternative?

20 We're clearly looking at a fee-for-service billed
21 system here as a way to transition to that perhaps with the
22 idea that as many current providers as possible could at

1 least be players in a system like this, built on fee-for-
2 service. But maybe that's not the best and most effective
3 way to transition.

4 Maybe what you want to do is put forward a true
5 bundled system that only a few organizations currently can
6 step up to. But if it works and if it's attractive, then
7 other organizations will create the ability in the future to
8 step up and do it. So I wouldn't totally ignore that option
9 as well. I'd like to see that in the discussion.

10 DR. HOADLEY: So I agree with Scott, that this
11 really took something we always talk about in sort of vague,
12 warm and fuzzy terms and tried to make it concrete, and that
13 gave us things to react to. Sometimes we don't like what we
14 see, and so that's where we've gotten to.

15 I guess some of the things that make me think
16 about that I haven't heard anybody specifically articulate -
17 - because the underlying payment systems that we're bundling
18 together are prospective payment systems with their own
19 bundles, the dollars that go in to make up the payments, to
20 make up the 41 or the 47, come in these big lumps.

21 So the hospital is getting one big DRG, and yeah,
22 maybe there's worry about what we do about outliers or other

1 things like that. And many of our other post-acute systems
2 come in big lumps. And so you might jump from 38 for the
3 hospital to you can either add 6 or 10,000 or whatever,
4 based on which post-acute.

5 You're tempted to think about it as if these are
6 continuously variables, like every day of the nursing home
7 is another \$200 or whatever, the way the older systems were.
8 I think it just gets harder to think about it with the
9 payments all coming in those lumps as well as the sort of
10 lumpiness of the different options for the post-acute care.

11 And there are such big differences between home
12 health and SNF and, especially, LTCH that, again, it makes
13 it hard to kind of think about. So, as soon as you're in an
14 LTCH, you've guaranteed you've lost the 4 percent. So it's
15 like an on-off switch.

16 Or, if you don't go anything, like several people
17 have said, and you only do the hospital stay, I assume the
18 single hospital stay would almost always, or always, be
19 below the benchmark. So then that's an on-off switch that's
20 on. You get the withhold back.

21 So, instead of having a little more of a dial
22 possibility, there's a lot of lumpiness.

1 Where that goes to sort of -- that leaves me kind
2 of unsure of how to answer Glenn's questions.

3 I kind of like the conversation that Kate
4 initiated, that maybe this is just a special case of the --
5 and Mark added to it. You know, the special case of the
6 readmission. If we actually work this through, we wouldn't
7 need the readmission and wouldn't need to be on top of the
8 readmission, at least for whatever part of the system.

9 This versus ACO -- I just don't feel I'm smart
10 about either of them yet to sort of think about the choice.

11 And the only other thing that was on the original
12 set of discussions was the beneficiary incentive issue,
13 which we haven't as much talked about. I may have some
14 philosophical concerns about how that's set up, but from a
15 practical point of view I really have trouble thinking about
16 how you would turn to a beneficiary and say these
17 differential -- some kind of differential co-pay built on a
18 system that already has a lot of very different co-pay rules
19 in it. Even if you ignore the Medigap issues and just
20 pretend that those weren't there -- how they would try to
21 think about this and potentially pretty gameable parts of
22 that system.

1 So I've got my doubts about that piece of it
2 although, obviously, the other aspects of trying to get the
3 beneficiary invested in why they might weigh one choice over
4 another, and figuring out a mechanism to get there is
5 something we need to think about.

6 MR. GRADISON: I'm sorry if I came through as
7 being dogmatic on this -- I really am -- because I just want
8 to say the thing that I want to be very comfortable with
9 that I'm not at this stage is that at the end of the day the
10 punishment fits the crime. That is to say that whoever is
11 getting dinged on this is getting dinged for something they
12 can influence.

13 And I look at the current hospital readmission
14 process and look at who's being penalized, and I wonder
15 about the soundness of the system. There seem to be large
16 categories of hospitals that I think are going to have a
17 very difficult time because of the socioeconomic
18 circumstances of where they are and who their patients are.
19 They can't control that, and I pick that as a very specific
20 example of why I'm concerned.

21 I've told you this story maybe once before. I was
22 talking to the head of a large hospital who was very

1 concerned and used this as an example about readmissions.
2 He talked about one young man who -- a teenaged African
3 American who got caught between two gangs in a shootout. He
4 was not involved in either of the gangs and left a
5 paraplegic. He was treated and discharged and readmitted
6 and discharged and readmitted.

7 And when they looked further, they found out when
8 he was discharged he went back to home, which was a crack
9 house. The hospital ultimately, although they said they
10 couldn't do this very often, rented an apartment for this
11 young man, large enough that the young man's father could be
12 there, and so there was some support system to try to keep
13 him on his meds and keep him off drugs.

14 Maybe that should be the responsibility of the
15 hospital, but I'm not sure. And you can say, well, that's
16 an extreme example, and I recognize it, but I think it makes
17 the point.

18 Let's make sure that -- if we're going to hold
19 somebody responsible, financially responsible, let's be sure
20 as we can that it's something they can do something about.
21 That's really -- that's my nagging concern.

22 MR. HACKBARTH: Bill, your nagging concern is a

1 really important one.

2 Here, I think, is the policy challenge. The
3 absolutely worst facet of the free choice, fee-for-service
4 system that has been the staple of Medicare in U.S. health
5 care in my book is not the fact that it creates incentives
6 to do more. Surely, that's a problem. The worst part of it
7 is that it utterly fragments accountability.

8 And so the policy challenge that we face is, how
9 do we move from a system where nobody is accountable beyond
10 their narrow, little silo to one where we do have people
11 accountable for patterns of care that span multiple,
12 different types of providers?

13 If your mind set is nobody can be held accountable
14 for anything that's not within their four walls, you're
15 locked in place. And so you have to start figuring out how
16 to move and create incentives for people to say, oh, I am
17 responsible beyond my walls but do it, as you say, in a way
18 that's measured and doesn't put people -- you know, the
19 institution -- at risk for things that are utterly outside
20 their control.

21 It's inevitably going to be a little bit of a
22 challenge, and some stops and starts, and difficult patches

1 along the way. But if you use as your rule of thumb, nobody
2 should be held accountable for anything that's not in their
3 current silo, you'll never get anywhere. And so, we're
4 trying to strike a balance.

5 MR. GRADISON: I hope it's clear I wasn't saying
6 that. Perhaps we have to reexamine this choice question
7 because if the hospital, to take that example, has something
8 to say about which institution is chosen, it's not within
9 their four walls. But they would then, by making that
10 recommendation, be taking some responsibility as to why they
11 selected it.

12 I just have to say I'm not thinking in terms of
13 four walls. I think that's a different matter. It isn't
14 that at all.

15 But the choice thing -- I think we need to
16 confront it. If we're gradually going to move away from the
17 very undesirable system we have now, with the silos and the
18 fee-for-service, and if that is an impediment ultimately,
19 then I think we ought to at least have some strategy how
20 we're going to move away from that.

21 We do it when people voluntarily go into an MA
22 plan, which is a perfect example of having the

1 responsibility for the whole thing. It's an ideal thing.

2 And here, we're trying to figure out some
3 intermediate step. I understand that, but whether that's
4 workable with the current limitations on choice -- I'd like
5 to hear more conversation about that.

6 DR. HALL: I agree with Scott, that I think this
7 has been a really stimulating discussion.

8 In terms of what you mentioned, Glenn, about the
9 whole issue of responsibility for good outcomes, we all
10 recognize that the whole here is not greater than the sum of
11 the parts.

12 But remember, this payment system hasn't changed
13 since the 60s when Medicare came into play. There weren't
14 even intensive care units then. When I was a medical
15 student, there was still an iron lung around somewhere that
16 they used to take us to look at that was operative. There
17 were no means of communication. There was no way to hold
18 everybody responsible. But the world has changed, and it's
19 changing very rapidly right now.

20 Our discussion doesn't make us ready to vote on
21 something that's ready for primetime yet, but I think this
22 is exactly the sort of discussion we have to have to be

1 ahead of the curve and be able to give good advice to
2 Congress and others who are going to have to make some very
3 difficult choices. But we can't ignore it.

4 MR. BUTLER: What comes after the caboose?

5 [Laughter.]

6 MR. BUTLER: If you felt like the caboose, I don't
7 know what I feel like.

8 So, thank you not just for the specificity of the
9 proposal, Evan and Carol, but you responded not only to my
10 issues but a number of other ones.

11 And you know I enjoy this data and this issue. I
12 started, myself, wanting to go down this path, as you know,
13 because I saw this Medicare spending for beneficiary index
14 and said that's going to get plugged into value-based
15 purchasing.

16 So, in a sense, in a small way, these incentives
17 are going to be built in there. Why not give an option to have
18 somebody even more boldly participate, particularly, I think
19 as Craig pointed out, those that may not have a big,
20 widespread primary care base but were getting these
21 illnesses in the door and felt, boy, I can make a difference
22 in managing this care?

1 And I like the virtual solution in terms of paying
2 claims as it is. I think the -- but I envisioned this more
3 as a mini ACO for those that weren't doing the full-blown
4 one. So I viewed it more as a shared savings versus a fixed
5 payment.

6 And I definitely didn't view it as a withhold. I
7 mean, why not withhold the 5 percent on the AAPCC that we
8 were looking for a long time ago?

9 I think that's a -- so I would prefer, as Mark
10 pointed out earlier, then just set a lower threshold under
11 which you could get some benefit.

12 And I don't think, contrary to some maybe, that we
13 ought to take something out of each of the providers. I
14 think you need somebody in charge, frankly.

15 I think you could create criteria for the
16 receiving organization that says, okay, you have to create
17 incentives among each other, or something. But to dictate a
18 certain slice out of everybody will not get the collective
19 behavior.

20 So I think I would view this as something that
21 would be an option. It would be voluntary. If you did it,
22 then you would not be subject to readmission rates and some

1 of the other things that the -- you know, some of the other
2 utilization tools that are being applied to reduce spending.

3 So that's my comments.

4 MR. HACKBARTH: This is a very good discussion,
5 Evan and Carol, and thanks for your work on it. Clearly,
6 we'll be back to it again.

7 So let me now have the brief public comment
8 period. Could I see the hands of anybody who's headed that
9 way?

10 Anybody going to the microphone?

11 Going once. Going twice. Sold.

12 Okay, we are done. We reconvene tomorrow at 8:30.

13 [Whereupon, at 5:48 p.m., the meeting was
14 recessed, to reconvene at 8:30 a.m. on Friday, April 5,
15 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, April 5, 2013
8:31 a.m.

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

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Medicare's coverage of services provided by advance-practice nurses and physician assistants - Kevin Hayes, Kate Bloniarz, and Katelyn Smalley	85
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1 P R O C E E D I N G S [8:31 a.m.]

2 MR. HACKBARTH: Okay. It's time to get started.

3 Our first session this morning is "Improving
4 payment for chronically critically ill patients."

5 MS. KELLEY: Good morning. Julian and I are here
6 to discuss improving payments for the medically complex
7 patients we call the "chronically critically ill," or CCI.
8 Medicare's payments for the services furnished to CCI
9 patients in long-term-care hospitals are generally much
10 higher than payments for CCI patients in acute-care
11 hospitals. But a decade of research has failed to provide a
12 compelling reason why this should be the case.

13 Today I will review the history of how we got to
14 different payments for these similar patients, depending on
15 the type of hospital they receive care in, and the
16 consequences this has had for both the Medicare program and
17 for patient care delivery in some areas of the country. I
18 will talk about an analysis we've done that attempts to
19 define and describe CCI cases and where they are cared for.
20 And then Julian will describe some approaches we're
21 developing to make payments for CCI cases site-neutral and
22 more patient-centered.

1 And before I go on, I just want to acknowledge
2 Lauren Metayer's assistance with this work.

3 Let's first discuss why Medicare pays differently
4 for hospital services in acute-care hospitals and LTCHs.
5 Remember that back in 1983, 84 hospitals with very long
6 average lengths of stay were excluded from the Prospective
7 Payment System for acute-care hospitals. These hospitals
8 predominantly had begun as tuberculosis and chronic disease
9 hospitals. Until 2003, Medicare continued to make cost-
10 based payments to hospitals with a Medicare average length
11 of stay of more than 25 days. The cost-based payment method
12 was inherently inflationary and led to growth in the supply
13 and use of LTCHs and, of course, to growth in Medicare
14 spending for these services as well.

15 When the LTCH PPS was implemented in 2003, its
16 rates were based on these inflated costs, resulting in
17 overly generous payments that provided few incentives for
18 efficiency.

19 In addition, the LTCH payment system includes
20 policies such as the 25-day average length of stay
21 requirement and the short-stay outlier policy that likely
22 distort the delivery of care and the use of resources in

1 these facilities. So let me review our evidence for these
2 conclusions.

3 This slide shows growth in the number of LTCHS and
4 LTCH spending over the last 20 years. The green line,
5 showing the number of LTCHs, suggests an attractive
6 reimbursement environment. The number of LTCHs has
7 increased more than five-fold during this period and
8 continued to grow following the implementation of the PPS.

9 The blue line shows that in the last years of
10 cost-based payment, Medicare spending for LTCH services was
11 growing at an average annual rate of about 18 percent. In
12 the first years of the PPS, that rate accelerated to 27
13 percent per year.

14 You've seen this slide before, which shows LTCHs
15 per case payments and costs. Here you can see that Medicare
16 spending for LTCH care has increased not just because of
17 growth in the number of cases, but because of growth in
18 payments per case. And you can see that LTCHs appear to be
19 responsive to changes in payment, adjusting their costs per
20 case when payment per case changed.

21 When the PPS was implemented, the aggregate LTCH
22 margin was about zero, as you would expect with a cost-based

1 payment reimbursement. After PPS, margins climbed to a high
2 of 11.9 percent in 2005. In 2011, the aggregate margin was
3 6.9 percent.

4 And this slides shows us how the payment system
5 itself can distort the delivery of care and the use of
6 resources in LTCHs. This slide shows the length of stay
7 along the X-axis. The lines show the number of discharges
8 at each day of stay for the two month common LTCH diagnoses.
9 Remember that under the LTCH PPS, payments are generally
10 reduced for cases that fall below the short-stay outlier
11 threshold for the DRG. The big spike of discharges in the
12 period immediately following the short-stay outlier
13 threshold suggests that LTCHs' discharge decisions are
14 strongly influenced by financial incentives. The 25-day
15 average length of stay requirement has a similar although
16 less striking impact.

17 The Commission has expressed concerns about LTCHs
18 for many years. Those concerns can broadly be described as
19 you see here. First, there are almost no established
20 criteria for admission to an LTCH. That means acute-care
21 hospitals in areas with LTCHs can unbundle care by
22 transferring costly patients. And LTCHs can admit any

1 patient needing hospital-level care as long as they maintain
2 an average length of stay of greater than 25 days. Without
3 criteria for admission, it's not clear whether or which
4 patients treated in LTCHs require that level of care.

5 Second, some parts of the country have many LTCHs
6 while others have none. The oversupply of LTCH beds in some
7 markets may result in the admission of less complex cases
8 that could be cared for in other less costly settings.
9 This, of course, is not difficult to do because, as we've
10 established, there are almost no criteria for admission.

11 At the same time, the fact that there are areas of
12 the country with very few or no LTCHs means that many
13 Medicare beneficiaries receive similar services in other
14 settings.

15 So does the use of LTCHs cost Medicare more?
16 Generally, the answer is yes. Studies of episodes of care
17 for medically complex patients have consistently shown that
18 Medicare payments are considerably higher for most episodes
19 that include LTCH stays. However, for the most medically
20 complex patients, Medicare payments for an episode of care
21 may be lower when the episode includes an LTCH stay. The
22 research findings are not consistent on this point.

1 Do LTCHs help beneficiaries achieve better
2 outcomes? Here the answer is possibly. Some studies have
3 shown improved outcomes but, again, generally only for the
4 most medically complex patients. As we've discussed before,
5 CMS' CARE demonstration did find that on a risk-adjusted
6 basis LTCHs had lower acute-care hospital readmissions rates
7 within 30 days compared with other post-acute-care settings,
8 although they performed no better on other outcomes. The
9 better readmissions rates may be due to LTCHs' ability to
10 provide hospital-level care.

11 It must also be noted that additional analyses of
12 CARE demonstration data found that readmissions rates after
13 30 days may be worse for LTCH patients compared with
14 patients who used other post-acute-care providers.

15 If LTCH care provides relative benefits only for
16 the most medically complex patients, the obvious question to
17 ask is: Are the patients who use LTCHs the most medically
18 complex? CMS contracted RTI International and Kennell &
19 Associates to conduct a number of analyses of LTCHs and the
20 types of cases they care for, as well as the overlap in the
21 types of patients and levels of acuity across acute-care
22 hospitals, LTCHs, and some specialized SNFs. This work

1 identified two extremes of the LTCH care spectrum.

2 The first are the high-acuity or chronically
3 critically ill patients who are described as overlapping
4 with hospital ICU patients and account for about one-third
5 to one-half of LTCH Medicare admissions.

6 The second group is the subacute patients who
7 overlap more with SNF patients and who account for about 15
8 percent of LTCH Medicare admissions, although for a much
9 greater share in some LTCHs. The remaining cases are not
10 identifiably CCI but have more complex conditions than the
11 subacute group. The high-acuity CCI LTCH cases were found
12 to be heavy users of ICU services in their previous acute-
13 care hospital stays. We used this work as a springboard for
14 our own work on identifying CCI cases and paying accurately
15 for them.

16 For this analysis, we examined Medicare claims for
17 IPPS and LTCH services in 2011. We identified direct CCI
18 cases as those discharges with eight or more days in an ICU
19 or CCU. We also identified claims for hospital stays that
20 did not include eight or more days in an ICU, but which
21 could be linked to another immediately preceding hospital
22 claim that did include charges for eight or more days in an

1 ICU. We call these "indirect CCI discharges."

2 While we found only a small number of indirect CCI
3 discharges in acute-care hospitals, the distinction was
4 especially important in identifying LTCH cases who were
5 heavy users of ICU services during an immediately preceding
6 acute-care hospital stay.

7 What we found is that 6 percent of all IPPS cases
8 are chronically critically ill, as we've defined it. They
9 include eight or more days in an ICU. Of the CCI cases in
10 acute-care hospitals, about half go on to use at least one
11 institutional post-acute-care provider -- a SNF, an IRF, or
12 an LTCH. We did not look at the use of home health care for
13 this population. Only 9 percent of CCI cases in IPPS
14 hospitals go on to use an LTCH.

15 We also found that, by our definition, most LTCH
16 cases are not CCI. About 5 percent of LTCH cases spent
17 eight or more days in an LTCH ICU, and an additional 35
18 percent spent eight or more days in an ICU during an
19 immediately preceding acute-care hospital stay.

20 So, to summarize, we have four major points of
21 concern about the way Medicare pays for chronically
22 critically ill patients.

1 First, the program makes very different payments
2 for these similar patients, depending on where the care is
3 provided.

4 Second, Medicare's payments don't match the
5 resource needs of these patients. Julian will show how this
6 is true for CCI patients in acute-care hospitals. There is
7 reason to believe that this is true in LTCHs as well, given
8 the inflated costs that were originally used to set LTCH
9 payments and the distorting effects of LTCH payment policies
10 that I mentioned earlier.

11 Third, the financial incentives of the two payment
12 systems are very misaligned. There's a push-pull effect
13 that results in increased costs to the program. Acute-care
14 hospitals face incentives to reduce lengths of stay. LTCHs
15 are able to provide hospital-level care, so where they
16 exist, they offer an opportunity for acute-care hospitals to
17 unbundle care by discharging patients early and thereby
18 reducing their costs.

19 Finally, I talked a lot about how the status quo
20 is costly to the Medicare program. As they are currently
21 designed, Medicare's payments for the most medically complex
22 patients encourage unnecessary transitions between care

1 settings. We're very mindful that these incentives may not
2 encourage optimum care for beneficiaries.

3 MR. PETTENGILL: So, as Dana mentioned, our policy
4 objective is to realign payment incentives by making payment
5 rates site-neutral and patient-centered. To accomplish this
6 objective, we would pay for all ACH and LTCH cases using
7 IPPS rates, and we would modify the IPPS to better align
8 payments and costs for CCI patients. If we can do this
9 well, then payments would reflect patients' characteristics
10 rather than the setting for inpatient care. In addition,
11 payment rates would also more accurately reflect patients'
12 resource needs.

13 LTCHs could continue to treat clinically complex
14 patients, but they would be paid under the same rates and
15 the same policies that apply for ACHs treating similar
16 patients. At the same time, restrictive features unique to
17 the LTCH PPS, such as the 25-day average length of stay
18 requirement, would disappear. Perhaps the resulting
19 realignment of incentives would enable LTCHs to develop more
20 effective practice patterns while lowering their costs.

21 In January, we talked a little about what might be
22 done. In one approach, we would make changes within the

1 IPPS to include payments for cases now paid under the LTCH
2 PPS. And we would also improve payment accuracy for CCI
3 patients.

4 There are two ways to improve payment accuracy.
5 Option 1 would increase outlier payments for the most
6 clinically complex patients, the CCI cases. We would expand
7 the pool of funds available to make outlier payments, and
8 then we would ensure that these added funds are focused on
9 the high-cost CCI cases by setting a separate outlier policy
10 just for them.

11 Under Option 1, current IPPS payment rates and the
12 outlier threshold for non-CCI cases would not change. The
13 outlier threshold for CCI cases would be lower than under
14 current policy, and hospitals would be paid 90 cents on the
15 dollar for costs above that threshold.

16 The second way to increase payment accuracy is to
17 carve out CCI cases into new CCI DRGs and reset the relative
18 weights for all DRS. We would also expand the outlier pool
19 in this option, but we would not make the outlier policy
20 more generous for CCI cases. Under Option 2, payment rates
21 for CCI cases would rise while rates for non-CCI cases would
22 fall somewhat. The added money in the outlier pool would

1 tend to lower the outlier threshold for non-CCI cases. It's
2 hard to say in advance, however, how the outlier threshold
3 for CCI cases would change, and I'll explain that in a
4 minute.

5 There's also the possibility of bundling expected
6 costs for institutional PAC services in LTCHs and SNFs into
7 the IPPS payment rates for cases in the new CCI MS-DRGs.
8 This would be Option 3. At this point we've done quite a
9 bit of work on Options 1 and 2, but less on the bundling
10 option. Rather than give you piecemeal results, we will
11 wait until we have all of the work done in the early fall.
12 Today we want to talk about Options 1 and 2 and give you an
13 idea of how they would work and how they would likely play
14 out.

15 So both Options 1 and 2 would expand the IPPS
16 outlier pool. This slide shows where the money would come
17 from and how it would be used. We would combine current
18 IPPS outlier payments with all LTCH spending for a projected
19 total of about \$10.4 billion. But not all of this money
20 would be available to make outlier payments. As shown on
21 the far right, because current LTCH spending is thought to
22 be too high, some portion of it might be held back as

1 savings to the Part A trust fund. The box at the lower
2 right-hand corner indicates that if all LTCH cases were paid
3 under the IPPS, money would have to be allocated to cover
4 their base IPPS payment rates and any other teaching DSH or
5 other IPPS payments that they would get.

6 The remaining funds would be allocated to the two
7 boxes on the lower left. The amounts in each would vary,
8 depending on how we split the funds between CCI and non-CCI
9 outlier payments. Now let's turn to how these options would
10 work.

11 To understand what each option would do, we first
12 need to talk about what current policy does. To illustrate
13 what happens under current policy and what would happen
14 under each option, I'm going to use the cost distribution
15 and payment data for IPPS cases in a single MS-DRG. The
16 horizontal scale here is in \$2,000 intervals that run from
17 less than \$2,000 to greater than \$48,000. Each bar shows
18 the share of all cases in the DRG that had costs in the
19 particular interval. So for example, about 14 percent of
20 all cases had costs between \$8,000 and \$10,000.

21 The IPPS payment rate, shown as the solid yellow
22 line, is roughly \$9,000 here. As you can see, some cases

1 have costs below the rate. The hospital keeps the
2 difference and makes some money. Other cases have costs
3 above the payment rate, and the hospital loses some money.
4 On average, for an efficient hospital, these gains and
5 losses are intended to roughly balance out, with the
6 hospital perhaps making a small surplus.

7 But some cases have extraordinarily high costs and
8 very large losses. Here the high-cost outlier policy kicks
9 in. If the cost of the case exceeds the outlier threshold
10 for the DRG -- and that's the dashed line in yellow on the
11 right -- the hospital receives an outlier payment that is
12 equal to 80 percent of the costs above the threshold. This
13 80 percent figure is called the "marginal costs factor," and
14 the outlier threshold is set by adding a national fixed-loss
15 amount -- currently about \$22,000 -- to the payment rate for
16 the DRG.

17 You can think of this as an insurance policy where
18 the loss deductible is \$22,000 and the coinsurance rate is 2
19 percent, because we're paying 80 percent of the costs above
20 the deductible.

21 When we look inside this DRG, however, what we see
22 is that non-CCI and CCI cases have very different cost

1 distributions. The bars for the non-CCI cases are shown in
2 light gray, while the bars for the CCI cases are shown in
3 green. This slide --let's go to the next one. Go ahead.
4 All right. This slide shows the two underlying cost
5 distributions, the current payment rate still the solid
6 yellow line, and the current outlier threshold now in light
7 gray that you just saw earlier.

8 It's clear that most non-CCI cases have costs
9 below the payment rate, so the hospital makes money, while
10 most CCI cases have costs above the payment rate, and the
11 hospital loses money. And CCI cases are much more likely
12 than non-CCI cases to get outlier payments under current
13 policy. But that only mitigates their most extreme losses.

14 Option 1 would simply add money to the outlier
15 pool and spend that extra money on additional outlier
16 payments for CCI cases. The current IPPS payment rate and
17 the DRG would continue to apply for both non-CCI cases and
18 CCI cases. And the current outlier threshold would stay in
19 force for non-CCI cases. So payments for non-CCI cases
20 would be essentially the same as they are now.

21 For CCI cases, the marginal cost factor would be
22 increased to pay 90 cents on the dollar above the CCI

1 outlier threshold, which is the dashed green line. Given
2 the extra money and the 90 percent marginal cost factor, we
3 would set a new CCI outlier threshold at a level that would
4 exhaust the extra money added to the outlier pool.

5 As shown on the slide, the new CCI outlier
6 threshold would be much lower than the outlier threshold
7 currently. While regular DRG payments would not change for
8 CCI cases, they would get a lot more in outlier payments,
9 and those extra payments would help to reduce existing
10 discrepancies between payments and costs and modestly
11 improve payment accuracy for CCI cases.

12 To illustrate what Option 2 would do, let's reset
13 back to the two cost distributions for non-CCI and CCI
14 cases, as you see here.

15 In this option, the first thing we would do is
16 break out CCI cases into new CCI MS-DRGs. After we do that,
17 the only cases left in this DRG would be the light gray non-
18 CCI cases with lower costs.

19 Next, we would reset the relative weights for all
20 MS-DRGs. The weights for the original MS-DRGs would fall a
21 bit because they now contain only lower-cost cases, while
22 the weights for the CCI DRGs would rise. We would also

1 expand the outlier pool, but in this instance, we would use
2 the same 80 percent marginal cost factor and a single fixed-
3 loss amount applied for both non-CCI and CCI cases; that is,
4 in Option 2, the outlier policy would not be more generous
5 for CCI cases than it is for other cases, but it would be
6 more generous than under current policy because we're adding
7 money to the outlier pool so we can spend more.

8 Okay. Next slide. So what happens -- so carving
9 out the CCI cases into new CCI MS-DRGs and resetting the
10 weights would realign payments and costs for both types of
11 cases. As you can see, the payment rate for non-CCI cases,
12 in solid gray, would be a bit lower than the current rate,
13 while the payment rate for CCI cases would be much higher
14 than the current rate.

15 Even though we would set a single fixed-loss
16 amount, the outlier thresholds would change for both non-CCI
17 and CCI cases because their payment rates change. As shown
18 here, the outlier threshold for non-CCI cases, in dashed
19 gray, would be much lower than under current policy because
20 the payment rate dropped and also because the fixed-loss
21 amount is smaller.

22 In contrast, what would happen to the outlier

1 threshold for CCI cases, in dashed green, is uncertain. The
2 rise in the payment rate would tend to push the threshold
3 up, but that would be offset to some degree, maybe totally,
4 by the decline in the fixed-loss amount.

5 To summarize, under Option 1, payments would
6 increase for ACHs that have a disproportionate share of CCI
7 cases. This would include primarily large hospitals in
8 urban market areas and major and other teaching hospitals.
9 ACHs that serve few CCI patients would see little change in
10 their payments.

11 As we showed in the mailing material, LTCH cases
12 generally have higher costs than IPPS cases in the same MS-
13 DRG. Paying them at IPPS rates would substantially reduce
14 their regular DRG payments, but their outlier thresholds
15 also would be lower for both non-CCI and especially for CCI
16 cases. Consequently, they would receive much higher outlier
17 payments than they get under the current LTCH PPS.

18 For Option 2, redefining the MS-DRGs and resetting
19 the relative weights would have much bigger effects because
20 they would redistribute payments across DRGs and hospitals.
21 The net result would depend on each hospital's case mix, but
22 generally we expect that ACHs that have a disproportionate

1 share of CCI cases would likely see higher payments.
2 Payments likely would decline for ACHs that have few CCI
3 cases, but the decline would be partially offset by
4 increased outlier payments. For LTCHs, regular payments
5 would decline generally, but the decline would be smaller
6 for those that serve lots of CCI patients.

7 We also want to note some other issues to think
8 about. Both options would significantly reduce payments for
9 non-CCI cases treated in LTCHs. This may be appropriate
10 given the research findings Dana mentioned earlier that
11 suggest that low-severity patients can be treated at lower
12 cost with comparable quality in ACHs. However, there are
13 some trade-offs between Option 1 and Option 2.

14 Option 2 would yield a larger improvement in
15 payment accuracy but also has a higher risk of gaming than
16 Option 1. The gain payment accuracy is due to creating new
17 DRGs and higher payment rates for patients who receive
18 prolonged care in a critical care unit. Historically, these
19 patients have been more costly, and ideally they should have
20 higher DRG payment rates.

21 However, if we offer higher rates for CCI cases,
22 hospitals would face an incentive at the margin to increase

1 critical care use and to get the higher payment. There is
2 no new DRG in Option 1 and no great incentive to game the
3 system. As we move forward with our work, we want to spend
4 some time to see if we can develop strategies that might be
5 used to mitigate the risk of gaming in Option 2.

6 So for our next steps, we have refinements to make
7 in our models and in our estimates for Options 1 and 2. We
8 want to complete the development of our model and estimates
9 for the bundling option. And then we want to do, as I said,
10 more work on trying to figure out strategies to mitigate or
11 discourage gaming. Then in the early fall, we plan to
12 return with impact estimates and other results from the
13 analysis.

14 That concludes our presentation, and we'd be happy
15 to take your questions and comments.

16 MR. HACKBARTH: Thank you, Dana and Julian. Good
17 work.

18 Let's see. We'll start with round one clarifying
19 questions. Any on this side? Scott and then Herb. Scott.

20 MR. ARMSTRONG: Are there any other post-acute
21 facilities where CCI patients may be cared for, or by
22 definition, is it only acute-care hospitals and then these

1 long-term care hospitals?

2 MR. PETTENGILL: Yeah, go ahead.

3 MS. KELLEY: Yes. We do think that -- we know
4 that some also go on to use SNFs, although I think we've
5 documented a declining number of SNFs that care for the most
6 medically complex patients since the SNF PPS was
7 implemented. I think that has improved in the most recent
8 year since some payment changes were made in the SNF PPS.
9 But, in general, a small number of -- well, let me restate
10 that. Most of them go on to use SNF care, of CCI cases.
11 The question is, where in their length of stay they go to
12 the SNF, and I think there are a small number of SNFs that
13 can care for them at that real high level of care that an
14 LTCH might provide.

15 MR. ARMSTRONG: So it's conceivable that if we're
16 building a payment policy that is geared to pay regardless
17 of the setting, a comparable -- under a similar set of
18 policies for a population of patients, it could go beyond
19 just the long-term care hospitals. It could potentially
20 extend into skilled nursing facilities, as well?

21 MS. KELLEY: Possibly, yes. But I think what
22 we're focusing -- what we've been focusing on is the fact

1 that both the LTCH and the hospital provide hospital-level
2 care, which is not necessarily what's provided, or not
3 typically what's provided in a SNF. So we've been thinking
4 of that as a lower level of care.

5 MR. HACKBARTH: So let me just pursue Scott's
6 questions. So as we've often noted, there are many areas of
7 the country where there are not LTCHs. So are you
8 suggesting, Dana, that in those areas, it's not SNFs picking
9 up the CCI patients. They're just staying in acute-care
10 hospitals as outliers?

11 MS. KELLEY: That is what I'm suggesting, yes.

12 MR. HACKBARTH: Okay. Then a second related
13 question. You noted that SNF care for medically complex
14 patients is declining, but -- go ahead.

15 MS. KELLEY: Yeah. Perhaps I misspoke. So I
16 think there are two things here. We have what we're
17 considering to be the critically -- the CCI patients who
18 we've defined as patients who use eight or more ICU days.

19 MR. HACKBARTH: Mm-hmm.

20 MS. KELLEY: And we do know, of those patients,
21 the six percent of IPPS patients -- cases -- half of them go
22 on to use some form of institutional post-acute care and the

1 plurality of them do use a SNF. But I think the separate
2 question is, at what condition --

3 MR. HACKBARTH: What stage --

4 MS. KELLEY: -- they are when they enter the SNF.

5 MR. HACKBARTH: Yeah.

6 MS. KELLEY: And what we know is that, beginning
7 when the SNF PPS was implemented, we saw a decline in the
8 number of SNFs that were admitting patients that fell into
9 the medically complex SNF patient groups, RUGs.

10 MR. HACKBARTH: And I understand that. Thanks for
11 the clarification. What I'm trying to get at, though, is
12 that in talking about SNF payment policy, I think we've
13 observed that part of the change in the pattern of care in
14 SNFs may be attributable to flaws in that payment system.

15 MS. KELLEY: Absolutely. Yes.

16 MR. HACKBARTH: And so -- and we've made specific
17 proposals on how to change SNF payment policy so that,
18 financially, they may be more willing to take on more
19 complicated patients.

20 MS. KELLEY: That's true, and I think --

21 MR. HACKBARTH: And I'm trying to understand how
22 these two pieces fit together.

1 MS. KELLEY: And Carol, I think, reported earlier
2 in the year that she had seen some growth in the number of
3 SNFs willing to take, or admitting, patients in medically
4 complex RUGs, beginning with some changes to payments that
5 were made.

6 MR. PETTENGILL: Still, our hypothesis would be
7 that --

8 MR. HACKBARTH: That would be --

9 MR. PETTENGILL: -- in areas lacking LTCHs, the
10 acute-care hospital keeps the patient longer, giving them
11 the step-down hospital-level care that they need and then
12 may transfer them onto a SNF.

13 MR. HACKBARTH: Okay. I think, Herb, you were
14 next.

15 MR. KUHN: Two questions, and one of them was kind
16 of answered a little bit in the first round here from what
17 Glenn and Scott, and that is where there are LTCHs in
18 communities, do we see the IPPS hospitals or the acute-care
19 hospitals having less outlier payments? Is that an
20 assumption we're making or does the data actually show that,
21 that there's fewer outliers?

22 MR. PETTENGILL: That's -- I don't know the answer

1 to that, but as we continue to do work on this project, one
2 of the things we're going to do is make comparisons between
3 areas that have a lot of LTCHs and areas that don't. And
4 we've actually broken the markets up, U.S. care markets up
5 into three groups: Those that have no -- pardon?

6 DR. MARK MILLER: I thought we did look at this a
7 couple of years back. I thought we saw shorter lengths of
8 stay in those markets.

9 MS. KELLEY: That was an analysis we did back in
10 2004, and we have not repeated that analysis since then.

11 DR. MARK MILLER: But that's what we found at that
12 time --

13 MS. KELLEY: But that is what we found then, and
14 RTI has found --

15 DR. MARK MILLER: [Off microphone.] That is also
16 what I thought --

17 MS. KELLEY: Well, I don't recall if RTI looked at
18 hospitals that have LTCHs in their areas versus hospitals
19 that don't. They did find that -- I think we've repeatedly
20 -- it's been repeatedly established that patients who use
21 LTCHs have shorter hospital lengths of stay than patients
22 who don't.

1 MR. KUHN: Got it.

2 MR. PETTENGILL: So all I was trying to do is
3 indicate that this is one of the things that we can look at,
4 and we plan to look at comparisons between these types of
5 areas to see what's different, because we have hypotheses
6 about that, too.

7 MR. KUHN: Got it. And the second question was on
8 Slide 4. And, Dana, when you were walking through this one,
9 you said the growth was both the number of cases as well as
10 the payment per case. Can you explain a little bit more the
11 reason behind the growth in payment per case?

12 MS. KELLEY: Well, some of this was, as I said,
13 related to the fact that payments likely under the PPS, when
14 the PPS was established, were too generous, and over time,
15 CMS has attempted to kind of take back some of that money.
16 Some of that has been through changes in the short-stay
17 outlier payment policy. I think it's generally accepted
18 that payments for short-stay outliers were far too high at
19 the beginning of the payment system. We've also had some
20 case mix creep, and so there have been changes for
21 documentation and coding improvements.

22 MR. KUHN: And then, also, if I remember right,

1 isn't it true, for LTCHs, they're the only PPS system that
2 doesn't have locked into statute a market basket update each
3 year? That's total discretion of CMS, is that correct?

4 MS. KELLEY: That's true. The update is at the
5 discretion of CMS.

6 MR. KUHN: Thank you.

7 MR. HACKBARTH: Round one clarifying questions?
8 Alice, Mike, Mary, and then Peter and --

9 DR. NAYLOR: Slide 11, please. So I just wanted
10 to understand the differences in findings between Dalton and
11 this refined analysis that you did, building on their work
12 in terms of percentage of cases that are CCI versus non-CCI.
13 So is this the added criterion of length of stay, eight
14 days, ICU, CCU, versus not? Is that how you arrived at
15 these findings?

16 MS. KELLEY: Yes. This was looking at our claims
17 for all hospital care and looking to see the share of cases
18 that had eight or more days billed to ICU or CCU.

19 DR. NAYLOR: And can you just remind me of the
20 rationale for that threshold?

21 MS. KELLEY: Sure. That was based on work that
22 CMS sponsored that RTI and Kennell and Associates did, and

1 it -- they found that looking sort of more broadly at
2 clinical characteristics of cases, they found that the kind
3 of highest level acuity patients in LTCHs generally had
4 heavy use of ICU services in their previous acute-care
5 hospital stay. Eight is a number that we chose based on the
6 work that they had done. That's a number that obviously
7 could be changed. It could be higher or lower, depending on
8 one's preferences. But that was a number that they arrived
9 at as a reasonable cutoff.

10 MR. BUTLER: One thing that was new to me -- by
11 the way, I think the graphs, in particular, really help tell
12 the story in this and that's really good. As in yesterday,
13 the very specific proposals are very helpful to respond to,
14 which I'll do in round two.

15 But the ICU days in LTCHs was a new -- that was
16 something new to me. My experience directly with LTCHs has
17 been mostly around complex critical patients and ventilator
18 patients, which I also assume were -- I mean, they were
19 beds, but they weren't necessarily designated in ICU beds.
20 Are ventilator patients in LTCHs sometimes not in ICU beds?

21 MS. KELLEY: Yes, but I don't know how that would
22 -- I don't know offhand how that would break out. Not all

1 LTCHs have ICUs, and I think, to some extent, it's a
2 designated unit that an LTCH may be providing an ICU level
3 of care but may not have designated a unit as such. So they
4 may sort of swing their capability as they need to. But a
5 ventilator patient in an LTCH may not be in an LTCH ICU.

6 MR. HACKBARTH: If they were in an ICU in the
7 acute-care hospital, they still qualify as a patient
8 covered. So you can qualify for the payment either as a
9 direct or an indirect CCI patient.

10 MS. KELLEY: Yes.

11 MR. BUTLER: It was more of a question of -- it
12 seemed like a new concept. I thought that they treated a
13 certain kind of patient at a certain kind of level. They
14 didn't worry about whether it was an ICU bed or not. But,
15 anyway, just a technical question.

16 MS. KELLEY: RTI and Kennell and Associates
17 conducted a number of interviews with LTCHs and found that I
18 think virtually all of the LTCHs that they spoke with either
19 had an ICU or were planning to establish an ICU. So I can't
20 say why they've been moving -- why they didn't have them
21 before and they think they want them now and why they're
22 moving in that direction, but that is a trend that they

1 noted.

2 MR. BUTLER: So my other question relates to
3 patient engagement, and obviously a lot of these patients
4 are not in a position, given their health, to engage too
5 directly, but their families are, and I've never seen any
6 patient satisfaction HCAHPS kind of data, or for that
7 matter, have a sense of preference, because these are often
8 big moves where the facilities may not be close to where the
9 patient or family lives. And you hear all kinds of stories
10 about hospice or other kinds of post-acute kind of care
11 options, but I don't have a sense of the patient themselves
12 and they say, this is great, we need more of it, or neutral,
13 or what.

14 MS. KELLEY: I have not seen patient satisfaction
15 data for LTCH users or for families of LTCHs. That's
16 something I can look further into. I know that there are
17 clinicians who are concerned that patients who have moved to
18 LTCHs don't understand necessarily the difference between an
19 acute-care hospital and a long-term care hospital, what that
20 transition between the two might signify. And we also have
21 been told by -- when we had our quality panel on LTCH
22 quality a few years back, we were told by many participants

1 that many of the patients that they admit arrive not
2 realizing that they may not be able to be weaned from the
3 ventilator, for example, or that they are nearing the end of
4 their life and that some decisions may need to be made for
5 their future care.

6 So I think there is good reason to be concerned
7 that patients and families don't get full information before
8 these transitions take place. Whether or not they would
9 make different decisions if they had that information, you
10 know, I don't think we can know.

11 MR. BUTLER: It just strikes me as one of those
12 areas where shared decision making probably could be a lot
13 better and end up in the appropriate placement.

14 MS. KELLEY: And we included a discussion on this
15 in our March report.

16 MR. HACKBARTH: Bill Hall, did you have your hand
17 up?

18 DR. HALL: [Off microphone.] No.

19 MR. HACKBARTH: Okay. Bill Gradison.

20 MR. GRADISON: It's been some years since I've
21 taken a look at the way the outlier pools work and I want to
22 make sure that I understand it today.

1 My understanding is that an estimate is made of
2 the anticipated amount of payments that may be required,
3 appropriate, in the upcoming year for the outlier pool, or
4 pools, and that that amount is actually a reduction -- is
5 used to -- is funded through a reduction in the base payment
6 amounts. And so we then have a pool. Now, this is where my
7 question comes in, and there's two different situations.

8 The first situation is that the amount in the
9 outlier pool is insufficient to meet the outlier
10 qualification -- outlier appropriate claims. And the second
11 is, what happens to the balance in the pool if the outlier
12 claims are less than the amount in the pool. And there's
13 some roll-forward or something, but I don't remember how it
14 works.

15 MR. PETTENGILL: Okay. Under the law, the outlier
16 payments must be between -- this is IPPS operating payments
17 we're talking about here.

18 MR. GRADISON: Yes.

19 MR. PETTENGILL: Under the law, CMS is required to
20 set the outlier threshold such that outlier payments will be
21 between five and six percent of DRG payments, which includes
22 both base DRG payments and outlier payments. So what that

1 really means is that what CMS has done, their longstanding
2 policy has been to set the pool at 5.1 percent, okay. But
3 what that really means is it's just about 5.4 percent of
4 base DRG payments, okay.

5 So you have a fixed amount of money determined
6 prospectively based on projected spending using the latest
7 claims. If it turns out that CMS ends up spending more
8 money for outlier cases, then they spent more money. It's
9 still a claim on the trust fund and it gets paid. If they
10 spend less on the outlier pool, then they spend less and the
11 Treasury ends up saving some money. It's a prospective
12 determination. The rule is set in place and it operates.

13 MR. HACKBARTH: So, Julian, have people looked at
14 -- have we looked at -- how that averages out over time?

15 MR. PETTENGILL: Yes, we have, and during the
16 1990s, the Medicare program was regularly paying out more
17 than 5.1 percent in outlier payments. And during the recent
18 -- since about 2005, we've been paying out less than 5.1
19 percent. And, you know, there are lots of reasons for that.
20 Making the projection is incredibly difficult and CMS has
21 refined its methods, but it's just really difficult to get
22 it right.

1 MR. GRADISON: Well, in this instance, it's a new
2 pool, so no historic -- well, there's limited historical
3 experience, especially since we can't be sure what
4 behavioral effects there may be --

5 MR. PETTENGILL: Right.

6 MR. GRADISON: -- of the change in the -- you
7 know, I think the case was a client I was working with who
8 felt that they had been shortchanged -- a very large
9 hospital chain, not-for-profit hospital chain -- which felt
10 they were, in a sense, being shortchanged because the amount
11 in the pool was not being used, as I recall, but it wasn't
12 restored back into the base of the --

13 MR. PETTENGILL: Yeah, there --

14 MR. GRADISON: -- of the payments going forward.
15 And that's why I wanted to make certain --

16 MR. PETTENGILL: Their usual argument is that CMS
17 has set the fixed loss amount too high and it should have
18 been lower and we would have spent out more money had it
19 been lower. But, you know, we've looked at CMS's methods
20 for making the forecast and it's just a tough job.

21 MR. GRADISON: Of course. Thank you.

22 DR. HOADLEY: Yeah, a couple quick things. On

1 Slide 11, when you have the nine percent of CCI cases that
2 use LTCH, that's national, right?

3 MS. KELLEY: [Off microphone.] Yes.

4 DR. HOADLEY: And you have or will do that within
5 these geographic groups, of whether there's an LTCH in the
6 region in the region or not?

7 MS. KELLEY: Yes.

8 DR. HOADLEY: Okay. Good.

9 On 14, on your methodology, I just want to be
10 clear. A non-CCI patient that's being seen in an LTCH, they
11 would, under this idea, they would go into regular IPPS, so
12 whatever their DRG is, and so when you're doing things like
13 impact analysis, you'll be thinking about the effect of that
14 part of the change, as well.

15 MR. PETTENGILL: Yeah. All cases would be paid
16 under the IPPS, under either option one or option two.

17 DR. HOADLEY: Right. Okay.

18 MR. PETTENGILL: Okay. So I don't know if -- I'm
19 not sure we had planned to try to make separate impact
20 estimates for non-CCI and CCI cases, but it's a thought.

21 DR. HOADLEY: Yeah. I mean, it just seems to make
22 sure there isn't something else going on in that side of the

1 story that we'd be missing when we get to that.

2 MR. PETTENGILL: Mm-hmm.

3 DR. HOADLEY: And then just one refresher
4 question. In the DRG system, the actual DRG categories,
5 that's assigned at the discharge point when everything is
6 known about what happened to that patient in the --

7 MR. PETTENGILL: Right. It's based on the
8 principal diagnosis, which is the diagnosis determined after
9 study that caused the patient to be admitted to the hospital
10 for care.

11 DR. HOADLEY: And so under these CCI things, you
12 would then know --

13 MR. PETTENGILL: Yes.

14 DR. HOADLEY: -- what the thing is. There is no
15 prediction involved.

16 MR. PETTENGILL: Right.

17 DR. NERENZ: Actually, if I can just follow up on
18 that, for a patient who then ends up in an LTCH, I'm looking
19 at your table that had the most common DRGs with septicemia
20 at the top. Septicemia, would that have been present on
21 admission to the initial hospital, or is this a new DRG
22 assignment based on now what's happened since?

1 MS. KELLEY: It's a new DRG assignment --

2 DR. NERENZ: Okay.

3 MS. KELLEY: -- and, in fact, the majority of LTCH
4 patients get a different DRG assignment in the LTCH than
5 they had in the acute-care hospital.

6 DR. NERENZ: Yeah, because a number of those, with
7 septicemia as an example, looked like complications of care
8 from the initial acute stay.

9 Okay. Also, if we go to Slide 16, it's just a
10 schematic. I'm curious, what do we know, since LTCHs are
11 typically post-acute care as opposed to a place where
12 someone is directly admitted, where along this line is a
13 person typically transferred from the acute-care hospital to
14 the LTCH? Is there a pattern to that that's worth knowing
15 about? Like, for example, do people get well out into the
16 outlier tail and then move, or do they move sooner? What do
17 we know about that?

18 MS. KELLEY: It really varies, but that's
19 something we can bring back to show you.

20 DR. NERENZ: Okay, because there'd be a question
21 about if somehow a payment change caused fewer of these
22 transfers, would you then create bottlenecks and backlogs in

1 the ICU setting or elsewhere in the acute care, which might
2 depend a little bit just on where in this they're coming.

3 Okay. But that's --

4 MR. PETTENGILL: Yeah, although if IPPS hospitals
5 are transferring patients who've had prolonged ICU care, it
6 may well be that it's after they've gone to a step-down unit
7 --

8 DR. NERENZ: A step-down --

9 MR. PETTENGILL: -- in the IPPS hospital, which
10 wouldn't cause a backlog.

11 DR. NERENZ: And that was sort of my question.
12 When in this long tail-

13 MR. PETTENGILL: Right, and we don't know the
14 answer, but we can look.

15 DR. NERENZ: Okay. Good.

16 And then my last thing. Just on Slide 5, with
17 these interesting 21- and 28-day peaks, does that clock
18 start on the day of LTCH admission or the day of initial
19 acute care admission?

20 MS. KELLEY: The threshold clock, you mean?

21 DR. NERENZ: Well, just whatever is day one on the
22 graph.

1 MS. KELLEY: Oh, this is admission to the LTCH.

2 DR. NERENZ: To the LTCH. Okay. Thank you.

3 MR. HACKBARTH: Okay. Let me --

4 DR. MARK MILLER: Rita has her hand up.

5 MR. HACKBARTH: Oh, I'm sorry, Rita. Go ahead.

6 DR. REDBERG: These are obviously very ill
7 patients. Can you just remind me what the mortality data is
8 for the LTCHs and if you have for the areas that don't have
9 LTCHs and the similar patients that are cared for in acute-
10 care hospitals, how that compares.

11 MS. KELLEY: We have not looked yet at mortality
12 rates for patients who use LTCHs in areas where they have
13 LTCHs versus areas where they don't. That's -- the question
14 of mortality rates for these patients, though, has come up
15 in other studies and in, of course, the work that we just
16 sort of generally do looking at LTCH claims.

17 Mortality rates vary very greatly in LTCHs. Some
18 DRGs have mortality rates both in facility and within 30
19 days of discharge of the LTCH combined of close to 50
20 percent for some of the most severe DRGs. Mortality rates
21 for other cases -- multiple or severe pressure sores, for
22 example -- are very low. So it does vary quite widely

1 depending on diagnosis in the LTCH.

2 DR. REDBERG: You were talking about hospital
3 mortality?

4 MS. KELLEY: I'm sorry. I'm talking about LTCH
5 mortality.

6 DR. REDBERG: But, I mean, that's 50 percent don't
7 leave the LTCH or die before leaving the LTCH?

8 MS. KELLEY: Fifty percent die within -- either in
9 the LTCH or within 30 days of discharge from the LTCH for
10 certain DRGs. I think the average in facility mortality is
11 about 15 percent in an LTCH.

12 DR. REDBERG: I'm trying to understand the value
13 added of the LTCH, what they're offering that the other
14 hospitals don't have.

15 MS. KELLEY: There's been -- other researchers
16 have looked quite -- or tried to look closely at this
17 question of whether mortality and other outcomes measures
18 are better for patients who use LTCHs, and as I said before,
19 the data on that -- the findings on that have been pretty
20 inconsistent.

21 MR. HACKBARTH: So let me kick off Round 2, and
22 I'd like to go back to Peter's question about ICUs and CCUs

1 in LTCHs and the fact that that's not common but apparently
2 growing. I'm trying to begin to think about the relative
3 merits of Option 1 and Option 2.

4 Julian I think mentioned that Option 2 potentially
5 was subject to gaming, and I would think that part of that
6 gaming risk is that you would spawn a rapid increase in
7 ICUs/CCUs within LTCHs. Is that right, that there would be
8 a strong incentive to start classifying patients that way?

9 MR. PETTENGILL: Well, that would be one risk.
10 Another would be that at the margin a patient who is an ICU
11 in an IPPS hospital for six days could be kept an additional
12 day or two to qualify, because, in effect, what you have is
13 kind of a payment notch here where, if you go over eight
14 days, all of a sudden the payment bumps up a whole lot.

15 MR. HACKBARTH: Yeah, and so on both sides, in
16 both the acute-care hospital and the LTCH --

17 MR. BUTLER: Could I ask a quick clarifying -- I
18 thought the Option 1 and 2 applied just to hospital
19 payments, not to LTCHs.

20 MR. PETTENGILL: Say that again?

21 DR. MARK MILLER: The way I would answer that is
22 this is now the payment system for both of those actors, and

1 so in Option 1, you get a PPS payment whether you're an LTCH
2 or an acute-care hospital, and then you would have the
3 commensurate outlier, depending on whether it was CCI or
4 non-CCI. And the thing I wanted to say in this exchange,
5 that notch effect on the payment applies to Option 2 because
6 it bumps you into a higher DRG.

7 MR. PETTENGILL: Right

8 DR. MARK MILLER: If you keep them two extra days
9 in the ICU on Option 1, you have to incur some cost and then
10 move into the outlier pool. I'm sorry. Did you get dealt
11 with? This is now -- there's no separate LTCH system.

12 DR. CHERNEW: We save a meeting session.

13 [Laughter.]

14 DR. MARK MILLER: Dana, it's not that they don't
15 want to.

16 MR. HACKBARTH: So that's a potential liability of
17 Option 2, this gaming due to the notch effect.

18 Now, Option 1, you don't have that, but with a
19 lower outlier threshold in a higher payment after outliers,
20 you in effect have more patients being paid for under sort
21 of a cost reimbursement structure.

22 MR. PETTENGILL: Yes, that's true. Now, how much

1 of a risk that is, I don't -- I don't think that's a big
2 risk because right now they're getting 80 cents on the
3 dollar over the threshold. But the big thing is that they
4 have to take a big loss before they get any additional
5 money, and there's no notch there.

6 MR. HACKBARTH: Yeah, because of the fixed-dollar
7 loss requirement to get in -- the deductible, as you put it
8 earlier, to get into the system.

9 MR. PETTENGILL: Right.

10 MR. HACKBARTH: Last question, and then I'll turn
11 it over to you, Scott. So for the non-CCI patients, LTCHs
12 would be paid under the IPPS system. What are the financial
13 implications of that for LTCHs. Is there any way to tease
14 that out? You know, the patients qualifying for the higher
15 payment would be taken out, and they'd be paid under a new
16 system. But now they'd have this remaining group of
17 patients paid at a dramatically lower rate. Help me think
18 about what that means.

19 MR. PETTENGILL: Well, I mean, I think you've hit
20 the nail on the head. They would be paid at a much lower
21 rate. I don't know exactly what the difference is on
22 average between the LTCH payment rate and the current IPPS

1 payment rate for the same MS-DRG. But in the one that I've
2 been using here, the payment rate is four times as high in
3 the LTCH for a non-CCI case as it in the IPPS. Now, that's
4 probably a bigger difference than you would find in many
5 DRGs.

6 DR. MARK MILLER: And the next step in the
7 analysis is to come back and have quantified distributional
8 impacts. Since this is fairly complicated, there was one
9 step of here's the idea and then notionally the impacts at
10 the end of the presentation. Then we come back and do the
11 distributional impacts.

12 It is a reduction in payments for LTCHs, but it
13 kind of goes back to but how many of those that are
14 currently in LTCHs, you know, really qualify as the most
15 complex cases, and that's the --

16 MS. KELLEY: And I think it's also important to
17 remember that we're concerned that the costs in LTCHs are
18 distorted by the payment system itself. So if we were to
19 implement one of these policies, new options, and the LTCH
20 payment system went away, so would the requirement that an
21 LTCH have an average length of stay of 25 days or that they
22 keep their patients to this short-stay outlier threshold in

1 order to get a full payment.

2 So the entire cost structure within an LTCH could
3 change as well to the extent that it is influenced by
4 payment policy as opposed to clinical indicators.

5 DR. MARK MILLER: And that was sort of the point
6 on Slide 4, that the payments change, the costs, you know,
7 seem to follow them, which is not unusual in the post-acute
8 care setting.

9 MR. ARMSTRONG: Thank you. You guys have done an
10 excellent job of taking a very complicated issue and -- and
11 I think Peter said this -- boiling it down to graphs that
12 help us at least understand directionally the work you're
13 doing. I just want to say I strongly encourage us to move
14 forward as you've described. I think you've demonstrated
15 that there are different payments across settings and
16 incentives that really don't help, in fact harm the Medicare
17 program. And this is also entirely consistent with very
18 clear policy directions that we've taken in other areas to
19 pay equally for comparable services, regardless of the
20 setting that this is in. And, frankly, I -- well, no, I'll
21 stop there.

22 So I just really strongly encourage the direction

1 that you're going in.

2 DR. REDBERG: Thank you for going through the
3 options and the history. I guess I'm still struck by these
4 started as TB hospitals, it seemed like, and, you know, for
5 patients that probably were in iron lungs or things like
6 that, things that we're not dealing with anymore, but even
7 though that has gone away, you know, on Slide 4, clearly the
8 number of LTCH hospitals has gone up a lot. And so I'm
9 still trying to understand what their role is and what their
10 value-added is in the system. And I think perhaps when we
11 think about, you know, besides the principle of certainly
12 paying the same no matter the site of setting, of
13 incorporating, as Peter mentioned, shared decisionmaking,
14 because it does trouble me that patients may not have chosen
15 to be -- you know, we know there's a high mortality, these
16 are very sick patients, but we know that most people prefer
17 to die at home, not in a hospital, and that perhaps patients
18 are entering these facilities really against their will if
19 they had known that they would likely die in this facility
20 and that there could have been alternatives, including home
21 care, that might have been preferable.

22 So I think that we should try to incorporate, you

1 know, some evidence that they understood all the
2 alternatives, or their family, and chose to be in this
3 facility before making any further changes.

4 DR. MARK MILLER: Back when we first started
5 looking at this, some of us went out and, you know, visited
6 facilities and talked to various medical directors. And
7 this was not an uncommon -- it wasn't against their will,
8 but the medical directors definitely said there's people
9 here where there really should be a conversation with the
10 family, but either there's no one who's willing to do that;
11 or if the conversation occurred, the family was very clear
12 that they didn't want to take the alternative. But,
13 decidedly, even the medical directors in the LTCHs were
14 saying this is a dilemma. There are people here that
15 probably shouldn't be here and should be thinking about the
16 next stage.

17 MS. UCCELLO: I think this is excellent work, and
18 I think you've done a really great job creating some -- or
19 establishing some order out of chaos. We always have some
20 trouble with LTCH issues, and I think this is just helping
21 us get some more direction.

22 Just initially, or at least in theory, I prefer

1 the Option 2 because of the increased payment accuracy. But
2 I am concerned about the gaming issues, so just providing
3 more information about the ability for both the acute-care
4 and the LTCHs to game this would be helpful.

5 What might also be helpful is some sensitivity
6 analysis surrounding the eight-day definition, if that were
7 changed either way, how much that would affect things.

8 And just one more minor comment. When we're
9 talking about, you know, what does this do to the LTCH
10 payments compared to what they are now and they would go
11 down a lot, they're going to go down even more for the non-
12 CCI folks under Option 2. So just something else to think
13 about with those changes. But great work, I look forward to
14 the additional analysis.

15 DR. SAMITT: The analysis was incredibly clear.
16 Thank you very much. It's actually very helpful to see the
17 financial projections and compare them between the options,
18 so thank you for that.

19 I'm most curious about the gaming analysis, and I
20 do have great reservations about Option 2 just because I
21 think the gaming potential is likely.

22 I'm also worried, though, about gaming potential

1 in Option 1 given that there is -- as you look at the bell
2 curves of CCI versus non-CCI, I guess the question is: Is
3 there potential gaming in Option 1 for acute facilities to
4 transfer CCI patients to an LTCH as opposed to retaining
5 them and essentially focusing purely on non-CCI in the acute
6 setting, essentially deferring responsibility for CCI to
7 other facilities? And so in some respects, you even begin
8 to wonder whether Option 1 needs to be associated with some
9 kind of bundling or accountability for downstream decisions
10 should transfers occur elsewhere. And I don't know whether
11 that risk is a patient in Option 1, but the question is: Is
12 there gaming in either scenario?

13 DR. BAICKER: Can I just jump in? I had a similar
14 question about gaming in Option 1, that I would have thought
15 if you have different DRGs for CCI versus non-CCI patients
16 even though there isn't the same notch effect, there's still
17 an incremental effect, I would think, to move people into
18 that CCI DRG versus the non-CCI DRG that would be a little
19 smoother than Option 2 but would still be there.

20 DR. SAMITT: Yeah, which then raises the question:
21 Why not Option 3? And --

22 DR. MARK MILLER: Did you have the same reaction

1 [off microphone]?

2 MR. PETTENGILL: I did, yeah. So, remember,
3 Option 1, we're not changing the DRG definitions. Only
4 Option 2 changes the DRG definition.

5 DR. BAICKER: So not a separate [off microphone]?

6 MR. PETTENGILL: Right, right. So -- and as to
7 the gaming potential in Option 1, what we're doing is we're
8 moving the outlier threshold to the left for CCI patients.
9 But the incentive to discharge a patient to an LTCH is the
10 world we live in right now. So I'm not --

11 MR. HACKBARTH: Stronger, currently --

12 MR. PETTENGILL: Yes.

13 MR. HACKBARTH: -- than it would be under Option
14 1.

15 MR. PETTENGILL: Right. So I think actually the
16 incentive to do gaming in Option 1 is lower --

17 DR. SAMITT: Is minimal.

18 MR. PETTENGILL: -- than it is in the current
19 world. So -- but I don't know. That's just my initial
20 thought about it.

21 DR. SAMITT: So if the incentive is still
22 potentially the same to refer to LTCH, is it worth expanding

1 the analysis to include what Option 3 would look like and
2 whether a bundling -- you know, going back to the discussion
3 we had yesterday about upstream accountability, do we want
4 upstream accountability here as well in Option 1 so that
5 we're not seeing multiple admissions occur and that the
6 acute facility does take some accountability for what
7 happens to the patient after that first admission?

8 MR. PETTENGILL: Well, we do plan to model a
9 bundling option here, so we will come back with that.

10 MR. KUHN: I, too, want to join everyone else,
11 Dana and Julian, this is really terrific work. Thank you.
12 Well written and great presentation. I have two
13 observations for me.

14 One, I think it is worth continuing in this
15 effort, but one on the Option 1. What I worry a little bit
16 or would like to know as you continue to do your analysis is
17 the administrative complexity of this issue. We're talking
18 now a second outlier threshold. And you had the
19 conversation with Bill about CMS' ability to estimate at
20 least one threshold, their ability to estimate a second one
21 and how accurate can they be in that environment and the
22 administrative complexity of the agency to manage that on a

1 go-forward basis.

2 I don't know if you have any thoughts now, but as
3 part of the analysis, that would be helpful to know.

4 MR. PETTENGILL: It's actually -- I don't think it
5 makes the situation any worse than it is right now in terms
6 of ability to be accurate in calculating a fixed-loss
7 amount. You just have a larger pool to work with. You fix
8 the one where it is and estimate the other. And I don't see
9 that as a huge deal, but it's worth thinking about.

10 MR. KUHN: Okay. Just if I were still at CMS,
11 that would be my first reaction, okay, can we even implement
12 something like this as it goes forward.

13 And then my second just comment as you continue to
14 do your analysis, when we look at Option 2, I guess one
15 question: How many additional CCI MS-DRGs do you think
16 would be created through this process?

17 MR. PETTENGILL: I forget what the number is.
18 It's probably around 100.

19 MR. KUHN: So we'd go from maybe 745 now, or
20 thereabouts, to about 845?

21 MS. KELLEY: It was not more than 150.

22 MR. PETTENGILL: Yeah, not more than 150 is

1 probably a good answer.

2 MR. KUHN: Thank you. So I guess what I would be
3 interested in the analysis is that if folks remember when we
4 migrated from the old DRGs to the MS-DRG system -- and you
5 kind of mentioned this in your presentation -- it did change
6 the weights and moved more towards surgical procedures
7 versus medical procedures. And as a result of that, we saw
8 a shift more from rural hospitals and those that did more
9 medical type procedures in to more tertiary kind of
10 facilities. So as we continued to lay out this analysis --
11 now, obviously, we're talking \$5.5 billion and \$140 billion
12 I think in total Part A hospital spend here. But it would
13 be interesting to know when you do the analysis the types of
14 hospitals which kind of do that analysis and how the
15 movement of dollars, and would we see further dollars
16 flowing out of rural areas into urban areas as a result of
17 this change as we go forward.

18 MR. PETTENGILL: We plan to do that.

19 MR. KUHN: Okay. Thank you.

20 DR. MARK MILLER: Which I think would be mostly
21 peculiar to Option 2.

22 MR. KUHN: Exactly.

1 MR. PETTENGILL: Yes.

2 DR. MARK MILLER: Whereas, Option 1, I think --

3 MR. KUHN: It wouldn't be Option 1, but Option 2,
4 I think you would see that it would be movement of dollars
5 and redistributational, and it would be interesting to see
6 what that looks like.

7 DR. MARK MILLER: Right, because I think in Option
8 1 mostly acute-care hospitals either benefit or are held
9 relatively harmless.

10 MR. PETTENGILL: Yeah, that's right, because the
11 only thing that's going to happen is that they're going to
12 get more outlier payments. The basic payment rate isn't
13 going to go down, so they would be okay.

14 MR. KUHN: Thank you.

15 DR. MARK MILLER: And as to the LTCH impacts,
16 which would be present in either options, LTCHs are not
17 heavily in rural areas.

18 MR. PETTENGILL: Right. That's right.

19 DR. COOMBS: Thank you very much. This actually
20 teases out a lot of the issues that we had earlier, and I
21 think we're on to the right course in terms of matching the
22 resources with patients' needs.

1 Just for a clinical lens on this, Peter, you asked
2 a question about ICU critical care beds, and there are some
3 institutions where they have a stepdown unit or even the
4 vented patient is actually on the floor. And so when they
5 transfer from that institution, they go from a floor now to
6 an LTCH that is considered to be a critical care -- a CCI.
7 And I'm wondering if there's a way to reconcile that because
8 they're not critical care like the critical care patients
9 that are, say, on the sixth floor in the sense that they're
10 stable enough to be on a floor situation or even in a
11 stepdown unit in the acute-care facility, and then when they
12 go to the LTCH, they've been bumped up in terms of acuity
13 for that institution, which is right, but there needs to be
14 a way to reconcile that piece of it. And what I'm trying to
15 say is all critical care is not all the same in that sense.
16 So that would be an issue that I would have some concern
17 about.

18 And then the eight-day cutoff, I know you said it
19 was arbitrary, if we could noodle around that to see what
20 the type of cases are requiring that eight days, and then
21 maybe you could work backwards to say there are some
22 different type of criteria that you could choose within the

1 framework of that eight days. And I think that's a place to
2 go. That gives you a better defined limit. Because I know
3 that the threshold for some ICUs, eight days is just -- it's
4 the difference between nursing care on the floor versus
5 nursing care in the ICU. My sister had surgery and had to
6 go to the ICU because they don't do epidurals and narcotic
7 infusions -- epidural infusions at the same time, so she
8 went to an ICU. And it's a very different criteria based on
9 what the regional resources are within hospitals. So I
10 think that's really important.

11 I think I like the fact that you've included
12 Option 3. I don't know how we can get there. I do think
13 that practicing ICU medicine, there's this whole notion of a
14 level of accountability in terms of 24-hour coverage, I mean
15 meeting Leapfrog criteria. There's all these criteria that
16 are met in the acute-care setting that are nowhere analogous
17 to some of the LTCHs' coverage for the same critical care
18 DRG.

19 So I'm still trying to work with that in terms of
20 the differences in the levels of acuity in terms of multi-
21 system organ failure and how you manage that. So I'd be
22 interested going forward in looking at what's in that

1 interval of eight days in terms of working around diagnosis
2 specifically and the co-morbid conditions that may be more
3 prevalent there versus a blanket DRG that's just in the
4 acute-care setting is exactly in the LTCH setting where the
5 resources in the acute setting are much more labor
6 intensive.

7 DR. CHERNEW: So I like this a lot. In fact, I
8 think the entire yesterday and today have been good because
9 we've been working in ways to, I think, clear out the
10 underbrush of a system that views it as a bunch of separate
11 providers towards a system that views it as a bunch of
12 patients with different needs. And I think this moves us in
13 that direction, which I think, generally speaking, is good.

14 As I've said before, I tend to think of payment
15 systems based on the incentives that they create as opposed
16 to how they move money around. That doesn't mean how they
17 move money around is not important. But the incentives they
18 create for me tends to be more important, and, of course,
19 gaming fits into that, although we talk a lot about
20 accuracy, and payment accuracy matters. Of course,
21 incentives to game will push you away from accuracy in some
22 particular way, even if ideally in a non-gameable world,

1 they would be perfectly accurate. And I worry -- very much
2 like what Cori said, I worry about the gaming.

3 So my loose and somewhat weak preference right now
4 is for something that's closer to Option 3 if we are
5 comfortable that we can get the quality measurement right
6 and the case mix adjustment right and deal with some of the
7 other things in them, I think broadening the way we think
8 about the patient across, you know, their entire spectrum of
9 care strikes me as better within that.

10 I do worry most about the gaming for Option 2, so
11 I think you've laid out quite well the issues and where the
12 work has to go, and I look forward to doing it. And I think
13 in many areas we're moving in the right direction, so thank
14 you.

15 MR. HACKBARTH: So would you just talk a for a
16 minute about gaming potential in Option 3?

17 MR. PETTENGILL: Well, okay. First of all, I'd
18 have to define Option 3 a lot more concretely.

19 [Off-microphone comments.]

20 MR. PETTENGILL: Yeah, and given the discussion
21 yesterday, I'm not sure that my initial definition of Option
22 3 is the same one that I would create tomorrow. But the

1 option that we've been talking about would bundle in a
2 portion of the expected costs of LTCH and SNF care
3 associated with CCI patients into the rates for the CCI
4 DRGs. And because it does that, I think it raises questions
5 about gameability of ICU stays in ICHs. Okay? Because,
6 again, you're dependent on the CCI definition.

7 And then the other thing it would do is it would
8 say the hospital's responsible for paying for -- the
9 hospital's responsible for the make or buy decision on post-
10 acute care. If they decide to buy care from an LTCH, that
11 care would not be paid for in the IPPS. The hospital would
12 pay for it out of the funds in the bundle. And then a
13 portion of what they pay would be eligible for outlier
14 payments in the IPPS. So we wouldn't put very much of the
15 expected cost of the post-acute care into the bundle. We
16 would make them claim it through the outlier policy. Okay?

17 You know, I haven't really thought very hard about
18 the gaming potential here, but it strikes me that the
19 biggest piece of that is not the outlier part of it, it's
20 the ICU part of it, to get into the CCI DRG in the first
21 place.

22 DR. MARK MILLER: I see it as kind of like Option

1 2 except it's a bigger pot of money now.

2 MR. PETTENGILL: It's a bigger pot of money, and
3 you've changed the responsibility for, you know --

4 DR. MITCHELL: Once you get [off microphone] --

5 MR. PETTENGILL: Right.

6 MR. HACKBARTH: You don't have the gaming
7 potential in the LTCH for them to characterize patients as
8 CCI patients.

9 MR. PETTENGILL: Right.

10 MR. HACKBARTH: You just have the acute-care
11 hospital.

12 DR. CHERNEW: I had a different vision of the way
13 the bundles might be defined, but I think the key point is
14 it hasn't been defined in detail, so we have some work to
15 do. And I think thinking about defining 3 or 2, or 1 for
16 that matter, in a way to mitigate any gaming potential
17 around pushing people to longer or shorter ICU stays is a
18 fundamental component of all of these options.

19 MR. PETTENGILL: Well, if you have thoughts about
20 that, we'd love to hear them.

21 DR. BAICKER: So, Mark helped clear up my
22 vocabulary issues in thinking about the gaming, that there's

1 still some gaming in option one in terms of pushing people
2 into CCIs to get the extra outlier payment, although, of
3 course, that would involve incurring the cost of the extra
4 ICU day. And I'm very much in favor of this direction of
5 harmonizing these payments and stopping having these
6 separate site-specific what look like big overpayments. And
7 the gaming seems fundamentally built on the fact that the
8 definition is based on use of care, and we see that in DRGs.
9 You know, DRGs were originally not supposed to be about use
10 of care and then use of care gets built in to try to define
11 really sick people versus less sick people.

12 And I know there's been a lot of background work
13 on the ICU-based definition of CCIs, but in some ways, you
14 solve a lot of the gaming problems if you change the
15 definition of CCI to be based on something less easily
16 gamed. You have to worry much less about these threshold
17 effects. And I don't know whether it's possible, either
18 practically or even with a lot of work, based on the data
19 available, to find conditions that map pretty cleanly to
20 that use of intensive resources, because if these
21 definitions of CCI patients were based on a set -- either
22 utilization from a year ago or diagnoses that are already

1 coded up, then we would -- then that opens up a lot more
2 possibilities of things that we can do to try to match the
3 payments to the real resource costs.

4 And I don't know whether that's just not feasible
5 or whether we don't have the analysis but it's feasible if
6 somebody would do a new study based on those definitions
7 instead and --

8 MR. PETTENGILL: Well --

9 DR. CHERNEW: Can I just say one thing? We have
10 to get it right on average. We don't have to worry about
11 getting it right for everyone all the time.

12 MR. PETTENGILL: Yeah. I think -- you know, I
13 hear you. I would absolutely love to do that, but, and
14 here's the kicker, two things, actually. One, I'm not a
15 clinician. And two, the real problem here is the diagnoses
16 by themselves don't do it. They take you just so far and
17 then they stop, because I can get a principal diagnosis or a
18 secondary of somebody who has congestive heart failure, but
19 it doesn't tell me anything about the level of severity of
20 that, the congestive heart failure. I might know which
21 valve is the problem, but I don't know how sick that patient
22 is and that's what I have to know.

1 DR. MARK MILLER: And the other thing I would add
2 to this is, so several years ago, we went through this
3 process as a Commission of saying what you really don't want
4 to do is pay on the basis of the silo. You want to pay on
5 the base on the characteristics of the patient. And we did
6 lots of consultations with different clinicians and
7 different associations and societies and so forth and we're
8 now years later and there is no consensus out there on this
9 is a patient who needs this level of care. And a lot of the
10 policy debate is beginning to devolve to lower common
11 denominators than even this.

12 But your point, you know, conceptually, is
13 correct. It's just the ability to say, this patient, yes,
14 this patient, no, even on average still leaves a lot of play
15 for people to game.

16 DR. BAICKER: Well, and so, then, going back to
17 Mike's point, the question would be, if you use the granted
18 cruder measures that are based only on data up to 60 days
19 ago but nothing in the most recent window, how good a -- you
20 know, what's the predictive value of that on average? Would
21 you be roughly aligning payments and reducing gaming, or is
22 it still so noisy at that point that it's not very helpful

1 in terms of flagging the patients we want to flag, you just
2 have to live with the gaming?

3 MR. PETTENGILL: Yeah, that's an interesting idea,
4 and maybe we can get somebody working on a parallel project
5 on that.

6 DR. MARK MILLER: [Off microphone.]

7 MR. PETTENGILL: No, I mean, if I have to deliver
8 something in September, an analysis, there's no way I can do
9 that between now and then.

10 DR. MARK MILLER: [Off microphone.] We'll talk
11 about that. But I do now capture better your idea. Your
12 idea is if you could capture some set of coding or
13 characteristics that precede what happens far enough that
14 the actual actor wouldn't have had a chance to --

15 DR. COOMBS: Well, I was saying earlier -- that
16 was my specific point, is not all critical care is all
17 critical care is the same, and that was my point, and that a
18 lot of times, and I see a doctor, I'll go down and triage
19 someone and say, no, this one doesn't need to go to the ICU,
20 whereas the benchmark for admission to a critical care will
21 vary depending on the resources. So a lot of times, it's
22 bed-dependent. What is the percentage of critical care beds

1 in an area? And so that translates to the post-acute care
2 course, as well.

3 So I think that there's some pieces of the puzzle.
4 Congestive heart failure is one. COPD with exacerbation.
5 There's a lot of clinical conditions for which the range and
6 the severity of illness is like this and it doesn't lend
7 itself to a purely scientific economic analysis like we
8 would like to be in a model.

9 DR. BAICKER: And this is a related point,
10 although I think somewhat different, in that you're saying
11 these conditions don't very accurately differentiate between
12 people who are truly critically complex, expensive, and
13 people who aren't, that they're too broad bucket. I'm
14 making a related point that by any definition, regardless of
15 how specific and sensitive it is in identifying the correct
16 payments, if it's endogenously determined based on whether I
17 deliver a specific item of care today or not, I have an
18 incentive to deliver that item of care. So I'm willing to
19 give up a little bit of sensitivity and specificity if I
20 eliminate a lot of gaming potential, and the question is,
21 how big is each of those things to trade off. See, it all
22 comes back to economics.

1 [Laughter.]

2 MR. PETTENGILL: But there's another point here
3 that also needs to be remembered. Yes, if you add ICU days,
4 you're going to get a higher payment, but you're also going
5 to pay the costs for that added care. So you have to
6 consider both.

7 DR. BAICKER: So you want to weigh the net
8 incentives to game, based on both the costs incurred and the
9 potential increases in payment against the failure of
10 adequately flagging the patients you're trying to flag.

11 MR. HACKBARTH: This is a really important
12 discussion and we're running a little bit behind, so we need
13 to keep moving ahead and make sure everybody gets a chance
14 on this.

15 Mary.

16 DR. NAYLOR: So I'm not going to talk about
17 endogeneity.

18 [Laughter.]

19 DR. NAYLOR: I honestly think the conversation
20 thus far really just highlights the -- first of all, great
21 report -- the critical need for clarity on the definition of
22 CCI versus non-CCI and how that is a continuous struggle.

1 So I love the idea of some sensitivity analyses around
2 whatever, either resource use or diagnoses. I think the
3 principles that are moving this agenda forward around paying
4 for comparable services to a comparable population
5 regardless of setting are critically important. I also
6 think the issues around -- that we talked about a lot -- of
7 continuity of care are critically important, and to the
8 extent that the policies can help to align these are big
9 things.

10 I do think the issue around -- focused on
11 accountability, as Craig mentioned, for decision making as
12 early or as downstream as possible. So we're talking and
13 engaging people in the kind of shared decision making
14 conversations that would say, do you really want to go to
15 the ICU or CCU given what we see as your trajectory.

16 And the last point I'd make is in addition to all
17 the complexities that Alice and Kate talked about, you know,
18 people transition pretty quickly from non-CCI to CCI, and so
19 it -- even within an episode. And so accounting for this
20 based on days of service, et cetera, is really challenging,
21 as you're describing. I wish the complexity of care needs
22 were that simple. So I do think we have to account for

1 transitions within groups who are high risk who move from
2 one level of care to another right within one setting at a
3 point in time.

4 MR. BUTLER: So, first, I have to say I'm
5 sensitive about our discussions of gaming. If I were a
6 caregiver in an LTCH or an ICU in a hospital listening to
7 this, it sounds pretty crass. I don't know. These are
8 people that are very dedicated to these things and we're
9 sitting fairly distant, talking about, oh, well, we'll give
10 this more day or that more day. I just had to say that.

11 Now, the option one, I think, just doesn't go far
12 enough to change behaviors or payments to me. I like option
13 two the best. And there's a history of us refining and
14 creating new DRGs when you can create enough of a
15 homogeneous definition of who those patients are. And I
16 know hospitals start to focus on the protocols associated
17 with those DRGs in a different way than if you just expand
18 an outlier payment. Certainly, tracheostomy is an example
19 of that, for example, which was a new DRG a while ago.

20 I think what trouble we're having is that, as Kate
21 points out, the lever for service, when it's just another
22 day of ICU care, it's a very different kind of thing than an

1 actual intervention where you're kind of doing something
2 specific to a patient, and that's what's -- and I do
3 understand the gaming issue relative to that, so it is an
4 important one. But if we had a different way to get at
5 that, that would be key.

6 Finally, I would say, let's remember where, from
7 my perspective, where this was at. The typical maybe big
8 urban hospital might have a 20-bed ICU and they might have
9 on a given day five of these patients that are staying a
10 heck of a long time and are viewed as they're here forever.
11 They could be here for months. And, therefore, you really
12 only have a 15-bed ICU, not a 20-bed ICU, and you cannot
13 give the focused kind of care that those wound care or
14 ventilator patients need, and if they could be in another
15 place, everybody would be better off.

16 And so that's where I still lead, and option three
17 is difficult, but you're trying to create win-win
18 collaborative relationships between the LTCHs that really do
19 a good job at this with the ICUs. And so the only -- my
20 downside of two is it's still a little bit of a silo, let's
21 take from one to give to the other because it's fair and
22 it's better than where we're at, but it still doesn't quite

1 get at kind of having the LTCHs and the ICUs and the
2 hospitals work directly together.

3 MR. HACKBARTH: Could you just go back to option
4 one. You said you didn't feel like option one went far
5 enough. It seems to me option one is still a pretty
6 dramatic change from current law.

7 MR. BUTLER: It is. It's better than doing
8 nothing. I'm just not sure what the behaviors -- how
9 behaviors -- again, it's about the patient and putting them
10 in the right place at the right time for the right
11 treatment, and I'm not sure that having that extra outlier
12 payment is going to create that change in behavior or that
13 thought process, where I was thinking in option two, you
14 really -- okay, who are these patients? What's their
15 protocol? Let's move them along. I mean, I have to think
16 about it a little bit more.

17 DR. HALL: Did you mention anything about mean or
18 average length of stay in LTCHs?

19 MS. KELLEY: I don't think I did during the
20 presentation. The average length of stay currently --

21 DR. HALL: Not length, occupancy rate, I meant to
22 say.

1 MS. KELLEY: Oh. I'll -- I don't want to
2 misspeak. I would have to get back to you on that.

3 DR. HALL: Well, it might be worth looking at
4 that.

5 MS. KELLEY: Yeah. Sure.

6 DR. HALL: We've seen this steady growth in LTCHs
7 --

8 MS. KELLEY: I have that number.

9 DR. HALL: Now, if that steady growth is
10 associated with, say, 50 percent occupancy, we might say
11 that there's a much more greater potential for gaming. And
12 I sort of agree with Peter that we probably should be a
13 little careful about how much we attribute to gaming. But
14 if there's been this incredible growth over 15 years in
15 LTCHs and they're all running at 100 percent occupancy, then
16 I think I would look more for another kind of discriminator,
17 whether we use option one or two.

18 And one that I think, if it's possible to do, that
19 I would just suggest this from my own experience, having had
20 some experience in LTCHs and also in non-LTCHs, is that in
21 Table 3 of the materials we were presented, virtually all
22 those patients had some kind of a respiratory issue. And I

1 would bet that the major clinical discriminator here is the
2 requirement for one-to-one attention to somebody, not
3 necessarily all people with trachs or on ventilators, but
4 just in terms of pulmonary hygiene that becomes so very
5 important in an emaciated person.

6 And if there was some way to add that as another
7 indicator or discriminator, I think we would see a little
8 more insight into this. I'm just not sure that it's
9 possible going just from the MS-DRGs to get to that point,
10 but I think it might be worth looking at.

11 MR. GRADISON: A quick comment about the outliers.
12 I'm not trying to stir up an issue about the current policy
13 with regard to outliers for hospitals, but since this would
14 be new and there are a lot of variables and uncertainties,
15 we might want to suggest with regard to the new outlier pool
16 that it be tried up in the subsequent years so you don't get
17 into the question of whether money is being diverted from
18 one group to the other. It would, over a period of a couple
19 of years, average out. We could talk more about that if you
20 have -- I don't think it's a big deal, but I did want to
21 mention it.

22 The specific thing I should have asked before, to

1 make either of these options work, would it be necessary to
2 change the payment rates for some of the high-intensity SNF
3 categories to get equal -- to level off the payments, which
4 I thought was one of our objectives?

5 MS. KELLEY: That's not been part of this work. I
6 think all things -- I think our concern about the payment
7 rates in SNFs has not necessarily been the level of payment
8 but rather the relative profitability of certain RUG groups
9 versus others, which I think is a -- so I think the issue of
10 leveling up is not so much level of payment, but rather
11 getting the weights correct so that payments are directed so
12 that we don't have some RUGs that are so much more
13 profitable than others. Have I characterized that --

14 DR. MARK MILLER: It's actually both. I mean, we
15 do have concerns about the payment levels, but you guys are
16 talking about the distributional equity within the payment
17 system, and to that end, what you're saying is correct.

18 MR. GRADISON: Yeah. I mean, I just thought that
19 that was one of the objectives here, where the treatment
20 could be as a case, apparently -- no, it could be either in
21 a SNF or it's properly equipped, or a long-term care
22 hospital.

1 MR. HACKBARTH: Bill, just go back to the first
2 part. I didn't quite follow. So what's your concern about
3 how this relates to SNF payments?

4 MR. GRADISON: I just wondered if any of the SNF
5 payment rates need to be modified to keep them in line with
6 these new payment levels that we're --

7 MR. PETTENGILL: I think that there's a
8 fundamental problem here with -- first, our hypothesis, I
9 think, is that when SNFs are used, they're not the same as
10 an acute-care hospital stay or an LTCH stay for these
11 patients. They're being used for the sub-acute care or the
12 recovery care that follows a long stay.

13 And, second, the SNF payment system is a per diem
14 system, so the payment is not really comparable to the way
15 we pay on a per case basis in the acute-care hospital or the
16 LTCH. So there's not that truing kind of problem here, I
17 don't think.

18 MR. GRADISON: Okay. That's very helpful. I want
19 to join in complimenting you on an excellent analysis of a
20 very complex issue.

21 With regard to the gaming, yes, there are those
22 risks. I'm sure we're all going to collectively try to

1 minimize them. But in no way do I think that should be
2 considered a deal-breaker because if the experience turns
3 out to be adverse, it's possible to come back later and try
4 to fix it.

5 DR. HOADLEY: So, again, I add my compliments.
6 This is just really great analysis and really has helped to
7 structure what's obviously been a good discussion.

8 You know, it almost goes just to what Bill is just
9 saying. The one thing I guess I keep trying to think about
10 is the history of getting into this category of payment was
11 that there were hospitals that, back in the 1980s when this
12 whole system was developed, that, well, they might not quite
13 work. And they were just defined, as I understand it, on
14 the number of days of the average length of stay.

15 And now we talk about it much more as post-acute,
16 and at that point, it might not have even necessarily been
17 that some of these things were doing post-acute cases as
18 opposed to initial admissions.

19 And so the question I have is, when we think about
20 these two options, for the more common case now, where they
21 are really dealing with a second stay, they've been in the
22 acute hospital and now they're going into this, and yet

1 they'd be thrown into sort of a comparable DRG category with
2 the person when they were in the original hospital and now
3 they're in a second hospital at some different stage of
4 their care. Is there some way to exploit that difference
5 short of the bundling approach, some in-between place, I
6 mean, so that it's almost like when they get to the LTCH,
7 they're not really on day one now. They're on day 17 or
8 whatever of their overall stay.

9 So I don't know quite where to go with that, but
10 it seems like if you have two patients and one of whom is
11 starting in the acute-care hospital and has a particular
12 length stay and another one is starting in the LTCH after
13 they've been in an acute-care hospital, and yet we're sort
14 of paying them the same payment --

15 MR. PETTENGILL: Right. Well, it's a combined
16 episode illness, but it's not the same stay --

17 DR. HOADLEY: Right.

18 MR. PETTENGILL: -- because the DRG they get into
19 in the LTCH is different.

20 DR. HOADLEY: It could be different --

21 MR. PETTENGILL: Almost always.

22 DR. HOADLEY: Okay. Almost always different. So

1 that helps.

2 MR. PETTENGILL: Yeah. So it's an intriguing
3 idea. I see where you're trying to go, but --

4 DR. HOADLEY: I'm trying to think about what the
5 parallels are and whether there's anything that can be
6 exploited about the fact that might even differentiate. I
7 don't know if there's any cases that sort of go straight to
8 an LTCH that are in this CCI kind of situation. There may
9 not be. But those could look different, and maybe that's
10 all picked up in the way you would code them into a
11 particular DRG.

12 MR. PETTENGILL: Yeah. Well, one thing we know is
13 that the indirect CCI patients are less expensive than the
14 direct --

15 DR. HOADLEY: Okay.

16 MR. PETTENGILL: -- which suggests that there's
17 something there.

18 DR. HOADLEY: Mm-hmm.

19 MR. PETTENGILL: But --

20 DR. HOADLEY: And with the indirect patient, once
21 they're in the LTCH, are they getting paid the same way that
22 the direct --

1 MR. PETTENGILL: That was our original design,
2 yes.

3 DR. HOADLEY: And whether that's an issue that
4 should be thought about --

5 MR. PETTENGILL: Right. I mean, the problem is
6 that the direct are here. The indirect are here. And the
7 non-CCI are down here.

8 DR. HOADLEY: Yeah.

9 MR. PETTENGILL: And, actually, the ones that
10 overlap, that are both direct and indirect because they go
11 from -- they had a prior stay with eight-plus days and then
12 they went to the LTCH and they had --

13 DR. HOADLEY: Another eight-plus.

14 MR. PETTENGILL: -- and they stayed in an ICU for
15 eight or more days, those are even less expensive than the
16 indirect. So I don't know what to make of that.

17 DR. HOADLEY: But, anyway, it's clearly going in
18 some -- and I, like a number of people, my gut was sort of
19 saying option two made more sense, but with all these other
20 issues, that could either push us to the gaming fixes or to
21 seeing some of the merits of option one, and I await hearing
22 more.

1 And the only other thing I wanted to add goes back
2 to the exchange between Rita and Mark about the decision
3 making kind of side, and the conversation I remember from
4 some years ago was almost the mirror image, the complement
5 to the example Mark did, which was a doctor in an area that
6 did not have LTCHs saying, yeah, because we don't have it,
7 we think we do end up with those conversations sooner and we
8 have a better conversation with a patient because there
9 isn't this sort of easy option, and so I just wanted to
10 throw that back into that part of the conversation.

11 MR. PETTENGILL: Interesting.

12 MR. HACKBARTH: Okay, David, last word.

13 DR. NERENZ: Okay. Well, I apologize for what may
14 appear to be a round one question, but if we could go to the
15 bottom of Slide 11. Just as this discussion has gone on,
16 I'm feeling less settled about the focus on CCI as opposed
17 to the broader spectrum of LTCH patients. So I observe here
18 on the bottom, non-CCI patients represent about 60 percent
19 of the total LTCH population.

20 Then we move to Slide 12 and then the focus from
21 this point forward is about alternative payment models for
22 the CCI population. And I apologize if I just missed it,

1 but I'm not completely clear why the rest of the patient has
2 been left out of the subsequent discussion. Now, I
3 understand the distributions are different. The outlier
4 cutoffs could be different. I mean, I understand the rest
5 of what was said.

6 But it does seem, then, to lead to a potential
7 gaming problem when the key distinction between CCI and non-
8 CCI is this eight-day stay, and others have brought that up,
9 that if you create a different set of payment rules that
10 have some attractive features to them for a CCI group only,
11 then you create these incentives to put people into that
12 group by virtue of decisions about eight-day versus six-day
13 stay.

14 So I feel like maybe I missed something between
15 Slide 11 and 12 about why the strict CCI focus.

16 MR. PETTENGILL: Well, the non-CCI patients in an
17 ACH under option one, they're treated exactly the way they
18 are, okay. Their payment rate doesn't change. Their
19 outlier threshold doesn't change.

20 In an LTCH, they go from being paid under the LTCH
21 payment system to being paid under the IPPS, which has much
22 lower rates, okay. So they're definitely being -- they're

1 going to definitely experience a policy change, okay.

2 DR. NERENZ: [Off microphone.] Yes.

3 MR. PETTENGILL: I'm not sure what else to say.

4 DR. NERENZ: No, that's okay. I didn't have any
5 great further direction to go except just to -- I want to
6 make sure I clearly understand where some of these gaming --

7 MR. PETTENGILL: Under option two --

8 DR. NERENZ: -- because just to follow on just
9 what you said, then, that would seem to just clarify the
10 incentives to have an eight-day stay that would put someone
11 perhaps into a higher-paid CCI category, other
12 characteristics being essentially the same.

13 MR. PETTENGILL: Right.

14 DR. NERENZ: Okay.

15 DR. MARK MILLER: But you understand the
16 distinctions between one and two, where in two, there's a
17 strong incentive to do that because it moves you into a
18 higher payment category. In option one, you can do that,
19 but you run some loss before you hit the --

20 DR. NERENZ: Yes. Right. No, no, understood.
21 Understood. And the net is complicated.

22 MR. PETTENGILL: Right. Very.

1 DR. BAICKER: So, would it be fair to say that the
2 goal that we're talking about, rolling LTCH payments back
3 into normal acute care payments, but we're worried about a
4 group of people who might be very expensive that we want to
5 protect facilities against and how do we flag those patients
6 to provide some financial protection for the extra care
7 they're going to need, CCI is the word we're using for that.
8 The definition of it is what we're trying to figure out.
9 But that's for the group of people that we're protecting
10 from this rollover whole cost. Everybody else is just going
11 to get paid under the standard acute care bundle.

12 MR. HACKBARTH: And we want to protect them
13 regardless of whether they're in an acute-care hospital --

14 DR. MARK MILLER: Yes.

15 MR. HACKBARTH: -- or in LTCH.

16 DR. MARK MILLER: Yeah.

17 MR. HACKBARTH: Okay. Obviously, you have
18 generated lots of interest and we look forward to future
19 discussions.

20 Okay. Our last session is on Medicare's coverage
21 for services provided by advanced practice nurses and
22 physician assistants.

1 [Pause.]

2 MR. HACKBARTH: Okay. Who's leading? Let's go
3 for it.

4 MS. SMALLEY: Good morning. Today we will discuss
5 Medicare's coverage of services provided by advanced
6 practice nurses and physician assistants. Most of this
7 presentation will be an overview of scope of practice for
8 these non-physician providers in general and a discussion of
9 how Medicare pays for the services they provide. Today's
10 presentation is not meant to be comprehensive but, rather,
11 to act as a starting point for the discussion of these
12 issues. We look forward to hearing your thoughts on where
13 to take this research in the future.

14 First, we will define the terms "advanced practice
15 nurse" and "physician assistant" and discuss the state,
16 provider, and payer policies that affect which services APNs
17 and PAs can deliver and under which circumstances.

18 Next, we will turn to Medicare's policies
19 regarding APNs and PAs, including covered services, payment
20 methodology, and a breakdown of services these clinicians
21 provide to Medicare beneficiaries.

22 Finally, we will outline some issues for you to

1 consider during your discussion.

2 Both of these types of clinicians must by
3 definition meet certain education and certification
4 requirements. APNs, a category that includes nurse
5 practitioners and clinical nurse specialists, must first be
6 registered nurses. They must complete additional training,
7 often a master's degree with some clinical experience, and
8 be certified by a national certifying body. They then must
9 be licensed to practice in their state.

10 Note that certified registered nurse anesthetists
11 and certified nurse midwives are also considered APNs.
12 However, for the purposes of this preliminary discussion,
13 when we use the term "APN," we refer only to NPs and
14 clinical nurse specialists.

15 PAs must also graduate from a PA program that
16 includes clinical rotations. They also undergo a national
17 certifying process. They then must be licensed by the state
18 in which they plan to practice and establish a relationship
19 with a supervising physician.

20 States regulate the practice of APNs and PAs in
21 two ways: licensure and scope of practice. Licensure
22 determines who is and is not a certain type of clinician.

1 State boards of nursing -- or in the case of PAs, boards of
2 medicine or other PA specific groups -- decide who receives
3 a license based on the completion of education requirements
4 and a national certification process. Licenses issued in
5 one state generally are not valid in other states. However,
6 there is some discussion around the creation of multistate
7 licenses.

8 Scope of practice, on the other hand, dictates
9 what having that license enables the APN or the PA to do.
10 Often, this means the extent to which these clinicians can
11 do certain activities, like prescribe medications, without
12 the supervision or collaboration of a physician. Each state
13 has developed a nuanced interpretation of what these terms
14 mean. For instance, in some states, collaboration implies a
15 written agreement that the APN will refer patients to the
16 collaborating physician in the event that the case exceeds
17 the APN's knowledge and experience. In others, the
18 physician must be physically present for at least some
19 portion of the time the APN practices.

20 Because working closely with a physician is
21 integral to the training of PAs, their scope of practice
22 does not vary as widely across states. They do not practice

1 purely independently, but it is often up to the discretion
2 of the supervising physician how much the PA can do without
3 being physically supervised.

4 Provider and payer policies may further influence
5 the scope of practice. For instance, facilities such as
6 hospitals and SNFs can decide whether they will allow APNs
7 or PAs to be a part of the medical staff or to have
8 admitting privileges. They can also determine the extent to
9 which these clinicians must work under supervision.

10 Payers can restrict both activities that these
11 clinicians perform and the roles they can play, such as
12 being a primary care provider, and can also determine the
13 billing processes they must ascribe to, including how much
14 they will be reimbursed relative to physicians.

15 These policies are in addition to state scope of
16 practice laws and cannot contradict state scope of practice.
17 Therefore, in a state that does not allow admitting
18 privileges for PAs, a hospital could not decide that they
19 can do so within the walls of the facility.

20 As I mentioned earlier, scope of practice laws for
21 APNs can vary widely by state. As an example, let's take a
22 look at two neighboring states with very different scope of

1 practice laws. This table is a list of some of the most
2 common activities performed by APNs, such as prescribing
3 medications independently, referring patients to physical
4 therapy, and acting as a primary care provider. As you can
5 see, APNs in Arizona can practice much more independently
6 than in Nevada. The variation in scope of practice laws
7 does not follow regional patterns as much as one might
8 expect. States tend to be quite individualized in setting
9 these rules.

10 Now Kate will discuss Medicare specific policies
11 regarding APNs and PAs.

12 MS. BLONJARZ: So turning to what Medicare covers,
13 generally the Medicare program covers all medically
14 necessary services provided by APNs and PAs permitted under
15 state law. Medicare requires that the services be provided
16 by a state-licensed advanced practice nurse or PA with
17 national certification, and APNs must be registered nurses.
18 But that is also consistent with the requirements in nearly
19 all states.

20 There are a few exceptions to this general rule of
21 Medicare coverage. For example, APNs and PAs cannot
22 authorize home health or hospice services. Only a physician

1 can do so. And some of the conditions of participation for
2 institutional settings described in regulation specify
3 activities that only a physician may perform. But these
4 issues are complex, and we're only giving you a sense of
5 them. So if you want us to do more in this area, we can.

6 I want to recap what Katelyn and I have just
7 covered. Generally, Medicare's coverage of medically
8 necessary services follows what state law allow them to do.
9 There aren't many areas in Medicare policy where there are
10 significant additional restrictions imposed by the Medicare
11 program.

12 So, in other words, the variation that we see in
13 whether APNS and PAs can practice independently is resulting
14 from state scope of practice law along with provider
15 policies. And then payer policies, such as whether insurers
16 will cover and pay APNs directly, is another factor.

17 Medicare pays for advanced practice nurse services
18 in two ways.

19 The first, down the left-hand side of the screen,
20 is the APN or PA billing directly for the services they
21 provide. There's a nuance with physician assistant billing
22 that I can cover on question. Under this method, they bill

1 under their own provider number and are paid at 85 percent
2 of the applicable fee schedule amount for the service.

3 The second way, down the right-hand side, is when
4 the physician bills for the services that an APN or PA
5 provides under their direct physician supervision, and this
6 is called incident-to billing. A physician can bill for any
7 services provided by an APN or PA as long as they meet the
8 incident-to requirements. In this case, the physician is
9 paid at 100 percent of the applicable fee schedule amount.

10 We can't tell how much incident-to billing is
11 occurring because only the physician's ID is submitted on
12 the Medicare claim. In other words, Medicare can't tell
13 whether a physician or other clinician working under their
14 direct supervision provided the service.

15 We did a claims analysis of APNs and PAs billing
16 Medicare directly. And, remember, this is only one of the
17 two ways that they can receive payment under Medicare.

18 APNS and PAs billing independently accounted for
19 about 4 percent of the spending in the Medicare fee schedule
20 in 2011. It's about between \$2 and \$3 billion. And these
21 services are paid at 85 percent of the applicable fee
22 schedule amount.

1 Looking at the services that nurse practitioners,
2 clinical nurse specialists, and physician assistants bill
3 for, we also see there's variation in the type of service
4 they provide, depending on which specific clinician type we
5 are talking about. About two-thirds of the services nurse
6 practitioners provide are primary care services; clinical
7 nurse specialists are about one-third; and physician
8 assistants are about 40 percent. Primary care physicians,
9 the right-hand bar, furnish about half their services within
10 primary care. So although APNs and PAs provide primary care
11 services at about the same rate overall as primary care
12 physicians, it varies by APN or PA specialty.

13 So I'll turn it over to Kevin to continue with
14 this line of inquiry.

15 DR. HAYES: Looking further at claims data, we see
16 that APNs and PAs tend to bill for office visits that are of
17 a lower level of complexity than the visits billed by
18 primary care physicians and by other physicians.

19 To see this in the chart, note that the billing
20 codes for office visits are defined according to a visit's
21 complexity, with Level 5 visits being the most complex.

22 Thirty-six percent of the office visits billed by

1 APNs and PAs are at the upper end of the scale, at Levels 4
2 and 5. But 46 percent of the office visits billed by
3 primary care physicians are the higher level 5 visits. And
4 42 percent of the office visits billed by physicians other
5 than primary care physicians are Level 4 or Level 5.

6 Nurse practitioners, clinical nurse specialists,
7 and physician assistants often furnish services in the
8 office setting, but not exclusively. The percentages of
9 their fee schedule services with place of service equal to
10 office are as follows: nurse practitioners, 46 percent;
11 clinical nurse specialists, 40 percent; and physician
12 assistants, 54 percent.

13 Other sites of care are important depending on the
14 health professional considered. Nurse practitioners and
15 clinical nurse specialists furnish about one-quarter of
16 their services in nursing facilities. Physician assistants
17 furnish about a fifth of their services in either the
18 hospital outpatient department or the emergency room.

19 So, with that, we have completed the overview
20 portion of the presentation. Our goal, of course, has not
21 been to be exhaustive but, instead, to give you some
22 perspective on the kinds of issues we could pursue further.

1 We would now like to move on to setting up your
2 discussion of how you see the policy environment and the
3 Commission's further work in this area.

4 Recall first that the Commission has expressed
5 certain goals for advancing value in the Medicare program.
6 One is to ensure equity through design of payment systems
7 that do not systematically favor some providers or patients
8 with certain conditions over others.

9 Another goal is to improve care coordination by
10 encouraging providers to coordinate care across sectors.

11 And a third goal is to move payment and care
12 delivery from fee-for-service to coordinated care models
13 with more global payments.

14 As to the current policy environment, the
15 Institute of Medicine, in a 2010 report, made a number of
16 recommendations about the future of nursing such as removing
17 scope-of-practice barriers and allowing advanced practice
18 nurses to practice to the full extent of their education and
19 training.

20 Specific to Medicare, IOM made recommendations
21 such as changing Medicare coverage rules and authorizing
22 APNs to certify patients for home health and hospice. Such

1 proposals have been in the environment for some time but
2 have not moved forward. Utilization of services has not
3 been a concern. In addition, there may be budget scoring
4 considerations.

5 In the policy environment, there are also concerns
6 about access. You might consider whether to focus your
7 conversations at future meetings on those issues. Recall
8 that at last month's meeting, we had a session on the
9 payment adjustment for services furnished in HPSAs. A
10 question that arises from our presentation today is whether
11 there is a role for APNs and PAs in addressing concerns
12 about access.

13 What role might APNs and PAs play? Some policies,
14 either current or proposed, apply to fee-for-service and
15 include APNs and PAs at different levels of involvement.
16 For example, there are two new billing codes for
17 transitional care management, billable starting this past
18 January. The codes are defined to include services for
19 patients transitioning from, for example, an inpatient
20 hospital setting to the community setting.

21 The definitions of these codes include non-face-
22 to-face services such as communication with patients or

1 caregivers within two days of discharge and assurance in
2 scheduling follow-up services.

3 The definitions also include a face-to-face visit.
4 Physicians but also APNs and PAs can bill for these
5 services.

6 Also in fee-for-service, there's the hospital
7 readmission reduction program you heard about at last
8 month's meeting and the more general focus on reducing
9 readmissions. And recall that the June 2012 report had a
10 chapter on care coordination in Medicare fee-for-service.
11 The chapter models of care coordination such as embedded
12 care managers, external care managers, and transitions
13 models.

14 Other options in the policy environment might be
15 characterized more as delivery system reform. For example,
16 CMS has programs and demonstrations underway that recognize
17 primary care and care coordination as critical components of
18 better care for beneficiaries.

19 Examples include the Multi-payer Advanced Primary
20 Care Practice Demonstration and the FQHC Advanced Primary
21 Care Practice demonstration. Both call on participating
22 organizations to conduct what the Commission described in

1 its June 2008 report as essential activities of a medical
2 home.

3 Then there are community health teams. PPACA
4 included authority, but alas no funding, for
5 interdisciplinary community health teams of nurses,
6 pharmacists, social workers, and others to support patient-
7 centered medical homes. These and other delivery system
8 reforms, if proven effective, could be adopted by ACOs and
9 MA plans.

10 To conclude, we list here three topics you may
11 wish to consider during your discussion:

12 What is the role of APNs, PAs, and other
13 clinicians in delivery system reform?

14 What is Medicare's role in this area relative to
15 others, including the states?

16 And what are the scoring implications of any
17 changes in current policy?

18 We look forward to your questions.

19 MR. HACKBARTH: Okay. Thank you. Good job.

20 I know, Mary, I asked you to lead yesterday, at
21 least once, but it seems like I really --

22 DR. NAYLOR: I have been waiting for this day.

1 [Laughter.]

2 MR. HACKBARTH: Yeah, right. So I'll give you
3 first crack at clarifying questions.

4 DR. NAYLOR: Thank you. Thank you for the
5 opportunity I think to really take a look at, as we use the
6 phrase, "physicians and other health professionals" to kind
7 of bring to life the other health professionals. Great
8 introductory chapter. And so I would love to go to Slide 9,
9 and I just have a couple clarifying questions.

10 Can you remind all of us the rationale for
11 deciding in terms of independent advanced practice nurse
12 billing an 85 percent reimbursement rate relative to
13 comparable services by physicians at 100 percent?

14 DR. HAYES: If we look back at the record, the
15 best discussion I've found of this was in a PPRC, Physician
16 Payment Review Commission, report along about 1991, and they
17 talked about a couple of things. One had to do with the
18 fact that while the codes are often the same used for
19 billing purposes -- and we saw that in one of the slides --
20 the mix of patients that can be seen just looking at one
21 individual code could be somewhat different.

22 There was also discussion there about differences

1 in training, duration of training in particular, and so the
2 view of -- and that was focused, you know, pretty much on
3 the issue of the payments in the fee schedule for work. If
4 you want, we can talk about practice expense. That's a
5 separate issue but related thoughts.

6 Anyway, based on those considerations, the
7 Commission recommended continuation of some differential in
8 payment for APNs and PAs relative to physicians.

9 MR. HACKBARTH: "The Commission" in that sentence
10 being the Physician Payment Review Commission.

11 DR. HAYES: Exactly. Exactly.

12 DR. NAYLOR: Can I just do a follow-up on that?
13 Now that we have this history of understanding the
14 complexity and the coding that's going on, does that help to
15 clarify, you know, who is providing what services?

16 DR. HAYES: It does. It would take some further -
17 - because we can see -- let me see if I can find the slide
18 here. So, for example, here we would see, you know, some
19 illustration of how the coding varies and what it would
20 take. But this is pretty crude. This is just, you know,
21 five levels of codes. There could be some diversity within
22 this. It would take some further work to kind of tease out

1 what the particulars are within an individual code.

2 DR. NAYLOR: Two last questions. In an earlier
3 report, we heard that about 15 percent of Medicare
4 beneficiaries use other health professionals exclusively for
5 primary care and about a third, at least based on your
6 report. So do the data that we have now, many years later,
7 help us to understand the growing importance of other health
8 professionals in providing access to Medicare beneficiaries?

9 MS. BLONJARZ: Sure. So I think the numbers we'd
10 had from the survey was that about 15 percent of Medicare
11 beneficiaries responded that they used advanced practice
12 nurses or physician assistants for their regular and routine
13 primary care. When I showed the pie chart of 2011 -- yeah,
14 2011 billing in Medicare, so APN and PA billing is about 4
15 percent, and this is double what it was five years ago.

16 DR. NAYLOR: And it's 15 percent of providers
17 accounting --

18 MS. BLONJARZ: 15 percent of providers, about --
19 yeah, and 4 percent of billing.

20 DR. NAYLOR: And one last one. The rationale for
21 APNs and PAs not being able to certify for home health or
22 recertify and for hospice, can you provide some basis for

1 that?

2 MR. CHRISTMAN: The very short answer would be no
3 in the sense that I'm familiar more with the home health
4 side of it, that, you know, the physician certification for
5 home health was created very early at the beginning of the
6 program, and the law specified that a doctor needed to be
7 able to certify this. And, you know, I guess the -- you
8 know, I couldn't guess what their thinking was at the time.

9 DR. NAYLOR: Thank you.

10 MR. HACKBARTH: On that point, is there -- in our
11 discussions of home health, we've been concerned that the
12 bar for certification is pretty low, at least in some parts
13 of the country, and there are a lot of episodes created as a
14 result due to a lack of supervision. And, you know, at one
15 level you might think if we add a new group of people able
16 to certify, it could increase costs. But if, in fact, there
17 are clinicians who will actually spend more time checking
18 with the patients and what their status is, it could be a
19 more effective control on certification of home health. Has
20 there been any analysis of that or thinking about that?

21 MR. CHRISTMAN: No. I mean, I think that there is
22 some concern that, you know, there are -- the home health

1 benefit expects that the physician who certifies care is
2 going to be sort of helping or supervising the episode in a
3 loose sense, and there is a concern, you know, that that
4 interaction isn't always very strong. If NPs were more
5 likely to engage in that type of work, it could be
6 beneficial.

7 You know, I think the thing that I kind of come
8 back to is at least in home health, we have yet to see
9 anywhere that there's sort of a systematic access problem,
10 you know, to the benefit, and so, you know, I guess what
11 I've struggled to see is, you know, who is the pocket of
12 beneficiaries who would sort of benefit from this change.
13 That's sort of a separate issue from whether, you know, NPs
14 have the training and qualifications to do it. It's just
15 sort of, you know, what access bump would I get from it, and
16 we haven't really identified a patient population.

17 MR. HACKBARTH: Okay. And then I just want to go
18 back to Mary's first questions about why the 85 percent.
19 Kevin, my recollection is that one of the premises of the
20 RBRVS is that level of training really ought not be a factor
21 in payment; it ought to be the nature of the service, so we
22 don't pay different amounts for the same service based on

1 specialty training. It's the service that matters. This
2 seems to be a departure from one of the core principles of
3 RBRVS in that regard. There is a question mark actually at
4 the end of that.

5 DR. HAYES: Yes, when you first talked about a
6 training difference, I was going to point out that, well,
7 no, it's actually an issue of specialty. But then you
8 closed with the point about specialty, and so if in looking
9 at what the PPRC said on this, they, too, you know, made the
10 point about no specialty differential, but they made a
11 distinction between a training difference between physicians
12 and other professionals, and that was the difference that
13 they focused on, not the within-specialty kind of
14 difference.

15 MR. GRADISON: Thank you. There are two
16 statements in here which I really have read over and over,
17 and I can't figure out whether they are consistent with each
18 other.

19 On page 4, it says, "Medicare requires that
20 physician assistants must have graduated from an accredited
21 physician assistants educational program or pass a national
22 certification examination and be licensed by a state," and

1 so forth.

2 And then on page 15, it says, "All states require
3 that PAs graduate from an accredited PA program."

4 Does Medicare use -- and what is it? Does
5 Medicare, as indicated on page 4, have this option that the
6 PA can pass a national certification examination and that
7 somehow is different from the state requirement that they --
8 do they all have to have a degree?

9 MS. BLONJARZ: Yes. And basically what Medicare
10 is saying is -- there was this option, you know, one path or
11 another. All states require a degree and certification.

12 MR. GRADISON: Yes.

13 MS. BLONJARZ: So it's kind of a moot point.
14 Medicare doesn't -- Medicare is defaulting to what the
15 States have done.

16 MR. GRADISON: So this national certification
17 requirement is not an element. The key element is
18 graduation. It's the second line from the bottom on page 4.
19 I just -- it's a minor matter, but I frankly think these
20 sort of -- I didn't find it clear. Let me put it that way.

21 More substantively, have you taken a look at the
22 implications of this to some of the efforts to expand the

1 use telemedicine in the Medicare program?

2 MS. BLONJARZ: We haven't. My understanding is
3 telemedicine, APNs and PAs can serve as telemedicine -- the
4 provider at the originating site. One way in which there
5 can be -- that state policies can affect it is whether there
6 is a direct supervision requirement for the APN or PA. So
7 let's say it's a rural area and an APN or a PA is practicing
8 out in this rural area. Some states have requirements for
9 the percentage of time that a physician must supervise, and
10 so it may impose kind of geographic restrictions on how far
11 away an APN or PA may practice from their supervising or
12 collaborating physician. So that has an implication, but
13 not directly for telemedicine.

14 MR. GRADISON: I have been spending some time on
15 this telemedicine issue. Generally speaking, state laws
16 control. As far as I know, the only major exception that
17 Congress has made so far has to do with VA hospitals, the VA
18 system. Some of us have been noodling the idea that maybe
19 Medicare should be considered a national program, like the
20 VA is a national program, and have its own rules with regard
21 to this. And it's possible there may be some legislation
22 introduced along these lines, and that's why I was asking,

1 because I'm trying to figure out how this would work if a
2 state -- let's take the extreme -- is one of those states
3 that does not permit advanced practice nurses or PAs to do
4 very much except under direct supervision, does that mean
5 that somebody from the outside who's being consulted has to
6 be part of that same rule? In other words, could somebody -
7 - could an advanced practice -- if an advanced practice
8 nurse from outside the primary state communicates
9 electronically into the secondary state, how does that work?
10 Or are they prohibited from doing so? And then that's the
11 kind of question I'm sort of grappling with.

12 Okay. We can talk more about that. If anything
13 comes of this, I'll let you know.

14 DR. HOADLEY: Yeah. On the same point that Bill
15 was making on the degree, you said the advanced-practice
16 nurses, typically a Master's degree. Is the PA -- what's
17 the PA degree typically?

18 MS. BLONIARZ: It can vary, actually. It can be
19 post-associate's or -- so, like, kind of a B.A. equivalent
20 or a Master's degree.

21 DR. HOADLEY: Okay.

22 MS. BLONIARZ: And there's -- the format of that

1 education and training is a little different because there
2 is also clinical rotations that are part of the education
3 requirement.

4 DR. HOADLEY: And on the pie chart on 10, which I
5 guess you already have up, the calculation -- this is based
6 on Medicare spending. So the calculation of four percent
7 already incorporates that 85 percent differential. So in
8 terms of sort of amount of services, it would be a tick
9 higher.

10 And the "incident to," I think you said that can't
11 be included in this.

12 MS. BLONJARZ: Yeah. We -- Medicare has no way of
13 telling what the level of "incident to" billing is because
14 the claim is just submitted with a physician identifier on
15 it and so you have no idea whether the service was directly
16 provided by the physician or provided by another clinician
17 under the "incident to" requirements.

18 DR. HOADLEY: And is there any kind of guess about
19 -- I mean, are we talking about it might be as much again,
20 or just a tiny bit more, or do we have any sense?

21 MS. BLONJARZ: So, the one piece of data -- it
22 doesn't directly answer your question -- that I have is the

1 Inspector General decided to pull a sample of claims where a
2 physician had billed for more than 24 hours of services in a
3 day --

4 DR. HOADLEY: Uh-huh.

5 MS. BLONIARZ: -- and they did chart review based
6 on that, and for that very small group, half of the services
7 were provided by a clinician other than the physician.

8 DR. HOADLEY: But you'd really have to go to some
9 kind of chart review to probably do that.

10 MS. BLONIARZ: That's right.

11 DR. HOADLEY: Yeah.

12 MS. BLONIARZ: That's right.

13 MR. HACKBARTH: And so remind me, Kate. The
14 "incident to" physician requirement is simply they be in the
15 building, right?

16 MS. BLONIARZ: It's that they have to be in the
17 same suite. The physician has to be in the same suite of
18 offices and that the clinician is providing care that was
19 under a plan of care established by the physician. And so
20 it kind of has to be in the middle of a continuing plan of
21 care that the physician has laid out.

22 MR. HACKBARTH: So in an organization like

1 Craig's, you know, a big group practice where there's a
2 physician that has an ongoing relationship as the primary
3 care physician for Mrs. Jones, and that physician has an
4 advanced-practice nurse working with him or her, it's pretty
5 easy to qualify for the "incident to" billing.

6 DR. SAMITT: But I think it's when the -- the
7 question is, is interpretation on the word "suite." So is
8 "suite" sort of in the facility, and if the facilities are
9 large, that there is the opportunity to have relative direct
10 contact with APs in a broader geography, if that's what
11 you're getting at.

12 MR. HACKBARTH: Yeah. I can't imagine that
13 anybody is really looking very closely at the configuration
14 of office space and what's a suite and what isn't. Sort of
15 "on site," I would think, is probably better.

16 DR. HOADLEY: And I had one other on this same
17 thing. What would the percentage of APN and PA be if you
18 did it out of only primary care? Have you ever done that
19 calculation? I mean, the next graph does the flip side of
20 it, what percentage of the PA services -- it would just be
21 interesting, because it would be more apples-to-apples
22 because they mostly do primary care. What percentage of

1 primary care is delivered by these providers?

2 MR. ARMSTRONG: I think you just asked the
3 question I was going to ask, but let me try it again to make
4 sure. So I'm working with a presumption that care delivery
5 is going to evolve and rely much more heavily on these
6 providers. Are we concerned about whether there are enough
7 being trained to meet the demand in the future, much as
8 we're concerned about the number of primary care providers
9 that will be available to us?

10 DR. HAYES: We did look at the -- the only
11 evidence that I have on that is the -- and I don't think I'm
12 going to have the numbers, but we did look at -- for the
13 March report, we did look at the growth in the number of
14 physicians and other health professionals billing Medicare,
15 and we found that the ratio of physicians to the beneficiary
16 population, I believe, was pretty constant, looking 2009 to
17 2011, but that there had been some increases, you know, in
18 the numbers of APNs and PAs billing Medicare relative to the
19 beneficiary population. So that suggests that there, at
20 least from that standpoint, from the standpoint of who's
21 billing Medicare, there's been more growth relative to the
22 beneficiary population, the APN and PA care. But it would

1 take a closer look at just what the output of the
2 educational institutions is like to kind of go and address
3 your question directly.

4 MR. HACKBARTH: Just let Kate jump the queue here.
5 She had a follow-up question about "incident to" billing.

6 DR. BAICKER: So, I understand that from the
7 claims themselves, you can't differentiate the "incident
8 to," and you gave an example of when you could get more
9 data. I wondered if there were other back-of-the-envelope
10 calculations just based on the total number of people there
11 are and the number of hours they provide and the share of
12 Medicare beneficiaries they serve to give us a sense -- I
13 don't have a sense of just how big the scope of the
14 "incident to" services is in terms of order of magnitude.
15 Is there a back-of-the-envelope you have in mind?

16 MS. BLONJARZ: We could think about it. The one
17 other thing I would say is that it also includes a number of
18 other clinicians, like therapists, occupational therapists
19 who may work out of a physician's office. So it's not
20 solely advanced-practice nurses and PAs, but --

21 DR. HAYES: The only other thing I would say, add
22 to that, would be that in some circumstances, we might be

1 able to look at -- or let's put it this way, that it would
2 be possible to estimate the amount of time that physicians
3 or other health professionals spend furnishing services, but
4 you need data from all payers to really get a comprehensive
5 look at what their workload is over the course of a day,
6 week, whatever it would be.

7 DR. REDBERG: Thanks for a really helpful report.
8 I have a few questions that are mostly related to
9 understanding better the educational and licensing
10 requirements.

11 So for advanced-practice nurses, I think most, you
12 said, have a Master's degree, but do you have any idea how
13 many, what that "most" is that have a Master's degree?

14 MS. BLONJARZ: We can get back to you, because I
15 know it's in some of the -- I know the educational
16 associations keep things like that, so we can get back to
17 you.

18 DR. REDBERG: For the ones that don't have a
19 Master's degree, what do they have? Sorry.

20 DR. NAYLOR: I was going to say, now it's a
21 requirement to have a minimum of a Master's degree.

22 DR. REDBERG: Oh, okay.

1 DR. NAYLOR: So the only ones remaining in the
2 workforce that don't -- as a matter of fact, there is great
3 movement to move toward DNP, Doctorate of Nursing Practice,
4 to prepare. But the only ones that don't are grandfathered
5 in.

6 DR. REDBERG: Okay.

7 DR. NAYLOR: So the requirement for much of the
8 workforce right now is all have a Master's and may have
9 more.

10 DR. REDBERG: That's fair. Then you don't have to
11 get back to me, because it sounds like it would be a moot
12 point.

13 And then if I understood your answer to Jack's
14 question, you can be a PA by having just a two-year
15 Associate degree. So after high school, two more years of
16 school and that's it --

17 MS. BLONJARZ: No. I'm sorry. I should have said
18 it looks like there's people who have about four years of
19 training after graduation or --

20 DR. REDBERG: After graduation from --

21 MS. BLONJARZ: After --

22 DR. REDBERG: -- high school or college?

1 MS. BLONJARZ: High school.

2 DR. REDBERG: High school.

3 MS. BLONJARZ: Yeah. So kind of the equivalent to
4 a Bachelor's or a Master's. And I think that about half
5 have either -- half the PA population have either. But I
6 can confirm all of that.

7 DR. REDBERG: And also, I was trying to understand
8 the numbers. I saw 124,000 are either APNs or PAs, but do
9 you know how that breaks down?

10 MS. BLONJARZ: So that's billing Medicare --

11 DR. REDBERG: Right.

12 MS. BLONJARZ: -- and we can get back to you on
13 how many are nurse practitioners versus clinical nurse
14 specialists. But overall, about two-thirds of the nurse
15 practitioner -- or the advanced-practice nurse workforce is
16 nurse practitioners.

17 DR. HAYES: If we look at this slide and the three
18 categories shown here, nurse practitioner, clinical nurse
19 specialist, and physician assistants, the clinical nurse
20 specialists are a small proportion of the total. If we
21 combine them with nurse practitioners, they represent about
22 56 percent of that total of those three categories

1 represented here, and physician assistants being the other
2 44 percent.

3 DR. REDBERG: And then -- thank you. In terms of
4 -- my other question related to the "incident to." Do you
5 have a feeling, for most advanced-practice nurses, would
6 they be in both categories, sometimes billing on their own
7 at 85 percent and sometimes billing as "incident to,"
8 because that would give us an idea of how many more APNs
9 there were that weren't captured in the billing.

10 DR. HAYES: We have that barrier of not being able
11 to identify the "incident to" in any definitive way, so --

12 DR. REDBERG: Unless the nursing profession keeps
13 numbers on how many have graduated. But they could be doing
14 non-nursing things, as well, I guess.

15 DR. NAYLOR: So I can get back to you on that,
16 right?

17 DR. REDBERG: I was just trying -- you know, it's
18 kind of related to Scott's question of what workforce we're
19 talking about and are there --

20 DR. NAYLOR: So there are a couple hundred
21 thousand, 220,000 advanced-practice nurses in the four
22 categories, 124,000 that bill Medicare. There's a huge

1 effort, including a Graduate Nurse Education demonstration,
2 that is trying to double the workforce of advanced-practice
3 nurses to prepare primary care. So there's a lot of
4 dynamic, but, yes, the nurse associations do keep data in
5 terms of who's in primary care even beyond the Medicare
6 program and so on. So we can get that.

7 DR. REDBERG: My last question for this round is
8 I'm a little interested, also, in the geographic
9 distribution of particularly nurse practitioners. I'm not
10 as familiar with what the PAs are doing in the primary care.
11 And in particular, I'm wondering if it is related to the
12 State regulations, because I would imagine some nurse
13 practitioners would prefer to practice where they can
14 practice independently and open their own clinics, and I
15 don't know how the salary compares to ones that are employed
16 in places like Craig's or where we have nurse practitioners
17 that work within our primary care practices. But I'm just
18 wondering how the distribution is and whether there's any
19 relationship between that. Like, are they more concentrated
20 in States that have more independence for nurse
21 practitioners or not? Thanks.

22 DR. SAMITT: So, the chapter references Medicare

1 Advantage, but I won't ask my question about that because
2 you can expect what I would ask in comparing the numbers.

3 So I will ask a question about Slide 14, if I may.
4 I guess the presentation in the chapter is extremely well
5 done, but it really begs the question, what problem are we
6 trying to solve, which isn't clear to me. I wonder whether
7 we've interviewed any physicians or APs or systems to
8 understand where payment policy interferes with any of these
9 things, because, again, you could say, well, are we under-
10 employing or under-engaging advanced practitioners because
11 of the 85 percent differential, and my guess is the answer
12 is no because there is the "incident to" pathway. So it's
13 not clear to me what the problem is, and I guess I'll leave
14 it at that. It sort of helps for round two if I could get a
15 sense of that.

16 MR. HACKBARTH: Okay. So, let me just put out a
17 couple hypotheses, and I guess these would relate most to
18 the first bullet on access. So, some people have said we
19 have a looming primary care access problem, not just for
20 Medicare beneficiaries but more generally. The pipeline for
21 training new physicians, even if we can persuade more
22 medical students to pursue careers in primary care, is a

1 long one. Can expanded practice opportunities for advanced-
2 practice nurses help deal with that looming problem, and if
3 so, what would be policy levers that Medicare and others
4 might pull in order to enhance the possibility that they can
5 fill some of the void?

6 A related set of questions, and this relates to
7 our conversations last time about HPSAs. You know, we have
8 areas of the country where those problems with access to
9 care may be greater. The ability to attract physicians to
10 those areas by jiggering the payment rate may be limited.
11 Would advanced-practice nurses be more responsive to bonuses
12 and opportunities for expanded practice in those underserved
13 areas if we paid them differently or we paid them more? So
14 questions like that, I think.

15 Tom.

16 DR. DEAN: In response to a couple of questions, I
17 think, Bill, my understanding is that the national PA exam
18 is required, I think, everywhere. So it's a national
19 certifying exam that PAs do have to take. So I don't think
20 it's quite as confusing, maybe, as it seemed to --

21 DR. HAYES: [Off microphone.]

22 DR. DEAN: Yeah. And, Rita, you asked about

1 background for PAs. I think it's mixed, in my experience,
2 because the PA program grew out of medics returning mostly
3 from Vietnam, I think, and there was a primary care shortage
4 and the view was that here are some very experienced people
5 who have a lot of skills and we're not taking advantage of
6 them. And so I think we were talking about that last night,
7 that Duke, particularly, started, and it's obviously
8 expanded widely.

9 So I think, now, the programs probably primarily
10 do grant a Master's degree, but there's a whole mix of --
11 for quite a long time, anybody with some kind of health care
12 experience, whether it's EMTs or various things, could
13 enroll in PA programs regardless of what their actual formal
14 degree was prior to that. Now, I think it's probably more
15 rigid now. I don't know. I haven't really kept up on that.
16 But there is a big mix in terms of the group that's out
17 there, how they came to that role, and so -- but I think
18 they do all -- at this point, everybody has to pass that
19 national certifying exam.

20 Does that fit with what you --

21 MS. BLONJARZ: It does, and it's helpful. A lot
22 of the PA materials that we look through did talk about the

1 education programs are trying to attract people with
2 substantial prior experience in medical care of some kind --

3 DR. DEAN: Yeah.

4 MS. BLONJARZ: -- and so that's helpful to know.

5 DR. DEAN: In fact, a lot of the PAs in our area
6 are nurses that, for one reason or another -- partly because
7 I think the PA program was more available -- and wanted to
8 expand their role, and so actually went into the PA program.

9 I'm still a little confused, and I should know
10 this because I worked with these people a lot, this
11 "attendant to" thing. You said that they have to be
12 following a plan of care. Does that mean that the physician
13 has to have been involved with that particular patient and
14 establish the plan of care, because I doubt if most places
15 are quite that precise. But I wonder if, technically, is
16 that the requirement --

17 MS. BLONJARZ: Technically --

18 DR. DEAN: -- that the physician sees the patient,
19 sets up a plan, and they just follow up? Is that the way it
20 was originally set out?

21 MS. BLONJARZ: The way that the Medicare manual
22 presents it, it's that it's a plan of care established by

1 the physician for that patient.

2 DR. DEAN: So it's much more demanding than just
3 having the physician in the, quote-unquote, suite, right?

4 MS. BLONIARZ: Right.

5 DR. DEAN: Okay.

6 MS. BLONIARZ: Yeah.

7 MR. HACKBARTH: So, does the manual characterize
8 what a plan of care is? It does? You don't need to go
9 through it right now. If there's something, I'd actually be
10 curious about what that says.

11 DR. SAMITT: But my understanding is the plan of
12 care is not with each visit.

13 MR. HACKBARTH: Right.

14 DR. SAMITT: The plan of care is for the patient,
15 and so it's in the record as the plan of care for multiple
16 visits.

17 MR. HACKBARTH: Yeah.

18 DR. SAMITT: And if the advanced practitioner is
19 supporting that plan of care, it doesn't have to be unit by
20 unit or visit by visit.

21 MR. HACKBARTH: Yeah. So if, in my earlier
22 example, if one of your colleagues who's the primary care

1 physician for a patient -- let's assume it's a patient that
2 has no serious ongoing problems -- the plan of care is that
3 they periodically come in for acute illness, I would assume
4 that it's okay for the nurse practitioner to see the patient
5 and bill "incident to."

6 DR. DEAN: I mean, that's the issue. If you
7 really enforce that precisely, it's very restrictive. And I
8 don't think that's the way it's usually applied. I mean, if
9 every new problem required a --

10 DR. NAYLOR: So "incident to" is billing and it's
11 different than scope of practice. So that, I think, will be
12 really important to clarify, because there are many, many
13 people that are working in very large suites or in very
14 different sites delivering services consistent with their
15 education, scope of practice, et cetera. So one's a billing
16 issue and the other a scope of practice and they're not the
17 same.

18 MR. KUHN: If I could go to Slide 10, please, just
19 a question on the four percent, which I think in response to
20 a question from Mary, you said has grown about 50 percent
21 over the last five years. So has that growth largely been
22 changes in State licensure laws, like urgent care centers

1 and just more opportunities for delivering care, or do we
2 know -- obviously, it's a small number, but I'm just curious
3 about the reasons for the growth.

4 DR. HAYES: Sure. This would be spending, so it
5 would be influenced by a number of factors. We could
6 probably try and disentangle what contribution each factor
7 makes to this, but part of it would be just the increases in
8 fees. We've seen increases in RVUs for the services
9 frequently billed by these practitioners, so that would be
10 one thing.

11 In response to Rita's question, I mentioned that
12 there's been an increase. There's been growth in the number
13 of these practitioners, the APNs and PAs, billing Medicare
14 relative to the beneficiary population -- more growth than
15 what we've seen in the physician population, so that would
16 be a consideration.

17 And then -- what else -- no, those would be, to
18 me, would be the key drivers.

19 DR. COOMBS: So with the resident reduction in
20 hours, one of the things I was interested in is the academic
21 institutions, if there's a predilection for a concentration
22 of PAs and nurse practitioners within academic centers. I

1 think there was a study, I don't know, five or six years ago
2 where they looked at the distribution in terms of where
3 nurse practitioners go geographically in terms of urban
4 versus rural, and there was a predilection for it to
5 parallel where physicians go. So that would be the second
6 point. Is there any update on the distribution of APNs and
7 PAs?

8 My other question has to do with the slide that's
9 up here right now, the APN and PA of four percent. I think,
10 and I'm not sure this is the case, that if you were to break
11 that pie part out and looked at the ratio of the PAs to
12 nurse practitioners, there would be a lopping disproportion
13 of nurse practitioners within that pie. The reason why I'm
14 saying that is because of them working independently outside
15 of the relationship of a physician.

16 And then, lastly, what I was also interested in is
17 the breakout on Slide 13. What happens if you were to kind
18 of tease out the outpatient, hospital, ER, and the office,
19 because the Health Affairs had these two wonderful article
20 series and one had to do with nurse practitioners going away
21 from primary care and that progression and PAs recently
22 going into more surgical subspecialties and kind of looking

1 at what kind of office that those two entities are in. I
2 think that makes a big difference, too, because we've got
3 the primary care distribution, but I'm wondering, if you
4 were to break out office, how does that break out? It
5 doesn't necessarily parallel the chart on primary care
6 versus non-primary care.

7 And I'm interested in this from a number of
8 reasons, because if we say there are access problems, then
9 you want to kind of see if the access needs are being met by
10 the decision making of the PAs and the nurse practitioners,
11 because if we're recreating the same dynamic that exists
12 within physicians' choices in terms of where they decide to
13 go, and then the nurse practitioners and PAs decide to go in
14 the same route, I'm not sure we're meeting the needs where
15 we need in terms of primary care.

16 And also this whole notion of office medicine
17 versus office-based practices. And I know that at our
18 hospitals, we had PAs across the board, and actually,
19 there's more PAs now than nurse practitioners in most of the
20 clinical services, even in the ICU. Thank you.

21 MR. HACKBARTH: So, do we know anything about
22 changes in patterns, location of practice, for PAs and

1 advanced-practice nurses?

2 MS. BLONJARZ: So, what I'll say is the share of
3 APNs -- of nurse practitioners providing primary care, I
4 think, is generally up around 75 percent to 80 percent.
5 That is a slight decline over time. Physician assistants
6 are more likely to practice in specialty care. Around two-
7 thirds of physician assistants practice in specialty care.
8 But the changes over time, I would want to get back to you
9 on it, just --

10 MR. HACKBARTH: Mary, do you know anything --

11 DR. NAYLOR: [Off microphone.]

12 MR. HACKBARTH: Mike? Kate? So let me ask a
13 round two question here, and maybe Scott and Craig and Mary
14 can help with this.

15 I've heard from a colleague who works in a big
16 practice that has long made use of advanced-practice nurses
17 that the economics of how they're used are changing over
18 time, and this organization, which will remain nameless, is
19 in big cities and actually has a unionized nurse workforce,
20 which may be significant. What he told me is that while at
21 one point in time it was feasible economically to use nurses
22 as team members, clinicians who did not have their own panel

1 of patients, that's becoming increasingly difficult because
2 the salaries of the nurses have been increasing to a level
3 where in order to justify the cost, they need to be able to
4 basically to bring in their own revenue. They've got to be
5 able to have responsibility for their own patients and
6 significantly expand the revenue capacity of the
7 organization.

8 So if that is true and that is generally the case,
9 that's a pretty significant development for the profession
10 and it means that it may need to be supported financially by
11 -- well, let me just stop there. I think it's a significant
12 development.

13 Does that ring true to people who use advanced-
14 practice nurses, or Mary, have you heard that?

15 DR. SAMITT: Well, I think it very much depends on
16 how the organization is compensated itself, so if in a fee-
17 for-service-based environment, I think that is absolutely
18 true that I think we're beginning to see an analysis at the
19 level of the advanced practitioner of the revenues minus
20 their own expenses. However, in a value-based organization
21 like our own, there's a whole other different phenomenon,
22 which is, you know, you want to maximize the talent of your

1 team members and have them work at the top of their license
2 in that type of environment. And in that particular case,
3 you see less of the dynamic of revenue minus cost because
4 it's now the comparison of not revenue versus cost but the
5 relative roles and responsibilities of the different team
6 members. You want the physicians to do truly physician work
7 and the advanced practitioners to do advanced practitioner
8 work.

9 And so I think it depends on the organization and
10 whether you're more value, Medicare Advantage, global
11 payment-like or whether you're more fee-for-service-like.

12 MR. HACKBARTH: Although if you're in an
13 organization that is paid on a prepaid basis, wouldn't it be
14 really important if adding advanced practice nurses could
15 increase your primary care capacity? So now as opposed to,
16 you know, having 2,000 per primary care clinician, you'd now
17 have a group of advanced practice nurses that expand your
18 revenue capacity and you don't have just 2,000 coming in for
19 each internist, you also have advanced practice nurses each
20 bringing in revenue for their own panels in essence.
21 They're not practicing as supports; they have their own
22 panels.

1 DR. SAMITT: I guess philosophically it would work
2 that way. I'm not sure that's the dynamic that we're
3 actually seeing in organizations that are fee-for-service-
4 driven. I don't know if Scott has a different experience.

5 MR. ARMSTRONG: Yeah, we're entirely capitated,
6 but we're very intentionally moving to a shift in the ratio
7 of more nurse practitioners and PAs per MD than we've been
8 at. And, yeah, the challenge is how do you build the
9 panels, and it's really -- I think where we're going to go
10 is it's around to teams; the panels are associated with not
11 just a single doctor but with a team. And then we'll
12 increase pretty significantly the size of those panels.

13 DR. NAYLOR: I totally agree with these two
14 perspectives and want to clarify also that nurse
15 practitioners, advanced practice nurses, have a
16 socialization around care coordination and the whole -- so
17 it's not just who -- you know, that they take on panels of
18 patients, but their capacity to really influence care across
19 systems and over time is a unique feature of their
20 preparation.

21 And so the extent to which we can maximize their
22 contributions, maximize what they bring to the team, is

1 exceedingly important, and this gets to the point -- I'll
2 wait. I was going to say -- do you want to go to Round 2?

3 So it gets to your question about what problem are
4 we trying to solve here, and I think the report did an
5 excellent job of highlighting what exists right now, huge
6 variations across states in scope of practice, variations
7 even within states, in which payers and providers are
8 enabling, or not, a group of health professionals to be able
9 to do in terms of their contributions.

10 Bloomberg News just had a piece on a nurse
11 practitioner who set up a practice in an underserved area
12 and was unable to get a physician collaborator to join, and
13 that was a requirement of the state, and could go a couple
14 of miles away into another state and set up that practice
15 and be able to serve a very underserved population.

16 So the issues around promoting access to a growing
17 population of Medicare beneficiaries -- and to the extent
18 that the Medicare program itself can help to get to a
19 position and an environment where we optimize the
20 contributions of advanced practice nurses and PAs, to be
21 able to deliver and address the challenging needs of a
22 Medicare population, especially the chronically ill, is

1 exceedingly important.

2 MR. HACKBARTH: So let's assume for the sake of
3 discussion that scope of practice laws are beyond the scope
4 at least of what MedPAC is going to recommend. What are the
5 things that would be high on your list of what Medicare can
6 do to achieve the goal you just described?

7 DR. NAYLOR: So I don't know what's possible here,
8 but I would say to the extent that Medicare pays payers and
9 supports plans, MA plans, to be able to deliver services, I
10 would really wonder whether or not we couldn't create the
11 conditions of participation that say you can't restrict use
12 of people. So if payers are restricting who is able to take
13 on panels, that should be an important part. The Medicare
14 program should do that.

15 We are supporting a lot of innovations in PPACA,
16 the accountable care organizations, and we heard yesterday
17 about the convoluted path that we must have in order to for
18 nurse practitioners to be able to lead. And yet they could
19 be opening ACOs in markets that are not the same markets
20 where MA plans are and address a whole population in the
21 states that don't have ACOs, et cetera.

22 So to the extent that we can enable and eliminate

1 these barriers, I think eliminating the barriers to
2 certification of NPs and PAs, APNs and PAs to be able to
3 determine who is right for home care -- I mean, this is the
4 work of nurses to understand home care -- to eliminate that
5 is to create the best -- I mean, a good solution to making
6 sure that everybody is getting the right kind of assessment
7 for those certifications, et cetera. So there are paths to
8 promoting enhanced access that Medicare has, I think, a
9 great opportunity.

10 I think everyone here should know there is an
11 opportunity here to really look at the complexity of
12 services and the payment for those services. And when we
13 talk about paying comparable rates for comparable services,
14 it doesn't necessarily mean that we have to pay 100 percent.
15 Maybe it is 85 percent that will get us to -- because we
16 know from evidence that we have the same quality outcomes,
17 30 years of evidence on looking at least at advanced
18 practice nurses.

19 So I think those ideas about use of efficient
20 providers, equity in payment for comparable services, these
21 are thing our payment program can really work toward.

22 MR. HACKBARTH: So I thought you were going to

1 say, Mary, on the 85 percent issue that at least for certain
2 levels of codes in visits, the more basic care, you know,
3 why shouldn't we be paying equal for equal work.

4 DR. NAYLOR: That's exactly what I am saying.

5 MR. HACKBARTH: Oh, okay.

6 DR. NAYLOR: But I'm not saying that it
7 necessarily has to be 100 percent; in other words, we should
8 be looking at what are those services and what should we be
9 paying for those services, and who is competent to deliver
10 those services getting those payments?

11 MR. HACKBARTH: Well, any information that you can
12 bring to bear on Alice's questions about location decisions
13 and sensitivity of location decisions to payment incentives,
14 you know, can we address specific shortage, geographic
15 shortage issues more readily through payment policies
16 directed at advanced practice nurses, anything along --

17 DR. NAYLOR: Foster more of the nurse-managed
18 clinics which exist in these underserved -- exactly, yes.

19 MR. HACKBARTH: Yeah, if you can help us think
20 through those things, that would be helpful.

21 MR. BUTLER: Yeah, so I think we still need to
22 describe the landscape a little bit more thoroughly to then

1 get to the payment or the Medicare role. We haven't
2 highlighted the fact that to train a physician -- to the
3 extent these are substitutes for physicians, a physician has
4 a minimum of seven years -- four years of school and three
5 years of residency. Not only is the cycle time long, but
6 the total expense is enormous compared to what's in this
7 pipeline if you were to accelerate it, which would be
8 cheaper and faster.

9 We have a College of Health Sciences with a
10 relatively new PA program that has more applicants per slot
11 than any program in our university, wildly popular. We have
12 a very large college of nursing that is one of the five
13 organizations in the study that Mary referenced, doubling
14 the size of GME programs.

15 The pipeline is going to grow rapidly one way or
16 another, but to get back to the point of these people, I
17 think today, despite the fact that it looks like there's a
18 lot of primary care here, they're getting gobbled up by
19 health systems, they're getting gobbled up by specialists.
20 The primary care picture is not as clear to me that they're
21 either going into primary care or going into places where
22 care is needed that isn't accessible now. And I think we've

1 been making this point, and I'm only saying I'm seeing that
2 firsthand in the pipeline that's coming out, that we need to
3 find a way to not have these people just kind of -- and we
4 have hired a whole bunch of them ourselves as one system to
5 be more part of the team still, not to be out on their own
6 generating revenue to cover their costs.

7 So a little bit more on that landscape, and, by
8 the way, they're all getting paid a ton, like the same as
9 primary care physicians, even if they don't generate the
10 same revenue. So they're very valuable.

11 DR. HALL: Well, just a couple of comments. This
12 is the start of what I think is a very important dialogue.

13 The national membership organizations that
14 represent physicians and nursing have become hopelessly
15 politicized on this issue, as I'm sure most of you are
16 aware. And I don't think we have any business inter -- or
17 should we get into that, because they're not going to solve
18 the problem.

19 The flip side of that is that any physician who
20 has worked with advanced practice clinicians in various
21 camps, the relationships are quite cordial, and the synergy
22 can be extraordinary in terms of the benefit of the patient.

1 So we have this -- maybe it's not surprising, but a funny
2 kind of dichotomy between attitudes and opinions that get
3 expressed publicly.

4 I should say in full disclosure I have daughter
5 who is a physician assistant, and she's practiced
6 independently since she was about six, as far as I'm
7 concerned.

8 [Laughter.]

9 DR. HALL: I think what we can do as an
10 organization is to follow a little more closely the
11 trajectory that we started, and that is, what's the problem
12 we're trying to solve, and I think it's high-quality care
13 for the Medicare population. And to suggest that only one
14 group has the ability to solve all of these problems with
15 the burgeoning population is silly. There's plenty of room
16 in the landscape for a variety of training trajectories and
17 patterns. And as Mary has mentioned, there are areas where
18 there is in my mind no question that the individuals who are
19 drawn to a professional career in nursing and possibly into
20 PA have attitudes and skills that are different. They are
21 much more collaborative. They are sensitized much more to
22 some of the biopsychosocial aspects of care. And so there's

1 a great merit, just as there's also merit in encouraging
2 primary care physicians who arguably would not necessarily
3 just be a pipeline to referral to specialists.

4 So I think the prize here is a health system that
5 is highly professionalized but highly compassionate as well,
6 and these are the roles that need to be filled, and then
7 that should start driving whether we -- rather than move
8 right to the issue of how much somebody has paid or all the
9 rest. In a way, I don't think this is as complex a problem
10 as we want to make it right now, but I think we should -- as
11 we carry this analysis further, let's really figure out what
12 MedPAC can do here in terms of our own, if you will, scope
13 of practice.

14 DR. HOADLEY: So two kinds of thoughts. One is on
15 this question of the 85 percent issue, and I don't know if
16 that's something we ought to look into or not, but it does
17 seem like as a researcher my inclination is to say, okay,
18 this was looked at in 1991, that's a long time ago, what has
19 changed. Have there been changes in scope of practice in
20 that 20-year period? Have there been changes in the actual
21 -- both the legal scope of practice and sort of the actual
22 practice of what these people are doing that would lead one

1 to reach a different conclusion in 2013 than we did in 1991?

2 So I'd just sort of throw that out.

3 On the broader question that you raise as to how
4 to think about what are the barriers to doing some of the
5 things that we all think need to be done, addressing both
6 the primary care shortage issues but also the better care
7 delivery and the care coordination and the transitions and
8 the team-based care and all that kind of stuff, but
9 particularly in a fee-for-service context, because I think
10 we've already had comments on what is probably going to
11 happen on its own in the managed care context.

12 It seems like there are two kinds of things that
13 can be done. One are things that are not specific to
14 advanced practice nurses or nurse practitioners, so that's
15 things like the codes that have appeared for -- you know,
16 these new codes that were mentioned, transitional care
17 management and things, you know, those are codes that can be
18 used by a doctor or used by a nurse, and if the nurse
19 practitioners are particularly oriented to providing that
20 kind of care, that will then happen. So those are things
21 that might be good moves for the program in general, and
22 that would be -- as a side-effect effect -- better use of

1 these advanced practice nurses and PAs. And the others are,
2 I think, things where it's specific barriers. And so the
3 two examples I've heard particularly talked about were some
4 of the things that came up yesterday in the ACOs and then
5 the question of home health certification.

6 Again, I don't necessarily have the answer to
7 what's the right solution there, but I think if we thought
8 about where are there explicit barriers that are addressing
9 the use of these types of practitioners versus the other
10 kinds that are things that we might just do in general
11 because they're good things to do and, in fact, they will
12 also benefit better use of these kinds of clinicians, that
13 may be a helpful framework.

14 DR. NERENZ: I would be interested in Tom and
15 Craig and perhaps Bill's thoughts about some greater
16 explicit differentiation of tasks within primary care. It
17 seems that over the last, I will call it, two decades we
18 have added a number of expectations and requirements of
19 primary care. We've embedded them in quality programs,
20 things like smoking cessation counseling, depression
21 screening, lifestyle counseling, various things. And a
22 number of these things don't really require the unique

1 skills that doctors gain during four years of medical school
2 and residency, and they're probably things that good nurse
3 practitioners and PAs can do. And it seemed like in some of
4 our team models, we've probably evolved already to a point
5 that nurse practitioners and PAs sort of step up and do
6 those things, but I don't know that. I'd be curious about
7 it.

8 But in terms of what you could do with payment
9 policy, presumably in the fee-for-service domain, one can
10 identify codes like you just said for these activities
11 specifically and then create rules by which nurse
12 practitioners and PAs can do those things, which then
13 perhaps get embedded in the scope of practice.

14 Now, I don't know if what we really want to do is
15 just expand the set of codes in fee-for-service. Maybe we
16 just want to push into bundled payment situations in which
17 these things can happen a little more naturally. But I'm
18 just curious, your thoughts about this, because up to this
19 point, I think we've talked about primary care as one thing
20 and whether folks either do it or don't do it. I'm a little
21 more interested in the tasks within it and how those can be
22 sorted out.

1 MR. ARMSTRONG: Actually, I'll build on David's
2 comments. My point of view is that -- and it's not just
3 limited to primary care, but the Medicare program is
4 purchasing billions of dollars of services that are provided
5 by doctors that don't need to be provided by doctors. And
6 it's analogous to some of our other payment policy issues
7 where we're paying for services that could be done in a
8 couple of different settings, but it's being done in the
9 more expensive setting, and we're paying the higher rate and
10 we shouldn't.

11 So I get all the restrictions around licensure
12 and, you know, that kind of thing, but it would just be
13 interesting to me to ask is there some way -- and this is, I
14 think, where you're going -- to identify what are all those
15 services that we pay for that you actually don't need a
16 doctor to perform. And to Mary's point, arguably, some of
17 those services could be done even better by some of these
18 other professionals.

19 So I just -- that's maybe a different way on a
20 very similar question, but it's -- and I don't know if it's
21 answerable, but I'm sure there are people in this room that
22 know much better than I do what those would look like.

1 And I would just say in our system that is how
2 we're thinking about this, and we think that we can solve it
3 and build a care system that will be much more cost-
4 effective but also effective in achieving the overall health
5 outcomes that we're trying to achieve.

6 DR. REDBERG: I think it's a really important
7 topic, particularly as we're addressing the future needs and
8 how to address our growing primary care deficit. But I just
9 think it's important to kind of play it through and think
10 about it, because I wouldn't want -- I mean, I highly value
11 the services of advanced practice nurses. I work with them
12 daily. But I wouldn't want to say, okay, doctors can't do
13 primary care, they can't talk to patients, and we're just
14 going to assign all of that to other health professionals,
15 because I don't think that would be in our best interests.
16 And, you know, some of that is not in payment policy, but
17 some of it is, as we have talked about, because there's a
18 great imbalance between primary care and specialty pay
19 currently, and that, you know, certainly there's large
20 differences in training. I did very intensive medical
21 training for 11 years after college. You know, for a
22 primary care specialty, it would be more like seven years.

1 But that's very different than someone who's done one or two
2 years, or in PAs, I think perhaps no years after a four-year
3 degree in terms of training. And so it's important to
4 consider what is the best role of those health
5 professionals.

6 I mean, certainly for a lot of routine things,
7 yes, patients I see in my office, I don't -- they wouldn't
8 have needed to see me as a cardiologist or even a medical
9 doctor. But the point is I have a lot of training in order
10 to make that determination, and you wouldn't want to have
11 missed. You know, so how -- the point is you don't know
12 what you don't know, right? So you don't want to have
13 someone who didn't have such training have missed something
14 that wouldn't have been missed by somebody with more
15 training. And that's really the key.

16 And where I see a lot of nurses and advanced
17 practice nurses being used now that I'm just not sure is the
18 best use -- and it's not necessarily because they're nurses,
19 but a lot of primary care practices, when the doctor's not
20 available, you get the nurse. And I only notice this
21 because when I'm on service and I got down to admit patients
22 -- I'm a cardiologist -- I see a lot of patients with chest

1 pain that I would have never, ever sent to the emergency
2 room. They're young people. They have very atypical
3 symptoms. And I ask them why didn't they call their doctor,
4 and they often say they did call their doctor, they got the
5 nurse, and the nurse, you know, as soon as they heard "chest
6 pain," they followed the triage, sent them to the emergency
7 room. And so it generated more, you know, unnecessary
8 visits.

9 Now, it's not necessarily -- I mean, I'm not
10 saying nurses have to do that, and it could have been, you
11 know, perhaps the covering doctor would have done that,
12 because part of it is when you don't know the patient,
13 you're more likely. But part of it is when you're not that
14 comfortable with those whole chest pain symptoms -- and
15 chest pain is certainly a challenging area anyway, even in
16 the emergency room. But I just think we should kind of
17 think in a sort of bigger picture of sort of where we -- how
18 primary care is best done and what the role is.

19 And I would just lastly say I'm not that
20 comfortable lumping nurse practitioners and PAs because I
21 think it's a very -- I think nurse practitioners are more
22 highly skilled, more highly trained. PAs, it was

1 interesting, I didn't know they came from medics, but
2 certainly now I don't think that's where they're coming
3 from. And I think some of them might be, as Peter kind of
4 alluded to, it's a shorter route to a lucrative medical job.
5 And I'm not saying that's what they're doing, but I just
6 wouldn't lump them all at this time.

7 And the last comment I'll make is if we do --
8 because I always think we should try to look at quality
9 metrics -- if we had quality metrics for these other health
10 professionals in comparison, it would be helpful to look at
11 those, too.

12 DR. SAMITT: So I think this is an essential,
13 critical topic for us to focus a lot more energy on. My
14 personal bias -- there's a lot of discussion about the
15 supply of physicians nationally. My personal bias is that
16 we do not have a shortage of supply of physicians, that I
17 think that if the care delivery model redesigned itself
18 appropriately, that we have ample number of physicians, and
19 a big component of that is assuring that we develop
20 complementary care teams that manage population health --
21 not just in primary care, by the way, but in nearly every
22 discipline, that there is an opportunity to really look at

1 which individual plays what role. But I think it takes a
2 lot of thought to really identify, you know, how do you
3 segment responsibilities. So I do have a series of
4 thoughts, if I may.

5 One is, you know, are there ways to modify the
6 payment policy to incent and reward the right individuals to
7 do the right work? So we talk about an 85 percent
8 differential for the advanced practitioners. Maybe actually
9 there are some diagnoses that it should be 100 percent for
10 advanced practitioners and 85 percent for physicians,
11 because we really want to rebalance the role and
12 responsibility, and maybe that's something that we should
13 think about.

14 The second thing is I think we absolutely should
15 remove barriers to certification and the things that no
16 longer make sense, and you even wonder about federalization
17 of certification requirements to address state-based gaps
18 where State A may have one approach and State B may have
19 another, and it really isn't consistent and it is a bit
20 problematic. So I wonder if that's a possibility that we
21 can recommend.

22 The third thing, which was in response to Glenn's

1 comment about what problem we're trying to solve, is it's
2 kind of interesting that the HPSA-related bonus in
3 underserved areas is kind of -- has applicability in this
4 particular case as well, which is, you know, do we -- is
5 there an interrelationship here? Do we essentially say that
6 we define underserved areas and we enhance payments for
7 advanced practitioners in those areas to encourage growth of
8 access-related needs in those areas? And, you know, the
9 same challenge pertains as it does to HPSA, which is how do
10 you define "undeserved," which I think has been the problem
11 with HPSA. But if we come up with a good definition of
12 that, the question is: Instead of trying to recruit
13 physicians, do we try to recruit advanced practitioners for
14 some functions?

15 And then the final thing that I would say is I
16 think the worst thing that we could do is to create
17 incentives that enhance a silo-based approach to care. What
18 we don't want is we don't want to change incentives so that
19 advanced practitioners are competing with physicians, that
20 the future is about team-based care. So I think all of our
21 discussions about alternative payment models and ACOs and,
22 you know, fixing SGR and shift to primary care, my sense is

1 that they will reward the right complement in primary care
2 if we do all those things right, practices will do the right
3 thing and will want to create these complementary
4 relationships between physicians and APs rather than a
5 competitive relationship if it's just arm's-length payment
6 from a payer to these various groups of providers.

7 DR. DEAN: I would echo much of what Craig just
8 said. I mean, I could not have survived in the location
9 where I've been for all these years had it not been for
10 these folks, both PAs and nurse practitioners. It just
11 simply wouldn't have been possible.

12 Plus, being married to one, that probably had some
13 effect, too.

14 [Laughter.]

15 DR. DEAN: And in terms of the quality, just on
16 that side, you know, when nurse-midwives' outcomes are
17 compared with obstetricians for the group of people that
18 they take care of, the midwives inevitably come out better,
19 just inevitably. So from a quality point of view, I don't
20 think there's a question.

21 I do quibble -- and I think we can get all hung up
22 on trying to figure out well, what is the right payment for

1 each individual. I don't think MedPAC or Medicare should
2 get caught up in that for all of the reasons that Craig has
3 talked about, and so forth. I think the whole answer is
4 that we need to set up structures and -- I shouldn't say set
5 up. We need to encourage structures that support a team-
6 based approach because you can't even make those decisions
7 based on what certificate a person has. I mean, I've worked
8 with a whole range of these folks. The certificate that
9 they have on the wall tells me a little bit, but it doesn't
10 in any way answer how much responsibility am I comfortable
11 with that person taking.

12 It so much varies with the individual and their
13 experience and their ability to make decisions, and all
14 those things. And I think those decisions can only be made
15 within a team, as to who can really -- who's the right
16 person to do this. And we need to remove the payment
17 barriers and allow the flexibility for those decisions to be
18 made within that team. And I think that's the way you'll
19 get the efficiency and the outcome that we want.

20 As Bill said, you know, this gets very politicized
21 and there's a lot of egos that get involved and my
22 profession, unfortunately, is probably overburdened with

1 that problem. But the whole idea of independent practice is
2 something that I think is probably an obsolete concept,
3 basically. I think that we have to move to a -- none of us
4 are reasonably an independent practice and we need to
5 recognize that. And again, it gets back to making sure that
6 we have payment structures that don't encourage that.

7 I am a strong believer that these folks have a
8 tremendous amount to offer. I think the decision exactly
9 what they do really needs to be done on a local basis and we
10 need to allow that to happen.

11 DR. BAICKER: So this is a very productive line of
12 investigation. I look forward to more of the details. I'd
13 love to get a sense of whether by focusing at the separately
14 billed ones we're looking under the lamppost because we can
15 see it, but there's a huge array of other stuff going on
16 incident to that we just can't see, or just what share of
17 the pie we're talking about.

18 I'd also love to see more about the relationship
19 between shortages -- and I know the challenges we discussed
20 last time in defining shortage areas -- the share of
21 services delivered by these types of practitioners, and the
22 state laws. I know it's going to be very hard to know cause

1 and effect there. Do people move to areas where they can
2 practice more freely? Or do they change practice laws
3 because of shortages?

4 But I would love to know the relationship among
5 those to get a sense of the potential scope of increased
6 access that could be gained by expanding state restrictions.

7 MR. HACKBARTH: Okay, thank you all. I appreciate
8 the good work on this.

9 DR. DEAN: Glenn, can I make one other comment?

10 MR. HACKBARTH: Sure.

11 DR. DEAN: One thing I forgot to mention, or
12 forgot to offer last night. If anybody would like to see a
13 truly functioning critical access hospital, the invitation
14 is open to see how a hospital works with an occupancy of
15 about two. I would love to show off one that I think really
16 meets the letter and the spirit of the law, as far as what
17 critical access hospitals do. So you're all welcome,
18 including the staff, and anybody in the audience. Whatever.

19 MR. HACKBARTH: Tom, could you tell us when summer
20 begins and ends in South Dakota?

21 [Laughter.]

22 DR. DEAN: We sort of know when it happens.

1 [Laughter.]

2 DR. DEAN: The statement in South Dakota is if you
3 don't like the weather, wait until tomorrow because it will
4 be different.

5 MR. HACKBARTH: Okay, we will now have our public
6 comment period.

7 Could I see hands? We have two. Anybody else
8 who's going to get in the queue? It's just helpful for me
9 to know the total number. So four. Anybody else? Okay.
10 We have four.

11 So please begin by introducing yourself and your
12 organization and limit your comments to two minutes. When
13 the red light comes back on, that's the end of your two
14 minutes.

15 MR. PRISTER: Thank you. Good morning, Mr.
16 Chairman and Commissioners. My name is Jim Prister and I'm
17 the President and CEO of RML Specialty Hospital, which is a
18 not-for-profit long-term acute-care hospital composed of two
19 freestanding LTCHs in the Chicago area. RML is organized as
20 a partnership with its current partners being Advocate
21 Health Care and Loyola University Medical Center. RML is
22 also the entity that Commissioner Butler described during

1 your January Commission meeting.

2 Patients come to RML from approximately 65
3 referring hospitals. Over 90 percent of all of our patients
4 come directly from intensive care units, and approximately
5 20 percent of all of our patients are on dialysis. RML was
6 a very active participant in RTI's alpha and beta testing of
7 the post-acute care tool.

8 The purpose of my comments this morning are to
9 encourage MedPAC to strongly support the need for additional
10 research, not just in the costs and the payments, but also
11 in the outcomes. We also need to look at the payments and
12 the outcomes over a longer period of time, whether it's 90
13 days, 180 days, or 365 days post-discharge from either the
14 indexed short-term hospital stay or the long-term care
15 setting.

16 It's interesting to note that there are no Model 3
17 bundles approved by Medicare for the LTCH setting as of
18 today.

19 As we all know, there is very limited objective
20 and consistent clinical information pertaining to the
21 Medicare sector and I'm here this morning to share with you
22 some significant innovative developments occurring in the

1 LTCH, both on a clinical and financial basis.

2 A study conducted at RML by Dr. Amal Jubran and
3 her colleagues was recently published in JAMA on January 22,
4 and it was conducted over the course of eight years and is
5 the largest prolonged mechanical ventilator study ever
6 conducted. The editorial was very interesting because it
7 describes some of the significant benefits of this research,
8 not just on prolonged mechanical ventilation patients, but
9 very much so on the CCI patients that were discussed this
10 morning.

11 And we have over 800 patients on prolonged
12 mechanical ventilation that are treated at RML at our two
13 locations. More than 60 percent of these patients are
14 weaned, and if we use the JAMA study guidelines, 76 percent
15 of these patients are alive at the end of one year. The
16 patients in the study also overwhelmingly stated that if
17 they had to go through this process again, they would not
18 hesitate to do so.

19 We're currently looking at a bundle through the
20 data use agreement, and given the time, I'd be happy to come
21 back and speak with the Commission staff further about that
22 study.

1 Thank you.

2 MR. KALMAN: Good morning. My name is Ed Kalman.
3 I'm with the National Association of Long-Term Care
4 Hospitals, and I'd like to make just two points, if I could,
5 in the time allotted. The first point relates to quality
6 and cost. The second point relates to the choice of ICU use
7 as a sole indicator of the high-complexity cases that you're
8 interested in.

9 As to the first, RTI has not reported any separate
10 explicit data on cost and outcomes for patients with just
11 ICU use. Their report is for the whole LTCH population. So
12 there is no data before you if you select just ICU cases for
13 this new payment policy as to what the effect will be on
14 their outcomes and cost.

15 But there has been a recent study that NALTH is
16 very interested in and that we're looking into very closely
17 from the University of Pennsylvania published this December,
18 and that study followed, I believe it's patients with ICU
19 use and ventilator use with 13 days in the ICU over an
20 episode of 180 days. It looked at payment, cost, and
21 outcomes. And the finding, as you would suppose, is --
22 where there is and is not LTCH use, that's the important

1 point. And the findings were, where there is LTCH use,
2 payments are higher, but notably, costs are much lower, to
3 the tune of \$34,000 per discharge. And in terms of
4 outcomes, SNF use is much lower, which implies more days in
5 the community. And also, the LTCHs are hospitals that
6 maintain patients at a higher level of care.

7 The number one and two alternatives that you are
8 looking at will substitute acute hospital cost, that is,
9 outlier payments, sooner for LTCH cost. The reason that
10 this study showed better cost as opposed to payments -- very
11 important difference -- is that, hands down, LTCHs cost less
12 on a per diem basis than virtually any acute hospital -- no
13 IME, no GME, no DSH, no overhead for an ICU or operating
14 rooms. They're very low cost on a per diem basis. And
15 also, you've got to be very concerned about quality
16 outcomes.

17 So we would suggest that as you go on with this
18 research, that you explicitly require a report on cost
19 efficiency and outcomes.

20 Secondly, my second point, in terms of ICU use,
21 NALTH has looked at this in the past. ICU use in and of
22 itself should not be the sole predictor of CCI patients

1 because, as pointed out, it is variable. It is a bad --
2 well, what is an ICU in one hospital is not an ICU case in
3 another hospital, and moreover, we're creating a higher-paid
4 incentive to use it.

5 We looked at this in terms of looking at payment
6 efficiency over a shorter episode of care than 180 days. It
7 was a combined LTCH PPS use. And what we found was there's
8 other predictors, and those include -- and it makes sense --
9 number of procedures and -- not or -- diagnosis. That's
10 predictive of a case that saves money if it comes to an
11 LTCH, on a payment basis as opposed to a cost basis.

12 So there are other predictors other than just ICU
13 use that may be -- are not as amenable to gaming that you
14 should look at. And we really think you should take a good
15 look at this quality issue.

16 Lastly, on the chart that bothers me the most,
17 which is Table No. 3, which shows discharging for payment as
18 opposed to medical necessity, I want to point out to you
19 that in the March report, there's a finding -- there's a
20 difference between low-margin and high-cost LTCHs, with low-
21 margin LTCHs having four times the high-cost outlier use.
22 They, hands down -- mathematically, they cannot be

1 discharging just before the geometric mean length of stay.
2 They are holding the cases longer. They are incurring the
3 losses. And they are producing these better outcomes. So
4 you might also consider that with relation.

5 But thank you. I see I've exhausted my time.

6 Thank you very much.

7 MS. BRASSARD: Hi. I'm Andrea Brassard and I'm
8 recently at the American Nurses Association and I'm formerly
9 from AARP. I'd like to talk about home health and I'd like
10 to talk about "incident to" services.

11 While I was at AARP, I wrote a Public Policy
12 Institute paper on removing barriers to home health care.
13 In the States like Washington State, there's an increase for
14 our Medicare beneficiaries of nurse practitioners who are
15 having specialized home care practices, and for these
16 providers, the requirement for the home health certification
17 being by a physician is just an extra cost. It would help
18 the overall system, it would help the physicians that have
19 to just sign the papers. There's no point.

20 And in my paper, I wrote about when Bill Scanlon
21 was on this committee and he said, you know, we should just
22 look at this. It was about ten years ago. And I would

1 really encourage the Commission to go back and look at home
2 health and talk to the American Association of Home Care
3 Physicians, many of whom are nurse practitioners and
4 physician assistants, about how it would help the Medicare
5 system.

6 Then I would like to talk about "incident to"
7 billing. I work full-time in health policy, but to maintain
8 my certification as a nurse practitioner, I need to
9 practice, and I recently had to leave a practice -- it was a
10 wonderful little job Saturday mornings in a family practice.
11 I was there by myself. The requirements, the Medicare
12 regulations for "incident to," a practice cannot bill
13 "incident to" for a nurse practitioner or PA services, three
14 Ns: If there's no physician on site; if it's a new patient,
15 you can't; and if it's a new problem, okay, it's not
16 specific how big the problem is. But, obviously, there was
17 no physician on site, so one Saturday morning, the biller
18 brings her husband in and I say, "It's getting towards the
19 end of the year. Can you give me my number of patients that
20 I've seen under Medicare?" She said, "Oh, no. He is not
21 billing under your number."

22 And I'm giving you just my anecdotal experience,

1 but I speak nationally. And whenever I talk to nurse
2 practitioners about the importance of billing under their
3 own numbers, they say, no, the practice won't let me. They
4 bill under the physicians. And recently, a nurse
5 practitioner went to a Medicare fraud continuing education
6 and brought it up to the speaker and the speaker says,
7 "There's nothing we can do about it."

8 I would encourage the Commission, it is just so
9 widespread. It is so widespread and it's unnecessary. I
10 would -- my personal opinion is just eliminate "incident
11 to," because -- or add a modifier.

12 Thank you.

13 MS. BUTTERFIELD: Good afternoon. My name is
14 Kristin Butterfield. I'm with the American Academy of
15 Physician Assistants. I would like to offer just a quick
16 clarification, a suggestion, and then also an agreement with
17 one of the slides.

18 Just as a point of clarification, the vast
19 majority of the 160-odd PA programs in the country are
20 Master's level programs. They are generally about 28 months
21 in duration and include over 2,000 hours of direct clinical
22 education, and there are just shy of about 90,000 PAs in the

1 country. That was a question that was posed earlier.

2 As to my suggestion, I'd actually like to make an
3 exception to the point made on Slide 8 about barriers being
4 imposed upon PAs that might restrict access. The inability
5 of PAs to provide hospice, to certify hospice and certify
6 home health care, to do things like certify and order fecal
7 occults, diabetic shoes, medical nutritional counseling,
8 those types of things do actually restrict the ability of
9 PAs to practice and to restrict access to care in medically
10 underserved areas, communities where there are no physician
11 providers. These PAs cannot do these things and it creates
12 delays of care to these underserved patients.

13 And, finally, I would like to make a statement of
14 agreement that we do feel that there needs to be greater
15 transparency of the care provided by PAs, both the commenter
16 before me as well as some of you all. In terms of how
17 payment is made to PAs with "incident to" and these other
18 things, there's not a lot of transparency right now as to
19 what volume of medical care is being provided by PAs. So we
20 encourage you all to look at that.

21 Thank you very much for taking a close look at the
22 role of these non-physician providers. We think it's really

1 important. PAs, NPs, other advanced-practice nurses are
2 really a key to the American health care system going
3 forward. Thanks very much.

4 MS. TOWERS: I'm Jan Towers with the American
5 Association of Nurse Practitioners, and I'm not going to
6 come up with a bunch of suggestions for you right now.

7 First of all, we want to thank you for taking this
8 issue up and helping to address it. Our major goal here is
9 to provide patient care in the best way we possibly can.
10 This means that we would like to see advanced-practice
11 nurses being able to function at the top of their license
12 and at their full scope of preparation, and as you are
13 delving into things, we will be glad to provide more
14 information for you in terms of what we do and how we do it.
15 We do have a lot of the data that you're talking about and
16 we're looking forward to dialoguing with you further.

17 MR. HACKBARTH: Okay. Thank you all.

18 We will see Commissioners at the retreat, except
19 for Tom.

20 [Whereupon, at 12:01 p.m., the meeting was
21 adjourned.]

22