MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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9:41 a.m.

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

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

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

So, Julie, are you leading the way?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

fifth age 85 and older.

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

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

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

on the right-hand bar.

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

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

Shifting gears again to look at recent changes in

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Okay. Thank you, Julie and John.

Are there any clarifying questions for Julie or John?

I have Bill and then John and Rita.

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

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

they're accustomed to.

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

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

MR. GRADISON: Thank you.

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

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

So I'm assuming two or more is correct.

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

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

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

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

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

in the chapter and make sure that you have --

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

DR. REDBERG: Thank you. That was excellent.

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

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

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

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

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

DR. REDBERG: Right.

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

DR. REDBERG: Thank you.

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

include it in future iterations of the chapter.

Other clarifying questions?

[Pause.]

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

DR. CHERNEW: So, thanks.

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

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

the medical community or technology stuff.

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

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

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

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

program.

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

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

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

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

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

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

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

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

MR. HACKBARTH: Any reactions?

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

So I think that that's really going to be

important.

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

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

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

Thank you.

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

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

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

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

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

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

And, with respect to that question, I think the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SOMERS: Yes, a little muddy.

DR. MARK MILLER: Right.

DR. SOMERS: Yes.

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

The reason you're question is complicated is we could probably calculate it for the HI Trust Fund.

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

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

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

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

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

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

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

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

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

Trust Fund question. That you can pretty much calculate.

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

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

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

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

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

later.

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

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

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

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

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

to change over the next tranche of time.

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

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

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

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

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

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

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

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

think that would be useful.

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

So just something to consider, I know our plate is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GRADISON: Thank you.

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Right.

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

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

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

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

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

possibility.

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

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

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

DR. CHERNEW: Or CBO.

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

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

DR. CHERNEW: Right.

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

scenario?

DR. SOMERS: No.

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

DR. SOMERS: Right.

DR. CHRISTIANSON: What is the CBO scenario?

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

MR. HACKBARTH: For physicians.

DR. SOMERS: Yes.

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

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

MR. HACKBARTH: That's a possibility also.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SOMERS: Generally OACT talks about drivers of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. COOMBS: And physician assistants as well.

DR. SOMERS: Let's see.

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

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

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

DR. COOMBS: Thank you.

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

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

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

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

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

changes that we talk about.

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

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

DR. CHERNEW: Friendly.

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

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

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

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

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

[Laughter.]

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

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

about being optimistic.

[Laughter.]

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

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

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

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

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

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

DR. MATHEWS: Within the next couple of weeks.

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

DR. MATHEWS: There will not.

MR. HACKBARTH: -- for comments.

DR. MATHEWS: Correct.

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are now about 220 ACOs in the Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

they are accountable for costs.

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

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

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

MR. GLASS: Oh, I'm sorry.

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

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

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

MR. GLASS: At issue --

[Laughter.]

MR. GLASS: Yeah. Thank you, Mark.

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

pays their cost sharing.

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

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

Now, we will turn to the quality issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

your discussion.

MR. GEORGE MILLER: Oh, okay.

MR. GLASS: You know, one --

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

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

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

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

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

MR. HACKBARTH: George, did that --

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

MR. HACKBARTH: Okay. Peter.

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

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

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

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

MR. GLASS: And then a lot of them could be very small, yes.

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

MR. GLASS: Right, who --

MR. BUTLER: Not a small number, right?

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

MR. GLASS: Yeah.

MR. HACKBARTH: -- but some of the physician-sponsored ACOs are quite small.

MR. BUTLER: Okay.

MR. GLASS: Right, the limit being they have to have over 5,000 beneficiaries.

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

Dave.

DR. NERENZ: Bottom of Slide 4, please. Just a semantic question, payment delivery system. Is this to mean that payment and delivery are more integrated with each other as you go to the right, or does it mean that payment and delivery as two separate things are more integrated within each of their separate domains as you go to the

right?

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

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

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

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

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

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

Others?

[Pause.]

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

urge people to be really concise in their comments.

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

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

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

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

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

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

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

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

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

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

scenario which creates an inappropriate balance?

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

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

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

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

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

political issues that have arisen in terms of reimbursing MAs.

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

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

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

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

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

And then one final comment on leakage -- leakage

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

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

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

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

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

into it.

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

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

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

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

advancing their own health.

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

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

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

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

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

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

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

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

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

And so I think those are really important issues

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

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

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

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

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

DR. STENSLAND: Yes.

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

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

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

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

MR. KUHN: Two quick points and two questions.

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

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

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

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

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

MR. GLASS: You mean risk adjustment?

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

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

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

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

MR. KUHN: Okay.

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

like that.

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

MR. GLASS: Yeah.

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

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

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

MR. GLASS: Yeah.

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

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

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

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

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

MR. KUHN: Yes.

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

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

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

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

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

DR. COOMBS: So I have a couple points.

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

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

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

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

DR. CHERNEW: So, two points.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

blind to their data.

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

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

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

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

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

DR. MARK MILLER: [off microphone].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

being referred to those specialists.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GLASS: Not that I know of.

MR. HACKBARTH: Okay.

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

MR. HACKBARTH: Right.

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

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

MR. HACKBARTH: Yes.

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

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

MR. GLASS: We should check that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to be the case.

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

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

I mean, the two things I'm most interested in are:

Do we need to close some of the on-ramps?

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

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

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

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

won't renew, and if so, why?

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

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

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

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

you at this point why that was?

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

I think there are a number of reasons, many of

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

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

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

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

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

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

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

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

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

So I'm not sure, you know, how we view that. Okay, is it terrible that they're not going into the ACO program, or is this the way things may evolve for more sophisticated organizations that weren't able to fare well under the historically based pricing system of the Pioneer ACO?

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

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

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

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

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

I would assume. I don't know that.

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

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

So that was the original policy objective within

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

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

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

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

MR. HACKBARTH: Right.

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

And I think one of the challenges is the private

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Entry.

DR. SAMITT: The entry.

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

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

MR. HACKBARTH: Right.

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

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

That's not how I feel.

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

need to prepare for those.

Okay, thank you.

We will now have our public comment period before lunch.

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

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

So with that, your two minutes begins.

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

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

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

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

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

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

Thanks.

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

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

AFTERNOON SESSION [1:16 p.m.]

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

DR. ZABINSKI: Just Medicare.

MR. HACKBARTH: Just Medicare -- okay.

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

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

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

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

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

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

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

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

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

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

risk scores as follows.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But arguments against concurrent risk adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

obtained, but only if risk adjustment works properly.

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

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

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

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

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

for episodes of care.

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

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

MR. HACKBARTH: Okay. Thank you, Dan.

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

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

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

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

DR. ZABINSKI: Right.

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

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

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

[Laughter.]

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

DR. CHERNEW: Is this a clarifying question?

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

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

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

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

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

DR. CHERNEW: That was terrific.

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

DR. CHERNEW: I asked a very simple clarifying

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

MR. HACKBARTH: Okay.

[Laughter.]

MR. HACKBARTH: Alice.

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

DR. ZABINSKI: Okay.

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

DR. ZABINSKI: Yes.

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

DR. ZABINSKI: Yes.

DR. COOMBS: What does that mean?

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

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

second group of conditions.

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

DR. COOMBS: Okay. Four conditions.

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

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

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

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

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

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

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

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

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

DR. NERENZ: Slide 16.

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

[Laughter.]

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

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

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

MR. HACKBARTH: Bill, a clarifying question?

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

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

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

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

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

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

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

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

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

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

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

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

DR. CHRISTIANSON: No.

MR. HACKBARTH: No? Scott.

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

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

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

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

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

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

overpayment? Or underpayment, as the case may be.

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

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

variation?

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

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

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

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

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

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

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

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

DR. REDBERG: Very well said, Mark.

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

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

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

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

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

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

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

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

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

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

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

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

And so, yeah, there are probably some things that

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

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

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

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

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

DR. MARK MILLER: Absolutely [off microphone].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

[Laughter.]

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

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

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

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

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

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

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

[Laughter.]

PARTICIPANT: Whatever they said.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

population.

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

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

DR. MARK MILLER: Currently, it does not.

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

DR. MARK MILLER: Right.

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

DR. MARK MILLER: Now I see.

DR. NERENZ: Okay.

MR. HACKBARTH: Cori.

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

I agree with the comments already made about

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

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

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

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

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

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

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

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

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

MS. UCCELLO: What would you do about it?

MR. HACKBARTH: Yeah.

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

MR. HACKBARTH: That doesn't seem feasible.

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

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

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

MR. HACKBARTH: Okay.

MS. UCCELLO: It's not as helpful.

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

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

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

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

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

more information.

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

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

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

MR. HACKBARTH: Yeah.

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

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

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

MR. HACKBARTH: Okay.

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

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

MR. HACKBARTH: Right.

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

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

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

MR. HACKBARTH: And when are the plan encounter data supposed to be available for --

DR. ZABINSKI: My understanding is 2014. Yes, Carlos?

[Pause.]

DR. ZABINSKI: Yes.

MR. HACKBARTH: It's always one year in the future.

DR. SAMITT: I'll stop asking until 2014.

MR. HACKBARTH: Twenty fourteen -- is that -- whoever knows the answer to that. Carlos, is that --

MR. ZARABOZO: That's what we're saying now, yes.

MR. HACKBARTH: That's what they're saying now, all right.

DR. HALL: So if I'm the administrator of a large successful MA plan and MedPAC comes to me and says, you know, your success is clearly related to that you've been able to avoid adverse selection, either by selecting out

people or disenrolling, and here's the data from the year 2013 to support that.

And I say, well, duh, what do you think we do in MA plans? We address the management of chronic illness more aggressively, early in the disease, and there are plenty of scientific data to say that we can at least postpone the problems of -- the complications of diabetes; we can make people with congestive heart failure have better function. And, of course, it's going to be that way. That's why our plan is an advantage to people.

I mean, I guess I'm coming from the standpoint of a great deal of humility of trying to prognosticate anything about older people. It's very, very, very complicated.

So what do we say to the plan that says you're penalizing me for my success of doing exactly what you asked me to do, and that is to create a better population over, say, some finite period of time -- five years?

DR. ZABINSKI: Okay. I think that's where the idea of the payment neutrality comes into play. If -- you know, the idea there is to pay the plan how much the beneficiary would have cost in Fee-for-Service. So if they're able to be efficient that way, they get the benefit.

And I don't think CMS has any issue with that.

MR. HACKBARTH: I think Bill's hypothetical question is so a plan enrolls a really complicated patient that has multiple chronic conditions and does a really good job, and as a result of that, maybe some of the conditions go away and aren't reported in the next round for that patient. Had that same patient stayed in Fee-for-Service, they may not only have the four they started with but two more. The plan has improved, but when they get their check next time it's going to be for a healthier patient and, therefore, lower.

And so they've improved relative to Fee-for-Service. The gains, however, will not accrue to them.

I think -- is that --

DR. HALL: Yeah, that's more or less it -- that if you -- you can do a lot of case management for lots of patients for the same cost as one day in the hospital for a very sick Medicare patient.

DR. ZABINSKI: At the same time, you know, most of the conditions that are risk-adjusted are chronic conditions. So, once somebody has them, a provider can code them until the person is dead.

MR. HACKBARTH: Indeed.

DR. ZABINSKI: And so the sense of--I don't know. I don't think the sense of getting penalized is all that great here.

DR. MARK MILLER: And that's right where I would have gone, too. If I have a diabetic patient and I manage their condition, I'm still every year reporting that that patient has diabetes, and the payment adjustment says you have a diabetic patient.

And this is part of our conversation. You have a diabetic patient. It's just now out of control.

Whereas, in Fee-for-Service, that diabetic patient looks like this, you've managed it to this point. And your payment still reflects this, but the patient still has diabetes.

And I think most of what goes into this model is that type of thing.

MR. HACKBARTH: Okay, Peter.

MR. BUTLER: I was going to make that last point. The worst part about the Fee-for-Service system is that we'll do everything we can and make money off of keeping people from dying, and we'll do everything we can to make

sure that they don't get better because then we won't have the money either. It's a weird system for sure.

But I think what -- why are we doing this, Scott?

I think this is really, fundamentally, pricing accuracy in the fact that we have worked on trying to get pricing accuracy under the current Fee-for-Service system as good as we can and we are moving to more and more passing off risk to somebody else. We're trying to get the prices right to create the behaviors and alignment.

So I think at the heart of it, the more we get these new models or even more in MA plans, the more important it is to get the pricing right.

So a couple quick guiding principles as I look at it -- and forgive me; this is a little bit redundant but not totally.

Working inside and outside of MA, as you pointed out, is important. So this ought to apply consistently to ACOs, to episodes if they take off and even to things like readmission rates. We have to think about this in the same kind of fashion, I think. It's not just an MA plan, in or out, in a given year.

I think my vote is for sale between predictive

ratio and R-squared, but I understand the point.

I think -- on the gaming issues, I think, Mike, there are two sides to this to me, and one is simply your point about do not reward treatments or services as a variable because that's not a condition; that is, you're getting rewarded for and paid more because of how you're treating, not because of the condition of the payment.

Taken to extreme, when we created the ventilator with tracheotomy and a DRG payment with X weight kind of think, I think that's different from potentially other gaming that could go on in just the diagnostic codes. It's quite a different kind of issue. Both are forms of gaming that you need to be alerted to.

And then the final point I would make is nobody has mentioned ICD-10, but we're going to exponentially increase the number of codes, potentially increase the explanatory power maybe, maybe not, but it's just a factor out there that could also increase the gaming possibilities as well. And that ought to be -- I don't know how we factor it in other than recognize that that is on the horizon here in the next year.

DR. HOADLEY: So I want to sort of go back to

Scott's challenge to us, with an example from Part D and with two examples that I think have relevance.

So Part D came in with both risk adjustment and reinsurance at the same time. So it's different in that way from Medicare Advantage and some of the other systems. In fact, it has a pretty extreme reinsurance because the plan is only responsible for 15 percent of the cost of the highest-cost cases, or highest-cost patients, over the year. It's based on the year.

I'm thinking about two different issues that came up in Part D. One was a suspicion or a concern that plans were trying to avoid the low income subsidy patients.

And there was research, some of which was sponsored by the Commission, to look into that and some issues raised with the risk adjustment system and eventually some corrections made to the risk adjustment system, which potentially -- I don't know if there's been a clear look back at this, but probably -- helped to illuminate that phenomenon of plans trying to avoid the LIS patients.

It seems like there's a parallel there to some of these adjustments that Dan talked about with either the Medicaid full or partial, or things like that.

If we think there's a particular thing that's going on and we got some refinements that could help to fix that, then those would make a lot of sense. On the other hand, there are some special issues with LIS bidding on the Part D system that made that a particular issue.

I think on the high-cost cases the reinsurance -- I certainly have a sense that the reinsurance probably has been overdone. So putting the plans only 15 percent at risk for the most expensive patients is taking away a lot of their incentives to try to manage the use of high-cost drugs.

And so that's something that probably should be reconsidered somewhat within the Part D world. But there are, I think, lessons there. It shouldn't necessarily completely be put away, so maybe looking some more at that issue, where we haven't.

And I think there are some Medicaid programs that use some 100 percent Fee-for-Service or high percent Fee-for-Service rates for the most expensive cases as well. And maybe by looking at some of these instances where these other -- which we're calling truncated cases here in this presentation, where that kind of methodology has been used,

see the extent to which it helps and the extent to which it doesn't help, or even hurts. From that other perspective, maybe we could learn something and figure out whether there's a role for truncation, reinsurance, whatever name you want to put to it, but for a particular way to treat the high-cost cases and when to use it and how deeply to use it.

MR. HACKBARTH: So, Jack, let me ask you a question.

So Part D has, from the outset, used reinsurance on high-cost cases. Analytically, is there a reason that might have been done in Part D but never in Medicare Advantage?

I would think that you would take that approach where there is more skewing of the cost. I don't think that's true in drugs versus other services, but I don't know.

DR. HOADLEY: It's not particularly true in drugs.

I think the issues probably were two things. One was the sort of concern that the notion of creating standalone drug plans was this untested thing, and so it was sort of going overboard --

MR. HACKBARTH: Yeah.

DR. HOADLEY: -- in hindsight, to try to make sure we'd have plans participate.

So we did not only those two, but we also had risk corridors. We actually had three methods that were redundant methods, potentially, and maybe it was an over-thing.

The other thing is that the drug costs are more predictable from year to year. So knowing things about people gives some information. In that sense, the context is a little bit different.

MR. HACKBARTH: Yeah.

DR. BAICKER: I just want to follow up on what you're saying.

My loose impressions is that the aggregate risk faced by health insurers is pretty manageable, pretty smooth, relative to lots of other types of insurance where you see like flood insurance in an area, or fire insurance, where you can have -- where insurers face enormous, highly correlated losses. These health insurance losses are uncorrelated enough that it's just a manageable problem for the most part.

But do you have -- is that right, or is that

intuition not so right?

DR. HOADLEY: I'm not sure I can necessarily direct that. I mean, I think -- directly answer that.

I think certainly the general direction of what you're talking about is right.

I think the question is, how far does it go?

And, you know, some notion -- I mean, I think that's why we're trying to look at some of the cases. In Part D, we've got some clean data, and we could do some of that.

You know, it's maybe even more complicated in Part D because of the donut hole that meant there was no liability, and that's changing, but no liability in that in-between period as well. So the point where the full liability ended was actually quite low, but maybe we could look at some of those data and try to get a sense of sort of what's going on with the high-cost cases.

What you can't do is say, well, what would have happened had the plans been more at risk, unless you're willing to change some rules and try some things out.

DR. SAMITT: So I'll start with Scott's charge to us as well.

I don't remember who had mentioned, maybe Peter, that one of the key drivers here is pricing accuracy, but I think it's more than that. I think it's also that we want to create a level playing field so that organizations that deliver higher quality care or better access to highly complex patients at a lower cost are rewarded as well as those organizations that don't do that. And so I think the level playing field is important to motivate these high performing systems.

I would say the third thing is I think we would all agree we want to move the industry from one that is volume-based to value-based. So to what degree are these risk adjustments important to keep the momentum going in that direction?

I guess I'll be even a bit provocative. Do we really want a level playing field?

Or, do we advantage, even from a risk-adjustment perspective, those organizations that are demonstrating better outcomes, lower cost, as opposed to a pure level playing field?

If, in essence, we have the same number of beneficiaries staying in Fee-for-Service versus other

alternatives, then how do instigate and motivate a shift to a better world?

And I don't know to what degree risk adjustment can play a role in that.

MR. GRADISON: I just want to add a word to what Jack had to say.

My sense is that there certainly will be opportunities for additional studies and improvement of the risk adjustment of systems that have been in effect to date.

I'm a little confused, frankly, or uncertain, as to why there hasn't been more studies that I'm aware of about the use of outliers or reinsurance along with a risk adjustment system to try to improve their effectiveness.

MR. HACKBARTH: In a minute, I'm going to turn to Mark, but let me just sort of sum up where I think we've been.

In June 2012, I think it was, we did a chapter on risk adjustment and Medicare Advantage and made a couple very concrete recommendations for improving the formula, namely, how many conditions and using two years' worth of data. As yet, CMS has not adopted those.

I don't think, at least from my perspective, that

another round of, you know, here are ways that the formula can be tweaked in the abstract would be a high priority for us to do.

However, if we have specific problems that we've identified -- for example, disenrollment of high-cost patients, so we need to figure out either a regulatory or a payment or a combination means to address that -- I think that would be a very important, high value use of time. But I think our work needs to be focused on solving some identifiable problem that we see as opposed to let's tweak formulas.

So my question for you, Mark, is, number one, do you have a sense of particular problems that you would like to see us not answer right now but at least do some more investigatory work on, or do you just disagree with my way of --

DR. MARK MILLER: In public, right?

MR. HACKBARTH: Be bold.

DR. MARK MILLER: No, no. This was what I would say. In all truthfulness I can't answer your second question yet, like which problems, but this is what I take away from the conversation here today. And I do feel like I

have some direction even though I can't answer your second question.

And I would alter one thing you said just a little bit. I agree that I think coming back in front of this group and having big, long discussions about some of the small changes that were identified is probably not a good use of Commission time.

But I will also say that, for example, when we stumble across something like the difference between the parameters for the dual eligibles -- I won't get deep here very much -- actually, there are people out in the environment who are dealing with certain populations in the MA program who see those kinds of changes as a big deal, and they're more willing to stay in the game if they feel like the risk adjustment system is sort of your point, Craig, there at the end, which is I'll stay in this game and I'll take this risk if I feel like I'm being treated fairly.

I think to the extent that we run across those -- and they can be written up in the chapter, but they don't have to be litigated. Sometimes they're so obvious and straightforward.

So that's a small difference.

MR. HACKBARTH: Or, we may not even need a chapter. You know, we could put those ideas for CMS in a comment letter --

DR. MARK MILLER: Exactly.

MR. HACKBARTH: -- on something and not really need to process it with the Commission because they're technical issues that we don't add a lot of value to.

DR. MARK MILLER: Right.

Do you want me to go on?

DR. COOMBS: I just wanted to say something to that point.

It doesn't mean that we have to be the heavy on it. It might be something directed to CMS.

I mean, if there are issues to disclose here, I think if we let that moment slip by -- I mean, there might be some crucial things that we should strike while we can.

DR. MARK MILLER: To the larger point -- and I think Scott set us off on the right direction -- what I take away from this is any reentry into this room and discussion with you needs to be framed as a policy question. This is what you're trying to solve as opposed to models can be improved this particular way. So I have a take-away there.

And I think your second question is the question. I think I need to process a little bit and come back and say, okay, this is an issue; here's how that issue could be addressed.

I also think another takeaway here is trying to evaluate how much gain there would be in pursuing some option. This will be small, so maybe we shouldn't spend a lot of time. Or, here, there probably is some big gain.

Then there's kind of a bifurcation between -- well, let me say this. I do think what we're trying to solve here or what we're trying to do at its most fundamental level is be sure it's accurate.

And I say accurate because, like you, Craig, it's keeping people in the game. I'm willing to take risk because I feel like I'm being treated fairly, and mitigating selection.

And that's for two reasons, not just the government and its situation, but competitors. So if I'm out in the field and I'm trying to do the right thing and this person is engaged in selection -- you want.

Now that brings us back to this point in my mind, which is there are some things you can do in the model. And

I'll try and be much more careful of when I come back in the room and say, here is a mechanical issue within the model.

But things within the model, I think, are probably multiple conditions and coincident condition types of things to improve the model and the notion of exploring maybe these hybrid ideas.

I think big gains in prediction, however measured -- gentlemen, however measured -- come along with them mechanisms that generally undermine the incentives that you're trying to create.

And so I think you can do some of the hybrid stuff if you carefully select conditions that are not gameable. I could see us exploring that a bit.

The big wholesale increases by let's go to costs, you know, you're back into cost reimbursement. And I'm being very glib, but -- that notion.

Then my last point -- and I'm sorry this is long-winded -- is there was a real emphasis on and all of the other stuff. There's the model, but then there's, what about disenrollment rates and this plan that has aberrant disenrollment rates? Maybe you start focusing efforts there. Reinsurance. You mentioned the marketing things,

and there was also the mention of standardization, that type of thing.

And so I think another big takeaway for me is looking at the things that go around the model to manage this problem, but most importantly, coming back framed in the context of: Here's the problem. Here are a couple of solutions, whether they're model or policy solutions, you can consider.

That's the most fundamental takeaway.

MR. ARMSTRONG: I just want to say I thought that was really an excellent summary of a lot of the ways in which we've evolved in our conversation on this topic.

I do still feel a little bit as if we're looking at this risk adjustment methodology as a process we need to protect from inappropriate manipulation rather than a process that we need to find how our industry can embrace it as a way in which it will help expand confidence in prepayment, whether it's ACO pilots or bundled payments or any number of other things. So, I mean, I think the way you walked through that we struck the right balance between those things.

And then the last point, which might have been

your last point, is that our role is largely defined around -- and we've been talking about -- the methodology and the accuracy of it and so forth.

But there is -- when we think about bridging strategies from where we are to where we want to get to in a reformed future, there is a whole world of complex operational and administrative issues that come along with doing this well for groups contemplating taking risk within an ACO pilot. If we're going to advance, when we get into those bridging discussions, we need to be thinking more broadly.

And, not unrelated to that, this is, by the way, not just about Medicare. I mean the exchanges, where risk adjustment is kind of becoming a reality to many, many parts of our health care industry that never thought they would have to figure it out.

MR. HACKBARTH: Thank you, Dan, David.

So now we'll turn to patient engagement and health disparities.

[Pause.]

DR. SOKOLOVSKY: Good afternoon. As many of you requested this summer, we are continuing with our work on

shared decision making. Today we are going to focus on a specific aspect of shared decision making and patient activation: whether they can be effective strategies to reduce health care disparities.

After discussing the study design, we will focus on the role of poor communication between patients and providers as a factor leading to health care disparities. Then we will examine efforts to improve communication and reduce those disparities through shared decision making and patient activation programs.

We have discussed shared decision making often before. I'll quickly remind you that it's a process that involved giving patients specific information about their clinical condition, possible treatment options, likely outcomes, and the probabilities of benefits and harms for those treatments. Patients communicate how they value the relative benefits and harms so they can participate in decision making. It generally includes decision aids that give them objective, current information on those treatment options.

"Patient activation" is a new term for us. It's a general term and involves teaching patients that they have

an important role to play in their care and providing them with the tools they need to communicate better. Shared decision making can be thought of as a kind of patient activation process.

And another new term that comes up a lot in this literature is "health literacy." Although there's no clear definition, by this we mean the ability of patients to understand health communication and to understand the services that they would receive.

Individuals who are older, poorer, and often minority status are often measured as having lower health literacy.

For this presentation we surveyed the literature on shared decision making, patient activation, and disparities. We used telephone interviews of program organizers. We conducted focus groups with beneficiaries who participated in shared decision making, and we visited sites that were testing shared decision making programs.

As you will see, this presentation is put together from many pieces, and most of these studies are demonstrations including control groups, and generally the sample sizes are quite small. So we cannot generalize from

these results, but they are suggestive of strategies that can help to reduce health care disparities.

Poor communication between patients and providers can be a problem for all patients. One study of patient comprehension of emergency department care and discharge instructions found that 78 percent of all patients did not understand their diagnosis, their treatment, and/or their follow-up care. The biggest gap was in understanding their discharge instructions. Further, the majority didn't realize their lack of comprehension -- in other words, they didn't know what they didn't know.

Nevertheless, the problem is more acute for racial and ethnic minorities as well as the elderly and other patients with low health literacy. Poor communication is not the only cause of health care disparities, but most researchers would agree that it plays a role. In AHRQ's annual survey of health care disparities, Hispanic and African American patients consistently report poorer communication with health care providers than do whites. There has been no significant change in this percentage since 2002.

Individuals with higher incomes are less likely to

report poor communication. However, differences between whites and members of racial and ethnic minorities hold at every income level although there is a narrowing of the gap at the highest income level.

Not only do patients have problems communicating with their providers, providers may not understand their patients' preferences and concerns. They may mistake poor communication with disinterest in shared decision making. In the same AHRQ survey, black and Hispanic patients reported being less likely to be asked their preferences in treatment decisions than white patients. In another study of patients being treated for diabetes in community health centers, African American patients reported receiving less information and having fewer opportunities to ask questions than white patients being treated in the very same facilities. But they expressed an equal desire for shared decision making.

In order to bridge the communication gap from the physician perspective, some teaching hospitals have begun shared decision making programs aimed at teaching new physicians or future physicians how to better communicate with all patients. For example, Massachusetts General and

Sophie Davis Medical School have incorporated the techniques of shared decision making and patient activation into their medical training.

Another innovative program was developed at the University of California-San Francisco breast cancer center. Pre-med students help patients prepare for, participate in, and remember their visits. The student coach contacts a patient who has been diagnosed with cancer and offers her shared decision making support, including providing decision aids, helping the patient to make a list of her questions and concerns, and accompanying her to her appointment to make notes about what the physician says. The coach also records the medical encounter so that patients can play it back at home as often as needed. The coach ensures that the physician receives a copy of the questions before the clinical appointment. Student coaches are not permitted to provide additional medical information or advice.

Although the program is not designed specifically to reduce health care disparities, the center doesn't have sufficient coaches to meet the demand from all their patients. Therefore, they prioritize patients facing particular challenges -- for example, those who are

unaccompanied, have low literacy, are older, or are non-English speakers. The program is seeking to recruit more student coaches and expand its focus to additional cancer clinics and other specialty clinics. Alumni of the program report that participating in the program has helped them as physicians to listen more carefully to their patients.

Shared decision making for minorities and others with low health literacy may benefit more from video decision aids compared to the traditional booklets. For example, researchers have compared the effects of shared decision making booklets on advanced care planning with people who received both booklets and videos on the same subject. They have found that the videos improved knowledge and participation in advanced care planning among minority patients compared to those individuals who only received the traditional booklets.

In our focus group in Philadelphia, minority patients also reported that viewing the videos in groups helped them to understand that they were not alone and let them discuss strategies for managing their diabetes with others in the same condition. Program organizers said that almost no patients used the booklets.

Because the data are limited, we can't make a definitive statement that minority groups benefit most from shared decision making. However, we were consistently told that in our interviews with ongoing programs that patients with lower health literacy received the most benefit from these programs. This is most striking when we compare results from the Philadelphia clinic population with other demonstration sites sponsored by the Informed Medical Decisions Foundation. Remember that the Philadelphia clinics are attended by very poor or sometimes homeless minority populations. On the slide the green bars represent Philadelphia, and the blue bars are the other demonstration sites.

Before the demonstration, overall medication adherence for diabetics was lower in Philadelphia than in the other sites. While adherence increased at all the sites following the intervention, as you can see from the chart, it increased in general the most at these clinics, reaching or sometimes even exceeding adherence elsewhere. Because the number of minority patients in these groups outside of Philadelphia was generally low, we can only say that this approach looks promising. And in most cases we can't

disentangle the effects of education and income from the effects of minority status.

Now Katelyn is going to talk to you about patient activation programs, a more general approach to improving communication between providers and patients.

MS. SMALLEY: As Joan mentioned, the Commission has become familiar with shared decision making over the last few years, but there are other methods for engaging patients in their care. Patient activation is a much more general approach that stems from the idea that more confident patients are better participants in their health care. They communicate better with their providers about their own goals, concerns, and preferences, and ask questions about the things they don't understand. These same patients are more likely to carry this concern with them out into the community, and thus will engage in healthy behaviors like physical activity, healthy eating, and medication adherence.

The evidence regarding this pathway is limited at this point, but it is suggestive, particularly with respect to patient-provider communication and self-management, which we will address in further detail in a moment.

In a way, shared decision making can be viewed as a kind of patient activation activity. Its goal is still to have more confident, better informed patients who are active participants in their care. However, shared decision making is condition-specific, whereas patient activation aims to equip patients to ask the right questions about their care in any number of different health care situations.

As Joan described earlier, minority patients may experience poor communication with their providers for a number of reasons. Although the evidence is not clear on this point, these deficits in communication could account for some of the racial and ethnic disparities we see in health behaviors and outcomes. Because one goal of patient activation is to improve patient-provider communication, patient activation may be used as a tool to address these disparities.

In general, patients often do not realize that they will have to make decisions during a visit with their provider or that they are allowed to ask questions about the information provided in the visit. As a consequence, patients are often not prepared to make informed choices. Highly activated patients are more able to engage with their

providers, assert their preferences and concerns, and ask questions. Because on average, minority patients tend to be less activated than white patients, they may have more trouble reaching informed decisions about their care.

An organization called the Right Question Project aims to help low-income individuals advocate for themselves. In the health care setting, this means asking questions of providers, asserting their concerns and preferences, and sharing in decisions about their care.

The Right Question Project developed a patient activation intervention for these low-income patients that was designed to be administered in a very short time frame. The program works like this: A health coach or other type of volunteer trains a patient one-on-one. After a patient's initial level of activation is assessed, the training begins.

First, the coach and the patient work together to define the word "decision" generally and demonstrate how asking strategic questions might lead to better decisions.

The coaches then help the patients to choose a focus for their current visit and to brainstorm and prioritize questions that are relative to that focus.

They then strategize about how to self-manage after the appointment or to have a conversation about that self-management with the provider in the consultation.

And then the intervention is meant to be open-ended rather than content-focused, and it takes about ten minutes.

The Right Question Project intervention has been adapted in several different ways. The focus is always on low-income, minority patients, but different demonstrations are structured slightly differently.

For instance, at Sophie David Medical School, medical students lead the training for patients at a primary care clinic. A pilot of this program was so well received by both the patients and the students that participated that participation in the program as a trainer is now required for graduation from Sophie Davis. In addition to the benefit to the patient, students at Sophie Davis and at the other programs Joan mentioned report that being involved in programs like this help them become better doctors.

Another new demonstration that uses the Right Question methodology is Massachusetts Medicaid managed care. The program targets the plan's high-risk beneficiaries,

including dual-eligibles, and follows them longitudinally with community health workers that combine information from both a clinical and self-management or activation perspective to track beneficiary progress over time. They are in regular contact with beneficiaries, both over the phone and in-person with home visits. This program is still in very early stages, so there is little information about results at this point.

The demonstration programs seem to improve patients' participation in their care, as patients were more likely to keep appointments, ask questions of their clinicians, and take medications than they were before the training. Likewise, patients who had undergone the training were more likely to avoid the emergency room.

In a study of Latino patients undergoing mental health treatment, both English-speaking and non-English-speaking patients who received the patient activation intervention were more engaged in therapy after the intervention.

However, in both cases it is unclear how long the effects of the training last. As more research is done in this area, it will be important to know if the training

needs to be repeated periodically in order to maintain the same effect.

At this point, I'd just like to reiterate our key findings. I'd like to make it clear that while our focus today was on racial and ethnic minority populations, the small size of the studies we reviewed make it difficult to be confident that the effects we see are exclusively a result of disparities based on race and ethnicity. Income and education may also contribute to the disparities that these programs attempt to address.

With that being said, we find that some shared decision making programs help providers to better communicate with their patients, and audio-visual decision aids and group meetings can help beneficiaries with low health literacy participate in shared decision making.

Some limited data suggest that minority groups may benefit the most from shared decision making, and patient activation seems to improve patients' willingness and ability to manage their care and better communicate with their providers.

As we move into discussion, we'd like you to consider the next steps that you would like the Commission

to pursue with respect to shared decision making.

As you heard earlier today, beneficiaries can be engaged to a certain extent with their ACO through cost sharing. ACOs are also required, as a part of both their initial application and their quality metrics, to engage beneficiaries. Medical homes also have some requirements around engaging and informing patients. We could review these current requirements more deeply and identify the places that they could be strengthened or expanded. One issue to consider here is how prescriptive the Commission would want such a policy to be. Should ACOs and medical homes be encouraged or required to provide programs like shared decision making or patient activation specifically? Or should they be responsible for the outcomes that may be associated with engaged patients?

Another line of discussion could be on programs that elicit patient preferences on advanced care planning. We discussed this briefly at the April 2013 meeting, and there have been some Commissioner inquiries into the topic. We could look more broadly at the many different kinds of programs around the country that attempt to address this issue and come back to you with findings that may be able to

drive policy, and also if there are any other topics that you would like to discuss.

With that, we look forward to your discussion and to answering any questions you may have.

MR. HACKBARTH: Thank you very much, Joan and Katelyn. Round one clarifying questions, do we have any?

DR. HALL: Thank you for the presentation. On your preliminary analysis, were you able to find out what sorts of indicators might be used in the actual administration of patient care that are in use in the United States now?

DR. SOKOLOVSKY: If you're talking about what ACOs and medical homes are measured on, I can tell you that there are HCAHPS modules, and I have, in fact, brought with me, just in case someone asked, what those questions are, and we can go through them if that is what you're asking. I'm not quite sure if that's what you mean.

DR. HALL: Well, I don't know if everyone is familiar with the so-called HCAHPS, but could you just read the questions relevant to doctors, what the patient has asked on HCAHPS, just so we're all on the same page.

DR. SOKOLOVSKY: On the shared decision making

module, they'll ask: Provider talked about the reasons you might want to take a prescription medicine

Second question: Provider talked about the reasons why might not want to take a prescription medicine.

And then there's a similar one about procedures, both why you would want and why you wouldn't.

And then when talking about surgery or a procedure, provider asked what you thought was best for you.

Provider talked about including family or friends in making a health care decision.

Provider talked about how much of your personal health information you wanted to share with family or friends.

Provider respected your wishes about sharing personal information.

And provider let you bring a family member or friend with you to talk with the provider.

Then there are two other modules, one is about team-based care, and --

DR. HALL: The only point is that these surveys are given almost always near the point of discharge. They're done in a very hurried fashion for the most part,

and there's not a hospital in the country that doesn't emphasize among their staff that -- and, by the way, the answers are not yes-no, but they're never, sometimes, always, was my care exceptional, that sort of thing. Our hospital is full of signs everywhere, in doctors' lounges and places where nurses aggregate, suggesting that in our hospital patients should be encouraged to say that their care has been excellent at all times, because the rating scales are very much at a ceiling effect, so that basically hospitals compete for being a tenth or even a hundredth of a percentage point difference than their community rivals.

I think we can do better, is the only reason I -- but I just want to make sure that we're -- that is sort of the gold standard right now.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: George, do you want to lead off round two.

MR. GEORGE MILLER: I will. Thank you. And thank you for this chapter. I want to thank the staff for going through this. This was excellent, and I really appreciate it, because I've asked many of these questions before.

I want to comment, and I don't want this to be taken as a criticism. It's just an observation. And I don't think it was intended, but it came across this way, at least to me.

On a couple points, like on Slide 4, health literacy, we talk about the individuals, but we don't talk about the providers. One of the things I think that while the health literacy deals with the consumer or the patient, one of the issues that I wrestled with as I read the chapter is that we did not talk about the competencies of the providers to take the responsibility to explain things in ways that the patient could understand.

Also then on Slide 6, at the top it says, "Poor communication between patients and providers influences health care disparities." That's a true statement, but the bullet points only list issues between the patients. Subtle issue, but we didn't listen. Problems of the providers.

I'll give you a perfect example. My mother was a nurse, a charge nurse at Miami Valley Hospital. My father was an electrical engineer, one of the smartest guys I knew. But they would never, ever -- and this may be more generational and when they grew up and where they grew up.

They never would question the doctor. Not ever. And my mother was a nurse. Not ever, not until I started -- when they got older and I started going to the doctor with them. And I questioned them. I am a product of the 1960s and the 1970s. It's a different generation. And they both grew up in the South. And there are some minorities that just don't question authority, and I think it's the responsibility or should be the responsibility to get some of those questions out from the providers. And that's a competency issue and put it in terms that they understand.

But I'm also very much encouraged by Slide 8 where they talk about what Mass. General is doing and the medical school. I think that's the right thing to do, and I applaud them for doing that.

Now, going over to the chapter, there's a statement in the chapter that really struck me as some of the concerns I have with the chapter and the tone. I don't think it was intentional, but the tone that says when patients are more confident and empowered, then they can participate in their care. What about if the patients are treated with dignity and respect and treated like decent human beings? They then can feel empowered. And, again,

it's just a subtle tone, but the inference is that they only become more confident if they're taught things versus if they're treated that way from the beginning. A little subtle difference, but that resonated with me.

Again, I appreciate the tone of the -- I appreciate the chapter and the things that are covered and the recommendations. I did like the SDM programs. I'd like to know more shared decision making programs, and also using different ways to communicate with visual and booklets. I think those were excellent also and would love to learn more about other organizations in America that are using them.

And then to the question about future work, what programs are being tested, elicit patient preference on advanced care planning, possible topics, I would like to know more about that as well.

I thought Joan and Katelyn did a good job. Thank you.

DR. HALL: I will just say I really applaud the Commission and all of our staff for taking this subject on. I think it's at the very heart of the delivery of medical care.

And just as a personal comment, I think as good

and as important as comprehensive electronic health records are to the delivery of health care, they have started to blunt this whole issue of the time engaging with patients in this regard. That's not a necessary outcome, but it is one that seems to be becoming more and more prevalent, and I think it adds strength and prestige to the whole issue of how important this is that MedPAC is talking about it.

MR. GRADISON: I, too, am glad we're taking a close look at this, and I was interested that some of those questions mentioned having a family member or friend present.

On discharge, a lot of patients are not in very good shape to receive all this and retain it. We're hustling people out of the hospitals pretty fast these days, and often there may be the delayed effects of anesthetic or just not having a good night's sleep for a couple of days. And my own observation -- and it's purely anecdotal -- is that everybody needs a patient advocate. I mean absolutely everybody needs a patient advocate, somebody to literally check up and make sure that the hospital and the nurses are doing the right job with regard to the dispensing of medications, that the food is appropriate. And some of the

more important but more subtle things that George mentioned are true. And I might just say, George, I certainly acknowledge the valuable contribution you've made by talking about your own family experiences. I think there also is a generational factor here. Doctors aren't quite as much God as they used to be, and I really choose those words carefully. I think there's a lot to that.

But I also -- you asked if there's additional work you'd like to focus on. I'd like to know if it's possible to find out whether we can get useful suggestions from any of the more organized plans, like the MA plans, that might shed some particular light on this subject that say that.

The second thing is that I'd be very interested in whether there's anything we can learn from on-U.S. experience. Generally I don't suggest this because, you know, every country is different. But to the extent I've been reading up on this subject, it's almost all, if not entirely, based on U.S. experience. I'd personally be very interested in what the National Health Service and other systems, maybe even more the Canadian system -- which is, in terms of delivery, more like ours, kind of a free enterprise, fee-for-service system -- what, if anything, we

could learn from these other countries that might be helpful as we move forward in thinking this through in terms of what's best in this country.

DR. SOKOLOVSKY: Just to quickly take your questions, last to first, Canadians are very active in this field. Some of the earliest work has been done in Canada, and they spearheaded -- there's an international organization that talks about the criteria for decision aids and what it would mean to be an acceptable decision aid, spearheaded by Canada. And there's a lot of work in the U.K. and Australia.

When we come down to MA plans, you really should listen to Scott because Group Health has done the most of any place in the U.S. They have the largest demonstration project, and that's what I talked about last year, but maybe not sufficiently. But he's the one who really should answer that question.

MR. GRADISON: Thank you both.

DR. CHRISTIANSON: Just a couple of comments, I guess. One is just to be clear that -- and I think the people who wrote the chapter are clear on this, but the concept of shared decision making is a very different

concept than patient activation, and we're putting them together in the same chapter. But shared decision making, as you know, is for situations where there are clear alternatives; there is not a clear appropriate medical route to go. Patient preferences enter in -- patient preferences with respect to outcomes of both pathways come into play. And that's where patient decision aids are very helpful in helping people reach a conclusion, make a decision that they're ultimately satisfied with.

Patient activation refers to people's ability -- making consumers better consumers, patients better consumers, better able to manage their own care. It's often a term -- the research on this has been done primarily for people with chronic conditions, so it's not the sort of I've got a decision to make about a screening test, I've got a decision to make about a surgery. It's how do you get people more self-confident in managing their own conditions and making decisions on their own.

So they're different -- they clearly cross at some point, but they're really different kinds of concepts, and I think in this chapter, you know, we have to continue to try to make sure that we don't confuse people when we go back

and forth between the two.

And then I guess one more question to kind of piggyback on what George said is I think training clinicians to ask the right questions is just as important as training patients to ask the right questions in terms of patient engagement. And, clearly, there's less time for that for physicians than there might have been in the past. But there are other alternatives to doing that. We just finished publishing the results of a randomized trial where non-clinicians in primary care offices were taught to do motivational interviewing with patients, get them engaged in managing their own care with sort of incredibly positive low-cost results.

So there are ways to get patient engagement that don't involve or in addition to involving training patients to ask questions, training patients to be better decision makers, and probably we need to focus on both aspects of this to get patient engagement.

MR. ARMSTRONG: First of all, I would just say, after the compliment you made about my organization, this was the best presentation I've ever heard.

[Laughter.]

MR. ARMSTRONG: More seriously, this is excellent work and I think a topic that is important for us to learn more about and find the right ways to apply to our policy work. But I have to say I was a little bit confused about what we are -- what the problem is we're trying to solve. Is this about disparities? And shared decision making or activation is one way of solving a disparities problem we have in the Medicare program? Or is disparities just one potential symptom, improved management of disparities a symptom of advancing patient engagement and activation? And so I think we kind of have to decide that, unless we already know the answer to that question. From reading the material, I think you could go both ways on it.

My point of view would be -- and we might not all agree on this -- that I'm not convinced this would be the best way to deal with a disparities issue. But I think talking about patient engagement is important, but I also think, to the point, Jon, you were just making, patient engagement isn't a set of tools. It's not a training program. To me, it's a feature or characteristic of how a health system is organized. And for an organization like the one I work at where shared decision making is, in fact,

something we've invested a lot in, I would just say it is just a relatively small component part of an overall set of system features that are designed to engage our patients actively as participants and owners in their health, whether it's interacting with their provider or it's deciding whether they're going to eat good food.

And so at least for our work here at MedPAC, I do think -- maybe those are two different issues, and we need to deal with them both. But we need to sort through are we really advancing ways of incorporating patient engagement into Medicare through our policy or are we trying to deal with the problem of disparities in the program.

MR. HACKBARTH: Do you want to respond, Joan?

DR. SOKOLOVSKY: I don't know if I want to respond to that.

[Laughter.]

DR. SOKOLOVSKY: I mean, I would say that this was not meant to say this is the focus we should take for shared decision making. But we have been talking about disparities since I've been here. We point them out in every sector. We rarely talk about anything that involves addressing it. So I thought it was worth, since we have been doing -- this

is like my fifth presentation on shared decision making. I thought it was worth taking one of those and using it to say here are some programs that are, in fact, trying to address it.

MR. ARMSTRONG: My own view would be to build on that, but I think this is another case point for why shared decision making and patient engagement is important for us going forward. That's the way I would approach it.

MR. HACKBARTH: So it may just be me, but I feel like we're sort of in a deja vu moment here. It was in the spring of this year that we had your last presentation on shared decision making. Did we actually include a chapter in our report? Now, we didn't. And my recollection of the spring discussion was that there was unanimous agreement that this was an important thing, "this" being that there was an ethical responsibility to engage with patients and especially around, as Jon was saying, where the choices that need to be made are, by definition, preference-sensitive. And there's no clinical right answer. It really turns on patient preferences, and we need to do a better job of helping patients make those decisions. So it's a good thing.

But my recollection of the discussion in the spring was also that we said even though it's a very good thing, what exactly is it that Medicare can do to make it happen? Is it really something that Medicare can effectively promote? And the key part of that conversation, as I remember it, was Scott's report on what a challenge it is to do this even in an organization like Group Health that has physicians and other clinicians that are really committed to the principles, a really organized delivery system and a supportive payment system.

MR. ARMSTRONG: You need a good risk adjustment methodology.

MR. HACKBARTH: Right.

[Laughter.]

MR. HACKBARTH: And so, you know, if it's really difficult, challenging, and took years of work, ongoing work actually, to do it there, are there really payment levers or regulatory levers that Medicare can pull that are going to make this happen in much less structured delivery systems?

And so to me that's sort of where we left it in the spring, and I feel like, you know, we're not taking off from that point, but sort of going back to, oh, this is a

good thing again. And I don't think that's in question. The issue is: What can we do about it?

DR. CHRISTIANSON: So this was many years ago, but some of the early proponents of shared decision making and the use of patient decision aids, when pay for performance was first coming on the scene, were advocating for including a pay-for-performance metric around the use of shared decision aids. So if you want to be specific -- now, I don't know where that went, and I don't know if anybody has ever done that. So, I mean, I'm just remembering reading some of the early literature on that and remembering that that was something that they were pushing for, obviously having a strong self-interest, you know, in seeing that happen.

MR. HACKBARTH: I don't want to respond and have a comeback like, oh, you know, I have all the answers and all that, but my -- I think we talked a little bit about that in the spring. And so what does that entail? That entails Medicare prescribing that, A, here are appropriate, high-quality materials, because the materials vary a lot in their content and quality; and, B, it's not a matter of just throwing materials at patients. The whole idea is engaging

with patients, which is very soft and difficult -- not soft. It's difficult to measure from a distance. And so if you really want an effective pay-for-performance system, I think it's very challenging to do.

I'm not trying to throw cold water on this, but I don't want to just have the same discussion we had in the spring. I want to figure out is there something that we can do with the tools that we have available. So I'll be quiet and, Rita, you're next.

DR. REDBERG: Thank you. That was a good lead-in to what I wanted to say, anyway, Glenn. And that was an excellent presentation.

I think this issue is really, really important, and it really goes to the core of medical care and sort of things we can do to improve certainly care for Medicare beneficiaries and all patients, because it really is about patient-centered care and communication. And I do think that sort of patient activation and shared decision making are similar; they're kind of on a continuum of communication with your patient, you know, where patient activation is just getting more communication, and shared decision making usually has a specific decision ahead of you. You know, a

lot of the current aids are around prostate cancer, breast cancer, or on cardiology interventions.

But there has been tremendous resistance, I'm sorry to say, in the medical profession to take it up for a lot of reasons, and I think we could have an input there. You know, for example, one of my colleagues at UCSF tried to do a PCI, a stent decision aid, because that's a very elective decision for most people, whether you want to have medical therapy or stents. But it is clear from the literature on decision aids that they always result in a reduction in procedures. Once patients understand the risks and benefits and that you do equally well with the conservative as well as the more invasive therapy, they tend to opt for a conservative treatment, and that means volume goes down of very lucrative procedures. And so physicians do not embrace these, hospital systems do not embrace these. And, you know, we get back to the problem with we have a fee-for-service system that rewards very generously these procedures, and decision aids are not consistent with these high-volume, very highly reimbursed procedures. And so there's very poor uptake for decision aids.

You know, we tried to do a pilot in California for

a PCI decision aid, and they said, well, you have to pay -- the professional group said you would have to pay cardiologists to make up for the loss in volume of PCI from using this decision aid, which I said, "Well, that implies that you're doing a lot of PCIs that patients would not opt to have," which is kind of the unwritten thing. But it didn't go anywhere. And I think we really do -- I mean, we've talked a lot about changing reimbursement, but you really have to have a lot better communication and better -- it's really also changing medical culture and just talking to patients.

You know, I think the stories George told still go on today. I have lots of patients I see every week, and I say, you know, "You have a scar. What surgery did you have?" "I don't know." "Why did you have it?" "I don't know. The doctor said I needed the surgery."

You know, I think that we still have tremendous room for improvement on doctor-patient communication. And, you know, some of those, I'm not saying they weren't necessary surgeries, but there's definitely a gap between what patients would like to know and what they do know, and a lot of trust in physicians, which is great, but -- so I

think that shared decision making programs are really important in going that, and that, again, we really have to kind of change our reimbursement, because continuing to pay very highly for procedures is not encouraging the shared decision making.

And just the last thing I wanted to say is we really have to define sort of what the goals are. In these studies that were cited, you know, you could have lots of different goals, like do you just want patients to say they felt better about the visit, you know, should they feel better about their decision, or should their actual outcomes be different? You know, you can look at what were their choices, how did they do after having -- and all of those are important, but I think they're all sort of different goals.

MR. HACKBARTH: Jon, is it on -- [off microphone]?

DR. CHRISTIANSON: Yeah, exactly. So a lot of the support for -- and the way that shared -- patient decision aids get in the hands of people is not through providers. It's through self-insured employers who buy access to shared decision aids. So some of this happens despite, you know, the fact that providers might resist the use of them.

They're out there and sort of being used.

And with respect to the measurement issue, I think if we knew that patients should choose one thing rather than another, the case for having a shared decision process would be a little weaker. So I don't think we can be prescriptive about saying it worked if they chose not to do surgery or if they chose to do this. I think the reason that the metric is usually how happy are you after the fact with your decision is that that's exactly what those decision aids are trying to accomplish.

DR. REDBERG: That's true, but patients can be very happy after having chosen unnecessary surgeries.

DR. CHRISTIANSON: Of course [off microphone].

MR. KUHN: Glenn, picking up on your thought about kind of what do we do next, let me ask if -- I know -- I think it was back in 2010, the Assistant Secretary for Health laid out an initiative which they called the National Action Plan to Improve Health Literacy. So they laid out this major strategy, all these action steps and these strategies to kind of move forward with a major health literacy effort. Is there anything that was part of that report or anything they've done in the last two or three

years that could be actionable that we could look at to build on to help support the Medicare program. That would be my one question. And I don't know if you're familiar with that report, but we could go back and look at it and see.

And then the second thing, picking up a little bit on Jon's point -- I was thinking about that -- I, too was thinking about others out there. So is there anything like a Khan Academy that's generating shared decision making tools that are up on the website free for everybody to kind of access and use?

DR. REDBERG: Foundation for Medical Decision Making?

PARTICIPANT: They're not open-source though.

MS. SMALLEY: I don't think they're free.

MR. KUHN: But I was thinking like the Khan Academy where everything is just kind of out there available for anybody to access whenever they want.

DR. SOKOLOVSKY: Mayo Clinic has a set of decision aids that are available for anyone. They're very different -- it's a very interesting, different kind of model. They're meant to be used by the physician with the patient

during the encounter. For example, if you're treating a patient with diabetes, there are set of seven cards for seven different medications you could be taking, and the physician asks the patient sort of, "What's the most important thing to you about controlling your diabetes?" And if you say one thing, you move to a particular card, and then there's a list -- and including cost -- to try to figure out what should be prescribed that would be patient centered. And those are available.

DR. REDBERG: I think Victor Montori, an endocrinologist at Mayo Clinic, has done a lot of that work, and it's very nice because he's getting back to health literacy. They actually have pictures on a lot of them, and it shows you like 100 people, and then they color them. If you take this drug, you know, five of them -- and they color them in red -- will have this side effect, and two of you will avoid this other adverse -- and so because it -- health literacy is a big issue for everyone, even certainly for uneducated people but even for educated people to try to explain, you know, because typically most drugs that we prescribe will benefit maybe 5 out of 100 people taking them, and people always assume -- and we don't explain it

well enough -- that, no, it's really just 5 out of those 100, and the rest won't make a difference. And so the Mayo Clinic -- and it is available -- uses those circles and different colors to try to explain the number needed to treat concept.

MR. KUHN: And so then the other kind of question on that, that information be available, whether it's through Mayor or a Khan Academy-like thing somewhere in the future, is -- Rita made an interesting point about most folks, when they go through this, will choose the more conservative decision. But is it also possible, as this information continues to generate, that some of the different folks could put together videos or decision aid tools, like drug companies, device companies, that could actually induce more utilization in different ways. And so it kind of depends how it's all skewed and how the data is presented where you can generate other kinds of results that would choose a higher-priced drug because they think it's more efficacy, things like that. So is that going on out there as well?

DR. REDBERG: I think it's called direct-to-consumer advertising.

DR. SOKOLOVSKY: But beyond that, I think Herb is

exactly right, that some drug companies and device companies are partnering with other firms to produce these kinds of decision aids, and as things stand right now, there's no certification process that says this is objective, current information.

MR. HACKBARTH: I've been sort of experimenting with a less structured round two.

DR. COOMBS: I noticed.

MR. HACKBARTH: But right now we're going to a rigid -- we're going to get through, and so let's just proceed with Alice and get through --

DR. COOMBS: This is one day that I wish I was over there. I'll be brief.

First of all, I think that the shared decision making makes a difference if it's titrated with not so much as -- and I hate to use this, I hope it's not offensive -- as a "soft outcome." How shared decision making links up with other kinds of outcome data I think is really important.

For instance, limb-salvage surgery is one of those things that, you know what? You can have a bypass, and you can save a limb. You can have a different outcome in terms

of the patient's longevity versus having an immediate amputation. There's so many stories, literature that supports this notion that blacks and Hispanics do not get the same kind of aggressive interventions when it comes to things that are protective, such as CABG surgery. I mean, the data is very compelling.

So on one hand, we're talking about shared decision making as more of in the office kind of thing, but I think of shared decision making on a whole -- when it comes to the surgical perturbations that are made to make a difference in outcome.

There's one specific thing that I can remember. In 2006, my brother had a stroke, and I'm in the ICU, and you should be able to get tPA and make a big difference in a patient's course with a non-hemorrhagic stroke. That wasn't offered to him because there was no neurologist on call, and it wasn't even discussed.

So when we talk about shared decision making, I think it's good for us to tie it to an outcome, because what happens is there are these paternalistic defaults that are kind of done by the provider, and it has a lot to do with both sides of the equation in terms of the cultural

competency of the provider. And I think that the Commission has actually looked at all of these things, and physician awareness is really an important part of health disparities and health care disparities.

I think, you know, going forward, it would be good for us to look at that. The Office of Minority Health has a monogram, and I think that that's a wealth of information that some of those concepts can be used. But I'd like to work with you off-line, if possible. But I think that I'd like to talk more, but I'm going to be disciplined.

DR. CHERNEW: So, my enthusiasm for shared decision making is tempered only by my trepidation over policies that reach deeply into the processes of care. I think the operational details of defining what qualifies for the right process and who did it and all of those things end up adding a sort of administrative overhead layer that may eat away all the potential gains from it.

So, I do think there are ways to go forward. I know CMMI has several -- at least one, I think two, demonstrations on shared decision making going forward that they control a lot of these details. So I do think it's an important issue and I do think there's a way of going

forward, but I think the challenge is, as Glenn said before, finding the right policy, and I'm skeptical of many obvious ones.

DR. BAICKER: Yeah, I agree. This is a wonderful opportunity, but one that we and the program are hard pressed to drive without risking the kind of micromanagement that often backfires. So, that leaves us in a little bit of a conundrum.

But, I very much agreed with Scott's rejiggering of the way we think about disparities and shared decision making in that I think our goal is to improve the number of patients who get the care that's actually the care they want, that aligns with their preferences, with their tolerance for various side effects, all those other things, and we want to reduce disparities in people not getting what they want by ensuring that everybody gets the right care for him or her and that if there's a gap in that based on race, ethnicity, income, education, we want to raise the bottom. We want to target the people who are not getting the care that's right for them.

Now, it might be that if everybody got his or her preferred care, there would be disparities along some of

those dimensions, differences in what people ended up getting, because it might be that people of different backgrounds, living in different places, prefer different things. And that's not a problem as long as they all have access to the full range and get what's right.

So, I would hate to target the outcome as we want everyone to get the same care, and if there's a difference in the rate at which patients are getting procedures that have -- where there are legitimate differences that might be driven by preferences, that's not the right thing to target.

There are clearly exceptions. There is nobody -- there are very few people who could rationally prefer to have their blood sugar out of control. There are some things where we know the right answer is everybody should be moving in this direction. But a lot of the shared decision making aids, which I know are just a subset, focus on cases where different patients may correctly, based on their preferences, choose different things. And so let's just keep that in mind, that the goal is to focus on -- to give people the care that's right for them, which isn't necessarily the same care.

DR. NAYLOR: I may have mentioned this before.

Tuesday of this week, the IOM released its most recent study, committee report, on cancer and its intersection with aging. It's all about achieving higher quality cancer care. And the first recommendation among ten is about the critical need to promote patient engagement. There were also recommendations, and I think CMS and others were part of the set of recommended activities around needing to really become actively engaged.

Another recommendation was around the critical role of advanced care planning. We also had a paper published this week which is a review of all the systematic reviews on patient engagement, which I'm going to send, too.

But I would say that in terms of the opportunity here, it is a tremendous opportunity for the Commission to begin to think about, because we talk in every session about beneficiary engagement and what does that mean, and usually, how that's defined is a deliberate and consistent set of actions on the part of clinicians, the clinical teams, health care organizations, to put patients at the center of care and to very involve them.

It's not just shared decision making. I mean, it is literally a conceptualization that, foundationally, is

built on health literacy, and we have not -- the IOM report earlier pointed out how many deficits we have in creating literacy and particularly for lower-income minority populations. And it moves its way all the way through accountability. So you come to informed decision making where relevant shared decision making accountability.

In terms of policy, I think we should be promoting as a Commission quality metrics or measures that really do acknowledge as outcomes that people say their care is aligned with their preferences, needs, and values.

In terms of payment, we know from evidence that aides alone do very little, that it is only aides when used by -- supported by counseling, the time and investment in making people go through a process of understanding. We don't have the support for innovative workforce models that include community health workers or others that could play a major role, and so maybe supporting demonstrations that help us to understand how we can get a society right now that is not very engaged, sometimes doesn't want to be engaged, to become more informed members.

There are tremendous barriers associated with aging, the unique needs of aged people who are cognitively

impaired and need to rely on others for support. Then where does engagement end, and I don't think it ends with that patient. It maybe involves a family caregiver.

So my own view is I think it's a great opportunity for us to begin to think about turning it around so that the beneficiary is at the center of it all.

DR. HOADLEY: Yeah. Earlier in this round, I think there were a couple of questions raised about what exactly is the policy problem that we're trying to address here, or perhaps in other words, why are we even talking about this, and it seemed to me -- in fact, this is what my notes were as I read the materials -- there's a very direct question that would seem to put this squarely in the middle of our bullseye and that is the question of should Medicare pay for this activity?

There are payment questions. If the general answer is yes, then you have the detailed questions of how, how much, to whom, through what mechanism. But I was curious as I read through this report, particularly, about how do we pay for this? A number of people have said that it is an essential part of the activity to have clinician time. It is not just a booklet. It is time.

And then, I think, Glenn, it's perhaps in your comments, you used the phrase "payment levers," and then earlier there was a comment about quality metrics in P4P programs that would reflect the use of this. But it seemed to me that those are sort of indirect pathways where we could also talk direct pathways. For clinician pays, spends 30 minutes with, engaged with a patient in shared decision making, should that not be a billable service? Those seem to be things we can debate.

Now, if prior to my time on the Commission these were debated and settled, then that's an issue. But that struck me as the answer to a question of, why are we talking about this?

MS. UCCELLO: When I was reading through this, which was excellent, I was thinking about, well, what are the barriers to implementation? And from Scott, you hear about, well, some just cultural issues. Rita brought up some payment system issues. But are there other -- and I don't know the answer to this, but are there other barriers that Medicare can help kind of address, whether they are, you know, payment, if it's a money issue, if it's a resource issue, who is going to be doing this, those kind of things.

But thinking about this as what are the barriers to adoption to this as part of a system.

MR. BUTLER: So, we obviously in the title, "Patient Engagement and Health Care Disparities," have acknowledged that we don't do either one very well as presented, despite the fact you have some wonderful examples. So I'm more encouraged or more interested in the impact Medicare can have on the disparity side as a deeper dive versus the patient engagement and shared decision, if I had to pick between which of the two.

I first want to ask a dumb question, because -- and somebody can correct me, maybe Herb or somebody quickly. We just had to complete as part of the Accountable Care Organization a Community Health Needs Assessment. Is that a Medicare -- it's technically a Medicare requirement?

MR. KUHN: I think that's an IRS requirement.

MR. BUTLER: Okay. Right. So, it was just to protect our tax-exempt status, among other things. I know it does that, but I -- hopefully. But, okay. So --

[Laughter.]

MR. BUTLER: So, alarmingly -- I mean, it's not that we don't look at this, but our primary care service

area has 67 percent obesity, doubling of diabetes in the last ten years. You're 50 percent more likely to die from breast cancer if you're an African American woman. That's disparities. That's the upstream. And so when we look at our own -- and we are required to have a plan around what we're going to do about some of these things to justify our tax-exempt status and move forward, and they're the right questions.

So our medical school has a block by block, literally, in the Hispanic community around diabetes. They have, whether it's health fairs or involvement in churches and engagement at, actually, the level that people want to be engaged at. And, obviously, this exercise enters way upstream at the point of the interaction of the care that's being provided. So I have a hard time doing this without that bigger context because, actually, most of our programs of engagement, as I said, including our training ones, are more focused on really engaging in the community at that front-end level and what to do as opposed to in a physician's office.

And so I think if we just dropped it in without that context, people would say, you think that you're

addressing disparities? You missed the boat. So that would -- I don't know what that means for Medicare program policy, but I think that that's a little bit of a backlash we might get if we entered it the way we've got it now.

DR. HOADLEY: I just want to say, thank you for this chapter, but I think all my comments have been well covered around the table already.

DR. SAMITT: You know, I also want to separate the notion of disparities from the other critical issue, which is shared decision making and patient engagement to drive appropriate utilization patterns. And I, frankly, have to say, I don't think there is more that we should do from a policy perspective in this regard. As I listen to the debate, it really underscores the imperative for an alternative payment methodology here.

To Rita's point, if there are providers that are saying, "I'm not going to do shared decision making or patient engagement because it's diminishing some of my future revenues," then we've got the incentives misaligned. I'd be curious to know, from my world, we can't do shared decision making fast enough. It's not about an unwillingness to adopt it. In the world of value,

capitation, shared savings, it's one of the first things that we want to do.

So, I would say, let's not micromanage, to Michael's point, shared decision making. Let's encourage systems to focus on population health and doing the right thing by the patients, and shared decision making should be one of the top things on the list that organizations will come to.

From a disparity standpoint, I would say the same is true. We should be measuring disparities. Shared decision making and patient engagement is one tool to really diminish disparities, but let's measure disparities and encourage the absence of them to health systems, not micromanaging key process elements to it.

MR. HACKBARTH: Okay. So, the title of the presentation was "Patient Engagement and Disparities," and a piece of good news is there's at least some early sort of tentative evidence that, in fact, that if we work -- improve our patient engagement, that it may help with disparities, but more work needs to be done on that. It sounds like it's still quite an early, tentative finding.

We've had several comments here that these are

both important subjects in their own right and maybe need to be considered separately as opposed to one piece. I want to, for right now, focus on patient engagement, not because it's more important than disparities but because this is the second time we've talked about patient engagement in the last, like, three meetings, and I want to figure out where we're going, if we're going anywhere at all, before we use still more time and resources on it.

Now, Mary and Dave mentioned, I think, two pretty concrete ways that Medicare might contribute to better patient engagement. Mary said, you know, as part of our assessment of performance, this is one of the things that we should be measuring and rewarding or penalizing.

Now, as Bill Hall pointed out at the beginning, there are, in fact, in our CAHPS instruments questions that at least begin to touch on how well is the physician-patient or clinician-patient communication working from the patient's perspective. It may well be that there's a huge opportunity to improve that assessment, but that's really not MedPAC's work. There are organizations that are responsible for improving the CAHPS assessment tools, and it's, as you well know, a very specialized field that I

don't think we can add a whole lot to. But we could say that we think this is a really important part of performance assessment.

A second issue that Mary touched on and then Dave sort of also hit was, well, shouldn't people be paid for doing this activity if it's important? Now, Kevin, correct me if I'm wrong about this, but the way it works right now in the professional fee schedule is that counseling is a factor within some of the codes and you can get a higher payment for counseling intensity, but there are not separate codes for counseling, is that correct?

DR. HAYES: [Off microphone.] Yes, that is correct. What we're talking about here is evaluation and management services, and so an example of that, of course, would be office visits. And so we have, within office visits, we have a potential for five different levels of office visits, depending upon -- normally, the movement from one level to another is dependent upon three factors, the history that's taken, the physical exam, and the complexity of medical decision making. However, there is an exception to that, which is that if most of the service involves counseling of one sort or another, then it's possible to

move up that scale depending upon the amount of time spent on these counseling activities.

MR. HACKBARTH: My vague recollection is that, in fact, the system has been moving more and more of the E&M activity is at the high end of the scale, right? It's sort of been shifting that way over time.

DR. HAYES: Yes. Yes. What we just don't know is whether that shift has been due to more counseling or whether it's due to the other way of reporting on these visits.

MR. HACKBARTH: So, the question would be, is this mechanism sufficient or do we need to break out of it and say there are completely separate codes for patient engagement counseling --

DR. NAYLOR: So I -- I'll go first. I believe, as others have articulated, that we should be focused on outcomes, which is to say that people are health literate, that people are able to make informed decisions, that we have -- you know, so I am not interested in adding codes. That would not be my recommendation. But I would say that we -- I would hope that we would pursue this as a chapter that would help people to understand the complexity of

patient engagement, that health literacy is a responsibility of the Medicare program in the sense of we should be paying for care that acknowledges how critically important it is for people to be engaged, to be literate, to be informed, and the challenges associated with that, that we may need to be supporting innovative workforce models and new competencies among the emerging workforce in order for this to happen.

I totally do not believe that we should be processing this out, but I think we need to be very explicit that this is a big challenge for an increasingly diverse Medicare population.

MR. HACKBARTH: Yeah. So, let me put that in my words. I think we're sort of headed in a similar direction, but I do want to emphasize that in the paper, there was this focus on training, that people aren't born necessarily with the skills to do this and certainly our health professions education hasn't always focused on this as a necessary skill, and there's some interesting work, it sounds like, going on to teach medical students and others how to be more proficient.

But what resonated with me, Mary, in your comment

is let's not reward the process but rather the outcome, and the critical outcome we're assessing here is does the patient believe that the communication was effective, they knew their options, and that's where we ought to focus our policy attention.

DR. NAYLOR: I agree, and there might be other kinds of measures, so let me just -- and I'll say one more. For example, there was a systematic review that looked at people that were engaged in a process of engagement who were able to get more timely access to services that they needed to avoid more costly. I mean, so the evidence is pretty interesting in terms of what could be better adherence, improved efficiency and effectiveness if we support people being able to understand what their opportunities and options and so on are.

MR. HACKBARTH: Yeah. Yeah. I have one other thought that I was trying to blurt out, Alice, but I've lost it momentarily, so why don't you go ahead and I'll --

DR. COOMBS: So, I want to not be too simplistic about this, and one thing that Kate said earlier was the hemoglobin A1C and how it's measured and we have some gold standards about what's -- how things are done best. And

there's also this area where you would discuss options for therapeutic interventions. For instance, you show a video to a family to say, this is what your loved one is going to be exposed to in the ICU if they're intubated. Then the family can make a more educated decision. However, you have to be careful about shared decision making because it's colored by the person who's talking about the options for therapeutic interventions.

So I think it's not as simplistic as just outcomes alone, and that's the only point I want to make, and that there are a lot of moving plates at one time. So if you just say just outcomes alone -- when I said outcome, I mean, looking at a population and saying, you have the potential to have these therapeutic interventions, but yet your outcomes are so disparate compared to the general population.

MR. HACKBARTH: Just to be clear, I wasn't referring -- when I used the term "outcome," I wasn't referring to the clinical outcome of the care, which, as you say, can be variable based on various things. I was talking about the outcome of the communication with the patient. Does the patient feel like they understood their choices and

was a decision made that they felt comfortable with?

DR. COOMBS: So what I'm saying is that a patient and a culturally competent -- -incompetent provider on one side can be faced with some choices that are not necessarily fair choices, is what I'm saying.

MR. HACKBARTH: Okay. Yeah, I agree with that.

DR. CHERNEW: So, first, let me say I agree with Mary and what I think Craig said, which is I'm opposed broadly to either adding more codes or finding some new way to pay something separate.

In spirit, I like the basic notion of measuring outcomes one way or another. I think one thing I took from what Bill said in the very beginning is part of the problem is, often, people are shooting for two-tenths of a percent on whether you thought you were excellently informed or just very good, very well informed, and there's differences.

So I guess what I would say in terms of going forward is knowing something explicitly about what -- how good the measurement is, what are the pitfalls of that, would be useful of knowing if there's other strategies, and thinking about even additional ways, which is CMS -- like, right now, CMS is doing it, not through the provider system.

They have their own programs that they're contracting for separately. So knowing if any of those things might be valuable would be useful for me to know and for us to understand.

MR. HACKBARTH: And here, you're talking about the measurement of patient engagement --

DR. CHERNEW: Yeah. So, the measurement of patient engagement. How good is it? Is it meaningful able to discriminate between people? And then how well are some of these programs -- separately, how well are some of these programs that CMMI are doing or contracting for outside of the delivery system, separately, do those look successful? Are they things that should be promoted? Maybe we don't need to know that because they'll do them if they seem to think they're successful. But I would be interested in knowing if those things that are being done outside of the delivery system are useful.

MR. HACKBARTH: And so I don't disagree with any of that. But my question, as always, is going to be, is this an activity that's high yield for MedPAC, given our limited staff resources and time together.

I think we could actually make an important

contribution if we said simply what we were talking about. Look, Medicare's role in this isn't huge. It's very important to do, but Medicare has limited levers to pull. The lever we think that ought to be pulled is rewarding effective performance in patient engagement, not prescribing process, not rewarding activities. It's the outcome that Medicare should focus on. Exactly how to measure that outcome is really not the Commission's expertise, but that's where we think the activity should be focused.

The reason I think that could be an important contribution is that this is really important stuff and everybody seems to be talking about it and saying, well, we ought to do more, and none of us disagrees with that. That's what we talked about in the spring. Our question, though, is what should Medicare do, and if we can just put a point on that and say, Medicare's role is X, not Y and Z, I think that can be a contribution.

One last comment and then we'll have a few other things. I think one reason this was on the agenda at this meeting was that at our July session, there was a fair amount of discussion about what a challenging environment this is for Medicare beneficiaries. Part of it is on the

clinical side and the patient engagement and how they get the care they want and need.

But another part of it is on the insurance side, where there's this proliferation of new acronyms and new things and they've got to make really complicated choices, and if they don't understand the choices or they feel like the choices are being jammed down their throats, it will spawn a backlash that we all want to avoid. And there, Medicare's in the insurance business. We're not in the clinical business.

Our biggest responsibility in terms of patient education is on the insurance side, and we can't spend all of our time talking about shared clinical decision making and then say, oh, we don't have time to do the insurance side, which is really our responsibility. And so I would like to see us spend more time trying to see how the insurance decisions look from the beneficiary perspective and what can we do to work with them on that.

Okay. I'm finished talking now. Others will have a few reactions, and then we'll need to move on. I have Scott, Peter, Craig.

MR. ARMSTRONG: Okay. So, just I wanted to affirm

where you were heading in this conversation around not creating some kind of payment structure for shared decision making conversations. I don't think we want to go there.

I think, in many ways, this conversation just put a bright light on the broader discussion we're having about, I think, why is it that my organization makes money by sitting down and having these conversations? It's the overall construct. And so we're just -- that's the frustration we're experiencing.

But one other point before we give up on this is that I think it's possible that some kind of special payment for this kind of conversation may have uniquely big impact around end-of-life decisions and that I would be -- I don't know that much about it, but I would be reluctant to give up on that. And if that is maybe some required component part of a bundle or something like that, I think that might be a uniquely financially-driven opportunity for us to apply this in a way we're trying to avoid getting specific about.

MR. BUTLER: So, just quickly, again, I think our discussion this summer was more about who's the trusted agent, who's the general contractor, who's the broker if it's an insurance plan, who's guiding the care above and

beyond just is the prostate surgery needed or not. I think that's the other part of our dilemma. I don't think that makes answering your question easier, but I think it is in that context that we kind of were really enthusiastic about finding ways to relate in this complicated environment to the beneficiary.

DR. SAMITT: The one thing that I would add is, you know, if we're going to go in the direction of encouraging favorable patient engagement measures of some sort, not at the process level but at the outcomes level, we can't forget the role of putting forth supportive tools and guidance on how to exactly do that. I mean, I think, again, with my own organization's experience, Scott's experience aside, this is not a proven science yet. There aren't really good examples of how to do this well.

And so the question is, is what role does Medicare play in helping to identify or highlight or promote best practices and to bring forward the tools so that to link to the incentives, there's a method that provider systems can really focus on and adopt. And I don't know whether Medicare ever goes there, CMS ever goes there, but I think that that, you know, when you link incentives with tools,

the implementation is much more accelerated.

MR. HACKBARTH: [Off microphone.] Other people?

MR. GEORGE MILLER: Yes. I'd just like to add that I agree that we should not pay for shared decision making, but I am struck with the comments that both Alice and Rita made, which are real life experiences dealing with the disparity issue. And while I agree with Mary about outcomes, the current system does not work well in a broad sense for minorities in many different ways. I think Alice quoted some statistics and Peter.

The problem, from my perspective, is of not only competencies, but willingness to do the right thing. Now, I don't know how you put a price on that or how you direct that, but if you look at outcomes and if folks are in plans where the outcomes are not -- are very clear, because there's enough evidence, at least in my view, on disparities, very well documented, and if they're being paid by Medicare dollars, whether an MA plan or a health plan, there should be some disincentives not to have favorable outcomes. I don't know how to do that, but I think we need to address it.

But I believe that shared decision making and

other things are tools and everyone should avail themselves of tools, but the Joint Commission has a requirement for competencies, that you must be able to communicate with all levels of folks that you take care of, then I think this is one that we should also at least talk about having some type of requirement that that is part of Medicare, that you have to be competent, be able to communicate.

And again, I am struck by -- and I don't mean to make a big issue of this -- I am struck by that we list the problems of communication, but we list the problems of the patient versus a large majority of the problem, at least in my view and listening to my colleagues around the country when I was in the hospital business, and particularly ASCs. ASCs do not see minority populations. They don't see them. We've got quantified documented evidence that they don't see minority populations in large numbers. That's a problem with me and I think this lends itself to the issue I'm describing.

MR. HACKBARTH: [Off microphone.] We need to move on for today, but Mike's not here.

DR. MARK MILLER: Where is Mike?

[Laughter.]

MR. HACKBARTH: I'm responsible for watching out for Mike. Okay. Thank you.

DR. MARK MILLER: [Off microphone.] -- the guy who said that.

MR. HACKBARTH: Okay. So, thank you, Katelyn and Joan, for the presentation, and we'll put together the pieces here and come back with a proposed plan of action. I think I'm a little closer in my own mind, but you may reject it completely when we get there.

So, our final session today is on Part D exceptions and appeals. This is enough to warm the heart of a lawyer.

[Laughter.]

MR. HACKBARTH: I've been waiting all day for exceptions and appeals.

[Laughter.]

DR. SOKOLOVSKY: Still here. Still me. Today, we're going to look at an area of Part D that's unfamiliar to most of us, the exceptions and appeals process. As you'll see, there are many levels of appeals, but only limited data are available. So, our analysis is limited to the appeals adjudicated by an independent review entity in

contract to CMS and to data on grievances supplied by CMS.

Beneficiaries continue to be satisfied with Part D. Many plans participate, and premiums have remained relatively stable. So why are we looking at exceptions and appeals, many of you asked, I'm sure.

[Laughter.]

DR. SOKOLOVSKY: A number of reasons. When the Commission recommended changes in the low-income cost sharing for Part D, it noted that it was important to have a well functioning appeals process to make sure that access to needed medication was not impeded. We found, in fact, that there's very little public information on this issue. However, CMS audits showed that the lowest performance among plan sponsors is in the area of coverage determination appeals and grievances. So we set out to see what we could find.

First, we'll quickly go over some of the key concepts. Then we'll examine the perspective of beneficiaries, physicians, and beneficiary counselors and we'll analyze the available data to see how the process is working and present our key findings.

Okay. There are a lot of terms on this slide and

you'll be happy to know that I'm not going to go over them all, although we'd be happy to discuss them on question. But I do want to point out some key terms.

The exceptions process is invoked when a beneficiary needs a prescribed drug that is not on their plan's formulary or the copayment is much higher than they expected. If their physician supports medical necessity of the patient getting that particular drug, the beneficiary may ask the plan for an exception to the formulary to get the drug. The plan makes a coverage determination, meaning they decide whether the reason given warrants an exception. If the plan refuses, the beneficiary can appeal the decision. Then, if the beneficiary exhausts the plan's internal appeals mechanism, they can ask for a reconsideration by an external review entity, and Shinobu is going to present an analysis of the data provided by that entity.

Grievances are other kinds of complaints by beneficiaries about their plan, and Lauren is going to present an analysis of the data on grievances.

If you found all of these terms confusing, you're not alone. We conducted 12 beneficiary focus groups, eight

physician focus groups, and 17 interviews with beneficiary counselors. Most of them were unaware of how the exceptions and appeals process worked and did not distinguish between the different levels of appeals.

Beneficiaries were generally satisfied with the drug benefit and the majority didn't know that they could appeal a plan's decision. However, when we asked focus group participants whether they'd ever gone to the pharmacy to pick up a prescription and found that it was either not covered by their plan or the copayment was much higher than they expected, at least a few beneficiaries in every focus group could point to situations where they faced one or both of these situations.

Their actions varied. Some just did without the drug, while others worked with their pharmacist, who contacted the physician to get coverage for the drug. If they could afford it, some patients paid out of pocket.

In most groups, at least one person had made use of the exceptions and appeals process. Particularly, some of the younger beneficiaries with disabilities who use many medications seemed to be most familiar with their appeals rights. Results were mixed among those who had used the

process.

Looking at what the physician perspective, appeals, exceptions, and prior authorizations all require physician intervention and physicians often express considerable frustration over coverage denials or prior authorization requests. They did make the point that some plans were much harder to deal with than others. In each group, physicians could point to at least one plan with processes that they found particularly burdensome.

One talked about a situation where a patient's chronic condition was under control with a particular medication and they had to change it to something else. The other option was to speak with the plan. But as one physician remarked, "Your nurse may be on the phone for upwards of 30 minutes" -- there's no dedicated line, they have to get on the regular customer service line -- to get the prior authorization. And a lot of companies want to speak to the doctor directly and doctors don't have time for that.

Counselors' involvement with the medication appeals and exceptions differed across organizations. They reported that they sometimes assist beneficiaries who have

difficulty getting coverage for their drugs, but the majority said that actually going through the appeals process is a rarity and things are usually resolved before that step.

Counselors saw the exceptions and appeals process as a last option. If a beneficiary had a problem accessing their drugs, counselors would try to help them switch plans, particularly if they were receiving the low-income subsidy and have the ability to switch plans each month. If they are not eligible to switch outside of the open season, counselors often direct beneficiaries to manufacturers' assistance programs or encourage them to ask their physicians for samples to cover them temporarily. Overall, counselors try to steer beneficiaries from plans that impose any restrictions on the drugs that they're currently taking.

Now, Shinobu is going to take you through the appeals process.

MS. SUZUKI: As Joan mentioned earlier, there are multiple levels to the appeals process, but the data we have is from the second level of the appeals process where the review of the case is moved from plans to the external review entity. In a few minutes, I'll be showing you how

the number of appeals that reach this stage compare to those observed under Medicare Advantage or MA.

One thing that I highlighted in the paper is that unlike the MA's appeals process, a coverage request that is denied by a plan at the first level of appeals is not automatically forwarded by the plan to the IRE, or the external review entity. Rather, the enrollee or the prescriber must take the initiative to submit the appeal.

To understand how the exceptions and appeals process is working under Part D, we talked to beneficiaries and physicians, which Joan has talked about, and we also looked at data. CMS's audit in 2012 found that plans were struggling the most with Part D's coverage determination appeals and grievances.

Examples of the kinds of issues that were identified include failure to make coverage determinations within a specified time frame; failure to notify the beneficiaries or their prescribers of their coverage decisions; and not making sufficient effort to gain additional information they need to make an appropriate clinical decision.

One interesting outcome of this audit is that

there has been a jump in the number of appeals in 2013. The number of cases for the first six months of 2013 has already exceeded the total number of cases for 2012. A large portion of the increase is attributable to two of the plan sponsors that were audited by CMS in 2012.

Here are some key findings from the analysis of the Part D appeals data. The number of cases that reached the IRE has ranged from about 11,000 to slightly over 20,000 cases between 2006 and 2013. That translates to less than one case per 1,000 in any given year, which is a much lower rate compared to MA, where the number of cases have ranged from three to eight cases per 1,000.

We found that the share of appeals that are sent to the IRE because plans fail to make a coverage decision in a timely manner has generally been decreasing.

We have also seen an increase in the share of appeals that are upheld by the IRE, meaning that the external reviewer agreed with plans' coverage decisions. We have also found a wide variation across plans in the share of cases that are upheld by the reviewer. For example, even though a typical plan had between 70 to 80 percent of their cases upheld by the IRE, in about a quarter of plans, less

than half of the cases were upheld. That means for these plans, the reviewer disagreed with plans' coverage decisions and reversed those decisions in over 50 percent of the cases.

Finally, about a third to 40 percent of appeals are dismissed in any given year. Often, the dismissals are due to technical reasons, such as not filing the appeal within the specified time frame or lacking a required document.

In 2013, a policy change removed the requirement to use an official form to designate an authorized representative. Based on the data for the first six months of 2013, that change appears to have reduced the number of appeals that are dismissed for technical reasons.

Although we identified aspects of Part D's exceptions and appeals process that appears to have improved over time as well as areas where further improvements may be necessary. It is not clear what the right level of appeals is for Part D.

On the one hand, the lower appeals rate compared with MA may reflect differences in the nature of the services provided under Part D compared with MA. Rather

than go through the exceptions and appeals process, enrolles may find alternative medications or switch to a plan that covers the medications they need.

On the other hand, the low appeals rate may reflect a lack of transparency in the appeals process or excessive administrative burdens imposed on enrollees and prescribers that discourage them from submitting an appeal. An automatic escalation to the next level of appeals may remove some of the administrative burden on the enrollees and prescribers who wish to appeal the coverage decision by plans.

Finally, although we did not find many plans that fit this description, a plan with a large number of appeals and a large number of cases that are reversed by the IRE may signal a problem with the exceptions and appeals process and is one of the elements that CMS uses to rate plans.

In the next slide, I'm going to switch to talking about a different appeals process that deals with Part D's late enrollment penalty. As you recall, enrollment in Part D is voluntary. However, if you do not enroll in Part D during your initial enrollment period, you are charged a late enrollment penalty. The penalty is based on the number

of months a person goes without Part D coverage. The exception is if the person had a coverage that's comparable to the standard benefit under Part D. That's called creditable coverage.

For a person who had initially been eligible in 2006 with their initial eligibility period ending in December of that year, the penalty to enroll in a plan this year would have been over $20 per month. This penalty is permanent and it rises with the increase in the base beneficiary premium.

For individuals enrolling in Part D outside of the initial eligibility period, plans have to determine whether they will be subject to the late enrollment penalty. To do this, plans will often ask beneficiaries to submit documents showing that they had comparable drug coverage. In every year since 2007, the number of appeals related to the penalty has exceeded the number of coverage-related appeals received by the external review entity.

The majority of the cases are reversed by the IRE, meaning that they should not have been charged the penalty. The high reversal rates observed for the LEP-related appeals suggest that the process used by plans to verify creditable

coverage status may not be effective in identifying enrollees' prior drug coverage. In addition, given that those enrolling in Part D outside of the initial eligibility period is likely to be a small share of those newly enrolling in Part D, the number of cases observed suggests that this problem is affecting a significant portion of those people.

We are also concerned that the resolution of the cases where the penalty is incorrectly applied may be delayed by low awareness among the enrollees about the penalty, and there may be some enrollees who are paying it when they shouldn't because they don't understand the penalty or are not aware of their appeals rights.

MS. METAYER: We analyzed grievance data from CMS for the years 2007 to 2012. To remind you, a grievance is any complaint or dispute, other than a coverage determination or a late enrollment penalty determination, expressing dissatisfaction with any aspect of plan operations. Grievances are collected for each plan and factor into the STARS plan rating.

We decided to look at grievances since the appeal rate was low. We wanted to see if there is any evidence in

the data of issues relating to coverage determinations. We found that most of the grievances filed have been unrelated to coverage determinations, exceptions, and appeals, and accounted for about three percent of grievances each year. Most grievances filed each year, about 62 percent, related to issues of enrollment, a plan's benefits, or access to a pharmacy.

At a more general level, among plans with 1,000 or more enrollees, grievances per thousand have been fluctuating over time. Grievances have ranged from about 5.6 to 11 per 1,000 enrollees.

For the years 2007 to 2012, we compiled a list of the 20 plans with the highest amount of grievances per 1,000 enrollees. Among these plans, we found that the number of grievances per year was still low and averaged about 25 grievances per 1,000. We found that some plans were among these 20 plans with the highest number of grievances for multiple years. Enrollment averaged about 15,000 enrollees and 82 percent were MAPDs.

The plans that continue to have a high number of grievances for multiple years may suggest a lack of improvement in quality or plan operations among these plans.

On the other hand, plans with very few grievances, particularly if it persists over time, may indicate a low aware awareness about the grievance process among their enrollees.

In summary, while beneficiaries continue to be satisfied with Part D, most are unaware of how the exceptions and appeals process works and many physicians find the process frustrating. CMS's program compliance audits, Part D appeals data, potential issues with the process used by plans to verify an enrollee's prior drug coverage status, and grievance data shows improvements in some areas and potential issues in others.

Commissioners may wish to discuss the potential implications of these findings on aspects of coverage determinations, exceptions and appeals, and grievances that may need improvement. Additionally, there may be issues the Commission would like to pursue further, such as the process used to determine which enrollees are subject to the Part D late enrollment penalty.

Thank you.

MR. HACKBARTH: Thank you. Clarifying questions? Bill and then George.

MR. GRADISON: You mentioned the substantial increase in appeals this year, particularly coverage determination issues, and seemed to tie it to the audit of two of the companies. What's the connection? I didn't get that. I would have thought that an audit might have had just the opposite effect.

MS. SUZUKI: So, the big increase was seen in the auto-forwarded appeals, which is the kinds of appeals that should have been forwarded to the external entity because the plan did not process it within the specified time frame, and that showed up in the first half of 2013.

MR. GRADISON: [Off microphone.]

MS. SUZUKI: We think so. I haven't verified that.

DR. BAICKER: So, I want to talk with you offline to better understand the metrics in the audits. But to understand this potential causal connection, do we know how CMS chose which plans to audit?

MS. SUZUKI: I think they used a couple different criteria. They want to be representative. There might have been performance, past performance type things to make sure that they capture those plans. The audit is conducted at

the sponsor level and so they chose about 40 sponsors, which covered about 70 percent of enrollees.

MR. HACKBARTH: George, and then Rita.

MR. GEORGE MILLER: Do you have demographic information on those who were audited? I'm sorry, of the beneficiaries that were included in the audit? And, number two, do you have a sense if there is regional variation that is similar to what we've seen in other sectors as far as the number of those who had grievances? I should have said not audited, but grievances for the demographic information.

MS. METAYER: We do have LIS information for the grievances and we may be able to do it by region if we look at where the plans are operating, but we haven't done that yet.

MR. GEORGE MILLER: Okay. Do you follow what I'm saying about the number of grievances, do they mirror or follow the regional variation, especially the high utilized areas of the country for medical care? Do we see more grievances from that area of the country, as well? Does it parallel or mirror that?

MS. METAYER: We haven't done that yet, so we don't know --

MR. GEORGE MILLER: Okay.

MS. METAYER: -- but we could look into it.

DR. MARK MILLER: Also, I think your question, even though you said "audit," you corrected yourself. I think he's asking the same question for what we know about coverage determination appeals. And so I think our answer is we'll look at what we can do by demographics and geography. Everybody squared away? Okay.

DR. REDBERG: Is it publicly available for each plan what their rate is of grievances and exceptions?

MS. SUZUKI: I'm not sure how public it is. There are some public information. When CMS produces plan STAR rating, and three of the 18 elements that plans get rated on are related to coverage -- the appeals and grievances. And so that information is available at the, I would say, plan level, but it's actually at the contract -- well, no, actually, that is at the plan level.

DR. MARK MILLER: So, for example, I think one of the things that goes into the STAR rating is the percentage of appeals overturned, right?

MS. SUZUKI: The other way, the upheld.

DR. MARK MILLER: Okay. Upheld. Sorry. So

there's things like that. But I think one take-away from this is whether that's sufficient or whether, in the end, we're beginning to think that maybe an indicator would be lots of appeals and lots of overturned, which means the plan was overruled, would be an indication that you might have a problem.

MR. HACKBARTH: [Off microphone.] Other clarifying questions? Jack, what do you make of this?

DR. HOADLEY: Well, I'm really glad to have this, because this is really a pretty important area, even though it feels like it's way obscured down in the weeds. But it's an important area of concern for beneficiaries, or maybe more accurately said, their advocates, since a lot of beneficiaries aren't that familiar with this whole part of the process, and it's an area where we really have very little information. So even the little bits that we've started to get here, I think, move us forward.

And I think it's important because, you know, really, in a sense, one of the logics in the design of Part D was providing, first of all, a privately-based benefit, but doing it in a way that gave plans quite a bit of flexibility on their formulary designs and their use of

tiers and their use of prior authorization and all these kinds of things.

One of the things that was always stated, every time you'd say, well, the plans have that flexibility, but everybody always has the right to get the drug they need on exception provided it meets whatever kinds of standards. And so we've never been able to say, and we really still can't say, is that promise fulfilled? Are people really able to get exceptions?

And I think, you know, we've been asking on several presentations today, what are the policy levers? Why are we doing this from a policy lever perspective? And I think already in some of the things we've heard here, there are issues like, well, maybe we need better notices going to beneficiaries so they understand their rights.

On this one that I was not aware of was an issue, this late enrollment penalty issue, the idea that people don't understand that penalty and what they need to do to, perhaps for many people who really don't need to pay it, to justify that they don't need to pay it, so is that a question of notice? Is that a question of really changing the process by which that verification is done so it's not

in the plans' hands or whatever? I don't know what the right answer is on a lot of these questions.

The value of the audits, we have some initial evidence that there's -- first of all, they're finding problems and that there's some, perhaps, sentinel effect by doing the audits, and then getting into what are some of the issues that the audits raise that are being done and seeing whether there are ways to address some of those.

And another one on the kind of the focus group findings is the burden that's placed on the physician and the difference that I think you pointed out -- it certainly was in the paper -- that whereas a lot of services in Part A and Part B it's a matter of whether the provider is ultimately going to get paid, so they have their own justification for going out and helping to pursue the appeal, in this case, the physician is the one who has most of the burden for saying, oh, this is a justified drug. It's not the physician whose payment is at stake for this. In fact, it's adding work to them that they aren't getting paid for and it's the manufacturer or the plan where the payment issue really resides. So there are some questions. Are there ways to address that physician burden, or what's

the standard of proof on that?

And then the one sort of technical issue of this issue of auto-forwarding some of the adverse decisions, which is done in Part C but not in Part D, was there a reason for that? Should that be changed?

So I think there are a bunch of policy things that we could do. We may not be ready to figure out which are the right ones or even to know what the answers are yet.

I've got a lot of sort of specific comments that I won't take the group's time on, but it did strike me there was a couple of larger sort of analytical things that could be put on the table. One is that CMS has been collecting since the start of the program on a quarterly basis a set of measures from the plans. It requires the plans to submit these with fairly specific and well designed criteria. And they are things like how many exceptions were requested by your enrollees? How many of those were granted? So that's just one example of a number of measures.

These are reported by the plans to CMS every quarter. They are not made public. I have said in the past they should be made public and it appears -- you know, we looked into this at one point -- it appears that CMS is

using them for various kinds of internal things, and one of the reasons that may be cited, or two reasons that may be cited for not putting these public is, one, these are plan reported and so there's a question of are they reported consistently from one plan to another, although in some cases, like the exception request counts, it's a pretty well defined measure. And the other is that they're -- and this was raised in the presentation -- there is really no right answer. I mean, is it -- are you better to have more exceptions or are you better to have fewer exceptions? You can see tracks by which you get the good results either way. But it's still useful, I think, to have a sense of how much this goes on. So that's something that I think, pushing on CMS to make those data publicly available.

And the other thing, and this is not a small request and so I don't know whether it's a good use of time to do this, but there are things that could be done with the claims data because there are -- you can look at the claims data, for example, for off-formulary drugs that are, in fact, paid for by a given plan, and the only way you can get to that result is do it under an exception. So there's no flag on the claims data that says "exception," but you can

deduce from the data that that had to be done on an exception. So there's some way to look at these -- there's obviously not a way to look at exceptions requested and not granted. There's not a way to look at drugs people paid for out of pocket because they weren't allowed. And, again, this will be also quite hard to do, but it is possible to look at drugs that are provided at a lower tier with a lower cost sharing than the stated tier for that drug. Those are not easy analytical tasks, but --

DR. MARK MILLER: I just want to be clear. Those analyses would require passing claims data through some separate quantified version of the formulary and the rules for the formulary for every plan.

DR. HOADLEY: It turns out that the public -- the researcher-available files of the claims data actually have some additional processing that isn't provided in the files that CMS gives to you guys.

DR. MARK MILLER: [Off microphone.] Then Shinobu is going to leave --

DR. HOADLEY: Right.

[Laughter.]

DR. HOADLEY: I'm being careful how I -- but -- so

when I get a claims data file to use, I get a flag on each claim of what tier it was on, what its formulary status is, and when it has no tier, the tier is missing, then that is the equivalent of saying it was done by exception. So that actually does exist in the files as they go through RESDAC and the processor.

DR. MARK MILLER: [Off microphone.]

DR. HOADLEY: But even with that, it's not an easy process to go through, and I'll stop at that without going into some of my wittier comments.

[Pause.]

MS. UCCELLO: So, I agreed with most of what Jack said that I could follow.

[Laughter.]

MS. UCCELLO: I agree that the high rate of reversal on the late enrollment penalty is a concern, especially that -- I mean, it seemed like from the mailing material that a lot of people don't even know that they're paying it. I mean, that's a problem. Is there an -- how does the billing come on this? Is there a line item for that or is it just all rolled up into one rate?

MS. SUZUKI: I don't think we know for sure. A

lot of people have their premiums deducted from their Social Security check. But I think plans are required to send the enrollee a letter, a notice, saying that there's a late enrollment penalty that's charged to that person.

DR. MARK MILLER: And we did talk this through with CMS because, actually, this one kind of fell in our lap. We were doing something else and then this kind of popped up. So we talked to CMS about it. And what their take on it was, the beneficiary is being informed. The plan sends a letter. The beneficiary either chooses to ignore it or doesn't understand what's being said and then it automatically goes to the next level and then overturns the plan. And I think you were hitting it, Jack, is there's some communication process there that's not working between the plan and the beneficiary.

MS. UCCELLO: Okay. The other concern that I had was the beneficiary counselors encouraging everyone to enroll in plans without utilization management. The beneficiary counselors, are they mostly for LIS folks or are they for everybody?

DR. SOKOLOVSKY: They're for everyone and their job, as they see it, and probably accurately so, is to

advocate for the beneficiary. So if a beneficiary has a prescription, the presumption is they need it. It was disturbing to me to realize that not a single one -- you know, you've got 20 drugs. It's going to be hard to find a plan. Nobody thought to say anything about that. But, again, that wasn't -- that's not how they -- they're not clinical people and that's not how they --

MS. UCCELLO: Well, does that -- you know, it's not necessarily right for the person to get all of these drugs. First of all, they may have a higher premium to begin with, and they might be getting things that they're not -- that's not appropriate. So, I don't know what to do about that, but it's a problem.

DR. BAICKER: So, I think this is a really important discussion even beyond this important silo that we're talking about, because so many of the policies we talk about, we say, well, sure, as long as there's a robust exception process. When it's limits to home health care or outpatient therapy or all sorts of things, we think there are always going to be exceptions and we need a streamlined way to identify those to be able to implement a policy that does a better job of cutting out inappropriate use.

So I think this is great, and the low-income determination -- or, sorry, the late enrollment determination, one thing I found interesting about the acronym page was how many of them were repeated.

[Laughter.]

DR. BAICKER: But the late enrollment penalty is clearly very important, but a little more specific to this. So I wanted to focus for a second on the coverage determination bucket, and all of this vocabulary was very new to me, too. And I thought, well, our goal is to figure out how often the plans are not doing the right thing, without being as judgmental as that sounded like I was being, and there are many different steps along the way and it sounded like some of them are much more readily observable than others. So I wanted to point to the ones that are important that I think were missing and maybe think about places we could get tangential information that might be suggestive about those things that are hard to observe.

So, there's a whole group of people who should be requesting a redetermination who aren't because they don't know their rights to do that. They don't realize that they have an option. And that, we just don't observe directly,

so I'm going to come back to that as one to think about indirect proxies.

Then there are the people who request a redetermination and it's deemed, well, you should have got that drug. That was a mistake. Maybe that's not the plan doing the wrong thing. Maybe that's just the way the process should be working, and we have some measures of that, although not really complete. It sounds like we have some ideas about that.

The next step is they are denied the redetermination and they appeal and on appeal it's determined, you should have gotten that drug. So the process failed earlier on, and that's where we focused and we have -- we're not sure whether we want that to be higher or lower based on the steps that have to -- you want people to know they have the right to appeal, so you want the bucket of people who are using the process that's available to them to be high if they need it, but you want the people who need the process to be low, and that creates this tension about what the right rate is.

So all of that uncertainty about what we think should be happening in a well performing, well behaving plan

makes me wonder if we could look at some correlates or proxies that might give us a sense. And one that Jack mentioned was looking at the tiers of utilization. Look at utilization patterns as way to think, well, if people are roughly similar once we adjust for their health risks in the big bundle of drugs that we think they might be taking and we see exceptions in some plans where they're not getting those medications, that would be one proxy.

Another would be satisfaction with their plans, with all the difficulties that those are fraught with. We could have some sense of whether people feel like the process is working for them, or total drug utilization, or consequences of people not having their drugs optimized in terms of other health care that they're using. All that's very squishy, and I realize none of it would be definitive and none of it would let us flag particular plans where we think that's a problem.

And that's why I wanted to know more about the CMS audit process, to know whether if they were going into plans that had demonstrated aberrantly low appeals rates in one year and then they reverted to trend. That would be a different story from if they went into plans that were

consistently low that suddenly jumped up a year afterwards. That would be a more persuasive piece of evidence.

So that audit process seems like a better way to flag individual-level problems, or plan-level problems. But maybe some of these sort of proxy analyses of what the basket of goods utilized by people in different plans, how that correlates to some of the parts of the appeals process that we can observe might give us a sense of how well the system is working to fill in the pieces we don't observe directly.

DR. HOADLEY: Just a quick follow-up. The quarterly data that I referred to that CMS collects from the plans do, in fact, collect some of the specific things that you're referring to as unobservable. They're unobservable right now. And so that's really part of my point in trying to get hold of those data, that plans are counting them, CMS is collecting quarterly accounts, so --

DR. BAICKER: So we just need to get Shinobu on that.

[Off record discussion.]

MR. KUHN: Just one quick question on the late enrollment penalty. Like others, those numbers are big. So

if the plan rules that there is a penalty for late enrollment, there wasn't creditable coverage, whatever the case may be, does that benefit of that additional penalty, does that go to the Treasury Department? Does it go to the plan? Who is the recipient of those funds?

MS. SUZUKI: It does not go to the plan. It basically goes into the Treasury.

MR. KUHN: Okay. Thank you.

DR. MARK MILLER: And, actually, I shouldn't have joked around immediately following that comment. In order for her -- which she and I tend to do -- but in order for her to get her hands on that data -- and we also have to find out the data that you have, so don't you leave after this -- it may be the Commission does need to say something in order to give some lift to this concept. Let's just bang away. Give us the data. They might do it, but it might take a little lift from this group.

DR. BAICKER: We really, really need that data and they should give it to us right now.

DR. MARK MILLER: Right. Right.

MR. HACKBARTH: That will work.

DR. MARK MILLER: We'll work on the language, but

--

[Laughter.]

DR. REDBERG: Are most of the appeals people that wanted brand name drugs and got generics, because the plans are structured so they have drugs of every type, right, in every plan?

MS. SUZUKI: We don't have the details of what the actual appeals were, but usually -- so there were two that we discussed with exceptions. One was something that's not on the formulary, or not on the formulary because you have to go through the utilization management before you get that drug. Or you can appeal the cost sharing on a non-preferred brand drug. So non-preferred brand name drugs usually have a high cost sharing, roughly $90, on average, and preferred tier, $45, $50. So you could appeal cost sharing on the non-preferred tier to be lowered to the preferred brand name drug level.

DR. HOADLEY: [Off microphone.] So it will be both brands.

DR. REDBERG: I guess just one other -- it's really a clarifying question, but I didn't -- you had said in March of 2012, the Commission noted that LIS enrollees

were mostly using, or tended to fill more costly brand name, and then there were changes in the cost sharing. Do you know if there have been changes in that trend since -- it was on page one of the mailing material.

MS. SUZUKI: So, there was no change in the cost sharing structure for LIS. That was a recommendation.

DR. REDBERG: I see. But it didn't happen.

MS. SUZUKI: Right.

MR. ARMSTRONG: Just a couple of things. First, I wanted to go kind of a ways back. Joan, you started this out by declaring there are a lot of things going really well, but I was trying to remind myself, why did we do this analysis again? Was it we stumbled on the fact that we haven't evaluated this process in a while when we were looking at this issue of the LIS, or were there some other reasons why we pursued this?

DR. SOKOLOVSKY: The main reason was because of our LIS recommendations and we heard a lot from the community about what would happen to people who needed drugs if we did this, if they really needed the drugs, and a number of the Commissioners who supported the recommendation were worried about that. And so we said in the text that we

needed to make sure that they could get drugs through the exceptions and appeals process, and so we thought -- we waited a year, but we thought we ought to look at it, and that was the main reason. And then we, of course, discovered how little information there was about it. And the late enrollment penalty, we completely stumbled into.

MR. ARMSTRONG: Okay. Good. So, looking at the questions up here, I would say, you know, and Jack, I think, was very articulate about -- the answer to the first question, I would say, is yes. There are issues that should be improved.

But I would say no, frankly, to the second question, and maybe I'm just out of touch with this, but it seems like this affects a fairly small number of beneficiaries. It seems like, relative to the grievance or appeals processes for other parts of the Medicare program, this is -- you know, people are triggering the process or getting involved in the process at a much lower rate. The rate of reconciliation through this process is incredibly high and fairly fast.

And then I relate this issue and the use of our resources to the spectrum of other issues in inpatient acute

care or post-acute, hospice, you name it, and it would be very difficult for me to suggest that we haven't sufficiently asked and answered the question.

Are there issues here? Yes. Could it be improved? Yes. Is this as important as a lot of other things for us? I would argue it's not.

DR. CHRISTIANSON: A question for Jack, really. So, if I understood you right, the data on all the stuff we've been talking about are not publicly available at the individual plan level?

DR. HOADLEY: Right.

DR. CHRISTIANSON: Okay. So --

DR. HOADLEY: Except for the ones that are in the STAR ratings --

DR. CHRISTIANSON: Right.

DR. HOADLEY: -- that they alluded to.

DR. CHRISTIANSON: Is there anything else, I mean, is there anything, if you could proclaim one of these measures that should be available to beneficiaries on a year to year basis at the plan level that isn't now that would really be beneficial to them, what would it be, if any of them?

DR. HOADLEY: I'd have to think about any -- I mean, there are about 50 or 60 measures on the list of these what I call the quarterly data. I'd say, the last I looked, maybe a quarter of them relate to the broad area of exceptions and appeals, and I would probably say that -- I mean, some of them are much more routine, you know, some basic quantity measures of things going on in the program that can be measured other ways. But I think the exceptions and appeals is probably at least the domain. Which measure within that domain, I'd have to think about.

DR. CHRISTIANSON: That's partly, I mean, it seems to me like that is something we could do which, if it was reasonable. I mean, I would look for you for suggestions that wouldn't be time or staff intensive and so forth. If it could improve things for beneficiaries, why not require that some of these things -- or at least something that has meaning be available to the general public?

MR. GEORGE MILLER: Just one comment about Jack's comments. I think they were very well stated and I would somewhat tend to agree except for the fact that we are looking at that issue -- looking at this issue and giving it scrutiny may keep some folks honest, that they know we could

be looking. What I'm afraid of, although it's not a large number, we wouldn't want abuse of the situation or for it to get worse. So I think the fact that we at least review it and keep it on the radar screen may mean that some folks may do things right.

DR. MARK MILLER: You know, I don't normally try to push you in one direction or another, but I do think what Scott was saying here a second ago of how much effort to put into more of this, and you could imagine a product of this conversation working like this -- and I think this is also consistent with the exchange between Jon and Jack -- we'll have a chapter in December on what's going on in Part D and then that will go into our March report. You could imagine a text box, some portion of that chapter that says, look, we looked at this. This is what we found, and a summary version of this, and there are a few steps that we could take. The call for releasing the data and reserving the right that, after some people look at that, maybe some of that goes into the STAR rating system, number one.

Number two, I don't want to forget this one, and I've just lost track of what we said in the presentation. There is this intense frustration on the provider side of

trying to get access to the drug plans when these processes are in play. And the notion of simple things, I recall some conversations with you guys, you know, dedicated phone lines, that type of thing, so that people are not hanging on the phone for 20 and 30 minutes. I know this is really small potatoes, but, you know, just a list of things that we could say.

And then, finally, I think there's probably some words we can put around this LEP thing. This is a little bit odd and people may be paying for something that they don't need to pay and there's just a bit of a communication thing there.

So you could imagine just the text box that sort of says, here are three or four things that we think need to be -- to push the agency on. I'm sorry.

DR. BAICKER: So, as one of the culprits in having wildly suggested all sorts of other things that one could do, that point is very well taken and I think suggesting that there are these avenues to explore might be sufficient rather -- the point is well taken that there are a lot of things that might go into this chapter and other chapters and that this might be a fair amount of extra work that's

not really warranted.

DR. MARK MILLER: [Off microphone.] But I also think the other comments you were making, I don't think you quite understood that a bunch of that other data could have laid to rest.

MR. KUHN: I think both Scott and Mark and others have made a good point on this, but also, we've kind of had this conversation in the past, and I think there was one in the spring where we were even tossing around a notion of a de minimis dollar amount before it kind of elevated to the important factor of where we need to kind of be involved. And I understand that and I think Mark's solution is a pretty good one.

But, also, we can't underestimate that we're talking about the cost and quality here, but the access issue is absolutely critical and we keep leaving that out of some of these conversations and that is a bit disturbing. When we were talking one time about a rural issue, I can't begin to tell you how important access is in rural areas with distances people drive.

Mark made an observation here, as did others, you know, if we don't fix these problems, it undermines the

confidence in the system by providers. They lose confidence, and just kind of like the SGR, Glenn has talked about that a lot of times, about if we don't fix that problem, they lose confidence in the system.

But, again, it's the access issue. So I'd hate for us to kind of draw a line, a dollar figure or something else. I think we can address this not in a full-blown report, but let's just be real careful of how cavalier we kind of treat some of these issues, because they might be small, but to a certain set of Medicare beneficiaries, they're absolutely critical. They're life and death situations.

MR. HACKBARTH: Craig, I apologize. Mike just pointed out that I started with Jack and then didn't get all the way around to you. So you will have the last word.

DR. SAMITT: [Off microphone.] It's okay. I pass.

[Laughter.]

MR. HACKBARTH: That's the last word, then, I guess. Okay. Thank you very much.

We will now have our public comment period.

Seeing nobody going to the microphone -- yes,

please.

Please identify yourself and your organization and when the red light comes back on, that signifies the end of your two minutes.

MS. SANDERS: My name is Stacy Sanders and I'm the Federal Policy Director with the Medicare Rights Center.

My organization operates a national help line for people with Medicare and we field about 15,000 calls per year from Medicare beneficiaries, family caregivers, and service providers.

And actually, the second most common call to our help line is for people who are dealing with appeals. They have been denied a service, or they have been denied a prescription drug. And most often, those calls are from people who have left the pharmacy counter without their prescription and they don't know where to turn. They don't know what the process is to ask for an appeal and they really have no good information.

I would just say, you know, from the beneficiary perspective, the appeals process really starts at the pharmacy counter and the plan has, essentially, three opportunities to deny a beneficiary a drug that may be a

medically necessary drug. They are refused at the pharmacy counter, there is the coverage determination, and then the redetermination.

I think we envision an appeals process that's much more manageable for beneficiaries, that has fewer steps, that's more transparent, that provides information about why a drug is being denied at the pharmacy when the person is refused.

And I will say, I think it's also very important to consider that because this process is so tedious and because the burden is fully on the beneficiary to navigate this process, there are many people who do not have the wherewithal to actually begin the appeals process.

So I think the scope of the problem is really in question. I think we can't rely on the data about coverage determinations and redeterminations because the process really does begin at the pharmacy counter when a person is denied a medication. And I think a more streamlined process would not only help beneficiaries, but would also be of a serious benefit to providers.

So thank you.

MR. HACKBARTH: [Off microphone.] Okay, we are

adjourned until 9:00 a.m. tomorrow.

[Whereupon, at 5:02 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 13, 2013.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 13, 2013
9:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

Update on Medicare's ability to innovate on payment and delivery system reforms
– John Richardson, Lauren Metayer 3

CMS financial alignment demonstrations for dual eligible beneficiaries: Status report
– Christine Aguiar, Carlos Zarabozo 73

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P R O C E E D I N G S [9:00 a.m.]

MR. HACKBARTH: Okay. Good morning, everybody. We have two sessions today -- one on Medicare's ability to innovate on payment and delivery reforms, and the second on an update on the dual-eligible demonstration projects. So we're going to begin with CMMI, I think. John?

MR. RICHARDSON: All right. Thank you. Good morning, everybody. In this session staff will update Commissioners on Medicare's new authority to test and deploy innovations in payment policy and health care delivery, which was substantially expanded in 2010.

We also will give a brief overview of the types of models that CMS is testing under this new authority, which are covered much more extensively in your mailing materials.

From among the dozens of projects described in the mailing materials, which, in the interest of full disclosure, I should acknowledge are based substantially on CMS' description of these projects, we will take some time to present more detailed information on six State initiatives where CMS is targeting some of its new innovation funding to work in concert with these states to implement their solutions to several of the issues, such as

episode-based payment and increasing patient engagement, that the Commission has grappled with.

The purpose of this session is to seek your guidance on two things:

First, are there any specific innovation models, either that we present today, that are described in the mailing materials, or that you know about from other sources, that you would like us to keep tabs on in particular?

Staff are already tracking initiatives in their issue areas, such as the shared decision making grants that we discussed yesterday, the bundled payments for care initiative, pioneer ACOs, and the financial alignment initiative for dual eligibles that Christine will talk about in a moment. But we want to know if there are any others that we should keep track of.

Second, we seek your input on issues concerning the process by which CMS and ultimately the Secretary of HHS will implement Medicare's new powers to expand payment and delivery models. Those decisions will involve difficult trade-offs between, on the one hand, policymakers' demand for strong empirical evidence that a model is successful

from a cost and quality standpoint, and on the other hand, policymakers' demands that the pace of the diffusion of innovations in Medicare move much faster than it has in the past. We are interested in your views of how to balance that trade-off.

In early 2010, the Commission examined Medicare's legal authority and administrative processes to test and implement payment and delivery system reforms. The Commission's three key findings were that:

First, funding for Medicare research and demonstration activities was very low relative to the size of the program and not stable from year to year;

That the administrative and regulatory processes for conducting and evaluating demonstrations were too inflexible and time-consuming to meet policymakers' needs for the rapid testing of policy innovations;

And, third, that the demonstration process would be more effective if there were a clearer locus of accountability for deciding what innovations to test and more transparency in the evaluations of demonstrations.

The Congress acted to address many of these issues in the Patient Protection and Affordable Care Act of 2010.

That law authorized the establishment of a Center for Medicare & Medicaid Innovation within CMS; streamlined the process of approving and testing innovation models; authorized a $10 billion multi-year funding stream for the innovation center, which is automatically renewed every decade; and authorized the Secretary to expand payment and delivery system models through the rulemaking process -- that is, without further congressional approval -- if certain cost and quality criteria were met. The act also directed the Secretary to submit a comprehensive report to the Congress on the innovation center's activities at least every two years.

While the new law and CMS' subsequent implementation of the innovation center have started to address many of the issues that plagued the previous Medicare demonstration process, we think some issues bear continued scrutiny.

For instance, we look forward to learning how CMS will evaluate the cost and quality impacts of the dozens of payment and delivery system models that have been launched since 2011, especially in areas where multiple initiatives may be operating at the same time and involving the same

providers.

As the Secretary prepares to exercise her new authority to expand models that meet the cost and quality criteria, we will be closely watching how that process unfolds and how the evaluation process will work and how the perspectives of external stakeholders such as beneficiaries, providers, and private payers will be included?

As I noted in the introduction, all of these questions involve complex trade-offs between transparency, accountability, and the speed with which innovations are diffused throughout the program. We discussed these trade-offs in the 2010 report, and we are interested in your views today of how these competing priorities can and should be balanced.

Now Lauren will give a high-level overview of the innovation center's activity and then present the particularly interesting payment and care delivery innovations being implemented in six states.

MS. METAYER: Currently, the CMMI is testing its innovation models under seven different categories. Participants in each of the models vary from physician group practices, FQHCs, to health plans, to state Medicaid

programs.

The first category, accountable care, includes pioneer ACOs, which David described to you yesterday.

The bundled payments for care improvement category includes bundled payment episodes for acute and post-acute services, as the Commission discussed in the spring.

The primary care transformation category includes the federally qualified health center demonstration as well as other models which seek to increase access to primary care services.

Initiatives focused on the Medicaid and CHIP population are initiatives which are administered by the states but are jointly funded by the federal government and the states.

The initiatives focused on Medicare-Medicaid enrollees category includes the financial alignment demonstration for dual eligibles which Christine and Carlos will present information on later this morning.

Initiatives to speed the adoption of best practices includes, among other models, the community-based care transitions program which aims to reduce readmissions to the hospital, of which the Commission discussed this past

spring.

Lastly, while we would be happy to answer any questions regarding the previous six categories, we would like to focus the remainder of this presentation on the last category: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models.

The models within this category include innovation awards, which are part of the Innovation Challenge CMS launched in November of 2011. Under this challenge, CMS accepted applications from innovators to test new service delivery and payment models for Medicare, Medicaid, and CHIP. Innovation award winners include, among other things, models aimed at reducing unnecessary imaging services and models to prevent readmissions to the hospital. Currently there are 107 different participants in this model, and award totals have varied from $1 to $30 million, totaling $1 billion. The CMMI has recently announced round two of the innovation challenge and will award another $1 billion.

One point to note here is that this is an area where the new CMMI is innovating in a fundamentally different way than CMS used to. Rather than the CMS creating demonstrations to test out across the country in a

top-down approach, this innovation challenge utilizes a ground-up approach where innovation is coming from those in the environment.

We'd now like to turn your attention to another aspect of this innovation category, which are the models run at the state level. These awards are given to the states to help fund state-based models for multiple payers. So far, state models have been given to six states who are currently implementing their models. The CMMI has also given funds to 19 other states who are in the pretesting and design phases of implementation in their states.

The state models seek to address several of the issues the Commission has been interested in. Specifically, in the next few slides we will give examples of the ways in which the state models have addressed the topics of episode-based payment, care coordination, patient engagement, expanding primary care, and disparities.

The states that we will be talking about today are those that have received funding from the CMMI and currently in the implementation phase of the model. These states are Arkansas, Maine, Massachusetts, Minnesota, Vermont, and Oregon.

All of the state models have some aspects of episode-based or alternative payment models. One state, Arkansas, has implemented an episode-based payment model which includes conditions such as upper respiratory infections, ADHD, and colonoscopy. A key issue which the Commission has grappled with is attribution or who is responsible for the episode of care. In Arkansas, they have a designated a principal accountable provider -- or PAP -- for each episode of care. Each PAP's average cost per episode will be calculated. If the average cost is above a certain threshold, the provider will pay a portion of the excess costs. If the PAP average costs are lower than a certain threshold, they are eligible to share in savings with the payer.

The state models also seek to better coordinate care. With its funding, Oregon's model has created coordinated care organizations, or CCOs. CCOs focus on coordinating physical, behavioral, and oral health care. According to Oregon, CCOs differ slightly than ACOs in that they are full risk-bearing entities and the model emphasizes the role of the community. A CCO also operates within a global budget. Within this global budget, CCOs have the

flexibility to institute their own payment and delivery reforms which they think would work best for their members. To ensure that cost savings from CCOs are the result of improved care coordination rather than from withholding care, over time payments to CCOs will be based primarily on performance incentives and not capitation.

Another issue the Commission has been exploring and that the state models have sought to address is patient engagement. The innovation model in Maine will provide a shared decision making training tool to providers in its state. Maine will use its funding to incorporate shared decision making into the practice work flow for all primary care providers in an effort to better engage patients.

Similarly, Vermont is using funds for its innovation model to run a public engagement campaign that promotes preventive services, better information about medical services and testing, and shared decision making between patients and their health care providers. In the spring, the Commission discussed that the best practices of Medicaid-Medicare coordination programs for dual-eligible beneficiaries included the ability to connect beneficiaries to community resources and social supports. In Vermont, to

help connect people to these resources, they have made a web portal with a health risk assessment tool to provide people personalized education materials, community-level resources, and social supports.

One of the critical aspects of all of the state models that has been a focus is the expansion of primary care. Massachusetts' model seeks to transform and expand the role of primary care in its state. To do this, Massachusetts is allowing participating primary care providers to enter into a shared risk and shared savings arrangement. Under this, providers receive risk-adjusted capitated payments for primary care services as well as additional payments based on their quality of care.

Primary care providers may also share in the savings on non-primary care spending. Massachusetts feels that allowing primary care providers to share in these savings is an incentive for them to coordinate those services as well.

Another focus of many state models is reducing disparities, a topic which the Commission discussed yesterday. To address the issue, Minnesota is creating 15 accountable communities for health, or ACHs. ACHs are

accountable for its population's health and have the goal of reducing disparities in its community. ACHs must, among other requirements, include an ACO, demonstrate significant community responsibility, and prioritize care for people with complex conditions and needs. ACHs must also seek to integrate medical care with behavioral and mental health, public health, long-term care, and social services. To measure its improvements in reducing disparities, Minnesota is planning on monitoring its performance of 14 population-based measures which will be tracked by race and ethnicity whenever possible. Measures include, but are not limited to, the percentage of adults with good or excellent health, heart disease mortality, and the percentage of adults with a usual source of care. Minnesota has set its baseline for these measures and has also set targets for the years 2016 and 2020. Minnesota hopes that the integration of all these services will also help to reduce silos in health care.

To recap, this presentation has given you a sense of the innovation that is currently happening at the state level through the innovation center. The mailing materials also included some additional information on other models which are running. We are looking for your guidance on any

issues or models which should be monitored going forward, guidance on any information about the coordination of multiple initiatives from the provider perspective, as well as Commissioner input on ensuring transparency and evaluations and the desire to move and expand models as quickly as possible.

Thank you.

MR. HACKBARTH: Okay. Thank you, Lauren and John. Well done. Do we have any round one clarifying questions?

MR. GEORGE MILLER: Excellent report. Thank you very much for the information.

As you were analyzing the different programs, did any of them deal with dental health? In our organization we're finding that many of our patients have some problems because of dental health, you know, eating and some of the other issues. So any of these demonstrations deal with dental health at all?

MS. METAYER: Yeah, I think a lot of them include a lot of different aspects, and I think Oregon for sure includes the integration of oral health care services. But we can get back to you on any other programs.

MR. RICHARDSON: One other clarification, not

exactly related to that question, but it is that Medicare so far is not participating in any of these programs. The states are very interested in having Medicare be a participant, but by and large, they involve the Medicaid and CHIP populations and in some cases private payers as well. I guess the relationship to your question, why I thought of it, was that it being a Medicaid benefit in many states, that's why it's integrated, but obviously also for the public health aspects of that.

MR. GRADISON: I hope this question won't be viewed as too parochial. I noticed on page 15 of the mailing that my home town of Cincinnati had 31 different initiatives. My interest may be a little more than average since I was mayor of Cincinnati in an earlier life, and I remember very well Mark Twain's comment about Cincinnati. He knew the river cities pretty well. He said, "When the world ends, I want to be in Cincinnati because everything happens there 20 years late."

[Laughter.]

MR. GRADISON: Which I took to be a compliment, to be frank. And it sounds like that has changed completely. But, offline, I would appreciate any additional information

you may have about Cincinnati or the source from which you got that number. And, more specifically, I -- it's sort of a theoretical quantitative that only time will be able to answer, but is it possible that a community of less than 400,000 people could have 31 different initiatives and still be able to evaluate these separately without -- I use a technical word -- the "contamination" -- I don't like that word. It has health -- it has a double meaning. But, anyway, technically, I think it's the right word to describe my concern.

MR. RICHARDSON: We can certainly get you the information about what's going on in Cincinnati, and I think you just put your finger on one of our concerns about places like Cincinnati where there are a lot of projects running at the same time. To the extent that CMS is trying to evaluate and isolate the impact of an intervention, it is going to need to identify a control group as well as a treatment group or have some -- or at a minimum have pre- and post-analyses of what happened. But even in that case, when you've got multiple initiatives, trying to have causality attributed to a particular intervention, we think it is going to be challenging, and we'll see how CMS sorts that

out. That's one of the things we want to follow up with them on.

MR. GRADISON: Can I assume from your response that, in the awarding of these grants, it was all done just on a separate basis without relationship to, let's say, the number of grants in a community and things like that?

MR. RICHARDSON: I don't know that for a fact. Lauren, do you want to weigh in on that?

MS. METAYER: I think they do give consideration to how many other things are running within the city. But just in Chicago, there are 59 different initiatives running, so, I mean, I don't know how much they do that.

MR. GRADISON: Well, there was a time when Cincinnati was bigger than Chicago. That has long since past. Thank you.

DR. NAYLOR: Is there an overall evaluation framework for these, meaning have we -- have a common set of core metrics been defined? One. And, secondly, could you clarify the role of the rapid cycle evaluation team?

MR. RICHARDSON: Let's see. In terms of the metrics, there is a broad framework which is laid out in the law, which is that the evaluation has to find that, on both

cost and quality, the following things happen: costs were not increased, or were decreased but at a minimum were not increased relative to a baseline; and, of course, there's a lot of art that goes into figure out what would have happened in the absence of the intervention. But that's the cost component. Costs didn't increase or were decreased. And quality was either improved or was not worsened.

On the cost side of that, the Chief Actuary at CMS needs to certify that the cost estimate or the cost part of the analysis is sound, you know, basically make a public certification.

As I noted, this is, as far as we can tell from what's in the law, going to be done through the rulemaking process, and so there will be some public process presumably with notice and comment, and by virtue of that process there will be some public scrutiny of what the decisions are.

I don't have very specific answers for you about each project. I do know that certainly for the ones that are more like initiatives and models as opposed to, let's say, the award, the grant awards, there is an evaluation that's being planned for each of those projects. The actuaries are involved in the design of the evaluation. You

know, and there's an evaluation contractor that's similar to the old model that's going to be involved in that. But in terms of the specific criteria for each individual model, I don't have that information.

And then the rapid cycle question, I don't have a lot of information about that either, but we can certainly dig into that for you.

DR. NAYLOR: Thank you.

MR. HACKBARTH: I don't mean for this to sound snarky, but it probably will. I don't see anything rapid about any part of this process, which is sort of my concern with all of this, is that one of the goals, original goals, was to speed the innovation process, and that's what I'm searching for. Consider this a rhetorical question. You don't have to respond to it. But I don't see enough emphasis on speeding the innovation cycle. Lots more activity, lots more money, but I'm looking for more speed.

MR. BUTLER: We've talked previously about CMS' resources and ability to do all their work. I'm clear about what's being funded. I'm not clear about what staff resources are added on, if any, in CMS to be able to do all this work.

MR. RICHARDSON: When they created the innovation center, that was staffed with some new folks from outside CMS, and they also absorbed the old Office of Research Demonstrations and Information. So some of the initiatives that are described in the mailing materials are actually pre-CMMI projects, and the staff that were responsible for that process came over to CMMI. And then when -- Dr. Berwick was heavily involved in the set-up of the innovation center; he created it to bring in new people from outside. For instance, Dr. Mai Pham, who was at the Center for Studying Health System change, is heavily involved in the accountable care organizations, which, as David reminded us yesterday, are also partly in the Center for Medicare, is a Medicare fee-for-service program, but components of it are being done through the innovation center. And I'll have to get back to you with specific details, but as far as the administrative structure goes, there is a physician in charge of each of the broader issue areas into which they've sorted these programs. And I think that was done intentionally to try and make sure that there was a clinical aspect to each of the projects as well.

MR. BUTLER: I'm just trying to get a sense. Are

there 10 people? Are there 100 people? Are there 200 people that --

MR. RICHARDSON: I'll have to get back to you with a specific number.

DR. MARK MILLER: We can give you the specific number. I think the perception is that given the way the funding worked, its stability and the amount, if there are parts of CMS that are struggling, at this point anyway, I don't think there's a big perception that this is where the problem lies. It's more on the appropriated side.

DR. CHERNEW: They've also contracted out with some very good people to help them think through, so even if you knew the number of people that were in the office, they've gotten a lot of outside advice from really top-notch people about how to solve some problems that actually might be unsolvable, but nevertheless, the people that are not solving them are really good.

[Laughter.]

MR. HACKBARTH: So I have a question about the Secretary's authority to extend successful projects. Let's take an example. Let's assume that the bundling -- some facet of the bundling around hospital admissions proves to

be successful. Is the Secretary's authority to say that for all Medicare admissions we are now going to move to this bundle? Or is it that this is no longer a pilot but it's still voluntary, this is a new voluntary option for providers nationally, much like the MSSP program?

MR. RICHARDSON: I'm just looking at the plain language of the statute. She could expand it nationwide through the entire program. And I think that that's one of the key issues that will get litigated one way or the -- you know, either in the formal meaning of that word or through the regulatory process. But, you know, just look at the words in the statute. My interpretation of it is that she could push it out to the entire program, the entire country.

MR. HACKBARTH: Okay.

DR. MARK MILLER: And it would be non-voluntary [off microphone].

MR. RICHARDSON: And it would be -- you know, if you want to participate in Medicare, this is what you're going to do.

MR. HACKBARTH: Yes.

MR. KUHN: Just one other thing in terms of this authority being tested of what they could push out. So, for

example, there are things that are in the statute now. So, for example, market basket update, that's set by Congress. And say a demonstration tested some things but also they thought the payment rate was not right. Does she also have the authority, absent Congress, to adjust payment rates as part of that in the future as well?

MR. RICHARDSON: Yeah, the only restriction is changing the benefits. There was a specific prohibition on, you know, changing the benefits to which beneficiaries are entitled. But as far as payment, the conditions under which services are delivered, I think like a lot of things in the statute, there's flexibility. So, you know, depending on the administration's discretion or aggressiveness -- and I think, you know, that will be balanced by what they try to do and then the response from the legislative branch.

MR. KUHN: And then per your response to Mary's question, the regulations for acting on those have not yet been promulgated or --

MR. RICHARDSON: That's correct.

MR. KUHN: Thank you.

MR. HACKBARTH: Okay. Let's move to round two, and I would urge people to take note of the questions that

Lauren mentioned. One objective for this presentation was just sort of a general update on what's happening with this important part of the program. But a second is: Are there particular models that you want to dig into in further detail, learn more about? Potentially, you know, we could say we want to go off and make recommendations about those independent of what's going on here, so as you formulate your round two comments. Kate, do you want to kick off? You don't? Kate respectfully declines.

DR. BAICKER: I'm saying I'm good for this round [off microphone].

MR. HACKBARTH: Okay.

DR. NERENZ: I'm just curious what your thoughts are about the general approach to evaluation in any of these domains that you wish to speak to.

A little more specifically, I'm thinking that in some of the past CMS programs, there has been a particular concept or model identified, and then it's performed in 10, 15, 20 different locations. And when you evaluate, you draw some conclusions about the performance of the whole as well as the individual ones.

It seems to me in some of these programs there are

a lot of one-off, unique, implemented in one place or in one state programs which, from one perspective, is just fine. I mean, that's sort of consistent with the concept of innovation. That part's okay. But it's a case study for evaluation.

What's your sense of how this is going to play out in terms of drawing broader policy conclusions about this portfolio?

MR. RICHARDSON: That's an easy one.

[Laughter.]

MR. RICHARDSON: Oh, boy. I mean, that's really the nut of the issue. I'm going to give you, you know, a classic Washington answer. I'm going to avoid answering it by talking a lot.

[Laughter.]

MR. HACKBARTH: You don't need to do that [off microphone].

MR. RICHARDSON: Okay. Thank you, Glenn.

DR. NERENZ: A real answer is okay.

MR. RICHARDSON: Well, I mean, I think that that's really the problem that they're going to have in a lot of cases, is this something -- and it's ultimately going to

come down to is this something that we can expand across the program? Is it something we're going to do regionally? You know, Medicare as a national program always has this problem with trying to come up with national policies that reflect the local market idiosyncracies of what they're doing. And you see that playing out in this particular initiative, too, because some of these things are going to tell them, you know, the bundled payment example, you know, maybe it makes sense to bundle some amount of post-acute care up to 30 days afterwards. But in other places, it's going to be, well, you know, we don't have a lot of physician groups here, so how are we going to organize this vast array of small practices that we have? That's not going to be national necessarily.

MR. HACKBARTH: During her presentation I think Lauren used the expression that some of these are top down and some of these are bottom up, the bottom up being in particular the innovation grants. I think the problem that you mentioned is particularly true in the case of the innovation grants, which are almost by definition, you know, the outgrowth of unique local circumstances. It's a challenge, I think.

DR. NERENZ: Well, and just the part of the kind of answer I was looking to explore is that if you structure a demonstration around a big concept and you do it in multiple places, and let's just say it succeeds wildly, there's a fairly straightforward path to making that national policy. You decide that on the basis of all this evidence this is a good thing and you move in that direction.

But in the case of a successful one-off project, the direction might conceivably be just to say this will now be open in the future for any entity or any state who wishes to do it. But now the direction is that Medicare, CMS, is supporting a whole number of different variations and models and what-not as opposed to a more simple, less varied set of options. I'm just curious about how this carries forward.

MR. RICHARDSON: Well, just to pick up on that point, I think part of the diffusion will be if they do some of these one-offs and they come up with a good idea. Say Arkansas thinks episode-based payment is going to work and they have a very diffuse provider network. One of the reasons they wanted to do it is that they don't have a lot of big groups there, and they have a lot of rural providers.

Maybe somebody in Maine or Colorado says, "Oh, that could work here," and that's part of the transparency and diffusion of the ideas, is back out from these local programs into other local areas. They may not turn into national programs necessarily. But one of the functions of the innovation center and one of the reasons I think the Congress wanted to keep the funding stream going is to perpetuate some of these ideas out of the local areas.

DR. NERENZ: Again, I was trying to anticipate back to some of our discussions. Would we be in a position then four or five years from now to say this is a good way for CMS to go in Arkansas, Maine, Wyoming, and Idaho, but not a good way to go elsewhere? We typically have not done that in the past.

DR. NAYLOR: Well, I mean, the other end of that coin is the 59 efforts going on in Chicago or 31 in Cincinnati that, absent a framework that helps you to think about the interactions of those options, these thousands flowers blooming will not, you know -- if you don't have a deliberate set of ways of thinking about not just what did a one-off accomplish but, rather, what are the interactions, that one example you provided of a site that said it's only

because we had both an ACO and a community-based care transition initiative operating simultaneously that we were able to achieve goals.

And so I think that the other end of this is how are we going to know what works or what are the sets of interactions that work, because for many it may not be just one of these. And, of course, all of the evaluation problems that you've outlined in terms of getting a robust comparison group and being able to disentangle, these are real issues, and it seems like going forward we should -- you know, it's not project by project, effort by effort, innovation by innovation. We should have a big-picture framework about how we're going to use the rest of the resources.

DR. BAICKER: So I absolutely agree with all of the emphasis on evaluation, and I think the challenge that you're highlighting is that what works in one area may not work in another -- you both said that -- and the strategy might be here's the set of tools that are available to you, and the way that could in theory be canonized, regulated, is, you know, here are the parameters under which you get flexibility, and that flexibility continues only as long as

you demonstrate results. So the outcomes we care about or the quality of care for beneficiaries, the costs with which that high-quality care is delivered, et cetera, and you can be much more flexible about the inputs into that process if you're well measuring the outputs and say you've got an innovative idea, great, give it a try. But we're yanking the plug if -- pulling the plug if it doesn't meet these endpoints within some reasonable time period to get up and running.

MR. RICHARDSON: Sorry, Kate. Can I just tease out? Would that be an ongoing evaluation process or a one-time? Because that's another issue, you know, you have a model that works, it's national policy, and, you know, you never necessarily come back and evaluate it again. Or you could --

DR. BAICKER: Well, I would think of it as an ongoing thing the same way, you know, it's not like if you get a five-star quality rating you're done.

MR. RICHARDSON: Right.

DR. BAICKER: That keeps getting re-evaluated. So I would think --

MR. RICHARDSON: Or the ACOs have three-year

contracts, so every cycle --

DR. BAICKER: Right, so that I would think that there would be -- you could free yourself up from micromanaging the mechanisms if you were well monitoring deviations from acceptable outcomes.

DR. CHERNEW: I think there's two very different types of interventions going on. One of them is sort of broad, like, say, Arkansas or Oregon, which they're big payment initiatives. And you can envision holding that payment initiative accountable for quality and cost broadly that you could monitor as you normally would.

A lot of these are very micro provider specific things where one organization is doing an intervention on how to get people to comply with medications or how to deal with ER observation days or things that are very micro.

My personal opinion is eventually you're going to pull the funding for those micro things and have to fold those organizations -- if they've learned, great, if others want to emulate them, great -- into a broader accountability framework, which is a different than a broader evaluation framework. I think the innovation center is meant to help organizations learn from each other in part, and whatever

works in different organizations will have to be put into a broader accountability framework, which I think would be useful.

And for that reason, I'm not worried that we know exactly how every little thing worked in all that level of precision.

One of my concerns, though -- and you might want to speak to this -- is the openness of all the evaluations about what's going on in CMMI. How confident are we that the data going in is going to be reported back and others -- I'm not even sure who others are -- will be able to come up with sort of some sense of what went on collectively in that process?

MR. RICHARDSON: I don't know the answer to that. I remember you raising that three years ago when we talked about the old process. I mean, it's still an open question. The evaluations they described as independent evaluations, but, of course, they're contractors to CMS. I think you mean even other external --

DR. CHERNEW: Yeah, but are the contractors allowed to publish them, or do they have to get it approved through the normal channels?

MR. RICHARDSON: I don't know the answer to that, but --

DR. CHERNEW: Is it forced to go through peer review, or is it going to come out in a CMMI report about how well they did, or not?

MR. RICHARDSON: All the statute says about it is that the evaluations have to published in a timely fashion, but there's obviously a lot of details that need to be ironed about that. But that's one of the things we can ask about.

DR. CHERNEW: What you mean by published might be different than what I mean by published.

MR. RICHARDSON: I do not mean peer reviewed. The statute certainly doesn't speak to that.

DR. COOMBS: So you asked the question about which of the projects and demonstrations that -- I'd be interested in specifically the physician-hospital collaboration. And looking at this particular demonstration in terms of coordination of care across settings and the quality initiatives, Kate and I guess your associate wrote an excellent piece on coordinated care and conflict with competition. And in essence, many physicians are trying to

get in an integrated health care delivery system, and under that there's this massive urgency to merge and consolidate health care systems. And I'm wondering if we can learn something specifically about this in terms of gainsharing. Mount Auburn, MACIPA, has been a poster child for collaboration between physicians and hospitals, and they've done very well at this in terms of being able to both bear risk. They also have a more preferable population in terms of patients. And it would be interesting to learn the type of patient demographics that are under the umbrella of this specific system. And going forward, if there are other physician-hospital collaborations, I'd be very interested in -- because I would love to learn from these kind of demonstrations. I think they speak volumes, and because we've always had this competition between physicians and hospitals in terms of one may have more emphasis on building capacitance and the other have more interest in terms of the overhead and the cost of doing business. And I think this is the kind of demonstration that really moves the meter in terms of patient care.

MR. KUHN: Like others, I'm a bit concerned about the number out there and the overlap that we see going on.

I just am really wondering how you're going to have enough evaluation contractors, let alone enough technical expert panels to be able to manage a couple thousand initiatives that are out there right now.

Having said that, I would just say that I remember when I was at CMS and when we launched the Acute Care Episode, or the ACE demo, we looked all across the country of where we could put that demonstration so that it wouldn't overlap with other activities. And ultimately that's why it wound up in Texas and Oklahoma and New Mexico, just a few states where they were eligible for that particular demonstration, because you wanted to make sure that you had the right control and intervention groups to manage that. When you have 50 or so running just in an individual city, I just do worry about the evaluation, how we're really going to learn from this as we go forward.

Having said that, I'm curious. Now that we've got a couple thousand things up and running, have they shut down any since they have been up and running? Or are all of them still going forward?

MR. RICHARDSON: Not that I know of, not that we have -- they moved over, some of the ones that had been

started before under previous laws. In fact, there was -- one of the demonstrations I talked about three years ago, the Medicare coordinated care demonstration was down to one site. It started with 15, I believe.

MR. KUHN: Right.

MR. RICHARDSON: And there was one site left in Pennsylvania, and that recently got another extension. So, you know, it's --

MR. KUHN: Well, and that's--

MR. RICHARDSON: Anyway.

MR. KUHN: And the thing is that I worry that when you've got that many, the ability for an agency to have the proper oversight, whereas the ones that aren't working, whether it's the integrity of the entities that are involved in it or whatever, there might be issues there. And I don't know about that particular one that you talked about, but what I do worry is the perpetuation of these things being reauthorized over and over again, and they almost become then a permanent kind of adjunct kind of one-off part of the program on a go-forward basis. And you could have -- instead of one national program, you have now thousands of little mini program operating around the country under the

guise of demonstrations. And so they've got to have some way to kind of end these things and wind some of these things down.

MR. HACKBARTH: Given your operational experience, Herb, at CMS, could you just sort of take that comment a little bit further? One of the concerns that I have with this approach of so many different models is that I think if these things work and we implement them, there are huge operational implications for the agency --

MR. KUHN: Exactly.

MR. HACKBARTH: -- an agency that's already struggling with an operational budget that is way too small.

MR. KUHN: You're absolutely right, Glenn, and so the question is, if you find -- you've got, again, a couple thousand out there, but even maybe operationalize five of them would be a huge undertaking. There would be major rulemaking. It would be putting together the contractors to manage it, changing with now the Medicare administrative contractors to help manage them. It would be a big undertaking.

So the criteria that they ultimately select the really good ones on a go-forward basis, these things really

have got to be stand-out stars as part of this thing, because you can't put together an apparatus like that for, I would think, just incremental gains. So I still don't know how they're going to do that evaluation process.

MR. HACKBARTH: Yes.

MR. KUHN: One other just comment just on the top dot point up there in terms of specific models of interest in the future. Obviously the ones that deal with coordinated care, bundling the pioneer, shared savings, and even some of the gain-sharing ones I would be interested in us continuing to look at.

MR. HACKBARTH: And so, Rita, before we go to you, I just want to pick up on that last comment and analysis and invite people to react to this. So Alice focused in on gain-sharing. It's Page 13 of the paper. We recommended gain-sharing, I think it was 2008-2009, actually I think the same time as the readmissions penalty and the bundling pilot. That was all apiece.

And part of the appeal of physician hospital gain-sharing to us at that point was, this was something relatively easy to do, at least I think -- I'm willing to be proven wrong on that -- as opposed to major changes in both

payment and organization of care delivery. This may be relatively low-hanging fruit, but here we are six years later and very little has been done on this.

I know there was some litigation about whether this could be done in New Jersey. I'm with Alice. You know, I'd like to learn more about this, and potentially this is something that we could recommend that could be done quickly. I use that term advisedly. So I invite others to react to that and see if there's some interest in pushing on that. Rita.

DR. REDBERG: Thanks for that excellent report. I think -- I just want to highlight, I think it's really important to be testing these care and delivery models. We have a huge health care system and it's very hard to innovate, obviously, nationally. And, you know, I am concerned about resources.

Just to sort of put it in context, you know, when you think about how much Medicare spends on health care delivery and we're now talking about ways that we could increase value and increase the quality of patient care, I mean, we spend billions, for example, on a lot of medical devices, you know, things that haven't been tested nearly

like we were talking about here. They haven't been evaluated, haven't been looked at, you know, metal-on-metal hip implants, we have lots of knees and hips, and Medicare routinely spends billions without asking for data and looking at it and going back and saying, How's this working? How is it working here? How is it working in this population?

And so, I think the $2 billion is probably not nearly enough, and especially in context of what we spend overall in the health care to look at it. I was really struck that they got almost 3,000 applications, and how to choose just a hundred? I mean, I think the idea that there are so many groups and organizations that are interested in innovating in care and delivery is fantastic and that I wish they had more money to fund more of them and that we could look at them.

I do think, of course, it's really important for us to look at them, but I think it's really important for us to keep in mind that it's a great innovator and really, I hope, can help us improve the quality of care as well as value for Medicare beneficiaries by things we're going to learn from CMMI, and that we need to still realize that as

they're learning and growing, they're still probably better ahead of a lot of our more traditional Medicare that we spend a lot more money on.

So having said that, I'm just curious, the Secretary had to report to Congress last year, and do we know anything about what that report said?

MR. RICHARDSON: It was a very, I guess you could say, preliminary report since the CMMI hadn't been up and running very long. It was a deadline for the initial report that was probably one of the ones that made more sense when the bill was drafted, and then by the time it's enacted, you know, there wasn't a lot of time between when that happened and when the report was due.

I expect the next one to be significantly more informative. It was essentially a recitation of, these are the things that we're doing, did not address the issues that we're grappling with here, which is how evaluations are going to work, whether the expansions would be program-wide or local and those kinds of things.

I think some of that will only get -- I'm sorry -- only get figured out or, again, litigated -- I don't necessarily mean that in the legal sense -- but as the

Secretary starts to make actual decisions about those things, they may not telegraph much of that ahead of time.

DR. REDBERG: My other question, Section 30.21 allowed a waiver of, whatever it was, Title 18, the fee-for-service requirement. Did any of the innovation models -- because it seemed like most of them were built within the traditional Medicare fee-for-service model, which, of course, those give them some limitations in terms of what they can do because -- were any of them taking advantage of that or not using a fee-for-service model?

MR. RICHARDSON: I'll have to get back to you on that in terms of the explicit payment. For example, the bundled payment for care initiative which they're actually doing under the Innovation Center involves a miniature episode payment to the entities that have agreed to participate in that. So that's different than the traditional fee-for-service approach. And I'll have to see if there are some other examples where they're diverging from that.

MR. ARMSTRONG: Two general points. First, it's hard for me to be too specific about where I would focus in on these initiatives. Frankly, I would pull out MEDPAC's

agenda and look at the blue and purple items and ask, This is what we think is important of this world of initiatives going on, which speak to those items that we care about and we're going to focus on and how can they help us be smarter about that as we go forward?

The second point I would make would be, I think, just to the anxiety about this being, you know, big and crazy and unmanaged and a lot going on, and this anxiety about, well, how is it that we're contributors to a process of reforming our industry? Can we do the best job of capitalizing on what we learn and translating it into, you know, faster improvement?

Well, I don't know the answer to that, but I would just say, I think it's actually much bigger than we've even identified. We're just talking about investments through either the Federal Government or the Medicare program in innovations, which I would argue is, frankly, a fairly small percentage of the innovation that's unfolding.

And the fast work and the work that I know I spend much of my time focused on is not supported by any of these initiatives. It's innovation that's unfolding in the local markets because people think, organizations think that it's

going to achieve better results.

So I would just say that I wish there was a grand plan, you know, where someone knows how Federal reforms through the ACA, CMMI grants, the work we do here around payment for the Medicare program, innovations sponsored at local markets or elsewhere, and all the change taking place just through the private sector, all kind of contributed their part to a big plan.

If someone knows kind of how that's supposed to work, I'd love to hear it. I just kind of trust that it will and that here at MedPAC we need to just be attentive to doing the best job we can of contributing in our way to something that's kind of big.

DR. CHRISTIANSON: One sort of general comment or contribution to the discussion about the messiness of all of this for evaluation, I think what we haven't talked about is, it's very messy for implementation, too, in the sense that, at least my experience with some of these groups that have the innovation grants, is that the same people are involved in multiple grants.

So I worry about the capabilities on the ground of actually doing what people are saying they're going to do.

So part of the evaluation is going to have to be a very close look at the fidelity, by that I mean is what's getting done actually what was promised. You know, we don't want to -- it would be a shame if the people evaluated what people said they were going to do instead of what they actually did. So that's a general comment.

In terms of the discussion points, the models that are most intriguing to me are the ones that try to -- in Oregon's case, coordinate, in Minnesota's case, maybe manage care or cost, what the grants are saying are silos, long-term care, dental health, behavioral health, and acute care, and I think our delivery system is not currently structured to do that very well, and I think there are big potential gains for this.

Although I would ask Lauren and John, these are Medicaid program efforts and so, is one of the things we should be thinking about in answering your question, you know, is there a lot to be learned from Medicare while looking at these things, and I guess I would just ask you how that should rank in terms of our -- that consideration should rank in terms of our recommendations to you?

MR. RICHARDSON: I think that's definitely on the

table as a high priority, and bearing in mind that if something is skewed toward a particular part of the Medicaid population, like pregnant women or children, it may not be as applicable. But if there are things that could be applicable to a broader patient population, definitely.

DR. CHRISTIANSON: Do you see the Oregon and Minnesota cross-silo efforts as being directly applicable to Medicare? I guess being direct about my question.

MR. RICHARDSON: I think that they -- yes, I think they should be.

MS. METAYER: And I think a lot of the states -- their plan is for it to be applicable to Medicare in the long term. I think Oregon's is going to move to dual eligibles, the CCO, soon.

DR. MARK MILLER: And that's what I was going to also add here. In the next session, they'll talk -- Christine will talk about the dual eligibles demonstrations, but she will also -- there are a couple of states, Minnesota is one of them, where they're moving to a dual eligible approach on a different platform than the demonstration. It's on a D-SNP basis.

And so, what I would say in response to that

comment is, I think we should be thinking about the state innovations in two or three ways. One is, if they have something going and they have Medicare -- sorry -- Medicaid in the private sector and we there's -- and again, given the lack of information and all the rest of it, but if for some reason we thought there was a good reason to get even more lift by Medicare's involvement in it, that's something that we could speak to.

Then I think there's John's point, if I understand it, which is, if there's something from the Medicaid side -- and part of the reason that I wanted the state stuff put in here, and this is just my own failing -- is, I wasn't paying attention to what was going on out in the states and sort of felt like there's some interesting things going on out there and I wanted to bring it in front.

If there's something to learn from it, I thought the Arkansas episode thing was very interesting. We've been tying ourselves -- and I mean we in Washington 20 years type of thing -- tying ourselves in knots with this concept and those guys just kind of did it. That was kind of interesting to me.

And then I think the third thing is, there are

populations that overlap specifically in Medicare, the duals and the social services with medical. We have been talking about, we will be talking about and it comes up to bat next session.

MR. GRADISON: When Medicare and Medicaid were legislated in 1965, the compromise, basically, was that Medicaid would operate on a Federal/state basis, but with the states not necessarily doing things exactly in the same way. Medicare was intended to be a uniform national program. I don't think either one has exactly worked out that way.

In the case of Medicaid, there's been pulling and hauling in terms of what the states should be required to do, and I think that it's very interesting to me to watch the deal-making, which I think is taking place as CMS attempts to negotiate with states that are hesitant about taking advantage of the expansion opportunities that the ACA provides in the Medicaid program.

In other words, those programs, the extension of those programs may not look the same in every state. My first awareness of the fact that Medicare wasn't exactly uniform is, a kind of pedestrian example, was finding out

when I was involved in the legislative side of these things that colostomy bags, the frequency of changing them varied from one part of the country to another. What's that all about in the national program?

And as time has gone by, I've become more and more aware of not only the fact that there are variations, but that that's a healthy sign, in spite of the intentions that there were initially. My own personal view is that this is way too big and complicated a country and there are too many variations to really stake the future of the program on making everything or even attempting to make everything uniform.

Or to say it in a more specific way, I think part of our job in the interest of the program is to make the Medicare world a safer diversity. I mention that because I think what's going on here through these experiments is fully consistent with that idea. And therefore, I don't look upon these so much as a question of should it be imposed everywhere? If something seems workable, it perhaps then should be made available everywhere, but not necessarily as a requirement.

That isn't necessarily the automatic way some

folks think about Medicare. So I just raise it here sort of as something that's in the back of my mind we might want to think about as a general principle one way or the other in the future.

DR. HALL: I'm wondering if there's something that we can do as Commissioner's that might help reap the benefit of this, irrespective of whether we think the program is coordinated or not. Two billion dollars being put into research on health care reform is nothing to wink our eye about. There are a lot of good people around the country who are doing good things, and as a group, we probably know a lot of those people, and also we probably know some that are perhaps not doing the best work.

Not that I'm suggesting we do more work, but I think we should keep our eye on this program, but also not just in terms of evaluating what staff are doing, but maybe to bring back ideas of things that would seem to be highly compatible with a lot of our goals here that we've talked about over the next couple of days. I think we could help reap the maximum benefit for Medicare recipients that way.

DR. CHERNEW: I want to ask a clarifying question of Bill's question, comment, if I can. Bill talked about

money going in, $2 billion, whatever it is, for evaluation. Of the money you've talked about, how much is actually for things like evaluation and how much is actually just paying the extra fees? How much of this is just a fee increase for doing whatever it is they say that they're ultimately doing?

MR. RICHARDSON: I don't know the amount of money that's going to evaluation. I mean, Peter asked about what the administrative infrastructure is here and we can add that fact to that analysis. But I think implicit in your question is, is some of the funding for CMMI going to extra payments or actually affecting the amount of money received by the --

DR. CHERNEW: Yeah, basically the operations that are giving money out to providers.

MR. RICHARDSON: Right. The grants -- so that the award programs, which are more, I view, as traditional grants where I would say that those are going to the providers for the purposes of whatever administrative changes they're going to make in their delivery system. And then there are the models where, as part of the program, the providers are agreeing to get paid differently and perhaps have some gain-sharing or whatever the aspect of that would

be.

I think in the latter case, though, where the models -- so basically you're putting a model on top of this flow of Medicare benefit dollars, I don't think that there's extra money, quote-unquote, from the Innovation Center going to those providers, as opposed to the grants, the awards, through the grant programs that are -- that's what the money is intended for, is the operation of the programs.

DR. BAICKER: I thought some of the state level things actually required, after a certain amount of time, demonstrating that you were saving the program money in terms of what was going to providers. Is that --

DR. MARK MILLER: Just for one second, okay, and if I could, I think what we're saying here is when you're talking about how the provider is paid, that's a benefit dollar. That's under the flows of dollars that go out on a regular basis. Then to the extent that there is money that we're talking about here, it's to help generate the idea, administer the idea, and evaluate the idea.

But if there's an extra payment or some incentive, that that's running more through the benefit dollars that go out of the trust fund on a --

DR. CHERNEW: So things like the primary care demonstration where they pay primary care providers an extra amount of money, that's not part of the CMMI-type budget? That's coming from some other place?

MR. RICHARDSON: I don't know. I'll have to find out.

DR. MARK MILLER: I'll check that fact specifically, but generally, yes, that's the way I think it works.

MR. KUHN: But, Mark, isn't it also true, on previous demonstrations had to be budget-neutral going forward?

DR. MARK MILLER: And then you get into Kate's question.

MR. KUHN: Right. They're giving them money up front in order to implement. And so, is that actually -- is that coming through CMMI or is that through trust fund --

DR. MARK MILLER: My sense of that is, in general, it comes through the trust funds, but we can check whether there's a specific difference here.

MR. RICHARDSON: For a given project, yeah.

MR. GEORGE MILLER: Yes, just a brief comment on -

- I agree with John that we should look at what the states are doing and private sector to learn from them as well, and as Bill talked about, there's a diversity of the country and diversity of ideas and the fact that we would look at all of these models and try to learn from them, I think would be helpful. At least it would be to me.

But this last discussion was very interesting to know where the dollars are really coming from, so I'd love to hear that answer as well.

MR. HACKBARTH: Any particular models, again, that folks want to dig deeper on? So keep that in mind as a question. George, is there anyone that you want --

MR. GEORGE MILLER: Well, the disparity in the Minnesota model I'm very interested in and will follow very, very closely.

MR. HACKBARTH: Okay, good. Great.

DR. SAMITT: So, with the risk that it may appear that I'm pandering to the Chairman, I'd put my money on Oregon and Massachusetts as the models that I'd be interested in for different reasons.

Oregon, mainly because the focus is on bigger bundles, and I'm a believer in bigger bundles because I

think my experience is that innovation occurs more commonly across silos and when you've got greater room to move. And I think that Oregon is also very much the next generation of ACO-like that we referenced yesterday as opposed to it being too fee-for-service-like or, you know, and not close enough to Medicare Advantage. The question is, does that create a scenario that's middle of the road?

Massachusetts is intriguing to me because of the primary care focus. It didn't go unnoticed in the materials from yesterday that 12 percent of spending goes to the Physician Fee Schedule, and I would imagine the component of that 12 percent that is primary care is even less. The Dean experience is about six percent. And other research clearly shows that physicians generate a lot of the balance of the remaining costs, and so I think if we can garner a clearer sense of innovation and incentive at the physician level, at the primary care level, I would imagine that we will reap quality improvement and savings downstream.

So if I were to pick the two models that I'd be curious to monitor, it would be Oregon and Massachusetts.

In terms of the multiple initiatives, I'm actually less concerned about the thousand flowers blooming. I think

we should let them bloom. I think we should see what folks can come up with when they innovate. I don't think we've done enough of that in the industry or within organizations and we should not suppress that. The whole notion of this initiative is to encourage innovation.

And then I guess the bulk of my contribution probably is really more in the spread category, because my personal experience is very deep there. You know, we've innovated in our organizations and the comments about framework are very important. I think CMS should develop a very sophisticated framework to evaluate these programs.

The way that we've gone about it is step one is obviously, does the innovation work? We need some clarity about how we're going to measure whether it works and we need to bless and say, this grouping works.

But then the next step that we've followed, particularly on the Dean side, is for the innovations that work, which ones of them go into a tool kit that's published and is available for anyone to use? So this whole voluntary notion. But the other bucket are innovations that work that go into a category that are mandated for everyone to use.

And we did the same thing. We said, these

innovations need to be open labeled and spread to everyone and every site in our system must do it. But these are very, you know, culturally sensitive or geographically sensitive and they may be voluntary. But we must do a better job assuring that they do work in certain settings, and making sure those who would be amenable to it know that it exists.

It's something that I referenced yesterday when we talked about shared decision making. Do we know what models work and have we done an effective job from CMS, Medicare, or anyone else, that ensures that we spread those innovations to anyone who would benefit from it?

So, I would encourage a more clear framework for evaluating these as well as a methodology to assure that spread doesn't take 17 years if we're going to share some of these best practices throughout the system.

DR. HOADLEY: So, in your basic question about sort of what the priorities might be, I kind of resonate with Scott's comment, I mean, to the extent that some of these can be looked at as ones that seem to fit into some of the issues that staff overall thinks or we've already expressed as a group that are priorities, sort of do that,

which is a little bit of bucking the question, but --

But I also think, particularly on the set of State initiatives, we really should look carefully at whether some of them are less applicable to Medicare and the nature of how they're done, if they're much more tied into some aspect of how Medicaid operates or how the State is otherwise envisioning the ones that go beyond Medicaid to private sector. Maybe you've already really made that cut and these are ones that seem like they have applicability, but we should make sure that some of them -- that they all do in the ones that we might want to pursue.

On some of the evaluation questions, it seems to me, and without knowing more detail on all the things on this list, it's hard to do this, figure out what exactly this cut means, but there's a difference, and several people have expressed versions of this, between things that are more fundamental and to disseminate further would require legislation or under this authority really changing something about how Medicare payment works versus things that are really more kind of like we were just saying, things that could be in the tool kit.

Mike was mentioning things that might have to do

with medication adherence or imaging or whatever, you know, things that are smaller that aren't so much, okay, we have to change based on this how Medicare does things. They just may be ideas that are out there for providers or the ways to address shared decision making or any of these kinds of things. They're just things that providers, in general, with their Medicare dollars could do, and it isn't necessarily -- and so those, you know, some kind of this softer evaluation that says, first of all, are they not doing harm and they look like they're making more information available and making the ability to disseminate them is useful.

The ones that are kind of a step more complex or more fundamental to how the rules of Medicare work, those are the ones that kind of need to be treated differently. So if there's some kind of a slice that can kind of divide things that way, that might be helpful.

And I guess my only other observation is, over the years under this sort of older way of doing demos, we, in theory, at least, did really systematic evaluations of a lot of these things and it seems to me that an awful lot of the evaluations of these things, A, weren't all that timely. I

mean, we criticized over the years things like that. But also, findings often were pretty ambiguous and we'd get through and we'd say, well, you know, it feels like it does some good things. It doesn't -- there's no clear evidence that it saved money.

And so I don't know that expectations should be that -- particularly with all these additional complications of overlapping projects and things -- that even if we could sort of line that up, we necessarily are going to get clean scientific results that we all could say, okay, that's the final proof we need to just change Medicare once and for all. So our level of expectations has to be realistic.

MR. HACKBARTH: Yeah. I almost bet against being clear, definitive results given all of the confounding variables and size of the cells and --

DR. HOADLEY: So, a sense of softer kind of evaluation, you know, making sure that it doesn't do harm, that it feels like a good thing, and then just -- but also with a transparency of all that and to the extent that it can be quick gives us the ability to say, okay, here's a bunch of things that have this amount of information about them and let, to some extent, the world figure out which

ones --

MR. HACKBARTH: And ultimately, the success of so many of the innovations is contextually dependent. It'll work some places and not other places. When you do the national evaluation, you average it out, the likelihood, if not probability, that there's going to be nationally no statistically significant effect is pretty high.

Peter.

MR. BUTLER: Four points relative to priorities, the first on the gain sharing. Historically, I think this is viewed as private physicians partnering with hospitals to kind of make improvements and share in the results and the skeptical side -- well, first of all, I think there's such a decreasing number of private physicians with which to do this, it's probably not a long-term scenario.

And, second, the ones that are still at it are kind of the specialty groups that want a piece of the technical component, and surgery center and imaging, and their idea of gain sharing is give me some of the money that you're making, and particularly for my, as George would frequently say, for my commercially insured patients.

Now, where I think gain sharing can work, though,

and ought to be focused is on clinically integrated physician-hospital organizations that have private employed and hospitals that are truly clinically integrated and, as a result, can accommodate the payment models that are the higher level than the lower level gain sharing. They can be an ACO. They can handle bundled payments. They have the data. So that level of gain sharing, I think, is something that is extremely important and going on successfully in some areas.

Second point is I always favor Statewide demonstrations versus anything that is at a lower level. DRGs, I think, were successful because it was tested in New Jersey, not in Hoboken or something like that. And so I think, politically and otherwise, whether, Bill, it's mandatory or voluntary, Statewide takes into account a political unit and a diversity of applications that are more likely to result in sustainable policy changes.

My third point is on which ones to do. Scott, you mentioned blue line, purple line, and Mark, you mentioned episode. So, episode is, to me, the journey from fee-for-service. We've got plenty of activity on ACOs and MAs. So the episode, I would reinforce as one, well, why not?

Nobody else is really -- maybe Arkansas isn't the right exact place, but why not?

And, finally, the last one, on the disparities, I like, not just because it's disparities but because of the population health focus. So, most people think population health is like ACOs or something like that, which really is just managing the continuum of care for those that have illness. This is the only one that I can see that actually is looking at the community health measures. And when we start at the beginning point and say we spend twice as much in this country and we have lower life expectancy, you know, this is one that gets at social determinants and the entire community in a way that none of the other demonstrations do because they're most -- not none, but most of the other ones on payment models for those that are sick, not how do you collectively improve measurement of the health of the community you're serving.

MS. UCCELLO: In terms of where we should focus, I think if we step back and think about some of the overarching themes that we're interested in, two of them are the ability of providers to bear risk and the ability of beneficiaries to understand and respond to different

incentives. And I think if we -- we may be able to look across these different programs and make use of the variation across them to maybe provide some insights into those two things.

DR. BAICKER: Just to follow up briefly, just emphasizing what Cori was saying and what Jack and Peter were saying, I'd add to Cori's list integration of payments, which goes along with providers bearing risk, and those things are sort of the obvious bridges to what we work on regularly, and for goodness sakes, let's get as much information from the States as we can.

But then that doesn't mean ignore all the other ones. There are lots of interesting other buckets. We had a discussion yesterday about shared decision making and thought, like, yes, that's a really important thing, but it's not something that we can necessarily generate with the insurance program levers at our disposal. Maybe some State figures out how to do it and we say, wow, that demonstration that's promoting shared decision making actually has components that we want to build into Medicare. I have no reason to think that it will or won't work, but those other things suggest levers that we're not looking at.

So there's the levers we look at in figuring out how they work and there's the potential for new levers to emerge.

MR. HACKBARTH: Just to pursue the shared decision making example, so yesterday, I said what I believed, which is I think Medicare has relatively limited levers to make that very good thing happen. Having said that, I think it's a good idea to fund local level innovations with it for the reasons that Craig and others have described. It's a good thing if people can learn from one another, or care delivery systems can learn some ways of doing that work better than others. I think it's an appropriate thing for the Federal Government to fund that sort of cross-delivery system learning, even if it doesn't mean that there's going to be a Medicare payment policy that results from the research.

Mike, and then Mary.

DR. CHERNEW: So, my sense of this is that at the big level, our job -- I apologize for this analogy -- is to make the soil of Medicare fertile and hopefully the seeds will grow in that without constantly being fertilized. So I'm a little worried that they're constantly -- they're constantly putting these things out and they only work

because they're paying extra, they're doing something extra. It needs to grow in -- I'll be more concrete. Sorry. I've had a lot of Froot Loops.

[Laughter.]

DR. MARK MILLER: You should have a flag or something --

DR. CHERNEW: Yes, exactly. This is what you need to do, Glenn. The question is, many of these will grow well in an ACO, and so you learn about shared decision making. You already have the structure that something will work. The same is true for a vast number of these things.

The question is, are there things that are really good that our existing big picture Medicare structures just won't accommodate? And then we have to think about how to change the broad big picture Medicare structures.

But if many of these of the thousands -- many of them will do just great in the existing structures we're building, and then I think we're probably going to be okay.

DR. NAYLOR: So, continuing the analogy -- no, I won't say that.

[Laughter.]

DR. NAYLOR: I totally, totally am -- the seed has

been planted now.

DR. REDBERG: [Off microphone.]

DR. NAYLOR: Yeah. I think, reflecting on this conversation, the extent to which the Medicare policies can promote a very common theme here, which is around transparency and a learning health system model. So not saying what needs to happen, but making sure that people know, when they get to better, that they have an accountability -- maybe that is the accountability framework earlier -- to share with others. And so that has been a pretty -- I mean, we're trying to figure out how to be -- create the soil. So I think that's a really important thing for us.

MR. HACKBARTH: Let me go sort of narrow again, answering my own question about which of these things I'd like to learn more about. Primary care medical home is one that I'd like to learn more about. Is there any more a Medicare-only medical home project, or has it all been folded into the multipayer comprehensive initiative?

MR. RICHARDSON: I think it's been folded in, but I'm -- we'll find out.

MR. HACKBARTH: What did you say, Mary?

DR. NAYLOR: [Off microphone.] I thought the advanced primary care included -- are you talking about Medicare-only?

MR. HACKBARTH: Only, yes. And the reason that I asked that is that under this rubric that's been created, where we test things and the Secretary has the authority to make them happen if they work, if there's not a Medicare-only, you know, what's being tested is what happens when multiple payers do it, so how does the Secretary and the actuary estimate the effect of Medicare alone doing it? So that's a question that I have.

A second aspect of this for me is that my hunch, and I may be wrong, but my hunch is that it's unlikely that medical home will be found to have a significant cost reducing effect. I hope I'm wrong about that, but that would be my guess. And in part, I think it's for what we were discussing with Jack. It'll work some places and it won't work others, and when you average it all together, you'll find no significant effect.

So you do medical home at Puget Sound, or you do medical home in Geisinger, you have one set of impacts. You drop medical home down into America's most fragmented care

delivery system with a real extreme imbalance of providers, you'll get a completely different set of effects. And mush those together and do an average and say, oh, it works or it doesn't, I think is just a conceptually flawed approach to trying to figure out whether this is good policy or not.

And I think even if medical home does not save money when you mush all this stuff together and average it out, it still may be good policy if it's successful in improving care coordination for beneficiaries, if it manages to extend further our limited primary care resources by providing more supports to those practices so they can handle more patients. We need to do that, given the imbalance that we have in primary care. So it may be wonderful policy even if it does not meet that cost test. And, oh, by the way, if we're doing all multipayer demos, we may not know the answer to the cost test for Medicare alone.

The bottom line is my fear, and I'm willing to be corrected, we're on the fast track to nowhere in terms of making a decision about whether medical home is a good idea for Medicare alone. And this sort of goes with my tirade about bundling around missions. We dump things into CMMI. We don't think about what we're trying to find out, what

we're trying to do, and it becomes sort of the death loop. You go onto the demo track, never to appear again, and that troubles me.

Any final --

MR. BUTLER: One comment. If the purpose of this is to develop demonstrations that ultimately end up in policy, I understand the value. If it, as you said, also has this benefit of providers and others sharing with each other so they can improve, I wouldn't spend Federal dollars doing that. We don't have the time, nor would we go to these projects as a source of -- because, like your medical home, it's going to be three years from now. We go to -- if you've got money to burn, let's go with Institute for Health Care Improvement or let's go with -- or let's we create our own networks to do real-time stuff and find out what's working now, not two years from now when these things may limp along. So do it for policy, but don't do it just as a way for us to learn from each other so we can improve. I don't think that that's a good purpose of this, my own feeling.

DR. SAMITT: The only other thing I would is that, you know, we shouldn't just look at CMMI demonstration

projects to find innovation. We need to cross the transom and look on the commercial side and say, maybe there are examples where private industry is innovating in its own right, a lot of which of these innovations are applicable to Medicare and Medicaid, as well. And so instead of investing a lot in new demonstrations that are Medicare-specific or just government payer, let's broaden our acceptance and view of innovation to many other sectors and see if some of those are also applicable to go into the tool kits we described earlier.

MR. HACKBARTH: At a minimum, maybe it would be useful for CMMI to say, you know, here are the projects that are aimed at changes in Medicare, testing changes in Medicare policy, here are others that are designed to promote innovation in care delivery, and say, what is the appropriate allocation of resources between these two broad purposes? And maybe that second category of those designed to spawn innovation in care delivery, we ought to think about having established partners like IHI and others to work with as opposed to going off on their own and trying to reinvent that wheel.

Okay. Thank you, John and Lauren. Well done.

[Pause.]

MR. HACKBARTH: Christine, you can start whenever you're ready.

MS. AGUIAR: Good morning. Today, Carlos and I will update you on the CMS financial alignment demonstration for dual eligible beneficiaries. As a reminder, the Commission last discussed the demonstration in April 2012 and submitted a comment letter to CMS regarding the demonstration in July 2012.

Today's presentation will start with background on the demonstration, followed by an overview of the states that are progressing towards implementation. Next, I will discuss how elements of the demonstration align with the Commission's comment letter. Then I'll go over the main reasons why some states have decided to no longer participate in the demonstration and why there is renewed interest among states in dual eligible special needs plans, or D-SNPs. Finally, Carlos will discuss the main similarities and differences between the demonstration and the Medicare Advantage program.

Let's begin with some background information. As you know, dual eligibles are a diverse population and

require a mix of medical care, long-term care services and supports, and behavioral health services. This is a population that can benefit from coordination of care, and the Commission has been assessing ways to improve care coordination for these beneficiaries over the past few years.

From the perspective of improving care coordination for dual eligibles, the Medicare and Medicaid Coordination Office at CMS announced the financial alignment demonstration in 2011. The purpose is for states to develop integrated care programs for full-benefit, dual-eligible beneficiaries. States can implement a capitated model, a managed Fee-for-Service model or both.

Under the capitated model, a health plan receives Medicare and Medicaid capitation payments. The plan payment rates will be set below expected Medicare and Medicaid spending in order to provide for up-front savings to both programs.

The managed Fee-for-Service model maintains Medicare Fee-for-Service. States finance a care coordination program and can receive a retrospective payment if the program meets quality thresholds and results in

Medicare savings.

This slide describes the states that are implementing the demonstration. I apologize for the small font on the slide, but this is important information we wanted to share with you all.

In order to participate in the demonstration, states first had to submit a proposal to CMS. Twenty-six states submitted proposals.

The next stage is for CMS and the state to sign a memorandum of understanding, or MOU. The states on this slide are the seven states that, to date, have signed an MOU.

As you can see in the second column on the table, six of these states are implementing the capitated model while Washington is the only state with an MOU for the managed Fee-for-Service model.

As you see in the last column on the slide, Washington's program began on July 1st, 2013. The other demonstrations are expected to begin in Fall 2013 or 2014.

Most demonstrations will begin with a three-month opt-in enrollment period that is followed by a period of passive enrollment. During opt-in enrollment, eligible

beneficiaries can choose to enroll in the demonstration. During passive enrollment, eligible beneficiaries that have not yet enrolled will be automatically enrolled into the demonstration and assigned to a plan.

The start dates for some of the demonstrations have been delayed. For example, California's MOU stated an October 1st, 2013 start date, but the demonstration is delayed until April 2014.

In the July 2012 comment letter to CMS, the Commission commented on the 5 aspects of the demonstration that are listed on this slide. Over the next few slides, I will describe how the MOUs align with the Commission's comments on these aspects.

We'll start with the scope of the demonstration. Most of the 26 states proposals included enrollment of the majority or entire subgroups of dual eligibles in the state into the demonstration.

The Commission commented that the scope of the demonstration was too broad and represented a program change because approximately three million dual eligibles would be enrolled in the demonstration if CMS approved every state's proposal. The Commission encouraged CMS to reduce the

scope.

As you can see on this slide, estimated enrollment across the seven states could reach over one million. Note that California had initially proposed to enroll up to one million dual eligibles but reduced the scope to about 456,000.

There are still 12 active state proposals that have not yet progressed to a signed MOU. As you see in the last row on the table, close to 900,000 beneficiaries are eligible to enroll across these 12 states.

If every state with an active proposal proceeds to implementation without reducing its scope, total enrollment in the demonstration could reach close to two million.

With respect to passive enrollment, CMS's proposed design for the capitated model included a passive enrollment strategy with opt-out. The Commission expressed support for the use of passive enrollment as long as certain beneficiary protections were included.

There is precedence for passive enrollment in the Medicare program because it is already used for the low-income subsidy population under Part D. The passive enrollment features, which are listed on this slide, are

consistent across all MOUs and align well with the Commission's comments. For example, beneficiaries will be notified of the demonstration 60 or 90 days prior to passive enrollment and can opt out both before and after enrollment.

Moving on now to plan requirements, the Commission suggested that MA, or Medicare Advantage, requirements represent the minimum standard in order to provide a baseline standard of requirements for the demonstration plans. Consistent with the Commission's suggestion, the MOUs indicate the MA requirements do represent a minimum standard for most plan requirements.

The Commission also raised concerns about the potential destabilization of the Part D market, given that a large number of dual eligibles will be enrolled in the demonstration and demonstration plans will not submit Part D bids. CMS indicated that it does not expect treatment of Part D under the demonstration to have a major effect on beneficiaries but that it will closely monitor any effects.

For monitoring and evaluation, the Commission emphasized the importance of collecting consistent quality measures across all demonstrations in order to evaluate and monitor the demonstration. The MOUs were largely in

agreement with these comments. CMS will collect a core set of quality measures across all demonstrations and will fund an external evaluation of the demonstration.

Turning now to program costs and savings, there is more detail on this topic in your mailing materials, but in the interest of time I will focus on the methodology for estimating savings on this side and the methodology for developing baseline spending on the next slide.

With respect to estimating savings, the Commission stated that CMS should estimate savings separately from Medicare and Medicaid and then adjust each program's capitation rates based on these estimates. This would be an equitable way to allocate savings since savings are more likely to come from one program or the other.

The Commission also encouraged CMS to develop realistic savings estimates so that plan capitation rates neither exceed nor are below the cost of care.

The methodology for estimating savings in the MOUs is largely unchanged from CMS's original proposal. CMS will develop a combined Medicare and Medicaid savings estimate, and both Medicare and Medicaid capitation rates will be reduced by the same savings estimate.

The savings estimates for each state are listed on this slide. Note that the savings estimates are generally 1 percent for the first year of the demonstration and increase each year.

With respect to estimating Medicare and Medicaid spending absent the demonstration, the Medicare baseline will be a mix of Fee-for-Service and MA spending based on CMS's assumptions of whether beneficiaries would have been enrolled in Fee-for-Service or MA absent the demonstration.

The Commission commented that the quality bonus payments made to MA plans below four starts under CMS's demonstration authority should not be included in the baseline. The Commission has strongly objected to CMS's use of its demonstration authority to make unilateral changes in payment rates, and including the bonus payments in the baseline would institutionalize these payments. However, as we understand, the bonus payments will be included in the baseline in addition to the statutory bonus payments made to four and five-star plans.

Moving on now, a number of states are no longer participating in the demonstration. Three states -- Arizona, New Mexico and Tennessee -- formally withdrew.

Three other states -- Minnesota, Wisconsin and Oregon -- are still working with CMS on programs for dual eligibles but under different demonstration authority. Hawaii is no longer working on the demonstration but may do so after 2014. All of these states had submitted proposals to implement the capitated model.

We interviewed state representatives, health plan representatives and other stakeholders to better understand why some states decided not to participate. The main reasons the stakeholders cited are listed on this slide.

For one, up-front savings may not be achievable in every state, and the removal of the up-front savings and the quality withholds may not leave plans with enough funding to address unmet need.

Second, if D-SNPs are paid higher than demonstration plans because up-front savings and quality withholds are not removed from the D-SNP rates, D-SNPs could compete with demonstration plans for enrollees by offering more attractive supplemental benefits.

Third, the demonstration focuses solely on dual eligibles, and states may prefer to make delivery system changes for the entire long-term care population.

Fourth, there has been less flexibility than originally thought for states to customize the demonstration to align with their individual Medicaid programs.

Finally, the timing of the demonstration can conflict with other state priorities and changes to their Medicaid programs.

Recently, momentum has developed among some states to pursue integration through D-SNPs. The stakeholders we interviewed stated that the D-SNP program may be preferable to states because, unlike the financial alignment demonstration, up-front savings and quality withholds are not removed from D-SNP payment rates. They also reported that there is more uncertainty among some stakeholders over the future of the demonstration than over the reauthorization of D-SNPs.

The stakeholders we interviewed generally agreed with the Commission's 2013 recommendations to Congress on D-SNPs. Changes that extend beyond the Commission's recommendations include consolidating Medicare and Medicaid reporting requirements, giving states a greater role in the D-SNP selection process and implementing a transition period to enable states to work with D-SNPs to incrementally become

more integrated.

The National Association of Medicaid Directors is currently working with states to identify legislative and regulatory changes to D-SNPs that would improve Medicare and Medicaid integration.

Carlos will now compare the requirements for the demonstration and the MA program.

MR. ZARABOZO: In the next two slides, we will review the major differences and similarities between the demonstration plans and contracts under the Medicare Advantage, or MA, program. The major differences are in the area of plan payments, how enrollment generally occurs and what additional requirements are being imposed.

With regard to payment, the demonstration plans will not submit bids for Medicare Part A and Part B benefits. In MA, plans bid against an area benchmark, and the bids determine how much a plan will be paid, any premium the plan would charge and the extra benefits the plans are able to offer.

In the demonstrations, plans will receive a capitated per-member per-month payment based on the cost that CMS projects that the Medicare program would have

incurred absent the demonstration.

So it would be a combination of projected Fee-for-Service expenditures and all projected MA payments, as Christine discussed.

Once the basic capitation rate is set, the savings percentage is then deducted up front, and there is an additional withhold of payments that can be returned to plans if they meet quality targets.

Some states are also including risk corridor arrangements whereby Medicare and Medicaid will share in the losses and gains of plans.

The demonstration plans will not have Part D bids but will be paid the national average bid amount plus a monthly estimated payment for the low-income cost-sharing and reinsurance subsidy amounts. As Christine discussed, the Commission expressed concern over the possible destabilization effect in the Part D market by the absence of bids.

In addition to the Medicare capitation payments, Medicaid will be making capitation payments to the plans which will cover the costs of Medicaid services as well as providing revenue for cost-sharing associated with Medicare-

covered services. Some states will also require plans to offer additional benefits not covered by Medicaid.

The two other major aspects of the demonstration that differ from MA are enrollment rules and reporting requirements.

Although it is common for MA plans to obtain enrollment through insurance agents and brokers who receive commissions, some states will require that all enrollment be through an independent third party.

Another difference is that the demonstration plans will be meeting some additional requirements, including the need to report additional quality data that will determine whether or not they are entitled to receive quality withhold amounts. The measures that must be reported for this purpose will vary from state to state.

There are a number of features that are common to both the demonstration plans and Medicare Advantage though some of the features are common only up to a point.

Plan payments will be risk-adjusted based on the risk scores of individual enrollees as in MA and in Part D.

It is currently the case that in MA low-income beneficiaries can enroll in or drop out of plans on a

monthly basis. This is also the case for demonstration plans.

In any Medicare Advantage plan, the plan is prohibited from charging cost-sharing for Medicare-covered services to dually eligible beneficiaries or qualified Medicare beneficiaries or who otherwise have Medicare cost-sharing covered under Medicaid.

MA plans can have premiums which beneficiaries would be expected to pay. The demonstration plans are not permitted to charge any premium for the Medicare Part A and Part B benefit package or for Part D.

In MA, beneficiaries may pay Part D premiums that vary depending on where the plan's bid is in relation to the national average bid and whether the beneficiary can receive the low-income premium subsidy.

We should also note that in 2013 the vast majority of Medicare beneficiaries have access to an MA plan with no premium that includes Part D drug coverage because plans are using the Part A and Part B rebate dollars to reduce the Part D premium.

As Christine mentioned, demonstration plans will generally be required to comply with all MA contract rules,

which includes the reporting of encounter data and compliance with the new minimum medical loss ratio requirements, except that CMS has informed us that the loss ratio requirements will not be applied in the two states that have risk corridors -- Massachusetts and California.

In summary, the purpose of today's presentation was to update you on the status of the financial alignment demonstration.

In terms of next steps and additional work on the subject of dual eligibles, possible work would include exploring additional ways of improving the care for dual-eligible beneficiaries through special needs plans or D-SNPs.

Related to the discussion the Commission had yesterday about a level playing field between ACOs, Fee-for-Service and Medicare Advantage, the financial alignment model is another capitated model with payment benchmarks and payment rules that differ from the existing Medicare Advantage capitated model.

Also related to this work is an issue that arises in connection with the Commission's discussions of redesigning the Medicare benefit package. If a redesigned

benefit package includes an out-of-pocket maximum for beneficiary cost-sharing but with a higher initial deductible, then such a design raises a concern as to whether there should be additional financial support for low-income individuals beyond what currently exists in the Medicare savings program.

Thank you, and we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Christine and Carlos.

Any clarifying questions?

MS. UCCELLO: In the mailing materials, it was mentioned -- Massachusetts's high-cost risk pool. Is that a reinsurance program?

MR. ZARABOZO: They have a high-cost risk pool for two Medicaid categories. They have the people who are institutionalized and high-cost community dwelling. And what happens there is that there's a withhold from the capitation, and then it is distributed among the plans.

So it's sort of internal just to those two particular risk categories. Within the plan, there's a redistribution of the dollars based on the cost for those two categories of people.

DR. HOADLEY: You said on slide 13 that there's uncertainty about the future of the demonstration, more so than the reauthorization of D-SNPs, but I just wanted to remember. The D-SNPs currently will expire; is that right?

MS. AGUIAR: Yes, by the end of 2014.

And I would -- you know, in the paper, I believe that we caveated this section with saying this is what we heard from the stakeholders --

DR. HOADLEY: Right, right.

MS. AGUIAR: -- that were involved in states that decided not to pursue but that there obviously are states that are going ahead with it that don't have these concerns.

One of the issues we did hear from those stakeholders that were involved in the states that decided not to pursue the demonstration was that there was a sense, a growing sense, that D-SNPs will continue to be reauthorized, whether permanently -- certain ones, permanently -- as the Commission recommended. And there was more uncertainty about the future of the demonstration.

But, again, we just caution that that is among the few stakeholders that we spoke with.

DR. HOADLEY: Okay.

DR. NERENZ: On slide 3, just to clarify, when you distinguish the two models -- the capitated and the Fee-for-Service -- the capitated means that the payment from CMS goes to a qualified managed care plan in the form of capitation. But, just to clarify, it does not mean that payment from the plan to providers is capitated. Is that correct?

MR. ZARABOZO: That's correct. Internally, within the plan, they can have whatever payment arrangements they wish to have.

DR. NERENZ: And of those that are active or have MOUs signed, do you know anything about what the pattern of those payment arrangements looks like, or is there no pattern?

MS. AGUIAR: What we have learned -- and we haven't spoken to all of them to see whether or not there was a pattern. The way that the demonstration was rolled out is that what we heard from the plans that wanted to participate in the demonstration; they had to build their provider networks and negotiate their provider rates with those networks before the plans themselves knew what the final rates they would be getting from Medicare and Medicaid

were.

So, from the plans that we spoke with, they were planning to pay Medicare payment rates for Medicare services.

DR. NERENZ: Okay. Well, that was actually going to be one of my specific questions because, theoretically, if you're blending two payment streams and you ask about how plans are going to pay providers, they could pay Medicare rates or they could pay Medicaid rates or they could do something else.

MS. AGUIAR: Right. Again, from the plans that we had spoken with that were involved in the demonstration starting up, at least for the first year, their plan was to get their networks and to pay the Medicare providers based on the Medicare rates.

MR. HACKBARTH: But my understanding from the written material was that only Massachusetts, of the states using the capitated model, has gone far enough to really find out how many plans will actually participate. And what they found is that some of the ones who previously expressed interest backed out, and they only have three plans statewide. Is that right?

MS. AGUIAR: Yes, that is correct. Massachusetts is the only state.

So, as I believe I had explained earlier, the steps are the proposal which was 26 states, then the MOUs which are 7 states and then the 3-way contract which is signed between the state, CMS and the health plans.

Massachusetts is the only state so far that has progressed to the three-way contract. And when that contract was signed, three of the states -- three plans -- that originally were going to participate in the demonstration withdrew.

MR. HACKBARTH: Right. Okay.

Other clarifying questions?

[No response.]

MR. HACKBARTH: Who wants to go first? Alice, do you want to go first?

DR. COOMBS: Thank you very much. I found this very interesting.

One of the things that you talked about just in the paper specifically was dealing with a deterrent for why some of the states withdrew and some of the states lost interest. And you mentioned the advent of the ACA and how

that would influence states' decisions whether or not to engage in the demonstrations. And I was looking at the ones that whittled down to the seven, and can you say something about the federal matching and whether or not the percentage of the Medicaid penetration in the various states based on the benchmark of the federal poverty level had an influence on the decisions in these states.

MS. AGUIAR: I can't say whether or not that was a reason. From our conversation with the State reports and also from the letters that the states that formally withdrew that they had sent to CMS. What they indicated is that between, you know, preparing themselves for health care reform and also for other state priorities, they had too many resources, and they were unable to devote that to this demonstration. But that level of detail was not in any of our research.

DR. COOMBS: So early on Massachusetts was very concerned about the cost shifting as to Medicaid and Medicare -- the dual eligible and how that would work out. And, conceivably, the formula based on the baseline from what we read in the paper will justify both entities since it would be -- you would incentivize the network to continue

to care for these patients in terms of that agreement. And how they work the baseline I guess is really the important piece of this.

MS. AGUIAR: Yes, I think so. And to use Massachusetts as an example, that is my understanding. Massachusetts does already have an integrated care program. It's called the Senior Care Options, the SCO program. It's very well known, and that is for the 65-plus dual eligibles. They didn't have a program for the under-65, which is what this demonstration would be for. And so, you know, my sense was they worked very closely with CMS to really try to determine what the baseline was, what the expected savings could be off that baseline, and then what the plan rates could be.

You know, as we talked about earlier with Glenn, obviously there were three health plans that felt that they weren't able to continue to pursue within this demonstration.

DR. COOMBS: And I guess, lastly, we probably should look and see if we can draw some conclusions about the penetration of D-SNPs and correlation with the demonstration states.

MS. AGUIAR: Yes, I guess we can answer that somewhat informally. Again, the states that -- and, again, I keep caveat'ing with this is what we heard from the stakeholders that we spoke with, so I don't want to say this is exactly the rationale from every single state, but from what we heard. You know, when you think about it, three of the states that formally withdrew -- so Arizona, again, has had an integrated care program for duals for years, has high Medicaid managed care and MA penetration there. The same thing with Minnesota, and the same thing with New Mexico. And so it does -- from what we heard, that was one of the concerns about those states because if you were starting this demonstration and the payment rates to the plans have up-front savings and quality withholds removed from them and most of your enrollees are likely to come from a D-SNP, an MA plan, or from a Medicaid managed care plan, that means that those health plans will be operating under payment rates that are less than what they receive now.

In the instance of Massachusetts, with the under-65, most of those beneficiaries are expected to come from fee-for-service. So there was less of that concern.

So that was, again, one of the concerns that we

heard from the stakeholders.

MR. HACKBARTH: Are you at liberty to say which three plans in Massachusetts are participating?

MS. AGUIAR: We are at liberty. I think it is public. I don't have all of them off the top of my head. I believe one is Network Health or Fallon? Do you remember?

MR. ZARABOZO: [off microphone].

MS. AGUIAR: One of them I believe is Network Health, but we could get back to you with that.

MR. HACKBARTH: Okay. As we go through round two, would you put your questions, your final slide up? So the principal purpose here was to provide an update on an issue that we've spent a lot of time on in the last several years. But I would like Commissioner input on whether we should go back into the D-SNP issue. You'll recall that we looked at this as part of a congressional mandate, whether to reauthorize or not in the last cycle. And so the question is: Should we revisit? There are always issues, new issues, new opportunities that come up, but where does this fit on your register of things for us to do? It is not on the work plan that we've discussed with you for the year to this point, so this would be a new addition to that.

MR. ARMSTRONG: I don't have a question, though to your question on our work plan, I don't have a strong opinion. But this has always been a population that we really struggle with, and they need a lot of care. They consume a lot of our resources, and we could do a better job of, you know, creating the kind of alignment we're trying to create through this work.

Having said all that, though, I think we've put into motion a lot we should be paying attention to, and I'm not sure that I would prioritize teeing up much more work on this beyond what otherwise would be the role we planned, which is monitoring the progress of these demonstrations.

MR. HACKBARTH: I should mention that the last item, related work, which is sort of tangentially related to this, may be more closely related to benefit redesign. That is on our current work plan, to look more at the low-income supports.

MR. GRADISON: I agree with Scott. I don't see that this changes anything in terms of the input to our earlier recommendations. Others may feel differently and could talk me out of that, but I don't see anything from what we are learning here that, had we known it, would have

changed what we recommended. At least that's my read.

DR. HALL: I was looking for some evidence that this might shed light on better ways of patient engagement. Do you have any information on that as one saving feature of this?

MS. AGUIAR: On whether or not the demonstrations might shareholder light on it?

DR. HALL: Yes.

MS. AGUIAR: The demonstrations are still so much in the beginning implementation phase, and, again, Washington's managed fee-for-service program began in July. Massachusetts' program is beginning enrollment now. So we don't yet have, I believe, enough experience.

I know that in the MOUs and then in the three-way contracts, there are information and the expectations of patient involvement. But whether or not -- how those are actually functioning, it's too early to tell.

DR. HALL: So it sounds like it's passive enrollment, but there is some notification a month or two ahead of time.

MS. AGUIAR: Yes, exactly.

DR. HALL: And that notification says, by the way,

we'd like to put you into this plan, or --

MS. AGUIAR: No, so all of the demonstrations are beginning with an opt-in or voluntary phase-in portion.

DR. HALL: Yeah, right.

MS. AGUIAR: And I believe that the notifications say, you know, here's this demonstration, if you care to -- if you want to enroll, you know, you are able to do so. And then that there's -- I'm not sure if it's an exact same document or if there's a subsequent document that comes out about 60 days before passive enrollment that says we will passively enroll you into this demonstration plan unless you choose a plan or unless you opt out.

DR. HALL: Okay. Thank you.

MR. GEORGE MILLER: Very briefly, great chapter. I really appreciate the information, and it helped me understand this population better, something we have a strong interest in. However, with the Chairman's statement, I believe we have enough to say grace over, and I would not suggest we do anything more.

DR. SAMITT: Thanks for the presentation. Very clear.

It strikes me that the demonstration projects and

the D-SNPs are actually complementary. It goes back to our discussion about ACO, that it encourages different avenues to develop a coordinated care model for duals, and so I would echo what others have said. I don't see a reason to re-evaluate D-SNPs. I think we should let them flourish, both they and the demonstration projects, and see where it brings us.

DR. HOADLEY: I, too, would say I don't think we need to sort of revisit what we did on the D-SNPs. And I think overall we're sort of at the right level of attention here. I mean, I think this was really useful, and, you know, if we anticipated another kind of an update like that -- you know, I don't know if it's a year from now or when, but you guys can figure that part out. And I think, you know, the monitoring -- and I don't know on some of these -- a couple of these things I'll mention, I'm probably really saying what CMS should be monitoring and we should be monitoring to make sure they're monitoring. But, I mean, some of the things that you raised that are not down at the level of the program evaluation but sort of the shorter term, you know, as the states move forward from the MOUs to the contracts, you know, where do they suddenly make little

changes. And you noted the one example that Massachusetts had not provided details on how they were going to do their intelligent assignment approach that was supposed to have come in that next step.

You know, I think the issues that I'm concerned about is similar to the comments I made on the ACOs yesterday and a couple of other people just have mentioned. Are beneficiaries aware? How do they understand and process that initial letter that says they have a choice to opt in? And how many really do opt in? You know, when it gets to passive enrollment, you know, do they understand what's going on, or are there problems because of that? To the extent that intelligent assignment is used, you know, how is it used? When is it used? And how does that work? That would be something we could take some examples from for potential use in Part D assignment issues.

So, I mean, I think there are just some interesting things that hopefully CMS will be monitoring and we can continue to keep track of.

MR. BUTLER: We talk about CMS' ability to handle all they have. We haven't talked as much about the states and what's on their agenda. So, George, I think you

mentioned enough to say grace over. I think a lot of states are -- Illinois has already bitten off more than they can chew. They're into their meal. And you've got state exchanges. You've got Medicaid expansion overall. And then you layer on these things. So analysis, no. Monitoring with a capital M, yes.

MS. UCCELLO: I agree with what others have said. I just want to touch base with you again about the Massachusetts risk corridor. If you just happen to find out any information about why those corridors were structured the way they were, which is in a way that I would not define as risk corridors, just I would appreciate you letting me know.

And just to explicitly confirm support for looking into more cost-sharing assistance for near-poor, not only in the context of benefit redesign but also the ACO cost-sharing discussion we had yesterday.

DR. NERENZ: In Michigan, as this program gets discussed, I would -- my own impression is that most of the concerns being expressed have to do with the Medicaid side of this, not the Medicare side of this, and that is, what will happen to long-term care services, community support

services, in a model where entities that have been more familiar with Medicare payment step in and become responsible?

With that in mind, has there been activity on this program from our counterpart commission focusing on Medicaid issues? Have they issued a report? Are you in touch with them? Because conceivably this is an area where both commissions would have perhaps converging interest.

MR. HACKBARTH: So let me address part of that, and then I'll defer to you folks for more detail. We have, in fact, talked with MACPAC, the Medicaid/Chip Commission. I think I've gone on two separate occasions to meet with them on this topic, and I don't know, have you done it separately as well?

DR. MARK MILLER: I've been with you [off microphone].

MR. HACKBARTH: Yeah, okay. He's been with me. Funny, I didn't see you there. I kept looking.

[Laughter.]

MR. HACKBARTH: So we have had both that sort of formal interaction, and there has been considerable interaction at the staff level as well.

DR. MARK MILLER: Apparently I didn't make much of an impression when I went.

[Laughter.]

DR. MARK MILLER: That's okay. So we talk to the other commission on issues frequently, and we always talk before our respective meetings on what issues are going on. So on the dual eligibles, generally we've been talking about -- talking to them, and as Jim mentioned yesterday, we have data set work going with them on duals.

On this, my understanding is that they're also keeping track of it, but they haven't come out and said I am going to, you know, speak to it at this point. That's my sense.

MS. AGUIAR: I will just add, when -- so our Commission, we first discussed this issue in April of 2012, and MACPAC also had one, if not at least two sessions, I believe, of their commission sessions on the demonstrations as well, and then as Mark said, that they're continually updating their Commissioners on it.

MR. HACKBARTH: I'm at least tentatively scheduled to go to the MACPAC Commission meeting on October 18th, and I'm sure this will be a subject for discussion.

DR. MARK MILLER: Did you want me to go with you [off microphone]?

[Laughter.]

DR. NAYLOR: I'm always following these comments. I am struck -- beautiful report, and I'm struck by the common-ground challenges and evaluation especially as these states are deciding to take all comers in the demos. And I would echo all that my colleagues ahead have said. To the extent that any of the existing demos focus specifically on dual eligibles and especially the diversity among the dual-eligible populations, to the extent that they can help us in understanding what are really common-ground issues that you brought up so beautifully in earlier work around beneficiary engagement and critical importance of care coordination, financial integration. That I think could be helpful. So I don't know if it's just monitoring or really, really helping us to target those demos. I think -- because I do recall that one of the challenges is building the capacity of the health plans to be able to take on more and more through a D-SNP process.

So I think that we could learn a great deal because I do know that some of these demos, either in

advanced primary care or some of the demo issues themselves or the innovations are focused on this population. And I think it's really important for us to continue to grow in our capacity to understand how to do that better.

DR. CHERNEW: I have a few points.

The first one is we've had a lot of sessions about the in efficiencies that arise because of a lack of coordination between Medicare and Medicaid. So, broadly speaking, I'm thrilled to see this type of activity going on.

My first sort of answer to the question is I agree with everyone, I wouldn't go back and revisit D-SNPs. I do think it's worth spending some time trying to look at sort of what I'll call broadly the level playing field question, but really I'm interested in how it fits in with some of the other programs, how these demos fit in with things like ACOs. My understanding of the question, if I know from -- if I remember from the mailing materials, if you're in an ACO, you can't be in this.

MS. AGUIAR: If beneficiaries have already been assigned or attributed to an ACO, they will not be removed from that ACO in order to be assigned or attributed to this

demonstration.

DR. CHERNEW: And so in Massachusetts there's a lot of ACOs. Do we know things, for example, like how many people are going to be pulled out of this demonstration and put in the ACO?

MS. AGUIAR: Well, no, the way that I believe it works is if the ACO in Massachusetts are already in existence and they already have some dual eligibles -- again, this is just the under-65 population -- attributed to them, those beneficiaries stay with that ACO. All other dual-eligible -- all of the other eligible population can either voluntarily enroll, and if they don't they will be passively enrolled into the demonstration.

DR. CHERNEW: And so I almost understand that, and that's useful. But understanding more broadly how this fits in -- Massachusetts, I think, has a unique position of being in both presentations this morning, and so understanding how the morning presentation, the first one, fits into this one and whether we want, first, understanding, and then asking the question: Do we want to segment the population the way it's segmented and segment the programs? I'm not asking you that question. I'm saying as a topic for the Commission to

understand where the seams are, and I think it's particularly interesting because of the things from this morning, I believe all the states have made different decisions about which populations to put in different types of things. And so learning about that would be interesting to me.

My last point is when we had those earlier discussions about the inefficiencies, there are always some sentinel things that we look at. The one that always sticks in my mind is the hospital admission and nursing home churning that would go on. That's something -- if you understand what I mean by that, people going to hospital, then coming back to the nursing home. Finding some measures of whether or not we see those inefficiencies going down would be useful because it would help me answer our broader question, and I'd be interested in other people's views, which is: Is this the -- ultimately I think we want to know, Is this the way forward, ultimately the way forward for dealing with the coordination between the programs? Or is there some other alternative that I'm not aware of?

MS. AGUIAR: What I would just add to that is there is also -- again, from the Medicare-Medicaid

coordination office at CMS -- another demonstration that I do not believe we've updated you on too much. But that is getting at -- trying to get at this issue of the churning. And basically I think what that model is trying to do is to take the Evercare model, which is a capitated I-SNP model, and bring it within fee-for-service. So that is still in the implementation phase, but I don't know if you have interest in that. We could add that to something that we monitor and report on.

DR. CHERNEW: [off microphone] for me, but I'd love other people's views. I'm interested in all of the issues of how these different programs aimed at similar goals are relating to one another, and ultimately if I think of the Medicare program in 2020 or pick some other point in time, I hope -- and maybe I'm crazy, but I hope that we don't have 12 different demonstrations with very similar goals working in a whole bunch of different places that get in each other's way and -- you know. I would hope that we could somehow streamline a model for the program overall, even if it gets operationalized differently. But I'm not sure that's feasible.

MR. ZARABOZO: On the churning point, we should

mention that under MA there is not a three-day hospital stay requirement for a SNF to be covered as a Medicare-covered service. So you wouldn't necessarily have churning going on within the MA program. And when Craig looks at the encounter data, he can tell us to what extent --

[Laughter.]

MR. HACKBARTH: Although the churning that we usually talk about in this context is between the long-term care facility and the hospital trigger Medicare payment for skilled nursing facilities.

MS. AGUIAR: Yes, and within fee-for-service. Yes.

MR. HACKBARTH: So I thought I understood the ACO assignment issue and the interaction with Massachusetts, but now I don't think I do. So let me just take an example.

Massachusetts has a flock of ACOs, Pioneer and other. Let's take an under-65 Medicare beneficiary qualified by virtue of disability --

MS. AGUIAR: Yes.

MR. HACKBARTH: -- that receives her primary care service from one of the organizations, many organizations in Massachusetts that is an ACO. Is that beneficiary eligible

for the Massachusetts demonstration?

MS. AGUIAR: Yes, that beneficiary can participate in the duals demonstration if she actively disenrolls from the ACO and re-enrolls -- and enrolls into the Massachusetts demonstration. But she will not be passively enrolled, so she will not be taken out of the ACO and placed in the demonstration.

MR. HACKBARTH: But she was passively enrolled in the ACO. It's not like --

MS. AGUIAR: Yeah.

MR. HACKBARTH: -- she's made a choice and we'd be taking it away.

DR. CHERNEW: Would she need to switch providers to passively -- I didn't realize you could passively -- or actively disenroll from an ACO.

MR. HACKBARTH: There's no enrollment at all.

MS. AGUIAR: Right. What I would say to this is that I think this is -- how this -- what we know is what has been written in the MOUs and three-way contracts, and it's sort of very -- not very detailed information about who's eligible, who won't be passively enrolled, and things like that. I think you're getting to really good questions on

how in practice this is going to work, and we just don't know yet. But I think that is something we will follow up on.

DR. NERENZ: This may be back to a clarifying point. In your example just now and a couple of other places, we picked up specifically under 65. I had not previously formed the impression that either this program or the ACOs were uniquely about under 65. Am I incorrect?

MR. HACKBARTH: The Massachusetts demo actually focuses on the Medicare-eligible population under age 65.

DR. NERENZ: That one state.

MR. HACKBARTH: Right.

DR. NERENZ: But not the whole program.

MS. AGUIAR: No. For the financial alignment demonstrations, each state sets their eligibility criteria. Massachusetts is for the under-6.

DR. NERENZ: Okay. That had been my impression. I just wanted to make sure wasn't missing something that it was broader than that.

MR. KUHN: And on the issue of the terms -- or the MOU, won't there be a subsequent detailed terms and conditions between the state and CMS?

MS. AGUIAR: Yes, that is --

MR. KUHN: Probably all that will be detailed out in --

MS. AGUIAR: Right. So that is the three-way contract, and to date, as we said before, Massachusetts is the only one that has gone that far. That does give some more detail, but not on everything.

DR. HOADLEY: Mike's comments reminded me, you know, there are also states that are doing waiver programs in Medicaid for their dual eligibles that are not -- where there's no Medicare involvement. Florida is an example that's implementing right now. Are you following those at all? Because, I mean, there's obviously implications for Medicare, at least indirectly if not directly.

MS. AGUIAR: Right. We're following it in the sense that the financial alignment demonstration -- so every state has obviously the eligible population, but then also populations are excluded. And so I would say in general -- again, it depends by state, but some states do exclude some HCBS waiver populations, particularly if it's for the ID/DD population. Florida has not yet progressed to an MOU, so I'm not quite sure how they would -- how that waiver

initiative going on there would align with this demonstration.

DR. HOADLEY: Because they're putting all of their -- pretty much all of their dual eligibles into initially the long-term care -- ones that are in long-term care into the long-term managed care program, managed long-term care program, and then starting in 2014 they'll be putting all of them into the managed acute care --

MS. AGUIAR: Oh, right. I'm sorry. I misunderstood what you meant by the waiver.

DR. HOADLEY: Yeah, I'm talking about the --

MS. AGUIAR: Yeah, the mandatory Medicaid managed care enrollment, yes.

DR. HOADLEY: Right.

MS. AGUIAR: So that did happen in New York, and I believe also in California, and the way that it worked in New York was that moving the duals into mandatory managed care for the Medicaid services happened first before the demonstration was implemented, and I believe that that's the same way that it happened in California, at least for some of their population, if not all. So they are, I think, to the extent that's possible, trying to align the

demonstration, the timings of the demonstration, with their other Medicaid initiatives, particularly around mandatory Medicaid managed care enrollment.

MR. HACKBARTH: Anybody else?

[No response.]

MR. HACKBARTH: Okay. I'm ready to call it. Let me just sort of sum up where I think we are here.

We've spent a lot of time on this issue over the last several years because it's a really important one. We're talking about a population of beneficiaries that, yes, is very expensive, but even more implement than that is very vulnerable, the most vulnerable portion of the population we serve. And, you know, we helped encouraged in a small way this idea that there are ways to integrate Medicare and Medicaid and the associated care delivery to better serve this population. And so that's a good thing.

We made comments on the CMS proposal for the demos, most of which have been accepted in one form or another. A couple have not. At this point I think mostly we're in the watching phase now to see how these things actually work in practice.

We made, I think, an explicit decision here,

despite the growing interest in some states in D-SNPs as an option, not to revisit that again. Our position is that they ought to continue, be reauthorized indefinitely where they truly integrate Medicare and Medicaid, and it sounds like there is some interest at the state level in that.

The other issue that we touched on today that we will pursue further is the low-income issue, the Medicare savings programs, and whether they need to be modified or extended beyond what they are today as part of benefit redesign or as part of other initiatives as well.

I think that's where we are. Agreed? Anything you want to add?

DR. MARK MILLER: No. You got it.

MR. HACKBARTH: I think we're done. Thanks, Christine and Carlos.

We'll have our public comment period now.

You know the ground rules but I need to repeat them anyhow. Please begin by identifying yourself and your organization. When the red light comes back on, that’s the end of your two minutes.

As always, I will repeat for the audience that this is not your only, or even your best, opportunity to

influence the work of the Commission. The most important opportunity is to interact with the staff or to communicate with Commissioners by letter, or by putting comments on our website.

DR. CONROY: My name is Joanne Conroy and I'm from the Association of American Medical colleges, which supports and represents our nation's teaching hospitals and medical schools.

We appreciate that MedPAC spent the morning talking about alternative payment models. Our academic medical centers, and the broader community, agrees that there's actually an urgent need to implement payment and care delivery innovations. And many of our members are actually leaders in the initiatives you discuss this morning.

The AAMC itself is a convenor of 10 teaching hospitals in the Bundled Payments for Care Improvement Initiative, and it looks like we may actually have a few more institutions joining us over the next few months.

The alternative payment methodologies you've been discussing all become very successful because we continue to shift care to a different and probably more appropriate

setting. We'd like to remind you, however, that this shift from inpatient to outpatient and post-acute settings does, however, have an effect on the amount of support to the Medicare program that provides for graduate medical education because the Medicare GME payments are a very direct tie between inpatient admissions.

We urge the Commission to monitor the effect of these payments as these alternative payment methodologies roll out across the country in order to not only ensure that there's an adequate number of physicians but certainly to ensure sufficient access for the growing number of Medicare patients.

Thank you.

MS. McILRATH: Sharon McIlrath with the AMA.

I just wanted to also suggest that there might be some areas that CMMI has not addressed yet or had done so only minimally.

One of those is in the area of specialty models. I think they just have a contract that they are starting to look at that, but there are a number of specialties that we have talked to and consulted with that are developing and have models that are fairly well developed and that could be

plugged in and looked at.

A lot of these are episode-based. And so, if you wanted to think about what you could easily drop into something that was broader, they seem to fit that. They would be, probably, tested in more than one area so you would get around, a little bit, the issue of does it work across sites.

You also know, sort of, going in -- assuming that you've designed the bundle right -- what the payments are going to be and you have some assurance that you're not going to be paying more. You'd have the technical expertise of the specialties doing that. Some of these, it's more than one specialty looking at it.

So just, as you go forward, to think about aren't there some ways that the specialty input and those kinds of models are also tested.

MR. HACKBARTH: Okay, we are adjourned.

[Whereupon, at 1:26 a.m., the meeting was adjourned.]