MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, 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

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1 P R O C E E D I N G S [9:43 a.m.]

2 MR. HACKBARTH: Okay. Would you take your seats,

3 please?

4 Before we begin our presentations and going

5 through the issues one by one, I just want to do a little

6 bit of stage setting for the audience.

7 First, sort of an overview of what we'll be doing

8 the next couple days. As those of you who follow our work

9 know, this is the meeting at which we complete work on our

10 recommendations on update factors that will go into our

11 March 2014 report.

12 Today we will have votes on a package for acute-

13 care hospitals and long-term-care hospitals, two

14 recommendations relative to Medicare Advantage, a dialysis

15 recommendation, and a couple recommendations related to

16 post-acute-care services.

17 On Friday, tomorrow morning, we will have votes on

18 ambulatory surgery centers, long-term-care hospital updates,

19 IRF updates, and hospice. We will not have our usual

20 extended staff presentation and Commissioner discussion on

21 those issues tomorrow morning. Based on our discussion in

22 December about the draft recommendations, it seemed that

1 there were few outstanding issues, and we decided to
2 truncate the time allotted to those issues so that we can
3 make room for some other topics, including ACOs, the Part D
4 landscape chapter, and discussion of recommendations on the
5 Medicare savings programs.
6 So we are trying to not use up all of our time at
7 this meeting on updates where there's no controversy among
8 Commissioners and reallocate it to some other topics.
9 We will not be discussing at all at this meeting,
10 either today or tomorrow, physicians, skilled nursing
11 facility, and home health agency payment. As we discussed
12 in December, in each of those cases we have a multi-year
13 recommendation that has been in place. In December,
14 Commissioners did not express any concerns about those
15 recommendations, and so we will be including, of course,
16 chapters in the March report, but we are not going to be re-
17 discussing those issues today or tomorrow.
18 Because of that, I want to emphasize here at the
19 outset that, on physicians, repeal of the SGR system for
20 physicians continues to be one of our top priorities. I
21 sort of scanned the press accounts of our meetings, and
22 after the December meeting, somebody inferred from something

1 I said about physicians that maybe we had backed away from
2 our position on repeal of the SGR. Nothing could be further
3 from the truth on that.
4 What I did say and tried to convey is that we are
5 glad that the Congress, the relevant committees of the
6 Congress are working actively on SGR repeal. We are
7 encouraged by the progress that they have made and the
8 general direction that they are headed and hope that they
9 will complete that work in an expeditious way. At this
10 point I just don't think MedPAC spending more on the issue,
11 while it's under active deliberation in Congress, I don't
12 think we have more to say on the topic. We are not,
13 however, backing away from our more than a decade long
14 position in favor of repeal of SGR.
15 So that's sort of an overview of the meeting.
16 The next thing I want to do is talk about the
17 sequester and how our recommendations work and the
18 implications for the sequester. The sequester, which, as
19 people know, reduces payments to Medicare providers and
20 suppliers by 2 percent, has recently been extended so that
21 it will be in effect, barring a future change by the
22 Congress, change via legislation, the sequester will be in

1 effect from April 2013 until March 2024. It was extended 2
2 years in the Bipartisan Budget Act of 2013.
3 Next slide.
4 This illustrates how the sequester works. The
5 yellow line in this graph is the base payment amount under
6 the Medicare payment system. Each of the Medicare payment
7 systems for hospitals and skilled nursing facilities and
8 long-term-care hospitals, et cetera, each of them has a base
9 rate that is then multiplied by various factors -- wage
10 indexes, case-mix indexes, et cetera -- to get the payment
11 rate for a particular service.
12 The updates that we recommend are updates to that
13 base rate. So the yellow line here illustrates the increase
14 in the base rate for a provider group that under current law
15 is to get a 2 percent update each year. So that yellow line
16 moves up in 2 percent increments each year.
17 The sequester is depicted by the green line. The
18 sequester is actually not part of the Medicare law. It is a
19 different statute altogether. And what the sequester does
20 is say that we're going to reduce the payment rate below the
21 yellow line by 2 percent at the beginning of the year; then
22 at the end of the year, the rate pops back up to the base

1 rate provided for in current law. The sequester is
2 temporary. The sequester is not cumulative. The sequester
3 does not change the base rate.
4 Next slide.
5 So MedPAC's approach on making updates is that we
6 make recommendations on the base payment amount, the rate
7 established in the Medicare statute, Title 18 of the Social
8 Security Act. We make recommendations on the yellow line.
9 The Commission opposes the sequester, and I want
10 to be crystal clear on this. The sequester is a way of
11 reducing payments below that yellow line to hit budgetary
12 targets established by the Congress.
13 Our approach is to recommend changes in the base
14 rate, the yellow line, and to make other recommendations for
15 changing the trajectory of Medicare expenditures. We don't
16 think that reducing the base rates for hospitals, for
17 physicians, for skilled nursing facilities by 2 percent
18 using the sequester as the mechanism is the best way to find
19 savings in the Medicare program. Each year we produce many
20 recommendations, some of them for update factors, some of
21 them for other policy changes, that will reduce Medicare
22 spending. There are better, more targeted ways to reduce

1 Medicare spending than arbitrary 2 percent cuts executed
2 through the sequester.
3 We don't ignore the sequester. We say there is a
4 better way to reduce Medicare spending. And we make
5 recommendations about Medicare payment rates that affect the
6 yellow line, the base rate. When the sequester reduces the
7 payment rate going to providers below our recommended yellow
8 line, MedPAC opposes that. We're not ignoring the
9 sequester. I want to be crystal clear. We oppose the
10 sequester when it reduces rates below our recommended yellow
11 line.
12 Now, we're not the decisionmakers. The Congress
13 makes the decisions. But where the sequester reduces that
14 rate below our recommended rate, we're opposed to it. In
15 fact, as I said a minute ago, as a matter of principle we
16 don't think this is a good way to reduce Medicare spending.
17 There are more targeted ways to go about that task.
18 Move to the next.
19 And so this is a real simple example to illustrate
20 what I'm saying. For this provider group, in fiscal year
21 2014, or it can be calendar year for a payment system, for
22 2014 the base payment amount, let's just say for the sake of

1 discussion, is $100. Now, the amount that providers are
2 actually getting because of the sequester is not the $100
3 but the $98, the sequester amount at the bottom of that
4 column.
5 Now, we have assumed in this example that the
6 current law update for this group of providers is 2 percent.
7 So as you move from 2014 to 2015, the current law update
8 would be to go from $100 to $102 in the base rate.
9 For the sake of illustration, let's say that the
10 MedPAC recommendation is not for the current law 2 percent
11 increase in the base rather but, rather, 1 percent. That
12 gives you the circled $101 base rate in 2015.
13 Under the sequester, if Congress doesn't enact our
14 recommendation, the current law provides for $102, and the
15 sequester would reduce that to $100. Since 100 is less than
16 101, it's clear that we oppose the application of the
17 sequester to this group.
18 Now, sometimes, in fact, even after the sequester,
19 the rates paid to providers may be higher than MedPAC
20 recommends. Sometimes it's lower, sometimes higher. But
21 rather than confusing things by saying, "Well, sometimes we
22 like the sequester, sometimes we don't," I want to be real

1 clear. We don't the like the sequester at all. We don't
2 think as a matter of principle this is the way to reduce
3 Medicare spending. A much more targeted approach is the way
4 to go. I am not ignoring the sequester, as has been
5 frequently reported. This is what we're doing. So
6 hopefully that makes it clear.
7 I think that's all I have for the introductory
8 session. Any suggestions from Commissioners for
9 clarifications on that?
10 [No response.]
11 MR. HACKBARTH: Okay. Let's do the first
12 presentation, which is on hospital services and LTCHs.
13 While the group is getting in place, I recognize
14 that the sequester and how it plays into all of this can be
15 confusing for people, and so next year, when we go through
16 this process again of formulating update recommendations, we
17 will consider changes in how we package our recommendations,
18 how we report projected margins, things like that. Given
19 that the sequester now seems to be if not permanent, at
20 least semi-permanent, permanent for the next decade or so,
21 it's going to be with us, and we need to think about how we
22 can most clearly communicate our message.

1 So as I say, there may be some changes in
2 packaging and presentation on the fundamental substantive
3 point, though don't expect any change. We're going to work
4 from the Medicare law, the base rates in the Medicare law.
5 That's what we're charged with making recommendations on.
6 And that will continue to be our approach.
7 Okay. So who has the lead?
8 DR. STENSLAND: Good morning. This session is
9 going to discuss Medicare payments for hospitals. First,
10 I'll review the adequacy of Medicare payment rates. Because
11 we've already discussed this in November and December, I
12 will go quickly through that part of the presentation.
13 Second, Dan will recap aligning hospital
14 outpatient rates with physician office rates.
15 Third, Dana will discuss aligning LTCH and acute
16 care hospital inpatient rates.
17 The common theme throughout the presentation is to
18 create incentives to improve the efficiency of care while
19 maintaining an adequate level of aggregate payments.
20 As we discussed in December, in general, most
21 payment adequacy indicators are positive. Access to care is
22 good, with excess capacity in most markets. Access to

1 capital is adequate, as measured by access to debt markets,
2 access to equity markets, and hospital construction
3 spending. Quality is generally improving, as measured by
4 30-day mortality rates and hospital readmission rates.
5 However, as we discussed before, Medicare margins
6 remain negative for the average hospital and are expected to
7 remain negative in 2014. The projected margin would be six
8 percent if the sequester is repealed, and that could go to
9 almost eight percent, or two percent lower, if the sequester
10 remains in place.
11 As we discussed in December, while average margins
12 are negative, there is a group of hospitals that have been
13 able to generate a small profit treating Medicare patients
14 while having relatively good quality metrics. This group of
15 relatively efficient providers has 13 percent lower
16 mortality, lower readmissions, and costs that are about ten
17 percent below the average hospital. The point of this slide
18 is to show that it is possible to produce good outcomes
19 while controlling costs.
20 Now, I just showed you the most recent data we
21 have, which is for 2012, and gave projected margins up to
22 2014, with and without the sequester. However, today,

1 you'll be voting on a recommendation for 2015 payment rates.
2 Under current law, we would expect payment rate to decline
3 by 1.3 percent in 2015 due to the changes in payment policy
4 that we discussed last month. If payment rates declined by
5 1.3 percent next year, we would expect Medicare margins of
6 the relatively efficient hospitals to fall below zero.
7 Now, next, we're going to shift to discussing
8 aligning payment rates across sectors, and after that
9 discussion is complete, I'll come back to you with the draft
10 recommendation for 2015.
11 A key problem in the Medicare payment system is
12 that Medicare hospital payment rates encourage care to be
13 shifted to higher-cost sites. This can increase provider
14 costs of care, increase Medicare program costs, and increase
15 beneficiary cost sharing without any evidence that care is
16 improved. We discuss aligning payment rates for similar
17 cases across silos in order to eliminate this distortion in
18 Medicare prices which can create inefficiency.
19 First, Dan is going to discuss eliminating the
20 adverse incentives in the outpatient payment system.
21 Second, Dana will explain how to correct the incentives that
22 currently encourage certain inefficient practices in the

1 delivery of LTCH care.

2 Now, I'll turn it over to dan.

3 DR. ZABINSKI: Efficiency in ambulatory settings

4 is becoming a larger concern because it does appear that the

5 billing of services is shifting from the lower-cost hospital

6 office setting to the higher-cost OPD setting. For example,

7 in this slide, we show that the volume of E&M office visits,

8 echocardiograms, and nuclear cardiology services that are

9 provided in freestanding offices all decreased in 2011 and

10 2012 while the volume increased in OPDs for the same

11 services.

12 Also, there has been widespread attention to this

13 issue in the press concerning the private sector. Stories

14 describe increased costs on insurers and patients in the

15 private sector due to shifts in billing from offices to

16 OPDs.

17 In the Medicare program, this shift in billing

18 from offices to OPDs increases program spending and

19 beneficiary cost sharing without any significant change in

20 patient care or quality.

21 We estimate that Medicare and beneficiaries are

22 paying about $2.1 billion more for E&M visits and other

1 services than they would if OPD rates were more closely
2 aligned with lower physician office rates, with program
3 costs being about $1.7 billion higher and beneficiary cost
4 sharing being nearly $400 million higher. And if the shift
5 in the site of service continues, the costs to Medicare and
6 beneficiaries will increase further.
7 The Commission has recommended equal payment rates
8 for E&M office visits, whether they are provided in
9 freestanding offices or OPDs and has had several discussions
10 about eliminating or narrowing the differences in payment
11 rates between freestanding offices and OPDs for other
12 services. We do want to emphasize, though, that it is not
13 appropriate to pay equally across these two settings for all
14 services, and we have identified five criteria that services
15 should meet in order for payments to be equal in offices and
16 OPDs and we have discussed these five criteria in detail in
17 previous meetings and the June 2013 report, so we won't
18 cover them here.
19 We have identified some APCs in the outpatient PPS
20 that meet these five criteria and are viable candidates for
21 equal payments across settings, where APCs are the system
22 for classifying services in the payment units and the

1 outpatient PPS. We call these APCs Group 1.

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

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

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

22 And a concern that many have expressed about these

1 lower OPD rates is that access to ambulatory services for
2 low-income patients may be adversely affected, so in
3 response, we have developed an illustrative example of how
4 losses to hospitals that serve low-income patients could be
5 mitigated.
6 And now, Dana will talk about payment reform and
7 LTCHs.
8 MS. KELLEY: The Commission has developed a draft
9 recommendation for the LTCH prospective payment system that
10 would reduce incentives to admit patients who are not
11 appropriate candidates for LTCH services. This
12 recommendation would maintain a separate LTCH payment
13 system, but higher LTCH level payments would be made only
14 for LTCH patients that were chronically critically ill, or
15 CCI. All other LTCH cases, the non-CCI cases, would be paid
16 IPPS-based rates. All LTCH cases, whether CCI or non-CCI,
17 would be eligible for LTCH outlier payments. The outlier
18 pool would remain set at eight percent of total LTCH
19 payments.
20 Under this recommendation, LTCHs would be required
21 to maintain an average length of stay of more than 25 days
22 only for their CCI cases. Savings from these changes would

1 be transferred to the IPPS outlier pool and used to increase
2 outlier payments for chronically critically ill patients in
3 the IPPS.
4 As we've discussed, under this recommendation, CCI
5 cases would include those that spent eight or more days in
6 an ICU during an immediately preceding acute care hospital
7 stay. In addition, we've expanded our CCI definition to
8 include those patients who received prolonged ventilator
9 services during an immediately preceding acute care hospital
10 stay. This was in response to Commissioner concerns that
11 the threshold of eight days in the ICU could prevent some
12 prolonged ventilator patients from receiving specialized
13 weaning services in LTCHs. Our analysis found that most
14 prolonged ventilator cases in LTCHs had had long ICU stays
15 during their preceding hospital stay and, therefore, would
16 meet the eight-day threshold. However, we've expanded our
17 definition of CCI to include all of these cases to maintain
18 access for these patients. We estimate that about 41
19 percent of current LTCH cases would qualify as CCI under
20 this definition.
21 Some have questioned why the Commission has
22 focused on ICU as a definition of CCI. The definition

1 arises from both the research literature and the industry
2 itself. Researchers are consistent in describing
3 chronically critically ill patients as having long acute
4 care hospital stays with heavy use of ICU services. In
5 addition, in CMS technical advisory panels and in site
6 visits conducted by RTI under contract to CMS, LTCH
7 representatives and acute care hospital critical care
8 clinicians agreed that the appropriate candidates for LTCH
9 care are medically stable post-ICU patients.
10 Findings from the PAC reform demonstration
11 strengthen the case for using ICU length of stay. In the
12 demonstration, it was found that ICU length of stay was the
13 most important factor explaining variation in LTCH routine
14 resource intensity. Our resource has found that ICU length
15 of stay can be used to identify the CCI patients who may be
16 appropriate candidates for LTCH care and who have resource
17 needs that are likely to be aligned with higher LTCH
18 payments.
19 Another question that has come up is why eight
20 days. There is no magic number, but ICU days, as I said,
21 are positively associated with case complexity. As the ICU
22 length of stay threshold is reduced, the average complexity

1 and resource needs of patients fall. If the threshold is
2 set too low, less-complex cases will be designated as CCI
3 and CMS will continue to pay too much for cases that could
4 be cared for appropriately in other settings at a lower cost
5 to the Medicare program.

6 Our recommendation is to implement LTCH payment
7 reform over a three-year period. This slide shows the
8 impact on payments to LTCHs and IPPS hospitals assuming no
9 behavioral change. As you can see on the left, when fully
10 implemented, total payments to LTCHs would decline by about
11 $2 billion. As I mentioned, 41 percent of cases would
12 receive the high LTCH payment rates. Fifty-nine percent
13 would be paid IPPS-based rates. On average, assuming no
14 behavioral change, an LTCH's total Medicare payments would
15 decline 36.5 percent by year three. The impact will be
16 greater for for-profit LTCHs and LTCHs in LTCH-saturated
17 markets, as well as for any LTCHs with relatively low CCI
18 shares.

19 On the right, we show the impact for IPPS
20 hospitals. Under our recommendation, savings from LTCH
21 payment reform would be used to increase outlier payments
22 for CCI cases in acute care hospitals. When fully

1 implemented, total outlier payments to IPPS hospitals would
2 increase by $2 billion. About six percent of current IPPS
3 cases would be eligible for higher outlier payments. There
4 would be no reduction in payments for any IPPS hospital.
5 On average, an IPPS hospital's total Medicare
6 payments would increase by 1.8 percent. It is not shown on
7 the slide, but the aggregate average increase for CCI cases
8 would be 10.8 percent. IPPS hospitals that care for more
9 CCI cases will benefit more under our recommended policy.
10 These include major teaching hospitals, low-margin
11 hospitals, and hospitals in areas with fewer LTCHs.
12 These impacts assume no behavioral change for
13 LTCHs. However, we do expect significant changes in
14 behavior, so let's talk about what we anticipate will
15 happen.
16 This slide shows the relationship between an
17 LTCH's margin and its CCI share of cases. As you can see
18 from this scatterplot, there is no relationship. An LTCH's
19 margin is not associated with its CCI share. This is
20 important because it means that LTCHs do not systematically
21 make their margins on their less-complex non-CCI cases.
22 LTCHs can focus on caring for CCI cases and still maintain

1 positive margins.

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

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

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

22 Now, Jeff will review the draft recommendation and

1 its implications.

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

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

18 And the rationale for this recommendation is,
19 first, that there's a need to reduce incentives to shift
20 care to higher-cost sites, and this would accomplish that in
21 three different ways. First, aligning selected APCs with
22 physician office rates would reduce unnecessary costs

1 associated with the shift of services from physician offices
2 to being billed as hospital outpatient services.
3 Second, equalizing the LTCH and acute care
4 hospital rates for non-CCI cases would eliminate the problem
5 of LTCHs keeping low-severity patients longer than truly
6 needed in order to increase their LTCH payments.
7 Third, increasing acute care hospital CCI payments
8 through the additional outlier payments Dana just discussed
9 would bring greater equity between markets with and without
10 LTCHs.
11 In addition, the draft recommendation is designed
12 to provide adequate payments. After considering
13 beneficiaries' strong access to care, the potential for
14 declining margins given changes in current law I just
15 discussed, and the two draft policy changes, an update above
16 current law is warranted.
17 This graphic shows you how acute care hospital
18 payments would change under the draft recommendation. The
19 first column shows acute care hospital payments in 2015
20 under current law, and we already talked about this. This
21 is the 1.3 percent expected decline.
22 The second column shows the impact of the

1 recommendations in 2015. If you look down the second
2 column, you see that the outpatient site neutral
3 recommendation would reduce hospital payments by about 0.6
4 percent, as Dan mentioned. The LTCH reform part of the
5 recommendation would increase PPS hospitals' payments by 0.4
6 percent, due to those outlier payments being phased in one-
7 third in 2015. Then the update in that last line is 1.05
8 percent higher than in current law. The net result is that
9 payments would be higher in 2015 than current law, but
10 payment growth would still be a negative-0.5 percent.
11 The last column shows what would happen when the
12 recommendation is fully phased in. The impact of the LTCH
13 reform now increase to 1.2 percent because the full
14 reduction in the LTCH payments is taking place and that full
15 amount of money is now available for IPPS hospitals as extra
16 outlier payments.
17 In the end, there is a 0.3 percent increase in
18 acute care hospital payments relative to 2014, which is 1.6
19 percent above the current law estimate of negative-1.3
20 percent.
21 Now, we talk about the implications of this
22 recommendation in terms of spending and for beneficiaries

1 and providers.

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

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

1 acute care setting.

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

3 MR. HACKBARTH: Clarifying questions first. Any

4 strictly clarifying questions on the presentation? I have

5 Bill, Herb -- anybody else? Bill?

6 MR. GRADISON: I do have one.

7 MR. HACKBARTH: A clarifying question?

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

9 hear you correctly. I thought you said that the savings

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

11 up here says $5 to $10 --

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

13 ten.

14 MR. GRADISON: Thank you.

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

16 MR. GRADISON: Thank you.

17 DR. HALL: Perhaps this is more of a semantic

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

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

20 particularly concerned about how we talk about the

21 adjustment of payments between the two outpatient sites of

22 seeing patients. Let's see. Under "Solutions." Okay. So,

1 if you look under "Solutions," there, halfway down the
2 slide, and we say, pay hospital rates that are comparable to
3 physician office rates for services that can be provided,
4 that's very clear to me. There's no equivocation.
5 In many of our previous statements in the material
6 we received at home, we actually use a different phrase at
7 least five or six different times, and the phrase is "reduce
8 or eliminate differences in payment rates between outpatient
9 departments and physician offices." Someone reading that
10 for the first time could reasonably say, well, I think what
11 they're trying to say is that we ought to pay the ambulatory
12 sites the same rates that we're paying the hospital, and
13 that's not what we're doing. It's just the opposite of
14 that.
15 So, I like the nomenclature in the slide here.
16 Pay hospital rates that are comparable to physician office
17 rates for services, et cetera. that is very, very clear.
18 Otherwise, I think we're going to confuse a lot of people in
19 what is a very good policy recommendation.
20 MR. HACKBARTH: Okay. Got that?
21 Herb.
22 MR. KUHN: Thank you. On page 15, where you look

1 at the LTCH margins, and just to be sure, that's all LTCHs
2 together. That doesn't differentiate between freestanding
3 versus hospital in-hospital, is that correct?
4 MS. KELLEY: No, that's all LTCHs.
5 MR. KUHN: Okay. If we did differentiate between
6 the two, do we think we would see much difference between
7 freestanding versus hospital in-hospital?
8 MS. KELLEY: No, I don't. No, I don't believe so.
9 MR. KUHN: Okay. Thank you.
10 MR. HACKBARTH: Any other clarifying questions?
11 [No response.]
12 MR. HACKBARTH: Okay. Since we went over this in
13 December, I think we'll just do one round here and each
14 Commissioner will have their opportunity to comment on the
15 proposed recommendation, beginning with Peter.
16 MR. BUTLER: Okay. So, this may take a little
17 longer than two minutes, but not too long. I'll try to be
18 efficient.
19 I like to remind Commissioners every year that
20 this is the most important vote we take because it's the
21 biggest amount of money. It's somewhere, I think, between
22 25 and 30 percent of the budget sits with this vote. And if

1 you look at the chapter, we spent $166 million last year, in
2 2012, $163 the year before, which is only about a two
3 percent increase, I think, by my math, and it is actually a
4 reduction in per capita spending for this component of the
5 Medicare program, which says from a fiscal standpoint -- and
6 we don't like to take things in isolation, but it's done
7 pretty well on the cost side of things. As shown, the
8 access, the quality, and -- not bad. And while the value-
9 based purchasing and other tools that we're trying to
10 implement are not perfect, this is a sector where we've got
11 some traction, particularly with things like HCAHPS that
12 seem to be a positive development.
13 I'd also point to the Health Affairs blog that,
14 Glenn, you sent my way, and maybe to some others, that
15 Kaufman, Hall looked at the Chicago market, and the title is
16 "Where Have All the Inpatients Gone?" -- "Where Have All the
17 Patients Gone?" And it was an interesting portrayal of the
18 reductions being not really due to a lag in the economy, but
19 due to systematic changes in care. And it's just one
20 example that I think things are really -- are happening.
21 And, also, it highlighted that the switch to observation
22 stays and things, also, was not an explanatory variable.

1 So, maybe some good permanent things are occurring.

2 I think all this is occurring, too, at a time when

3 hospitals have invested in IT, are adapting with ICD-10, are

4 investing in ACOs at probably higher numbers than we

5 expected, and all costs money at the same time this sector

6 is showing it's not really increasing very rapidly, if at

7 all, on a per capita basis.

8 So, four things I like about the recommendations

9 here, and I support the recommendations. The first is the

10 treatment of the sequester, which applies to, really, all

11 the sectors, but I think the public shouldn't underestimate

12 the amount of sensitivity and attention Commissioners,

13 staff, Glenn, himself, has paid to wanting to get this

14 right. The fact is that the sequester is not Medicare law.

15 It is law, but it is not Medicare law, and we are opining on

16 Medicare law and there is a difference.

17 Glenn, I thought for a minute you were going to be

18 Jack Nicholson when you were saying, "Am I clear as

19 crystal?" --

20 [Laughter.]

21 MR. BUTLER: -- because you said it many times,

22 and we're trying to be very clear about sequestration as the

1 wrong tool and really outside our domain, anyway, in terms
2 of a specific recommendation. So, I like the sequester.
3 I also like how we're handling the pricing issues,
4 where we said repeatedly, some pricing is just -- not only
5 does not make sense, it's leading to behaviors, or enabling
6 behaviors like maybe employment in cases where it really
7 shouldn't occur and increase ultimately in Medicare spending
8 and we need to put a stop to that.
9 I like this particular recommendation because
10 while I have previously supported the E&M codes, I think the
11 APCs is a better starting point because it also deals with
12 the test and procedure issues as opposed to the office
13 visits. And I also like it because I think it's a better
14 place to start, and I do want to be clear that I think that
15 if you were to put E&M and APC on the table at once, I
16 couldn't support -- the whole recommendation doesn't hang
17 together. So, I'm supportive of the APCs, although I
18 realize there are some technical issues in terms of the
19 current list of APCs that would have to be worked out to
20 make this work.
21 The third thing I like is the fact that this
22 crosses payment silos, and that's kind of precedent setting

1 for us, where we're trying to price things in a way that
2 puts patients in the right place, at the right time, at the
3 right price, and I think that that is an important thing for
4 us to do and I think this does this.
5 And, finally, I think this meets the test of
6 paying providers -- efficient providers -- at a level that
7 is acceptable. It's the 3.25 percent, as people will be
8 quickly to translate means 5.25 percent if you did not have
9 the sequester, which is we're opposing the sequester, is a
10 significant update over what is occurring now. And I think
11 it's an important message as over the next three months we,
12 once again, find -- try to find dollars to support SGR
13 repeal. It says that maybe this isn't the sector that is
14 the well you want to go to too aggressively to achieve those
15 kinds of offsets.
16 MS. UCCELLO: Yes. I support the recommendation,
17 as well, and agree with pretty much everything Peter said.
18 I especially like, as Peter did, the alignment of payments
19 across silos. We really need to stop providing incentives
20 to provide care at higher cost settings when lower cost
21 settings are available, and I think the way that we've
22 approached this is appropriate.

1 DR. BAICKER: I would echo Cori's sentiment about
2 enthusiasm for the equilibration of payments and also
3 reiterate your initial comments that what we're recommending
4 is the payment rate that we think should be in effect, and
5 if the sequester does something different from that, that's
6 not what we think the right answer is. This is what we
7 think the right answer is, and I support the
8 recommendations.
9 DR. HOADLEY: I also support the recommendations,
10 and I really think we've got a nice package here, you know,
11 addresses the site-of-care differentials, addressing the
12 LTCH issues, as has been described, both cases where we're
13 trying to get the payment right and not attached to just the
14 sector where, you know, a particular thing came from, but to
15 overcome sort of our underlying rules and make adjustments
16 to try to put things in a better place. And I think the
17 update, you know, there are plenty of arguments for high
18 updates; you know, we want to make sure people are paid
19 adequately and access is protected. There are a lot of
20 arguments out there for, you know, keeping updates low for
21 budgetary reasons. And I think we've really tried to hit a
22 sweet spot that kind of balances the things in the ways that

1 have already been described, sort of pay attention to where
2 the margin issues are, pay attention to access, pay
3 attention to budgetary considerations, not go crazy with
4 unnecessarily large update but really try to hit it right.
5 And I think we're in a good place on this.
6 DR. HALL: I would echo what others have said, and
7 I'm in support of the recommendations. And I think what I
8 really like about this is the tremendous amount of research
9 and analysis that has gone on by MedPAC staff on this.
10 There's nothing like this anywhere in the literature. I
11 think you've really gotten it right. And it is a marvelous
12 way of saying that we don't just cut rates irrationally, but
13 what we try to do is redistribute rates in a way that
14 incentivizes where we think the health system should go to
15 improve the quality and efficiency of care to older adults.
16 So I think this is a wonderful recommendation.
17 DR. COOMBS: First of all, I want to say I support
18 all three recommendations. I would agree with the APCs
19 selected. As I go through them, I think they're the most
20 appropriate ones that have been selected for this phase of
21 our advancement. And the other thing is I'm glad that, you
22 know, we -- we struggle with this whole issue of getting

1 around non-CCI versus CCI and criteria. I think this does
2 exactly what we want in terms of no matter what setting the
3 patient's in, is to treat them and to reimburse it according
4 to whatever setting they're in based on their status, so
5 that if they're non-CCI, whether they're in the hospital, or
6 whether they're in the LTCH, I think this gets around that.
7 So job well done. Thank you.
8 DR. CHERNEW: I also support the recommendation,
9 and I guess I want to say three quick things.
10 The first one is in support of what other people
11 said that we have to recognize that our task is not simply
12 to get a certain amount of money into a sector, but to try
13 and make sure that the prices are set correctly to give the
14 right incentives. And I think this is an example of where
15 we're beginning to move in that direction, and I strongly
16 support that.
17 The second thing is -- and Peter mentioned about
18 silos; I'll say it more explicitly -- we focus here in ways
19 on types of patients in terms of site of care in the sense
20 that we look at CCI, non-CCI patients. And the more -- so I
21 think it's basically a patient-centered approach, which I
22 think is important, and that is why it ends up being working

1 across silos.

2 And the third thing is something I've said before,

3 which is I do believe margins are an important criteria, but

4 they're not a definitive criteria about what we do. There's

5 a range of other criteria: access, quality, things of that

6 nature. And so I think it's important to understand that

7 when thinking about what the right update is, at least in my

8 mind, you don't simply look at the margin, you look at all

9 the other things going on and try and make a determination.

10 And I think that we've done a reasonably good job, as Jack

11 said, in hitting a balance.

12 DR. REDBERG: I support all of the recommendations

13 and for all of the reasons that my fellow Commissioners have

14 already outlined. I think it really represents a very

15 thoughtful process to maintain our principles to access to

16 care, maintaining quality of care, and neutralizing site-

17 specific payments, and that we oppose the sequester.

18 MR. KUHN: It's a good body of work, and I

19 appreciate the comments Glenn made this morning and the

20 conversation you had in the presentation about the

21 sequester. It's real clear that the Commission, like

22 everybody else, doesn't have a tin ear on this issue, and we

1 have a good sense of self-awareness of what the sequester
2 means, its impact. And I really appreciated when you put up
3 the margin information, indicated that those margins would
4 be 2 percent less if the sequester was in place. And I look
5 forward to the drafters' reports to also reflect that as
6 well as we continue not only this year but in future years
7 as we go forward.

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

17 DR. SAMITT: I wholeheartedly support the
18 recommendations. I think Peter described all the positive
19 elements eloquently. And the one point that I'd underscore
20 is even beyond the notion that this recommendation spans
21 silos, I would go one step further, which is I envision that
22 it actually really will drive a greater collaboration

1 between these various parts of the system because now this
2 will encourage LTCHs, hospitals, and physicians to truly
3 identify what is the right care in the right place with the
4 right provider at the right price. It will really encourage
5 those various silos to come together to evaluate the care
6 for a population, the care for the beneficiaries, which is
7 what is so critical here.
8 MR. GEORGE MILLER: Yes, I also echo what my
9 colleagues have said about this process and the tremendous
10 amount of work, and particularly that across settings, with
11 the right incentives, that we can put the patient in the
12 right location, not worry about what's the most cost-
13 effective method but the best site of care. And I
14 wholeheartedly support the recommendations as my colleagues,
15 but in the reading I've got a couple of things that I'd just
16 like to get clarity on.
17 One is on the hospital outpatient department. As
18 I understand it, on the hospital side we collapsed ten codes
19 into one, so we've got one code. But on the physician side,
20 physician fee service side, there's still ten. So we've got
21 ten E&M codes and ten different payments, but on the
22 hospital side there's just one. So my question is: How

1 would the caps work under that scenario since we're dealing
2 with ten versus one? How do you envision the caps working?
3 DR. ZABINSKI: I can picture a situation of, say,
4 on physician claims, they report site of service. So you
5 know when these E&M codes, which of the ten was provided in
6 an OPD, and you can use that information then to do an
7 average, you know, use the volume that you have in each of
8 those ten codes to create a single payment rate for that
9 single -- you know, that APC that now has only one code.
10 I'm not sure if that's being clear or not, but --
11 MR. GEORGE MILLER: No, but I can follow up later.
12 [Laughter.]
13 MR. GEORGE MILLER: Because I don't know how you
14 compare the two. On the hospital side now it's just one
15 code, but if that patient goes to a physician, that
16 physician can code that 1 through 4, and it's still ten
17 separate E&M codes.
18 DR. ZABINSKI: Well, let's simplify it a little
19 bit. Suppose you only had two E&M codes --
20 MR. GEORGE MILLER: Well, that would be helpful.
21 DR. ZABINSKI: -- instead of ten on the physician
22 side and one on --

1 MR. GEORGE MILLER: That would be very helpful.

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

3 MR. GEORGE MILLER: Yeah, suppose.

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

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

7 [Laughter.]

8 DR. ZABINSKI: You still have one on the hospital
9 side, and you know that the -- and suppose that the payment
10 rate for one on the physician side was $10 and the other was
11 $20, and half of the E&M codes were in -- you know, it was
12 divided equally, you know, half was in one E&M code, the
13 other half of the volume was in the other. So an average of
14 that is 15, okay? And that's what you'd -- you can picture
15 that's what you're going to then apply to the single --

16 MR. GEORGE MILLER: Cap.

17 DR. ZABINSKI: -- hospital outpatient code.
18 Something like that.

19 MR. GEORGE MILLER: Something like that, okay.
20 All right. We can come back to that later offline.

21 DR. MARK MILLER: And just to tack back to a point
22 that Peter was making, this is a discussion of the E&M

1 codes, and it's a fair question, and I hope you're getting
2 close to an answer. But just to remind people we're on the
3 other 66 codes for the purposes of this recommendation. But
4 your question still stands.
5 MR. GEORGE MILLER: Yes, right.
6 DR. MARK MILLER: I just don't want anybody to
7 misunderstand us here.
8 MR. GEORGE MILLER: Well, I'm going to ask about
9 the APCs also. As I understand it, the final OPPS rules
10 pack this into five different areas, which recategorize all
11 the APCs. So how do we differentiate between the OPPS and
12 the physician fee-for-service? Did they recalibrate when
13 you came with the 66 after the package in the five different
14 categories?
15 DR. ZABINSKI: I think I know what you're driving
16 at.
17 MR. GEORGE MILLER: Okay.
18 DR. ZABINSKI: This year there was an increase in
19 the packaging -- you know, for the --
20 MR. GEORGE MILLER: Yeah.
21 DR. ZABINSKI: Okay. Well, what's going to happen
22 there is any of the -- you're going to have some APCs in our

1 Group 1 where, you know, in Group 1 --

2 MR. GEORGE MILLER: You have two groups.

3 DR. ZABINSKI: The idea is to have APCs that have

4 minimal levels of packaging, our definition less than 5

5 percent.

6 MR. GEORGE MILLER: Right, right.

7 DR. ZABINSKI: Under the new packaging rules, the

8 packaging of those -- the amount of packaging in those items

9 is going to -- for some of them it's going to increase, and

10 that might push them to Group 2, but they'll still be in the

11 analysis. And, you know, any savings that you get from

12 lower OPD rates is going to be the same, whether they're in

13 Group 1 or Group 2, because we make the adjustment for that

14 additional packaging.

15 For example, suppose you have -- making more

16 assumptions, suppose you have an APC that's in Group 1 where

17 the outpatient payment rate is $100, and if we equalize the

18 payment across the two settings, that would drop the payment

19 rate to $50. All right? And suppose that, you know, under

20 the old system it had nothing packaged with it, okay, so

21 it's in Group 1. Now suppose under the new system with

22 greater packaging in the system, the packaging cost is $20.

1 That would raise the outpatient PPS rate to $120.

2 MR. GEORGE MILLER: Right.

3 DR. ZABINSKI: But we would say to equalize the

4 payment you'd raise the -- you'd drop the payment rate to

5 $70. So it was $50 when it had no packaging, and now it's

6 70.

7 MR. GEORGE MILLER: 70. Okay.

8 DR. ZABINSKI: The change in the payment rate pre-

9 and post-expanded packaging is still $50, so --

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

11 DR. ZABINSKI: So it washes out.

12 MR. GEORGE MILLER: Okay, got it. Thank you. I

13 support the recommendation -- even after those explanations.

14 DR. NAYLOR: I want to echo everyone else's

15 comments about the extraordinary quality of this work and

16 the analytics -- quality of evidence, the analytics, and the

17 efforts to really look at intended and unintended

18 consequences with a real strong Medicare beneficiary focus,

19 both from the standpoint of access and quality and also on

20 implications for cost sharing. So I support the

21 recommendations.

22 If I had one other recommendation that really

1 honestly flows from this work, it is to make very explicit
2 in the chapter that the goal here is to really get people
3 with the right set of services given the challenges that
4 they need. So on Slide 16 you talk about behavior changes
5 expected in LTCHs We want to also think about behavior
6 changes expected in acute-care hospitals, and ultimately
7 we're interested in making sure that chronically critically
8 ill and non-chronically critically ill people are in the
9 right context. And it might not be either of these when
10 they're in the right point in their trajectory.
11 So I would really want to make sure that we
12 continue to monitor seeing how patients are directed as a
13 result of these, and I think that that's just part of the
14 evolution that you've stimulated with this whole analysis
15 saying we can move to the next step, but we have to continue
16 to do so. So thank you very much.
17 DR. NERENZ: Yeah, I will vote in support of the
18 recommendation, and I repeat what others have said about the
19 excellent quality of the analysis.
20 Just two comments looking forward to issues of
21 implementation and back to our future agenda, one on
22 behavioral response. If you could go to Slide 20? We talk

1 about this may slow the shift of services. I think actually
2 what I anticipate happening is much stronger than that, and
3 I think we actually may sort of assume that in our
4 discussion, that we might actually expect a reversal, a
5 shift back. In fact, it seems almost essential. Unless
6 hospitals are willing to just sit back and absorb these
7 cuts, it would seem that some of the services currently
8 provided in the HOPD settings are going to have to be
9 provided elsewhere, in lower-cost settings. It would seem
10 that without explicitly saying so, that's what we think
11 might or should happen. Or perhaps as a variant, hospitals
12 may create settings that currently do not exist that are, in
13 fact, lower cost. They're not subject to the cost-driving
14 functions of the hospital.
15 So with that assumption essentially in mind, I
16 just would observe that there are probably some settings and
17 some hospitals in which that shift in the other direction
18 cannot occur. There is not a network of private practice
19 offices in which care can be provided. Medically
20 underserved settings as a class are probably one way to
21 think about that.
22 So now if we could flip to Slide 10, bottom

1 bullet, we talk about mitigation. I realize this is not
2 formally part of the recommendation, but I would just
3 suggest that as this moves to implementation that there be
4 good consideration of other possible mitigating either
5 situations or strategies, meaning if there are hospitals
6 currently providing services and being paid on the provider-
7 based rates, where the services simply cannot be provided
8 elsewhere -- the office settings don't exist -- that there
9 be some consideration about some mitigating strategy. I'm
10 not proposing a specific one, but I realize the DSH-based
11 strategy here is one example, but there may be others. And,
12 again, that doesn't undercut the basic recommendation, but
13 it says there may be some cases where the expected
14 behavioral response perhaps cannot occur.
15 Okay. Second comment. I have appreciated and
16 accepted the general idea we've had when we talk about site-
17 neutral payment that the payment stream should be as cleanly
18 as possible directed to where the costs truly reside, and
19 that we should generally not have payments that effectively
20 cross-subsidize one body of work with payment to another
21 that then end up sending inappropriate signals. I think
22 Mike, among others, has been quite eloquent about that. I

1 agree with that.

2 When we think about what hospitals must do in

3 areas like standby ER capacity, I just hope that we are then

4 open in the future that if a cut in this particular -- in

5 the HOPD payment actually produces some difficulty, that

6 then we can be open to some discussion about adequacy of

7 that payment under a model that actually pays for that

8 activity in a more direct way. Now, again, that may or may

9 not arise because we've also made this recommendation about

10 3.2 percent overall, but just hoping that we can at least

11 consider that if it arises in the future.

12 DR. MARK MILLER: I'm sorry. The only comment on

13 that, because I just want to remind the Commissioners how

14 this particular set of site-neutral APCs varies from when we

15 talked about the E&M stuff. When we talk -- and we didn't

16 go into it in detail because we had been through it. We

17 talked about the mitigating strategies. We pivoted off of

18 whether they were serving significant proportions of poor

19 folks, and so that access would become an issue.

20 In this particular instance, you can set up a

21 mitigating factor -- a mitigating, you know, policy. It

22 doesn't have a lot of impact because the people who are

1 benefitting from these APCs don't serve the poor in large
2 numbers. And, in fact, a lot of them are specialty
3 hospitals. But your point stands, and in particular, when
4 people ere talking about E&M, this was a much bigger deal.
5 MR. GRADISON: I support the recommendation. I've
6 been trying to come to a better understanding in my own mind
7 about this increase in the number of physicians that are
8 employed by hospitals. From the physician's point of view,
9 there are two factors that seem to me, as I've thought about
10 it, to be particularly important. One is newly minted
11 physicians, I can see a lot of advantages now, rather than
12 striking out fresh, to begin a practice, certainly solo
13 practices. That isn't happening very much anymore, or even
14 very, very small groups.
15 The second thing is the perhaps unintended
16 consequence of the EHR. It's extremely expensive. I went
17 into one of my doctors in an office building just a few
18 blocks from here recently and was surprised to see a sign
19 out front with the name of one of the prominent local
20 hospitals. And I asked my physician what was that all
21 about, and she said, "Well, we have four of us here in our
22 specialty. Our analysis is that we'd have to add one full-

1 time tech person in order to make this work. And it just
2 didn't make sense financially for us to do that." In other
3 words, there are reasons apart from an inappropriate
4 reimbursement system to justify this.
5 What I'm kind of curious about and will be
6 watching over time from the hospital's point of view is what
7 this means if we continue to have a decline in inpatient
8 admissions, and particularly if that decline is not somewhat
9 balanced by the increase they've been experiencing in
10 outpatient revenue. And the reason I say that is simply
11 that, you know, depending on the contract, the kind of
12 contract that the hospital has with the physicians, the
13 hospital's fixed costs could be increased very substantially
14 through this kind of change, which raises some interesting
15 strategic and financial questions if we are in an
16 environment where their revenues are under pressure. I
17 won't say any more. It's just something we need to keep an
18 eye on.
19 Thank you.
20 DR. CHRISTIANSON: I support the recommendation.
21 Maybe we could go back to the recommendation slide? And I'm
22 particularly enthusiastic about the first bullet point

1 there. I know it has been the Commission's policy for some
2 time to try to eliminate differences in payment rates
3 whenever that's feasible, and I support that. I think it's
4 actually simply fiscally irresponsible not to do that. So
5 I'm a very strong supporter of that. But I also think it
6 would be irresponsible of the Commission not to do it in a
7 thoughtful way. So I want to commend the staff, as many of
8 you have done, for recognizing situations where there might
9 be differential payments that would be appropriate and
10 situations where there wouldn't be. And I was glad to hear
11 Alice's comment that she thinks they've got it right in
12 terms of what they've identified.
13 I also support David's comments, that I think
14 continuing to investigate possible mitigating policies would
15 be useful. Even though I hear you say, Mark, that the
16 impact might be on relatively few facilities, I think it's
17 still important to look at that.
18 And then switching courses a little bit, I was one
19 of the Commissioners, I think, that was a little bit
20 concerned about relying too heavily on the 8-day ICU
21 criteria. And I again want to thank the Commission staff
22 for putting some thought into that and modifying that.

1 That's all I have to say -- oh, one more thing.
2 If there's any time left in this session, maybe we could
3 call on Glenn to tell us what he really thinks about the
4 sequester.
5 MR. HACKBARTH: We need to save time for that.
6 [Laughter.]
7 MR. ARMSTRONG: First, I also support the
8 recommendations and won't reiterate many of the points made
9 about them. I would just add to comments a few other
10 Commissioners made about I think within the constraints of
11 rate setting within silos, we've done really a valiant and
12 elegant job of trying to advance the improvement of our
13 health care systems' incentives for moving patient care to
14 the right place given their needs.
15 I would, though, acknowledge, you know, $160-some
16 billion, this is a significant area of spending for the
17 Medicare program, and I think we're being very responsible
18 about setting rates for how that money gets spent. But
19 despite, you know, busting through silos through this
20 recommendation, we still aren't really dealing with the fact
21 that there's huge percentages of hospital admissions and ER
22 visits and other services that we're spending through this

1 part of the program that are preventable and that just
2 shouldn't be spent at all. And we just need to keep that in
3 mind as we turn to some of the other payment policy
4 opportunities we have outside of our current rate-setting
5 process, which I know we'll pick up next month and the next
6 couple of months.

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

11 DR. CHERNEW: Keep going.

12 [Laughter.]

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

22 On the other hand, I don't think it is feasible,

1 desirable in the long run to pay hospitals much higher rates
2 for services that can be more efficiently provided at a
3 lower cost in other settings. Not only is that a big issue
4 for Medicare spending and the taxpayers, it also is a big
5 issue for Medicare beneficiaries, and also a big issue,
6 judging by the press, for many private payers as well.
7 And so what I look about this package is it tries
8 to strike that balance. Let's make sure we're paying
9 adequately for those services that we really depend on
10 hospitals for, but let's also move towards neutrality on
11 services that can be provided at a much lower cost just as
12 safely and effectively for Medicare beneficiaries. And, you
13 know, I hope we struck a reasonable balance towards that
14 goal.
15 So it's time to vote at this point. All in favor
16 of the recommendation, which is on the screen, please raise
17 your hand.
18 [Show of hands.]
19 MR. HACKBARTH: Okay. Opposed?
20 [No response.]
21 MR. HACKBARTH: Abstentions?
22 [Mr. Kuhn abstains.]

1 MR. HACKBARTH: Okay. Thank you very much. Well
2 done.
3 [Pause.]
4 MR. HACKBARTH: So we're now turning to Medicare
5 Advantage plans, and we'll have two recommendations -- one
6 related to employer-sponsored plans and the other to hospice
7 patients.
8 So who's going first? Scott.
9 DR. HARRISON: Good morning. I'm going to present
10 a one-slide summary of the MA landscape that we presented in
11 detail last month. Then Kim and I will reiterate the
12 material to set up your discussion and votes on the two
13 draft recommendations, which we have discussed in November
14 and December. Of course, we will also take questions and
15 comments on the draft MA chapter in your material.
16 Two thousand thirteen saw the highest enrollment
17 in MA in terms of both the 14.6 million enrollees and the 28
18 percent share of all Medicare beneficiaries. Enrollment
19 grew about 9 percent over the year. Plans project continued
20 enrollment growth for 2014 though at a lower rate.
21 Plans continue to be available to virtually all
22 Medicare beneficiaries. Only 0.4 percent have no plans

1 available -- the same as in 2013. There is some decrease in
2 the number of plans available due primarily to private fee-
3 for-service plans cutting back as was expected from previous
4 legislation.

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

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

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

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

19 On to the recommendations.

20 Recall that we laid out over the past few meetings
21 how the bidding dynamic is different for the employer plans
22 compared with the nonemployer plans.

1 Nonemployer plans try to bid well below the
2 benchmark so they will have rebate dollars to provide extra
3 benefits to attract enrollees. Nonemployer plans compete
4 for enrollees through their bids.
5 However, employer group plans do not complete for
6 enrollment through the bids they submit to CMS. Instead,
7 the closer the bid is to the benchmark the better it is for
8 the plan and the employers because a higher bid brings in
9 more revenue for Medicare, potentially subsidizing expenses
10 that would have required a larger contribution from
11 employers.
12 Evidence of the strength of the employer plan
13 incentive lies in the fact that the median bid of employer
14 plans is 99 percent of the benchmark.
15 Because the employer plan bids do not reflect
16 competitive market incentives, we looked to an alternate
17 payment policy that would set payments to employer plans,
18 using the market-based bids of the nonemployer plans. Such
19 a policy is used for setting Medicare Part D payments.
20 So here, unchanged from last month, is the draft
21 recommendation which reads: The Congress should direct the
22 Secretary to determine payments for employer group Medicare

1 Advantage plans in a manner more consistent with the
2 determination of payment for comparable nonemployer plans.
3 The wording of this draft recommendation would
4 allow the Secretary to use a range of policy options.
5 However, over the last several months, we have discussed
6 several specific options.
7 Our initial discussion centered around using the
8 national bid-to-benchmark ratio for nonemployer plans, which
9 we have calculated as 0.86 for 2014, and using it to set the
10 employer plan bids. If you've forgotten how that would
11 work, I'll go into it in a little more detail on the next
12 slide.
13 Then we discussed an industry suggestion to use
14 separate ratios for HMOs and PPOs. However, that raised
15 some concerns.
16 First, this would set a precedent of paying
17 differently by plan type. The Commission has always
18 stressed that all plans should be on a financially neutral
19 basis.
20 Such a policy would produce less market pressure
21 for beneficiaries to choose the most efficient plans.
22 And, if PPOs were paid more, then HMOs would be

1 disadvantaged in the market.

2 So the option we are stressing would set each

3 employer plan's bid at its individual benchmark times the

4 national bid-to-benchmark ratio for nonemployer plans,

5 which, from the last slide, is 0.86. That formulation would

6 treat all employer plans the same, would accommodate the

7 different benchmarks that the plans may face in local areas

8 and would incorporate the quality bonuses in the plans'

9 benchmarks.

10 The total Medicare payment to the plan would then

11 be its resulting bid plus the rebate dollars which are also

12 based on the plan's quality rating.

13 So, for implications, we expect that the draft

14 recommendation would reduce Medicare spending by between

15 $250 million and $750 million in the first full year, and

16 between $1 billion and $5 billion over 5 years.

17 Most employer group plans would be paid less by

18 Medicare because of the lower Medicare subsidies. Thus,

19 plans would either charge employers more, make lower profits

20 or lower their costs.

21 Some employer group plan enrollees might choose

22 plans in the nonemployer market or move to fee-for-service

1 Medicare if employers dropped plans or increased charges to
2 plan enrollees.
3 And now Kim will present the draft recommendation
4 on hospice and MA.
5 MS. NEUMAN: As we've discussed in past meetings,
6 the Medicare hospice benefit is carved out of the Medicare
7 Advantage benefits package. This carve-out has a number of
8 effects that seem inconsistent with the goals of Medicare
9 Advantage.
10 When a beneficiary in Medicare Advantage elects
11 hospice, financial responsibility for that beneficiary's
12 care becomes split between Medicare fee-for-service and the
13 MA plan. Fee-for-service pays the hospice provider for care
14 related to the terminal condition and pays other fee-for-
15 service providers for any Part A or B services unrelated to
16 the terminal condition. The MAPD plan pays for any
17 unrelated Part D drugs and supplemental benefits such as
18 reduced cost-sharing under certain circumstances.
19 In terms of care coordination responsibilities,
20 the hospice provider is responsible for coordinating the
21 care that the hospice furnishes and is expected to share
22 information with and coordinate with unrelated providers.

1 However, no one entity, neither the hospice nor
2 the MA plan nor any other provider, has overall financial
3 responsibility
4 and accountability for all care received by an MA
5 beneficiary enrolled in hospice, and this contrasts with the
6 situation prior to the patient's hospice enrollment when the
7 MA plan is responsible for all the patient's Medicare
8 services.
9 Another issue with the carve-out is that it
10 results in complex coverage rules that can be confusing for
11 beneficiaries who have been used to having all their care
12 provided through Medicare Advantage.
13 In addition, the hospice carve-out makes an MA
14 plan's responsibility for end-of-life care uneven across its
15 enrollees. The MA plan has full financial responsibility
16 for end-of-life care for some of its enrollees but not
17 others, depending on whether they elect hospice.
18 In contrast to Medicare Advantage, ACOs are
19 accountable for hospice costs through their benchmarks, and
20 most private insurers include hospice in their benefits
21 package.
22 If the purpose of Medicare Advantage is to give

1 plans financial responsibility and accountability for
2 managing the care of their enrollees in an integrated and
3 coordinated manner, it would make sense for plans to have
4 responsibility for the full continuum of care, including
5 hospice.
6 Another potential benefit of including hospice
7 within Medicare Advantage is that MA plans could offer
8 concurrent hospice and conventional care as a supplemental
9 benefit if they wish to do so.
10 So the Commission is considering a draft
11 recommendation to include the hospice benefit in the MA
12 benefits package.
13 Here are the operational details of the proposed
14 policy:
15 First, the full hospice benefit would be included
16 in the MA benefits package. That would mean the plan would
17 be responsible for the full hospice benefit as outlined in
18 the Social Security Act. The plan could not pick or choose
19 what services within the scope of the hospice benefit it
20 would cover. And we expect that this could be monitored
21 through the MA encounter data that plans submit to CMS.
22 The second aspect of this policy is that the

1 government base capitation rate for MA plans would need to
2 increase for all MA enrollees to reflect plans'
3 responsibility for a broader set of services than they are
4 currently responsible for. Different from the current
5 system, the capitation for an individual MA enrollee would
6 not change if that beneficiary elected hospice.
7 The MA risk scores would also need to be
8 recalculated so that they predict the relative risk of total
9 Medicare expenditures including hospice.
10 So this brings us to the draft recommendation, and
11 it reads: The Congress should include the Medicare hospice
12 benefit in the Medicare Advantage benefits package,
13 beginning 2016.
14 As you'll recall, at the December meeting, there
15 was a lot of discussion among commissioners about wanting to
16 move more quickly on the proposed policy. So the time frame
17 in the draft recommendation has been revised from 2017 to
18 2016.
19 In terms of the effects of the draft
20 recommendation, we expect the impact on Medicare program
21 spending to be negligible, meaning close to zero. We always
22 report spending impacts using standard budget categories.

1 So this policy would fall in the smallest category which is
2 a cost or savings of less than $50 million over 1 year and
3 less than $1 billion over 5 years. But, as I said, we
4 expect the effect will actually be close to zero.
5 In terms of beneficiaries, we expect no adverse
6 impact on beneficiary access to hospice care. Like other
7 Medicare Advantage services, choice of providers may be more
8 limited than fee-for-service. Some beneficiaries might
9 obtain access to concurrent care as plans would have the
10 option to offer it as a supplemental benefit. Plans also
11 would have the option to charge cost-sharing.
12 As far as the implications for plans and hospice
13 providers, there would be administrative costs for plans and
14 hospices related to contracting. Plans, though, would be
15 better positioned to manage and coordinate end-of-life care
16 than they currently are. And this may give hospices
17 opportunities to work with plans, to participate in new
18 models of care delivery.
19 In terms of quality and delivery system reform,
20 this would promote integrated, coordinated care and would be
21 a step toward synchronizing policy across Medicare systems.
22 So that concludes our presentation, and we turn it

1 over to the Chairman.

2 MR. HACKBARTH: Thank you very much.

3 Clarifying questions?

4 I have Alice and then Jack and Dave and Mary.

5 DR. COOMBS: Thank you very much for the

6 presentation.

7 So, if I can just drill down a little bit on this

8 notion of the capitation in terms of the rate that you would

9 try to monetize this within the system of the MA, are you

10 saying that the exchange from what we do with the fee-for-

11 service carve-out now is essentially the same even when you

12 consider the administrative costs -- the administration

13 costs -- on either side of the fee-for-service for the

14 carve-out versus putting it all under one umbrella?

15 MS. NEUMAN: What I was saying is that the

16 Medicare Advantage capitation base rate would be increased

17 to take the average spending in fee-for-service on hospice

18 and put that in for Medicare Advantage so that now the

19 Medicare Advantage capitation covered the full range of

20 services.

21 Is that helpful?

22 DR. COOMBS: Yeah. And maybe if I could ask you,

1 Mark, wouldn't you expect some savings based on now the
2 coordination and using just the scale margin in terms of
3 being able to better address this 28 percent of Medicare
4 beneficiaries?
5 DR. MARK MILLER: Okay. So let me just track
6 through your question.
7 What you're hypothesizing is that if the managed
8 care organization is better at coordination, shouldn't some
9 small savings occur?
10 And I think what Kim is saying, consistent with
11 the way MA rate methodology is in general, is if that occurs
12 those savings would accrue to the MA plan because the
13 capitation rate would be set on the base of fee-for-service,
14 unless you have a different idea. But --
15 DR. COOMBS: No, no.
16 DR. MARK MILLER: Right. [Inaudible comment.]
17 MR. ZARABOZO: No, you did not screw it up.
18 MR. HACKBARTH: I was a little leery when Carlos
19 hit the light. I thought it was going the other way for
20 you.
21 DR. MARK MILLER: For the record, with Carlos, it
22 usually does. Okay.

1 MR. HACKBARTH: Jack, clarifying.

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

9 Do we know these? Has CMS set those policies?

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

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

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

20 MS. UCCELLO: I might not be right on this, but I
21 looked up some of this with Part D, and if they're run the
22 same way, it looks like the refund goes back to the

1 government but doesn't get refunded to the bene, from what I
2 could tell. I could be wrong on that.
3 DR. MARK MILLER: We'll look into this.
4 MR. GRADISON: I want to make sure if this is
5 correct. Let me just, to save time, say it as factual. And
6 please tell me if I'm wrong.
7 What I jotted down here is: Most MA plans are run
8 by organizations which already offer non-Medicare plans, for
9 example, to employers, which cover hospice care.
10 In other words, most MA plans at some part of
11 their organization already have experienced doing this sort
12 of thing. Do you think that's correct or not?
13 MS. NEUMAN: As far as we know, that's correct.
14 MR. GRADISON: Thank you.
15 DR. NERENZ: Slide 6, please.
16 Okay. Just to clarify, the quotation marks around
17 the word, bid, are meant to imply that this is not really a
18 bid in the usual sense in this model, right, that it's
19 simply a calculation where the plan has no discretion over
20 what that amount turns out to be. That's what that means,
21 right?
22 DR. HARRISON: Correct.

1 DR. NERENZ: Thanks.

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

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

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

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

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

19 DR. MARK MILLER: The answer to her question is
20 even if an employer decided to step back, by making your
21 nonemployer point, you're saying that beneficiary still has
22 access to a plan. Is that your point?

1 DR. HARRISON: Correct. And it might even be that
2 the employer decides to help subsidize that choice also.
3 DR. NAYLOR: And, two questions related to the
4 hospice recommendation.
5 The industry response, meaning what you've also
6 articulated earlier, can you just summarize that very
7 briefly?
8 MS. NEUMAN: The hospice industry, the MA industry
9 or both?
10 DR. NAYLOR: MA industry to the plan to the
11 proposed recommendation.
12 MS. NEUMAN: Okay. The health plans that we've
13 talked to have generally been supportive of the idea of
14 including hospice within Medicare Advantage. We heard from
15 them that they felt that would better position them to
16 manage and coordinate end-of-life care, and it would
17 simplify things for the beneficiary.
18 The hospice community -- the response has been
19 less favorable. There's concern about the administrative
20 burden of contracting with the private plans. There is some
21 of that that goes on now --
22 DR. NAYLOR: Right.

1 MS. NEUMAN: -- but that's a much smaller
2 population than the Medicare population is. And so it would
3 increase the amount of those activities.
4 There's also concern from both the hospice
5 community and, to some extent, from the plans about what the
6 rates will be and whether -- you know, the hospices, whether
7 they will view the rates as too low or the MA plans will
8 view the rates as too high.
9 So there are those issues that we've heard, and I
10 would say those are probably the biggest.
11 I guess one last thing I would note is on the
12 hospice side they've been worried about prior authorization
13 kinds of requirements that sometimes they see from
14 commercial plans.
15 You know, we think if this was expanded -- hospice
16 was expanded to the MA population -- that that size of that
17 population is so large, that prior authorization would not
18 be a viable approach for plans and they would have to take
19 more expeditious routes to ensuring care is appropriate.
20 DR. NAYLOR: Great. And, one last comment.
21 When you describe the hospice benefits integration
22 into the MA plans, you stress the possibilities here of

1 concurrent palliative care and hospice services. So it
2 implies that the eligibility criteria currently used would
3 not be integrated in, too.
4 MS. NEUMAN: So the eligibility criteria for
5 hospice would be integrated -- would be included in the
6 Medicare Advantage benefits package. So that would be the
7 base.
8 And so it would be the same benefit, the same
9 eligibility criteria and so forth, but MA plans have the
10 ability to offer supplemental benefits which are broader,
11 that are not covered by Medicare traditionally. So it would
12 be within the ability of an MA plan to offer concurrent care
13 as a supplemental benefit.
14 So they wouldn't have to, but they would have that
15 option, just like they have the option to offer home health
16 visits to beneficiaries who aren't homebound, let's say, if
17 they find that to be valuable in certain circumstances.
18 It's the same kind of thing. They have more flexibility
19 than we do in the fee-for-service program.
20 MR. HACKBARTH: George, clarifying questions?
21 MR. GEORGE MILLER: Yes, on slide 2.
22 And I think, Scott, as you were going through

1 this, you mentioned the percentage or breakdown of costs,
2 that 84 percent -- I think you quoted 84 percent goes to the
3 beneficiaries, 11 percent for administrative, 5 percent for
4 margin. Is that codified in law, what that ratio has to be?
5 Do we monitor that?
6 Is 5 percent appropriate?
7 DR. HARRISON: Before the actual MLR provisions go
8 into effect, it has not been regulated.
9 Now the other -- and so the MLR requirements are
10 going to be that 85 percent is spent on benefits.
11 MR. GEORGE MILLER: Right.
12 DR. HARRISON: I am not sure that what is reported
13 in the bids -- the spending -- is categorized the same way
14 as what would occur under the MLR situation. So I don't
15 know that it's completely analogous.
16 We're going to check into that more also.
17 MR. GEORGE MILLER: Okay. All right. Thank you.
18 DR. HARRISON: I don't know if Cori has any --
19 MS. UCCELLO: [Inaudible comment.]
20 DR. HARRISON: Okay.
21 MR. GEORGE MILLER: You think that's right, okay.
22 DR. SAMITT: On slide 8, I have a question about

1 ACOs and their -- the experience with hospice thus far. We
2 may not have enough experience to study this, but I'm
3 wondering if this can foreshadow the implications on
4 hospice, given that now ACO is the only sector in Medicare
5 that has financial accountability for hospice today. Have
6 we looked at whether we've seen any change in hospice
7 utilization or relationship in the ACO world yet?
8 MS. NEUMAN: We have not looked at data on ACOs'
9 experience with hospice care, but anecdotally, you know,
10 we've asked about, you know, how ACOs view hospice. And, in
11 general, it seems to be favorable, good for the beneficiary,
12 good for the program. And so that is something that we can
13 look at in the longer run.
14 It would seem that the ACO model would sort of get
15 the interests of the patient and the interests of the
16 program in line with regard to hospice.
17 MR. HACKBARTH: So when will we have access to
18 patterns of care in ACOs -- you know, a large claims base --
19 that we can begin to explore that? Does anybody know the
20 answer?
21 DR. STENSLAND: You can do it.
22 MR. HACKBARTH: Okay. That's a bold statement. I

1 like that.

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

3 explore.

4 [Laughter.]

5 DR. MARK MILLER: I'm not sure I would have said

6 that quite as strongly, but I think we're sort of starting

7 to get to that point now that there's been enough

8 experience. Is that just a little different way of saying

9 it?

10 DR. SAMITT: And when would we get that same thing

11 for Medicaid?

12 DR. MARK MILLER: Yeah, I hear you.

13 And the thing I wanted to emphasize on this point

14 is we have done a survey of ACOs and kind of what kinds of

15 experiences that they've had, and we've had a lot of one-on-

16 one session of people in. And David and Jeff have handled

17 this a lot more than I've been able to be in the room

18 although I have tried to be in there.

19 And there has been some pretty explicit

20 discussions about, you know, trying to get a better handle

21 on what happens at end of life and that some of the ACOs are

22 seeing that as -- you know.

1 You talk to them, and they all have slightly
2 different orientations -- I'm going after this; I'm
3 approaching things this way.
4 But this came up more than once. So they seem to
5 be paying attention, and what Kim said describes the
6 experience.
7 DR. CHERNEW: This is about slide 6. I just want
8 to make sure that the slide is meant to be understood as an
9 illustration of something the Secretary might do but is
10 actually not part of the recommendation.
11 So words like calculate one national bid -- that's
12 not part of the recommendation that came right before;
13 that's just an illustration of how it might play out.
14 DR. HARRISON: Correct.
15 DR. MARK MILLER: I mean, the only thing I would
16 add is there's the one slide -- I can't remember what number
17 it was, Scott, where we --
18 DR. HARRISON: Right before that, I think.
19 DR. MARK MILLER: Exactly. There was a discussion
20 of it, and some problems did surface there.
21 MR. HACKBARTH: Any other clarifying questions?
22 [Pause.]

1 MR. HACKBARTH: See none, let's go to round two.
2 This will be our final round and followed by the vote.
3 Scott, do you want to kick it off?
4 MR. ARMSTRONG: Thanks, Glenn.
5 So let me begin by saying that I support both sets
6 of recommendations and plan to vote in support of them, but
7 let me comment briefly on each one, beginning first with the
8 employer group issues.
9 Initially, I did have some concerns with this, but
10 ultimately, equalizing the Medicare program's contributions
11 to these two different categories of MA plans is good
12 policy, and I support that policy.
13 The issue was really in some of the implications
14 of the initial approach that we were describing for setting
15 -- you know, equalizing -- those payments. And I just want
16 to commend the MedPAC staff for great work you've done.
17 I think there's still work to figure out exactly
18 how that unfolds, as these last couple of comments implied,
19 but the direction that you're heading in there after, you
20 know, some of those first ideas is a direction I do support,
21 and I appreciate your work on that.
22 One other point on this I would make is that I am

1 a little concerned about the implications for current
2 Medicare Advantage beneficiaries through these employer-
3 based plans who potentially, as our analysis suggests, could
4 see a diminishment in the value of their benefits and/or
5 lose benefits and be forced to move elsewhere.
6 And I think we just need to pay attention to
7 whether that's really an implication of some of these
8 changes or not, particularly since it's inconsistent with
9 the broad goal that we have for moving -- if we have a goal
10 to move patients between fee-for-service and Medicare
11 Advantage, it's to move them from fee-for-service into
12 Medicare Advantage and not the other way around. I just
13 think we need to pay attention to that.
14 With respect to the hospice benefits, this, I
15 strongly endorse.
16 I work for an organization that covers Medicare
17 patients through an MA plan, and the minute we admit them to
18 a hospice program we need to -- even though it's our own
19 hospice program, run by our own staff -- bill Medicare
20 directly for those hospice services. And it's an
21 administrative hassle. It's a nightmare.
22 We're able to overwhelm kind of the care

1 consistency through that transition, but the industry itself
2 -- I just think this is a big issue and this is a nice way
3 of resolving it.
4 You made several other arguments for why this is a
5 good policy to advance, and I support them all.
6 I would just say that you've mentioned some of the
7 operational implications of this. We do need to pay
8 attention.
9 I'm particularly concerned about a topic we've
10 spent time on before, and that is the risk adjustment and
11 the way in which, particularly for patients who are
12 incurring a lot of expenses at end of life, that risk
13 adjustment is made to the payment in the year after the
14 patient dies. And that's just one example that -- you
15 probably have many others.
16 I really do think paying attention to how this
17 assures that the payments are appropriate and adequate will
18 be an important piece of work for ourselves.
19 So I do support both sets of recommendations and
20 think it's great work.
21 Thanks.
22 DR. CHRISTIANSON: Yeah, I also support both

1 recommendations and I think it's been -- I think we should
2 commend the staff for educating us on these. I think one of
3 the reactions of the Commissioners early on was we were not
4 maybe as well informed about these particular aspects of the
5 law as we might have been, and I think you've done a great
6 job on educating us about that.
7 So, I think they're both really compelling, the
8 logical things to do. I think we have to do, as Scott
9 suggested, pay attention to the details as we move forward
10 and how it plays out, but I certainly support the
11 recommendations.
12 Kim, I'm not sure I understood one thing correctly
13 about what you were saying about prior authorization, but we
14 can talk about that later. I mean, I totally agree with
15 that.
16 MR. GRADISON: I support both recommendations.
17 DR. NERENZ: A question about, again, behavioral
18 response, and this will tie loosely to Slide 7. If an
19 employer-based plan currently is national in scope, or let's
20 just say multi-region in scope, and let's imagine that the
21 method of a national benchmark and that a ratio of bid-to-
22 benchmark were implemented, is it possible, then, that an

1 employer-based plan in that environment could shut down some
2 regions but not others? Is that either plausible or likely?
3 And then if that happened, what would be the net effect on
4 program spending? Would we -- because, presumably, they
5 would continue to operate in those places where they thought
6 it was financially attractive, but not in others. The first
7 question is, would that even be possible? And then, if so,
8 should we worry about that?

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

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

22 DR. HARRISON: A private Medicare exchange.

1 DR. MARK MILLER: -- a kiosk of access to
2 Medicare, individual-level, non-employer plans, and Scott
3 said this earlier in response to Mary's question. The
4 employer might subsidize that person making a choice,
5 because the other part of your question is, isn't there a
6 cost here. To the extent that a person walks away from MA
7 into fee-for-service, then, actually, it's a savings until
8 we hit around 2016, 2017, given the transition.
9 I would have said -- and, Scott, I'd like to know
10 whether you agree -- I know Carlos will tell me I'm wrong --
11 that the likely, most likely scenario is if somebody pulled
12 out, the person would walk to a different MA plan. That
13 would be my guess. That is not --
14 DR. HARRISON: That would be my guess, also.
15 DR. MARK MILLER: That is not based on a model.
16 DR. HARRISON: I think that there's very few
17 employers that are offering only MA options. They're
18 probably also offering wrap policies.
19 DR. NAYLOR: I support the recommendations and
20 just think, of course, we need to track what happens here as
21 a result of the employer recommendation.
22 And the chapter, in terms of the recommendation

1 about integration of hospice into the MA plans, I would
2 maybe encourage using this as an opportunity -- because only
3 those that choose to offer this as supplemental, the
4 curative, do that, and you've made that explicit. But I
5 would use this as an opportunity to encourage the kind of
6 experimentation, because MA plans are in such a great
7 position to do this, to do some of the things we've talked
8 about in prior years of earlier access to palliative care,
9 concurrent therapies, and so on. So, maybe encouraging as
10 part of the recommendation that kind of demonstration or
11 experimentation.
12 MR. GEORGE MILLER: Yes, I support the
13 recommendations, as well, especially on number two, and Mary
14 just hit the nail on the head for me, and that is this is an
15 opportunity and I'm just wondering if we shouldn't be -- at
16 least express more that we'd look for that experimentation.
17 I think the comments that Rita has made about end-of-life
18 care is a perfect opportunity to use this as a springboard
19 for us to be very, very prescriptive instead of using heroic
20 efforts at end of life, but look at this as an alternative
21 and try to push this. If we truly want to make savings in
22 the Medicare program nationwide, this is, I think, an

1 excellent opportunity to start walking down that path and
2 having those discussions and we should use this opportunity
3 to encourage more experimentation with this, the hospice and
4 end-of-life care, palliative care, versus heroic efforts.
5 DR. SAMITT: I support both recommendations, as
6 well. I do want to make a couple supplemental comments,
7 specifically about the hospice benefit. You know, I think,
8 to tag onto Mary's comments, that we should track what
9 happens not just with the employer plans, but with the
10 hospice experience, as well.
11 In prior meetings, we've talked about, really, an
12 imperative to begin to measure differences between quality,
13 service, cost for the fee-for-service population from the
14 ACO from MA, and now this is an example where a benefit that
15 was historically always treated the same will now be treated
16 a bit differently between MA and fee-for-service, and I
17 would be very interested to track the patient experience
18 with end-of-life care now in those two models when this
19 benefit changes. And I think we would look at quality, we
20 would look at service experience, we would look at
21 appropriate utilization of hospice services in those various
22 settings.

1 Assuming we can get at that information, I think
2 we have an opportunity to measure before and after, and I
3 would be interested in subsequent years to really analyze
4 this, because it may, again, begin to tell us, are there
5 differences in quality, service, and cost between the
6 various Medicare programs and what does that tell us about
7 what we should seek to incent and spread to other markets.
8 MR. KUHN: I support both recommendations for all
9 of the reasons that everybody has cited before. And
10 particularly on number two, the one on hospice, I think it's
11 important that we create enough transition time here, and I
12 think creating the date of 2016 does that, so it's a good --
13 more worked and compliments to the staff for thoughtful work
14 on this and thinking through all those elements as we go
15 forward.
16 DR. REDBERG: I also support both recommendations.
17 In particular with regard to the hospice plan, I mean,
18 certainly, there wasn't any particular, I think,
19 justification for having the carve-out in the first place.
20 It just kind of happened as a historical quirk, it seemed.
21 And that it is an opportunity, as Mary and others noted, to
22 think about expanding -- you recommended full coverage

1 benefits, but expanding and trying other things like
2 concurrent care.
3 I think it's encouraging that more Medicare
4 [indiscernible] have used hospice over the last few years,
5 but it's still pretty much less than half, and I think we
6 could consider incentivizing or making a benefit -- even in
7 the "Welcome to Medicare" package, I think, a discussion
8 about what your preferences are at end of life. Obviously,
9 people aren't at end of life at that time, but it's always
10 good to have the discussion before you're in the acute, you
11 know, life-threatening or terminal illness, so -- and then
12 to have it again, because I think it is an opportunity for
13 better care, higher quality care at lower cost, but mostly
14 because patients, I think, prefer, if given the choice, not
15 to get care that is not going to extend their life and
16 actually often is a decrement on quality of life, keeps them
17 in the hospital with lots of tubes and lines and unpleasant
18 side effects when they could be home spending the last few
19 months with family and loved ones.
20 So, I would support the recommendations and also
21 support trying to expand conversations about shared decision
22 making, patient preferences, and incentivizing use of

1 hospice.

2 DR. CHERNEW: So, I support both recommendations
3 and want to make two general comments. The first one is
4 that I think the high payment rates and benchmarks and
5 associated payment rates that we've had in Medicare
6 Advantage were a patch for, in some ways, incomplete
7 coverage in the general basic Medicare benefit program, and
8 so although I might become typecast in every comment as
9 talking about the consistency about parts of the program, I
10 do believe that paying in one sector to solve that problem
11 is inconsistent if you don't do it in the other sectors.
12 So, this notion of, we've talked about before, level playing
13 field, and, frankly, that masks some of the problems of the
14 Medicare benefit, in general. And, of course, we've done
15 other work on Medicare benefit design, which I think is
16 important work and we're going to have to continue.

17 I think that as we move forward, in general, we're
18 going to have to monitor the impact of these changes in
19 Medicare on the beneficiaries as the concerns with the
20 underlying Medicare benefit package become more transparent
21 when the payment generosity drops. And, frankly, I'm
22 worried that employers are going to drop. So, as I've said

1 for years, we are going to have a potential problem in the
2 future. We have a lot of beneficiaries with much less
3 generous supplemental coverage, either in MA or not, and
4 that has important ramifications that are going to have to
5 be monitored generally. But, I like the idea of
6 comparability across the fee-for-service and the Medicare
7 program as a general rule.
8 The other point that I want to make relates to the
9 one versus two ratio discussion and this issue of
10 consistency. So, all the critiques on Slide 5, I think, are
11 correct. I believe all of them. In fact, I think there's a
12 few other considerations, as well, that would probably push
13 towards one ratio.
14 But I would just point out two things. One is,
15 these are not part of the recommendations, so the Secretary
16 could do what she wants, or whomever, whenever the Secretary
17 or whichever Secretary has to do it. But, nevertheless, the
18 broader point is, all of those disadvantages, I think,
19 generally exist in the non-employer sector. In other words,
20 I think the non-employer sector also pays differently by
21 plan type and also reduces the pressure to move to the most
22 efficient plan, and also disadvantages some plan types

1 relative in the market. So, I think that there are
2 legitimate concerns up here, all of which I agree with, but
3 those same concerns, I think, exist in the non-employer
4 market, as well, so there's a question about consistency
5 across the markets versus getting the most efficient design
6 in one.
7 DR. HARRISON: So, in the non-employer market,
8 generally, the PPOs bid higher than the HMOs do. But what
9 happens is the HMO benefit packages are then richer so that
10 they're more able to attract the beneficiaries, because
11 they're using the rebate dollars from the lower bids. And
12 so if you -- that's how they compete.
13 DR. MARK MILLER: Yeah. The way I would say it is
14 differently. They're not treated differently under the
15 payment system. They have chosen to offer, or to submit
16 higher bids and skinnier benefits.
17 MR. HACKBARTH: And they also may selectively
18 choose markets where benchmarks are higher and then that
19 goes into the calculation.
20 DR. CHERNEW: So, we can have a longer discussion
21 of this. My only point -- because I -- we can have a longer
22 discussion of this, but I think if you work through the

1 math, I think it's a little more complicated one way or
2 another. My broader point is not the merits of one versus
3 the other as much as the recommendation is silent and so
4 it's going to take some more work to sort through the
5 implications of different approaches.
6 MR. HACKBARTH: Yeah, and I understand that point,
7 Mike. But just for the record, the non-employer side does
8 not pay differently by plan type. Now, it can result in
9 different payment levels, again, based on choice of
10 geography and things like that. But it doesn't say, oh, we
11 pay PPOs this way and we pay HMOs that way.
12 DR. COOMBS: I support both recommendations, and
13 Kim, you said something about the industry in terms of some
14 reluctance in the industry. Before when we discussed this,
15 I was concerned that what the fee-for-service patients look
16 like in terms of the demographics and their comorbid disease
17 versus the MA that have the carve-outs, and from the
18 information that you provided in the chapter, it's excellent
19 in that it supports that there's great similarity between
20 the two groups, with the exception of the neurologic
21 diseases being a little bit more prevalent in the fee-for-
22 service. I think it's really important for us to understand

1 if industry is reluctant to support it, is it because that
2 the patient groups look differently. But that's not the
3 case, and it's not supported by the information in the
4 chart. And also, in terms of the results of the dissidence
5 in terms of how likely is it that someone is actually being
6 discharged from hospice, because it has a lot to do with the
7 criteria for admission to hospice.

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

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

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

1 care piece.

2 DR. MARK MILLER: I think that that's true from

3 the MA plans' point of view. I think if you followed Kim's

4 comments earlier, I think the MA plans' view of the hospice

5 change is they're fine. They're interested in it. I

6 thought just now you were talking about the hospices'

7 reaction to it, and to the extent my --

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

9 DR. MARK MILLER: Yes. I've been in the room,

10 too, and I don't -- I think you said "less favorable." I

11 don't think they like the idea. But most of the comments

12 come down to comments that you would hear from almost any

13 provider. They'll say, this means I have to negotiate with

14 the MA plans, and what if they don't put me in their

15 network? Of course, the MA plans are required to have

16 comparable -- I mean, to have network requirements, but that

17 might not mean that they take each and every hospice in

18 every market. And I've got to say, there's probably some

19 markets where even the hospice industry would agree that

20 that might be a good idea.

21 Then they're upset that, you know, well, what if

22 the rates aren't as high as Medicare rates, and again,

1 that's a negotiation.

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

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

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

16 DR. MARK MILLER: That's true.

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

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

22 MR. HACKBARTH: If you enroll in MA, yes.

1 DR. HALL: Am I up? I'm in favor of both
2 recommendations.
3 And just a comment, also, about hospice, which I
4 think is something we're all thinking about here. You know,
5 Medicare as an insurance product is unique in many ways, but
6 one way that it is truly unique is that it's the only
7 insurance product if you're marketing to say, if you take
8 Medicare, there's a 100 percent probability you'll die.
9 It's a life form of health insurance. It's a major
10 component of the benefit structure.
11 So, hospice has come in and has made enormous
12 progress over the last, I don't know, 25, 35 years, and it's
13 not surprising that there are some inconsistencies, that why
14 does Medicare Advantage have a carve-out on this? It is
15 historic, but it wasn't really by design.
16 Curiously, also, end-of-life care is one area
17 where we've talked a lot about shared decision making, where
18 we're doing a pretty bad job overall across the country,
19 even in terms of advance directives, pain control, and
20 family engagement. Where you think it would be at the very
21 top of our priorities, it isn't.
22 Medicare Advantage, so far, seems to have been a

1 product that has been able to develop innovation, and I
2 would predict that one of the positive outcomes of this may
3 be that Medicare Advantage plans may be able to even enhance
4 this field more than we have up until the present time. So
5 it's a -- and the timing couldn't be better right now in
6 terms of the degree of expertise and medical knowledge
7 that's there.
8 DR. HOADLEY: I'm also in favor of both of the
9 recommendations here, and I won't add to the discussion on
10 the hospice one.
11 On the employer plan one, the only thing I would
12 do is note, sort of like David mentioned earlier, some of
13 the potential geographic issues, and I think I brought that
14 up in another meeting. But our recommendation has the
15 flexibility, and if the Secretary sees that that could be an
16 issue for more regionally-based employers, that perhaps
17 there's a policy tweak in that direction that the Secretary
18 could use.
19 My other comment, really, is that, you know, these
20 recommendations are part of a broader chapter. I really do
21 appreciate all the stuff that's in this chapter in terms of
22 landscape material and the ongoing Commission analysis of

1 the payment rates compared to fee-for-service and sort of
2 the documentation that we're still -- have payments that are
3 higher than fee-for-service and we're not through the
4 transitions to some new policies there, and I think that's
5 just an important part of the chapter.
6 And I guess my one other thing is, and partly
7 triggered by this discussion of the network inclusion
8 relative to hospice, is that maybe the network adequacy
9 standards in general are something we should think at
10 looking at over the next year. You know, there have been
11 some issues, somewhat anecdotally, this year about plans
12 that have cut back substantially on their MA provider
13 networks or their physician networks, and I must say, in
14 thinking about this, I'm not too aware of -- I know what the
15 standards are, generally, in Medicare Advantage, but sort of
16 the degree of enforcement and the degree of monitoring that
17 CMS is doing, and maybe that's something we could take a
18 little bit of a look at over the next year.
19 MR. HACKBARTH: Could I just pick up on Jack's
20 last issue? There is intertwined here several different
21 issues. You know, there's the traditional notion in an MA
22 of having an adequate network. Then there's also the issue,

1 which I think has arisen in these recent cases, of giving
2 beneficiaries adequate notice of what the network is so
3 there isn't a bait-and-switch, where they think they're
4 buying this physician network and, in fact, they're getting
5 a very different one. And those are different sorts of
6 issues.
7 Kate.
8 DR. BAICKER: I support the recommendation and I
9 share my concern that the devil is in the details with how
10 you do the change to the employer-based MA plans, but they
11 are different from the other plans in the way that they're
12 working now and some update clearly is in order, and the way
13 the recommendation is framed, to me, seems like a great
14 start down that path.
15 MS. UCCELLO: I also support the recommendations,
16 and in terms of the employer MA plan, thank you for this
17 additional discussion about the plan type stuff. I think
18 this was really helpful to think this through.
19 And in terms of the impact on employer decisions
20 to offer MA plans to their retirees and the impact on
21 retirees' access to MA plans, I think it is completely
22 appropriate for us to consider what those impacts will be.

1 But I also think we have to remind ourselves that these
2 plans are getting paid in excess of fee-for-service, so it's
3 other people who are helping subsidize, in effect, those
4 payments, and I think we need to keep that in mind, as well,
5 when we consider what the impact on these retirees is.
6 MR. BUTLER: So, I support both recommendations.
7 I don't want to say that one is more important than the
8 other, but I'm more sensitive to unintended consequences in
9 recommendation two. What tips me over is the fact that the
10 private plans now have it in their benefit package and I
11 don't hear any outcries about how it's working, including in
12 those plans that are fairly tight in their networks now.
13 And the second reason is it does bring another
14 example of the silos coming together. And as hard as we've
15 worked on the U-shaped pricing, my guess, but I don't know
16 and we don't know, that bringing this together is likely to
17 actually accelerate the end-of-life -- entry into true end-
18 of-life care sooner and maybe have an additional oversight
19 on the over-utilization where inappropriate in a way that
20 the fee-for-service pricing may not or has struggled to do.
21 So, I think we're going to align things and I think overall
22 hospice care is still going to go up under this model. I

1 think there's just some fear about change and about being
2 left out as a hospice in a narrow network, but I think we'll
3 get through it.
4 MR. HACKBARTH: Just one other thought on this
5 issue of network adequacy, Jack. I have read that at the
6 State level, there is a movement, at least in some States,
7 to impose, reconsider, "any willing provider" laws, and this
8 whole issue has been given new life by the relatively narrow
9 networks in many of the exchange plans under the Affordable
10 Care Act. This is very reminiscent of the 1990s. If you
11 want to kill private plans' ability to manage care and cost,
12 there's no faster way to do it than "any willing provider"
13 laws.
14 So, my own personal view, and obviously this isn't
15 a MedPAC view, is that, yeah, we need to assure there are
16 adequate networks. We need to assure that there's not bait-
17 and-switch with beneficiaries on enrollment. On the other
18 hand, we've got to preserve the ability of plans to make
19 decisions about who's in the network and who's not. That's
20 their contribution to trying to make the system better.
21 That's how they can help us. Traditional Medicare finds it
22 basically impossible to steer beneficiaries to higher

1 performers, and so it's through Medicare Advantage that we
2 have at least the potential of some parties trying to steer
3 volume to the more efficient providers. We cannot kill that
4 off.
5 Okay. We're ready to vote on this, so let's put
6 recommendation one up here. So, all in favor of
7 recommendation one, please raise your hand.
8 [Show of hands.]
9 MR. HACKBARTH: Okay. And number two. All in
10 favor.
11 [Show of hands.]
12 MR. HACKBARTH: Opposed.
13 [No response.]
14 MR. HACKBARTH: Abstentions.
15 [No response.]
16 MR. HACKBARTH: Okay. Nice work.
17 Before we turn to the public comment period, I
18 want to just go back to the hospital LTCH recommendation for
19 a second. I'm operating at less than peak performance
20 today, and there was something else that I wanted to say at
21 the very end, and that is that we view that recommendation
22 as a package, not sort of a menu of possible things to do.

1 And I know that was very important from the perspective of
2 some individual Commissioners, that it is a package and so I
3 wanted to make that clear to the audience, and, of course,
4 we will make that clear in the text.
5 Okay. We'll now have our public comment period.
6 [No response.]
7 MR. HACKBARTH: Seeing none, we will adjourn for
8 lunch and reconvene at 12:30. Excuse me, I got that wrong -
9 - 1:30, yes. I told you, I'm operating at less than peak
10 performance.
11 [Whereupon, at 11:52 a.m., the meeting was
12 recessed, to reconvene at 1:30 p.m. this same day.]
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1 AFTERNOON SESSION [1:30 p.m.]

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

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

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

16 DR. CHERNEW: [off microphone].

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

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

21 MR. HACKBARTH: Okay. Before we turn to the three
22 afternoon sessions, I did want to quickly talk about the

1 effect of the sequester on our update recommendations for
2 those of you in the audience who were not here this morning.
3 Let's see. Actually, can we skip to the next
4 slide, David? So I'm not going to go through everything
5 that I went through this morning. I just want to highlight
6 a few points.
7 So what this graph illustrates is on the yellow
8 line is an illustrative increase in the base payment amount
9 for one of the provider sectors, say hospitals. And the
10 yellow line has steps up that are 2 percent in magnitude.
11 That signifies that under current law they are scheduled to
12 get a 2 percent update.
13 The green line below represents the sequester
14 effect, and which you can see is that at the beginning of
15 each year, the sequester takes the base amount down by 2
16 percent, and then at the end of the year it goes back up.
17 A couple points are really significant here.
18 First of all is that the sequester adjustment is temporary
19 and non-cumulative. It does not permanently affect the base
20 amount. Indeed, the sequester is a separate statute from
21 Medicare, and so what we are focused on, what we are making
22 our recommendations to the Congress, is the shape of that

1 yellow line. How should the Medicare law's base payment
2 rates change from one year to the next?
3 We recognize that the sequester can in any given
4 year work to reduce the flow of dollars to, in this case,
5 hospitals. Our recommendations, however, are focused on the
6 Medicare law's base payment amount.
7 So let's go ahead to the final table there. The
8 next one. This is a real simple numeric example. So in the
9 year 2014, let's assume that the base amount for this type
10 of provider is $100. The sequester takes 2 percent of that
11 away from each of the checks, and you can see that in the
12 bottom row, the sequestered amount of 98. We are making
13 recommendations for 2015 this year. The first row under
14 2015, 102, that signifies what the current law update would
15 be in this sector, which we assume to have a current law
16 update of 2 percent in the base amount.
17 What we are focused on is the next row. What is
18 the Commission's recommendation for the base amount under
19 the Medicare law? And in this hypothetical example, we've
20 said 101.
21 Now, let's assume for the sake of argument that
22 Congress does not take our recommendation, current law stays

1 in place, and so the base amount becomes 102. But the
2 sequester takes away 2 percent, so the checks written to the
3 provider fall to 100. We have recommended 101. What we are
4 saying is a number higher than the actual flow of dollars.
5 We do not support the sequester in this case because it
6 results in payments less than we've recommended to this
7 provider group.

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

21 So, in principle, we do not support the sequester,
22 and its application in particular cases, we don't support

1 the sequester. We are asked by Congress to recommend what
2 the right amount is. That's the 101 that's circled in this
3 illustration.
4 So that's the process. After the last meeting,
5 there were some articles written and statements made that,
6 well, MedPAC ignores the sequester. That's not the case.
7 All we can do is recommend to the Congress what we think is
8 the proper rate. They are the decisionmakers, and they
9 decide the actual flow of dollars.
10 So I will stop there, and I hope that is a little
11 bit clearer to people. We will for next year look at
12 whether there are some ways that we can clarify our approach
13 given that the sequester now seems destined to be with us in
14 the long run. It has gone from temporary to something
15 that's written into current law for the next 10 years. So
16 we will look at issues like how we frame our projected
17 margins, where that is part of our analysis, or how we frame
18 the wording of our recommendations to try to make all of
19 this a little bit clearer to people. But we are not
20 ignoring the sequester.
21 Okay. So let's now turn to ACOs. David, are you
22 leading off?

1 MR. GLASS: [off microphone].

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

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

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

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

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

18 In 2015, the next phase of the program starts.
19 That is, the second round of three-year contracts in the
20 MSSP. Coming up, we anticipate some information on the
21 first year of performance later this month with new quality
22 reporting to follow.

1 There are several opportunities for policy
2 refinements coming up. For Pioneer ACOs, CMMI issued a
3 request for information called "The Evolution of ACO
4 Initiatives at CMS." They're interested in comments on a
5 second round of applications for the current Pioneer ACO
6 model and ideas on new ACO models to encourage greater care
7 integration and financial accountability such as full
8 capitation, including Part D, and integrating with Medicaid.
9 Comments are requested by March 1st.
10 For the Medicare Shared Savings Program, we
11 anticipate a proposed rule for the MSSP in the next few
12 months. As the second phase of the program begins in 2015,
13 comments in the summer of 2014 could be a good opportunity
14 to weigh in on issues the Commission considers important.
15 If the Commission is interested in refinements
16 that include changes to statute, recommendations could be
17 included in a future report to the Congress.
18 We'll talk about four areas for refinement today.
19 We have the beneficiary attribution to ACOs, benchmark
20 calculations, one-sided versus two-sided risk models, ACOs
21 sharing savings with beneficiaries. So first let's consider
22 beneficiary attribution.

1 Currently beneficiaries are attributed to ACOs
2 based on the plurality of primary care claims over the past
3 three years. Primary care claims are defined as qualified
4 E&M visits, and they essentially exclude inpatient hospital
5 visits.
6 In the MSSP program, direct attribution to mid-
7 level practitioners such as nurse practitioners or physician
8 assistants is not allowed. This is because of how the
9 statute is written. In response to comments, CMS created an
10 indirect method for attribution but it's somewhat
11 complicated. This issue is a problem in general and in
12 particular for rural health clinics and FQHCs where use of
13 NPs and PAs is common.
14 In Pioneer and MSSP, if there are few or no visits
15 to primary care, there is a second stage of attribution to
16 specialists. This could make sense if, for example, a
17 cardiologist was in effect someone's primary care provider.
18 So in our comments we favored that approach.
19 Finally, although MSSP ACOs are given a
20 preliminary list of beneficiaries that is determined
21 prospectively, final attribution in MSSP is retrospective,
22 which means that savings and loss calculations are made

1 after the fact based on patients who used the ACO in the
2 course of the performance year. This is sometimes referred
3 to as prospective attribution with retrospective
4 reconciliation.

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

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

18 Specialty practices have voiced concerns as well.
19 The first is that specialists can only be a member of one
20 ACO if they can be used for attribution. This is referred
21 to as being exclusive to one ACO. The way the algorithm
22 works is the ACOs have to submit a list of physicians in the

1 ACO, and then CMS associates all claims for beneficiaries
2 with those physicians to the ACO. If a physician were in
3 two ACOs, the algorithm would not know which ACO to align
4 the claim with. So physician assignment must be exclusive
5 to one ACO for the algorithm to work.
6 In MSSP physicians are identified at the practice
7 level, not at the individual physician level. The problem
8 is that the entire practice can be made exclusive to an ACO
9 if one physician can be used for attribution. One faculty
10 practice reportedly became exclusive to an ACO that way, and
11 it was not the ACO the university hospital was in, and that
12 caused a problem.
13 A physician organization brought the exclusivity
14 issue to our attention because they were concerned that
15 primary care providers in other ACOs would not refer
16 patients to them if they were exclusive to one ACO and that
17 might mean they would lose business.
18 In light of these issues we have rethought
19 attribution and come up with a few ways to simplify it and
20 make it more predictable.
21 First, allow direct attribution of mid-level
22 practitioners. The text box in your mailing materials shows

1 how the statute could be modified to do that, and this might
2 attribute more of the expected beneficiaries to ACOs,
3 particularly ACOs with FQHCs or rural health clinics as
4 members.

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

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

18 Fourth, second stage attribution based on
19 specialists would no longer be necessary if the above steps
20 were taken. The second stage attribution seemed like a good
21 idea, but it is apparently not accounting for many
22 beneficiaries in the Pioneers, and it adds complication and

1 unintended consequences such as the exclusivity issue.
2 These changes would allow specialists to share savings with
3 more than one ACO.
4 Finally, make attribution fully prospective. This
5 would allow MSSP ACOs to know who they would be accountable
6 for in advance as we discuss on the next slide.
7 Prospective attribution means the ACOs know who
8 they are accountable for at the beginning of the year and
9 they remain accountable for exactly that list of
10 beneficiaries. This is the case for Pioneer ACOs now.
11 However, the current MSSP model has preliminary prospective
12 attribution but retrospective reconciliation, which means
13 the ACO knows who may be attributed but that list of
14 beneficiaries can change over the year based on actual use
15 of services, and the final accounting is toted up on
16 beneficiaries who it turns out were actually touched by the
17 ACO during the year.
18 Under prospective attribution, because the ACOs
19 know that they will be accountable for those beneficiaries
20 no matter what, they have the incentive to make the
21 investment to educate the beneficiaries and manage their
22 care, furthering beneficiary engagement. It removes the

1 incentive to send potentially expensive beneficiaries
2 elsewhere for care, that is, engage in selection. For
3 example, if a patient is known to need an expensive
4 procedure such as a knee replacement that would not be
5 indicated by their risk score, an ACO might want to refer
6 the patient to some other provider rather than be on the
7 hook for the cost of that treatment.
8 In addition, prospective attribution is compatible
9 with prospective benchmarks, the next issue, which we will
10 discuss on this slide.
11 There are two issues concerning the benchmark for
12 ACOs:
13 First, the final benchmark is not known in
14 advance. This makes planning difficult because the ACO does
15 not know what target to shoot for. It also makes it
16 difficult to make mid-course corrections as spending becomes
17 known in the course of the year.
18 The other basic issue is whether improvement over
19 one's own baseline is sustainable over time. The benchmark
20 is calculated based on the historical expenditures of the
21 ACO's beneficiaries. For the second cycle, the benchmark is
22 rebased and will be those beneficiaries' experience in the

1 ACO for the three previous years. If the ACO has done a
2 good job of controlling spending, that means the benchmark
3 will be low. This has already been raised as an issue by
4 those ACOs who feel that they were already efficient before
5 the first cycle started.
6 Improving the benchmark calculation takes a few
7 steps.
8 First, it could be made fully prospective so that
9 the target is known in advance and the ACO can make mid-
10 course corrections. To do so, CMS would have to forecast
11 fee-for-service growth rates, but it already does that for
12 MA plans. ACOs would have to live with poor forecasts which
13 may or may not be to their advantage. But those forecast
14 errors would not compound; they get corrected year to year.
15 The benchmark should also take into account ACO-
16 specific mortality rates and input prices. Mortality rates
17 are an issue for benchmarks in the Pioneer demo because the
18 only beneficiaries in the baseline are alive at the
19 beginning of the period. That means their historical
20 spending does not include any end-of-life costs. End-of-
21 life costs need to be added in to compute a realistic
22 benchmark because some beneficiaries will die in the course

1 of the year. It's important that mortality rates be ACO
2 specific because the rates can differ among the ACOs.
3 Input prices are important to take into account as
4 well. Currently a nationwide absolute dollar amount is
5 calculated and applied to all ACOs. ACOs in high-input-cost
6 areas, such as San Francisco, get the same as ACOs in low-
7 input-cost areas and are, thus, put at a comparative
8 disadvantage. This can be corrected by accounting for input
9 prices in the absolute dollar amount.
10 The other improvement would be to not rebase
11 benchmarks for relatively efficient ACOs. "Relatively
12 efficient" would be defined as ACOs whose use rates are
13 below the national average. ACOs that remained high use
14 would be rebased. This is a matter of equity and of making
15 the model sustainable over time.
16 The next issue is which risk model to use.
17 We have discussed one-sided versus two-sided risk
18 sharing before, so we'll go over this very briefly.
19 The advantage of one-sided risk -- that is, a
20 model with no shared losses only shared gains -- is that it
21 could draw in more ACOs to participate in the initial phase
22 of the program, even those that were not sure of achieving

1 any savings. And, in fact, almost all of the MSSP ACOs have
2 chosen to be one-sided.
3 The advantage of the two-sided risk model, where
4 the ACOs share in savings and losses, is that it gives much
5 stronger incentives for efficiency. The incentive is
6 greater for two reasons. First, any improvement in
7 efficiency will pay off for the ACO either in more shared
8 savings or lower shared losses. In the one-sided model,
9 only if there are shared savings will efficiency be
10 rewarded. There is, therefore, greater incentive to invest
11 in care management and less incentive to invest in growing
12 volume as we'll illustrate in a moment. Second, the savings
13 threshold can be lower because random variation will balance
14 out over time in a two-sided model. The program does not
15 need the protection against random variation that it does in
16 the one-sided model.
17 So in this illustrative example, we examine how an
18 ACO bonus structure could reduce a practice's incentive to
19 purchase or lease an MRI machine. And, remember, all the
20 values here are hypothetical and just for illustration. So
21 absent any ACO incentive, which is the case in current fee-
22 for-service, the profit for the practice from leasing and

1 operating the machine would be $100,000 in this example, and
2 that's calculated as shown, revenues minus costs.
3 Now, we assume for this example that Medicare
4 patients account for 40 percent of the revenue, or $200,000,
5 and that spending for the ACO's beneficiaries is increased
6 by that amount.
7 The rest of the calculation proceeds from that
8 $200,000. The key difference is in the next row. We assume
9 that in the one-sided model there's only a 60 percent chance
10 that the ACO will get a bonus and that the increased
11 spending will offset that bonus. In the two-sided model,
12 the $200,000 is guaranteed to either offset the bonus or
13 result in a larger loss. Working through the calculations,
14 the one-sided model results in an incentive of $16,000 to
15 lease the machine. In the two-sided model, the loss is
16 $140,000, and there is a negative incentive to lease the
17 machine and, therefore, they wouldn't do it.
18 Thus, the two-sided model has a stronger incentive
19 to avoid cost-increasing investments. Because ACOs were
20 invented to control unnecessary utilization, that's an
21 important result.
22 With that in mind, how should we think about the

1 issue of one-sided versus two-sided risk sharing?

2 The Commission commented on the MSSP proposed rule

3 that the two-sided risk should eventually be the only

4 option. Pioneer ACOs now all have two-sided risk, although

5 they did allow some ACOs to be one-sided in the first year.

6 As you discussed in November, there seemed to be a

7 consensus for allowing one-sided risk in the first agreement

8 period, but requiring MSSP ACOs to move to two-sided risk in

9 the second agreement period and subsequent agreement

10 periods. And that is the current regulation as well, so no

11 change is needed there.

12 I would also note that two-sided risk does not

13 mean full risk. There could be caps on losses, or

14 reinsurance, or other limitations. Now there are limits or

15 caps on the maximum loss allowed. These ranged from 5 to 15

16 percent for the Pioneers in the first years, and in the

17 MSSP, for those under two-sided risk, from 5 percent in the

18 first year to 10 percent in the third year. One

19 complication is that 5 percent of total Medicare spend for

20 an integrated provider that gets all the revenue may be

21 pretty manageable, but for a primary care practice that

22 forms an ACO and only gets a small share of the revenue, it

1 could be a pretty big deal. So they are in some sense
2 leveraged on the downside as well as on the upside.
3 So to the next issue, as the Commission has noted
4 in the past, the beneficiary does not now share in any
5 savings if the ACO succeeds. One could argue that the
6 beneficiary is getting better care coordination and higher-
7 quality care, but those benefits may not be obvious to the
8 beneficiary. This could raise the issue of a consumer
9 backlash if beneficiaries think the ACO and Medicare gets
10 savings and they get nothing.
11 The ACOs are aware of this problem, but
12 restrictions on beneficiary engagement are unclear to them.
13 Communication is an issue; in particular, the notification
14 letter for the beneficiary is confusing. Beneficiaries seem
15 to think it is giving their doctor permission to share
16 information with the government not vice versa. One ACO we
17 spoke with did not send it out for fear of alienating the
18 beneficiary, which meant the ACO could not get any claims
19 data from CMS until the beneficiary came into the office on
20 an office visit and said it was okay.
21 Another issue is limitations on offering
22 additional benefits. Regulations derived from fee-for-

1 service may be overly restrictive. It is important to note
2 that incentives are different than they are in fee-for-
3 service. In fee-for-service, inducement of services is a
4 big issue; therefore, much regulation is devoted to
5 prohibiting volume-inducing actions. In ACOs, inducement
6 for more services is not as much of an issue because the ACO
7 is accountable for all spending and has an incentive to
8 reduce it. So regulations need to recognize the difference.
9 So here are a few ideas to make it possible for
10 ACOs to share success with their beneficiaries. First is to
11 clarify marketing and communication guidelines that prevent
12 ACOs from readily communicating. It's important that
13 beneficiaries have privacy and other protections; however,
14 it is also important that ACOs be able to engage their
15 beneficiaries. For example, one approach might be to have
16 regulations crafted in consultation with the ACOs that
17 guarantee rapid turnaround for communication reviews and a
18 one-stop shop rather than regional review.
19 Second, improve the notification letter. It
20 should be short and clear and not subject to the current
21 misunderstanding.
22 Third, clarify regulations on inducements. In

1 particular, explicitly allow the ACO to waive cost sharing
2 for primary care visits with ACO providers. We see this as
3 having several benefits.
4 First, it might enable the ACO to get the
5 beneficiary to use ACO providers exclusively for primary
6 care, which would build identification with the ACO system.
7 This might help the ACO to decrease leakage and control
8 utilization better.
9 Second, it might make beneficiaries more likely to
10 buy Medigap plans without first dollar coverage, which has
11 been shown to be beneficial to Medicare.
12 Finally, clarify that ACOs can recommend high-
13 quality post-acute-care providers. A number of ACOs that we
14 have spoken with are recognizing that post-acute care costs
15 can be considerable and are often much higher for ACO
16 beneficiaries than they are for beneficiaries in the same
17 practice in MA plans. Part of the explanation is that
18 certain PAC providers are better than others in terms of
19 cost and quality. ACOs are working to develop networks of
20 efficient PAC providers, and they should have the capability
21 to recommend them to their beneficiaries.
22 I will leave you with these issues for discussion:

1 changes to attribution, improving benchmark calculations,
2 moving to two-sided risk in the second cycle, and allowing
3 ACOs to share savings with beneficiaries.
4 As Glenn pointed out in November, these issues are
5 all linked, and Scott suggested a general principle that the
6 goal is to create accountability for outcomes in a care
7 delivery system. Thinking about the issues related to that
8 goal leads, I think, in the direction of prospective
9 attribution and benchmarks to promote accountability for a
10 clearly defined population, and two-sided risk, and some way
11 to better involve the beneficiary.
12 We would be happy to try to answer any questions
13 on the presentation or paper you may have.
14 MR. HACKBARTH: Okay. Thank you.
15 I envision doing three rounds here -- round one,
16 clarifying, then round two, and then I would like to be able
17 to get to round three where we can focus on a few specific
18 issues where I would really like to get your input.
19 Starting with round one, I've got a couple of
20 round one clarifying questions.
21 David, could you put up slide 12?
22 [Pause.]

1 MR. HACKBARTH: So, in this illustration, could
2 you talk about the row, Probability of a Decreased Bonus or
3 Increased Penalty, the 60 percent and 100 percent?
4 Where does the 60 and the 100 come from?
5 MR. GLASS: Okay. Well, the 100 percent is easy.
6 They're sure to be either penalized or rewarded --
7 MR. HACKBARTH: Yeah.
8 MR. GLASS: -- for the extra spending.
9 MR. HACKBARTH: In a two-sided --
10 MR. GLASS: In the two-sided model.
11 MR. HACKBARTH: Where does the 60 come from?
12 MR. GLASS: The 60 -- we just made that up and
13 said there's not a -- you know, what is the chance that they
14 will get a bonus?
15 So it's not a 100 percent chance they'll get a
16 bonus; it's something less. For this illustration, we said
17 60 percent.
18 MR. HACKBARTH: And just as a reminder to people,
19 the reason it's less than 100 is because there's this
20 threshold that you have to get more savings than X --
21 MR. GLASS: Right.
22 MR. HACKBARTH: -- based on the size of the

1 organization so that --

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

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

4 MR. HACKBARTH: Yeah, yeah.

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

6 that experience.

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

8 percent. Then people can do the arithmetic easily.

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

10 [Pause.]

11 MR. HACKBARTH: So the third bullet -- explicitly

12 allow waiving cost-sharing for primary care.

13 So, as I understand it, the Stark rules prohibit

14 this in other contexts. It's considered an inappropriate

15 inducement for beneficiaries to use services. Is that

16 correct?

17 MR. GLASS: I think that's right.

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

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

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

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

22 you become less concerned about the Stark issue of

1 inducement to use more services.

2 MR. GLASS: Right. And I don't think you'd want

3 to do it in a one-sided, yeah.

4 MR. HACKBARTH: And so that was just going to make

5 that clear. This is the sort of thing that you would do in

6 the context of a two-sided model.

7 Okay. Other clarifying questions?

8 [Pause.]

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

10 MR. BUTLER: On this slide, but a narrow question.

11 They recently announced a number of new ACOs. So remind me;

12 we went from like 250 or something to how many, and how many

13 million do we estimate are now covered by ACOs?

14 MR. GLASS: There were 220 in the MSSP program.

15 They added 123 this month.

16 And what was the next question?

17 MR. BUTLER: How many millions of the 40-plus

18 million are in ACOs?

19 MR. GLASS: Oh, I think the number is something

20 like 5.1 million in all forms of ACOs in Medicare.

21 MS. UCCELLO: So, in terms of improving the

22 benchmark calculation, there were a couple different options

1 for the efficient ACOs. There was the don't-adjust-the-
2 benchmarks-downward, and there was also this use-a-national-
3 standard-amount. And I just wasn't clear on whether these
4 were competing options or whether they could both be done.
5 MR. GLASS: I think that we could do them all,
6 yeah.
7 MS. UCCELLO: Okay. I just wanted to make sure.
8 DR. REDBERG: Yeah, I wanted to understand a
9 little better the secondary -- second stage attribution
10 because -- for example, I'm a cardiologist, and I practice
11 in a faculty practice. And so for some of my patients I am
12 their only doctor; they're relatively uncomplicated. Some
13 of them clearly have a primary care physician. Some have
14 multiple cardiologists and primary care physicians.
15 So I have two questions.
16 How do I know when I'm being considered the
17 primary care physician in an ACO?
18 And then the other question was it says a few
19 visits for a Pioneer; and what are a few, and what is the
20 time period?
21 Those are two separate questions.
22 MR. GLASS: Let's see. How does this work?

1 So I think the Pioneer was if they're 10 -- what
2 was it?
3 If under 10 percent of the visits were with a
4 primary care person, then you could consider a specialist.
5 DR. REDBERG: Last year?
6 MR. GLASS: Last three, I think.
7 DR. REDBERG: Last three.
8 MR. GLASS: In the MSSP, it was if there were no
9 visits with a primary care provider. So that's how that
10 works.
11 I'm sorry. And the --
12 DR. REDBERG: For the varying types of patients,
13 would I be an ACO provider for some but not for others if
14 they had --
15 MR. GLASS: Well, say you're in the MSSP -- and
16 you're exactly who they were thinking of when they said the
17 secondary stage attribution -- and you have a patient with
18 no primary care visits in the prior three years but who had
19 qualified E&M visits with you, then you would -- that
20 patient would be attributed through you to the ACO, assuming
21 you were in a practice whose taxpayer identifier number was
22 registered with that ACO as an ACO member.

1 So, as long as you're -- the practice's TIN is
2 part of that ACO, then you would be in that. Your patients
3 would get attributed to that ACO, and you and all your
4 practice would be exclusive to that ACO.
5 MR. HACKBARTH: Rita couldn't be unwittingly
6 connected to another ACO because her practice in that TIN is
7 associated with only one ACO.
8 DR. MARK MILLER: But, if I understand this, if
9 somebody else in her tax ID gets attributed to an ACO, she
10 goes with it.
11 MR. GLASS: If the TIN somehow gets --
12 DR. MARK MILLER: Right.
13 MR. GLASS: -- is signed up as a member with
14 another ACO, then the whole TIN has to go that way.
15 DR. MARK MILLER: That's some of what the concern
16 is, and so a different way to -- sorry.
17 A different way to understand all this problem is
18 just to look at what we're trying to say to solve it, you
19 know, because there's a lot of moving parts and, you know,
20 MSSP and Pioneer and all the rest of it.
21 I do want you guys to understand this; it may be
22 hard at any given moment to understand exactly how it works

1 now, but what we're trying to say is identify the
2 practitioner as opposed to the TIN, let the ACO or A -- what
3 are these things we're talking about?
4 [Laughter.]
5 DR. MARK MILLER: I'm sorry. Which is the one?
6 Medicare, okay. All right.
7 So let the ACO -- and probably within some range
8 of specialties, but you guys need to discuss that --
9 identify that, you know, Rita can act as a primary care
10 provider, you know, because there are certain patients where
11 their cardiologist serves as a primary care provider. Then
12 you become an attribution node through that designation.
13 So we're trying to clear away all the underbrush
14 of it could happen this way, it could happen that way, and
15 just say the ACO has actively looked at you and said this is
16 one of my specialists who acts as a primary care provider.
17 That's sort of what we're saying, right, David?
18 MR. GLASS: Correct.
19 Yeah, and the point is then you'd have one stage
20 of attribution and add up all the primary care visits with
21 the ACO. And some of them would be yours. Maybe some would
22 be someone -- a primary care person's, but you'd add them

1 all up for that ACO.

2 And we think that that would attribute

3 beneficiaries who actually go there for their care a little

4 better than having the second stage attribution.

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

6 sure I'm clear from this exchange.

7 The provider gets to choose whether they're part

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

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

10 The issue is in the current model all the

11 providers in the same TIN have to basically make the same

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

13 providers in the same TIN to make different choices.

14 But the key point is the providers are always

15 making their choice, and they could choose no ACO.

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

17 then their visits count towards attributing patients to the

18 ACO that the provider has chosen to be part of.

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

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

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

22 So I think the issue is whether or not Rita and

1 her colleagues make different choices if they want to or
2 not. That's the way I interpret this.
3 DR. REDBERG: I think that's true and the
4 clarification -- what you suggested about individual
5 attribution -- makes sense.
6 It's just at teaching hospitals the primary care
7 practice is huge.
8 DR. MARK MILLER: That's the key point.
9 DR. REDBERG: The faculty -- the specialist
10 practice is huge, and so it's very hard to keep track of all
11 the ACOs.
12 DR. CHERNEW: Right.
13 DR. MARK MILLER: So I think I need help here. It
14 could very well be that this TIN has made a decision, but
15 you could end up having practices so large that somebody
16 like Rita could be surprised that she's in an ACO.
17 DR. REDBERG: My primary people could have an ACO,
18 and they did it on their own, but then I happen to be the
19 primary care doctor for those designated beneficiaries.
20 DR. STENSLAND: The only thing I would add is I
21 think it's a point of discussion of whether you want to let
22 each individual provider opt in or out because there could

1 be some selection issues there.

2 Or, do you want to say: Okay, we're taking all

3 primary care providers. So all your family practitioners,

4 your general practitioners, your internal medicine doctors

5 under this TIN are in, but you tell us which of your

6 specialists actually provide primary care?

7 Maybe this cardiologist is really just doing

8 interventions and he's really not doing primary care, or

9 this endocrinologist does some primary care and this one

10 doesn't. But we would let them decide that for those

11 certain specialties.

12 And you might not want to let all specialties in

13 either. You're not going to say your radiologists can

14 declare themselves as primary care physicians -- that kind

15 of thing.

16 DR. MARK MILLER: That's what I was trying to say.

17 The rules we were describing pertain to the specialists. So

18 I was trying to say that, but I didn't say it precisely.

19 MR. KUHN: On the benchmark calculations, it

20 talked about the end-of-life costs and how we can kind of

21 bring that in there, but in the advance reading material we

22 also talked a little bit about SES, or socioeconomic

1 factors, as part of that activity.

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

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

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

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

18 But there may be some differences in SES in your
19 life expectancy, like we might find out that life expectancy
20 is lower in rural Louisiana than it is in Honolulu. And so
21 there's going to be a bigger portion of your people are
22 going to have end-of-life expenditures in rural Louisiana

1 than they do in Honolulu. So you might want to make an
2 adjustment for that.
3 But I think the SES really only flows, as far as I
4 can think of -- maybe I'm missing something, but it only
5 really flows through that expected mortality rate we have
6 for your population because the rest of it is built into the
7 baseline.
8 MR. KUHN: Okay. That's helpful to get a bit of
9 clarification on that.
10 And then the second issue -- in terms of benchmark
11 calculation, just for a point of reference for me on this,
12 in addition to MA and outliers, are any prospective
13 benchmarks used elsewhere in the program right now?
14 MR. GLASS: I'd have to think about hat. I don't
15 know.
16 Mark, do you have anything?
17 DR. MARK MILLER: Yeah, I'm thinking about it, but
18 I'm not --
19 MR. KUHN: And the reason I'm -- because, I mean,
20 CMS has had pretty good experience with that. But, as I
21 think you all well pointed out, if CMS overestimates versus
22 underestimates, you know, there's some juggling there.

1 So I'm just looking at, you know, experience that
2 they've had, their ability on their predictive modeling and
3 things like that.
4 And so that is the only two areas, I think, in the
5 program they use now, but I just wanted to see if there were
6 any others.
7 MR. GLASS: Part D? Is that -- I'm just not
8 familiar enough. Possibly.
9 MR. KUHN: Okay. Thanks.
10 DR. HOADLEY: There are payments that are made
11 prospectively, but that's really just a cash flow.
12 DR. MARK MILLER: We'll think -- [inaudible
13 comment.]
14 MR. GEORGE MILLER: On slide 2, please, I believe
15 in the presentation you mentioned out of all of the new ACOs
16 that there currently are a total of 5. So are any of them
17 the new two-sided risk models, or were they in the previous
18 group that started in 2012-2013? Where are these?
19 MR. GLASS: I'm not sure, but I think they were in
20 the previous group.
21 MR. GEORGE MILLER: Previous.
22 MR. GLASS: Yeah.

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

2 MR. GLASS: We'll have to check that, but I think

3 that may be correct.

4 MR. GEORGE MILLER: I think that would be

5 interesting, at least for me, to know.

6 Thank you.

7 MR. ARMSTRONG: Back to the issues of attribution,

8 so given the direction we're going in, if a patient doesn't

9 have any primary care visits, they will never be attributed

10 to any ACO; is that correct?

11 I mean, the ideal ACO --

12 MR. GLASS: Under the patient that they get paid

13 for but never shows up for a visit, and what we're saying is

14 that that can't happen under this methodology.

15 DR. STENSLAND: There's the three baseline years.

16 So we're saying we look at 9, 10 and 11 and decide

17 which ACO you're assigned to.

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

19 years.

20 DR. STENSLAND: The full three years.

21 MR. ARMSTRONG: Oh, okay.

22 DR. STENSLAND: And if you saw no one over those

1 full three years, then we have no idea who to assign you to.
2 So you wouldn't be prospectively assigned.
3 But you could have seen somebody in 2010, and then
4 you're just healthy as can be, and you don't see somebody in
5 '11 or '12. But you're still assigned to that doctor for
6 '12 even though you never saw them because historically that
7 was your primary care doctor, as best we can tell.
8 MR. ARMSTRONG: That answers it.
9 MR. HACKBARTH: Okay. Any others?
10 [Pause.]
11 MR. HACKBARTH: So moving to round two, let me
12 just ask a question here.
13 So I'm trying to imagine what it looks like to
14 lead an ACO, and let's set aside the Pioneers who are unique
15 in their organizations that have more structure and
16 experience with this.
17 So I'm thinking about a newly created ACO, and I'm
18 very ambitious and idealist, and I want to improve medical
19 care for beneficiaries and hopefully get some benefits to my
20 organization as a result. What tools do I have at my
21 disposal?
22 Now, as I understand how all this works, the

1 dollars continue to flow on a fee-for-service basis.

2 And so let's assume that this isn't an integrated

3 group practice and you got people on a bunch of different

4 practices and legal structures that we're trying to meld

5 into an ACO. So all of them are continuing to get their

6 checks from Medicare.

7 I, as the idealistic, ambitious leader of this new

8 ACO, am not getting any checks. Unless we beat the target

9 and there's a savings to be had, I assume that goes to the

10 ACO corporate structure. Is that --

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

12 a half later.

13 MR. HACKBARTH: Right, right. So --

14 MR. GLASS: There's no -- except for something

15 called advance payment, which a few of them are in.

16 MR. HACKBARTH: Yeah.

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

18 front.

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

20 my disposal

21 MR. GLASS: But

22 MR. HACKBARTH: Yeah, yeah. So the tools to

1 influence practice inside this new ACO are pretty limited.
2 Hopefully, I'm an inspirational leader and speaker because I
3 don't have any money that I could offer people; I don't have
4 any new money, no money from Medicare other than the advance
5 payment model that I can invest in programs.
6 If I want to change, you know, the structure of
7 physician payment, I can't do that. The flow of dollars to
8 specialists versus primary care is still driven by the
9 Medicare fee schedule.
10 MR. GLASS: So, essentially, even in the one-
11 sided, you're at risk for whatever initial investment.
12 MR. HACKBARTH: Exactly, exactly.
13 And so if I wanted to do something, you know,
14 basic, like say: Well, you know, I want to not require
15 patients to come in for face-to-face visits all the time. I
16 think I can really improve the efficiency of this operation
17 if we have more email and phone appointments and really use
18 our face-to-face appointments for the patients who need to
19 see the physician face to face. And that's how I'm going to
20 streamline our practice, improve access to care for sick
21 patients, et cetera.
22 I really don't have any tools to do that because

1 under the Medicare payment rules Medicare doesn't pay for
2 the email and Medicare doesn't pay for the phone calls, and
3 so I've got to exhort my physicians to do these things that
4 they're not getting any compensation for. Right?
5 MR. GLASS: Correct. There are no fee-for-service
6 payments coming in for anything that they wouldn't come in
7 for to begin with.
8 MR. HACKBARTH: So we've often talked about the
9 one-sided model being a weak model, and David's
10 illustration, the table on slide 12, is a numeric
11 illustration of why it's a weak model.
12 This is another sense in which it's a weak model.
13 The flow of money through the organization is still driven
14 by the Medicare fee-for-service structure, I think.
15 DR. BAICKER: I have a clarifying question about
16 your question. Medicare wouldn't pay the ACO for the phone
17 call. But, couldn't the organization -- couldn't the
18 physician group -- say we think we're going to reap savings
19 from this in this model, so we're going to pay our
20 physicians to make those phone calls?
21 That's not precluded.
22 MR. HACKBARTH: They could, but they wouldn't have

1 any new money to do that. They'd have to reach into their
2 pockets and say we're going to take a chance and do that.
3 DR. BAICKER: They'd be taking a chance on the
4 savings that they thought that they would accrue, but it's
5 not precluded.
6 MR. HACKBARTH: Yeah, whereas in Scott's model,
7 where he's getting a global capitation, he can reprogram the
8 dollars, you know, subject to the constraints on winning
9 consensus within his organization and say, I don't have to
10 ask my physicians to reach into their personal bank accounts
11 to finance this; you know, we'll try to build a consensus
12 that the dollars need to flow a different way.
13 MR. ARMSTRONG: And just to build on your
14 clarifying question, so the hypothetical ACO leaders that
15 were putting this together -- really, you are describing two
16 different levels at which they have to invest in certain
17 capabilities. One is just around payment policy and that
18 they don't have the funds to set up the kind of incentives
19 within the system that you're talking, but there's a whole
20 other set of functions and capabilities that simply don't
21 exist.
22 I mean, the first thing I'd do is call my regional

1 Medicare Advantage plan and see what they could do to help
2 me build some of those capabilities. It still doesn't
3 answer, though, that funding point.
4 But it's both. It's really both of those things.
5 DR. SAMITT: Can I pile onto that clarifying as
6 well?
7 I mean, correct me if I'm wrong, but there was
8 also an advance payment option for ACOs that wanted access
9 to resources to invest in ACOs. So it wasn't as much of a
10 cash flow issue.
11 But I think what most organizations do is they
12 would estimate to what degree could they influence savings
13 even though the ultimate reward for that is a year and a
14 half later, and the cost of achieving those savings is
15 invested as part of the organization's budget with the
16 premise that it would produce savings downstream. So I
17 think that's how several ACOs have been thinking about it to
18 date.
19 MR. HACKBARTH: The advance payment model -- is
20 that limited to certain types of ACOs?
21 MR. GLASS: That was limited to, essentially,
22 small ACOs. I think there was an emphasis on rural

1 physicians.

2 MR. HACKBARTH: Yeah.

3 Alice?

4 DR. COOMBS: Glenn, this is so round three, but I

5 have to say this is one of the hurdles for the onesie-twosie

6 groups. What you have highlighted that is really important

7 is this big hurdle of getting over infrastructure

8 development to be able to progress to an ACO.

9 And we saw this in Massachusetts when we were in

10 the process of that whole payment reform.

11 And I know with the AQCs that they actually

12 earmark and they look at certain doctors in certain regions

13 and say, okay, we have information.

14 But a piece of it is the providers actually

15 knowing what their panel looks like, and that's all IT and

16 infrastructure in terms of being able to have an EMR with

17 the bells and whistles.

18 The other piece of it is actually having the

19 regionalization of onesie-twosie doctors coming together and

20 being able to say this is what our patient profile looks

21 like in this area.

22 And I think that's really important going forward,

1 to get over that initial hurdle, to say that I can do this.
2 The I-can-do-this is built and predicated on the resources
3 that are available to those docs, but you have highlighted
4 an essential issue with the buy-in to get the next level of
5 providers together and to move forward.
6 If we don't get over this hurdle, I think it's
7 going to be one of those things that we need to address
8 before we can see that real swing in terms of the number of
9 ACO development.
10 MR. GLASS: I would point out, though, that there
11 are entities out there, private sector entities out there,
12 that are making -- that are essentially providing the up-
13 front capital and information, you know, the IT capabilities
14 and all the back office stuff --
15 MR. HACKBARTH: Right.
16 MR. GLASS: -- to groups of practices.
17 So they'll find some practice and say I want to
18 set up an ACO, and they'll provide all that.
19 MR. HACKBARTH: Yeah.
20 MR. GLASS: So that is happening.
21 MR. HACKBARTH: Yeah. So the reason I raised this
22 whole line is that it is something I'm considering for round

1 three.

2 You know, we talk about strengthening the model,

3 as being from -- moving from one-sided to two-sided, but I'm

4 trying to raise the possibility of another dimension of

5 strengthening the model, which is to move at least some of

6 the payments away from fee-for-service so that they flow on

7 a different basis and provide leverage to really transform

8 practice.

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

10 DR. CHRISTIANSON: Okay. Just to clarify, so the

11 idea is our thoughts on these policy issues and their

12 relative importance?

13 MR. HACKBARTH: You can frame it as questions or

14 comments, whichever way you want.

15 DR. CHRISTIANSON: Well, I will focus on the

16 benchmark issues, and I'll do that because I think without

17 resolving the benchmark and how to set an appropriate

18 benchmark the ACO program will fail in its objectives.

19 And I know that -- I actually took this down:

20 ACOs were invented to control unnecessary utilization.

21 I hope more than that. I hope that their goal is

22 to actually reduce the rate of increase in Medicare costs

1 through better coordination of care.

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

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

11 So now we have savings plans here, which say keep
12 7 percent. Well, 7 percent of an appropriately set
13 benchmark is a savings. Seven percent of a benchmark that
14 somehow is 150 percent of what reasonable costs are lets
15 Medicare say, oh, we saved 7 percent, but in fact it cost
16 Medicare a lot more money.

17 To me, this is the critical issue.

18 And I'm not actually reassured by the experience
19 we've had with the MA program, starting with the AAPCC back
20 in the mid-1980s and on. It seems like we're continually
21 changing the way we're reimbursing MA plans. We end up
22 paying MA plans, as the data that the staff has generated

1 over the years suggests, more than the cost of providing the
2 care in traditional Medicare. And the politics of changing
3 that is pretty intense.
4 I don't see any reason why ACOs won't go down that
5 same path.
6 And so, to me, the number one issue in terms of
7 whether this turns out in retrospect to be a good move, in
8 terms of restructuring the Medicare program, is how you
9 establish and maintain a benchmark that reflects something
10 resembling reasonable costs plus a margin that's acceptable
11 to us and to the industry. So I would think a lot of
12 attention should be given to that.
13 And the presentation talks about, you know, some
14 of the sort of more technical issues in setting the
15 benchmark.
16 I think we have a bigger issue in setting the
17 benchmark -- what's our policy as a Commission going forward
18 in terms of setting the benchmark? And, if we don't get
19 that right, we don't get the program right.
20 MR. HACKBARTH: Of course, that links into the
21 conversation we had in October, was it, about a level
22 playing field and how you define what the playing field is?

1 DR. MARK MILLER: It wasn't in October.

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

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

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

18 But I think it would be worthwhile for the staff
19 to try to monitor whether this is occurring in any more than
20 a handful of instances. And, if it is, does it (a) help us,
21 or does it (b) raise any issues in terms of how we want to
22 think about ACOs going forward?

1 In the private sector, the people I talk to who
2 manage networks now tell me, you know, total cost of care
3 contracts -- they refer to this as a transition arrangement.
4 They don't see this as something which is going to be
5 maintainable in the long run, and it has a lot to do with
6 the issues that you folks have raised in terms of if you
7 continue to base it on historical costs, how long -- you
8 know, how much savings can you continue to crank out of
9 that?
10 So it comes back to the whole benchmark issue.
11 MR. GLASS: Yeah, this ACO within an MA plan --
12 we'll have to follow up on.
13 But, if it's within an MA plan, then I guess
14 there's some lock-in involved, which would, you know, torque
15 things around quite a bit.
16 MR. HACKBARTH: Just for the record and the people
17 in the audience, the discussion we had about the level
18 playing field was November, not October. October was the
19 government shutdown. So we didn't meet.
20 So, if you want to look up the transcript, it's
21 November that you should look at.
22 DR. MARK MILLER: Yeah. And even then, was it

1 November, or was it September? I know it wasn't --

2 MR. HACKBARTH: Just for the record and people in

3 the audience, the discussion we had about the level playing

4 field was November, not October. October, there was the

5 government shutdown, so we didn't meet. So, if you want to

6 look up the transcript, it's November that you should look

7 at.

8 DR. MARK MILLER: Yeah, and even that, was it

9 November or September? I know it wasn't October. I was

10 here, but everyone else --

11 [Laughter.]

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

13 I was here.

14 DR. REDBERG: [Off microphone.] Did you talk

15 about it?

16 DR. MARK MILLER: I did.

17 DR. STENSLAND: November.

18 DR. MARK MILLER: November, all right.

19 MR. HACKBARTH: Okay. Bill.

20 MR. GRADISON: Thank you. I've been troubled, as

21 many have, about the attribution question from the time ACOs

22 first came up. At times, I say to myself that I'm like the

1 economists who are very troubled by something that works in
2 practice but doesn't work in theory, and in this instance, I
3 don't really know how bad it is. That is to say, I'm not
4 sure that the definitions exactly -- that we've used are
5 clear, at least, not to me.
6 We say this is retrospective, and I understand
7 that. But my understanding is that the potential patient,
8 beneficiary, is notified and has a chance to opt out and
9 about five percent of them opt out. So, in that sense, it
10 is a choice. It's a negative choice, but somebody who
11 doesn't want to be under this can get out from under it --
12 MR. GLASS: Well, their --
13 MR. GRADISON: -- but they can't say, I want to be
14 under one. It has to start from the other end, from the
15 provider end. Is that sort of correct?
16 MR. GLASS: Well, the ACO is given a list at the
17 beginning -- and we're talking MSSP -- at the beginning of
18 the period, they're given a list of who seems likely to be
19 in their ACO, and yes, for those people, those people are
20 then given the opportunity to opt out of data collection.
21 Now -- to opt out of their data being shared from CMS to the
22 ACO. But their spending will still be counted if, at the

1 end of the year, it turns out that, retrospectively, they
2 were, indeed, in the ACO. So, in other words, their
3 spending is counted. It's just their -- CMS can't send
4 their data to the ACO.
5 DR. MARK MILLER: Or, to put it differently, I
6 wouldn't say -- I wouldn't characterize it as five percent
7 of the people opt out.
8 MR. GRADISON: Oh, that's what I want to
9 understand.
10 DR. MARK MILLER: I wouldn't put that --
11 MR. GRADISON: How would you -- help me. I'm
12 really just trying to --
13 MR. GLASS: They opt out of data sharing.
14 DR. MARK MILLER: Five percent of the people don't
15 --
16 MR. GRADISON: Oh, they opt out of data sharing.
17 Okay. Well, then that raises an interesting question,
18 whether there should be a clearer opt-out opportunity if
19 they want to opt out, that's all. I mean, the attribution
20 strikes me as so weak that, looking down the row, as I say,
21 at least theoretically, I don't see how it works over time,
22 but I may be wrong about that and we'll find out soon enough

1 from so many different organizations that are trying to do
2 this right now.
3 The other thing I want to just simply mention, and
4 please don't throw anything at me about this, but when we
5 talk about providing incentives or trying to share savings
6 with beneficiaries, whether it's under MA or in the
7 discussion here, we've left out -- we haven't left out, but
8 left out of the discussion almost always is a sharing of
9 something called cash. I mean, the assumption is that we're
10 going to have some additional benefits or some lower cost
11 sharing or something like that, but there are things in life
12 which lead me to believe that cash can also be a powerful
13 incentive and that savings along that line really ought to
14 be thought about. I know it's a radical -- seriously, I
15 know it's a radical idea, but I really hope at some point we
16 can give a little thought to that across some of these
17 programs.
18 That's all I really have. All I'm trying to do is
19 reflect a lot of uncertainty and the fact that I found this
20 discussion and your presentation excellent and I know I've
21 got to give a lot more thought to it to know where I'm going
22 to end up.

1 DR. NAYLOR: So, let me just echo that last point.
2 I also found this work and your presentation just really
3 important. It seems to me that we're in an process with an
4 experiment to try to figure out what we can learn. We have
5 three years with 23 and two years with 220 and just starting
6 others.
7 The set of recommendations that you've described
8 to get us from the set of challenges around attribution or
9 beneficiary rules or benchmarks seem quite reasonable to me
10 if looked at as a set. You know, I would be concerned if we
11 begin to take things apart and don't see this as a planned
12 opportunity to really tackle what seem to be challenges on
13 different fronts.
14 I hope we will really use the opportunity, as we
15 think about ACOs and the emphasis on primary care, on shared
16 accountability, on accountability, that we really do think
17 about it from the insurers' and clinicians' and
18 beneficiaries' perspectives, and it seems that this set of
19 recommendations has done that.
20 I also think that access has been a kind of golden
21 rule around the Commission and I think it's very important
22 that we not just tackle regulatory adjustments, but where

1 there are needs for statutory adjustments, such as thinking
2 about all of those people who access, are trying to access
3 accountable care through ACOS, through NPs and at PAs, that
4 we really begin to see this as part of the set of primary
5 care services that we should be promoting access to and
6 holding accountability for.
7 So, I think that this is a really excellent plan
8 looked at holistically, from multiple lenses, and really
9 based on our learning, and I think that's what the
10 Commission is supposed to be doing.
11 MR. GEORGE MILLER: Yes. I'll echo what many of
12 my colleagues said about this being excellent work. But
13 something Mary just said struck a chord with me and I was
14 going to address that, and that is if we -- first of all, my
15 statement would be, what have we learned from this, from the
16 ACO model and where we are today, and then if we were able
17 to restart this over again, what would we do differently?
18 And more importantly, at least, more importantly
19 from my perspective, as the Medicare beneficiary, would this
20 be valuable to me, what we have now, or how could we make
21 that better? And it's a two-sided risk model. While it may
22 be better for the Medicare program to have risk, shared risk

1 and savings, but would that get the outcome we want for the
2 patient, to improve quality of care, lessen the spend, and
3 is there another way to do that?
4 So, I don't know the answer to those two
5 questions, but certainly -- and as Bill said, this has got
6 us all thinking. It certainly raised the question in my
7 mind, how to look at this so that the Medicare beneficiaries
8 improve and we have some increased quality and certainly
9 lower the cost spend. So, the question in my mind, does
10 this do that and can we take this opportunity now to tweak
11 this to move in that direction.
12 And if we make it too complicated, the discussion
13 about if a physician doesn't know which ACO she's in or not
14 in, or he is or is not in, how do we fix that issue, and
15 does the patient have the free opportunity to decide they
16 don't want their information shared with anybody, and if
17 that is the case, then how does that impact the goals that
18 we're trying to get at. So, those are just some of my
19 thoughts.
20 DR. SAMITT: So, before I share my remarks, I
21 guess I should admit my inherent bias that I'm a big fan of
22 the ACO movement because I do believe that it helps us

1 overcome the inertia of the fragmented fee-for-service
2 system. And while it may be an experiment, I think it is
3 progressively moving us in the direction of alternative
4 payment models that we really need to encourage, with the
5 presumption being that these alternative models, we believe
6 that they have promise to deliver better care at a lower
7 cost. I would imagine that what we want is to ensure that a
8 greater number of providers are incented to move in this
9 direction and a great number of beneficiaries are incented
10 to move in this direction.
11 And so I would say of the four proposed changes, I
12 am actually a big fan of all four, but I want to dig deep on
13 two in particular, the benchmarks and the sharing of
14 benefits with the beneficiaries.
15 So, I completely echo John's comments that the
16 benchmarking and getting that right is going to be probably
17 the most significant element in making this work. My
18 greatest concern is if we're dealing with inaccurate
19 benchmarks and at the same time we're encouraging the
20 current one-side to move into two-side, this becomes
21 exceedingly problematic, and it's most problematic, I would
22 argue, for the most efficient providers.

1 And so working for one previously and now one
2 currently that's on the efficient side of things, if you're
3 in the one-sided space and the benchmarks are a bit
4 imperfect, you probably can live in that world because there
5 isn't risk. There's up-side, but you can still effectively
6 survive there.
7 But as you move into two-side, and if the
8 benchmarks are inaccurate, and, in fact, it's based on
9 historical performance and so every time you improve, in a
10 two-sided model, you're actually facing increasing amounts
11 of risk, not increasing amounts of gain, then I would be
12 concerned that the efficient providers would not stay in a
13 two-sided model and would seek to either move all the way to
14 Medicare Advantage or go back to fee-for-service. And I'm
15 not so sure that's the type of movement we'd want.
16 So, I completely echo the notion that we need to
17 continue to create incentives, even for the most efficient
18 providers, to find new opportunities as opposed to find
19 great risk.
20 On the benefit sharing with beneficiaries, I'm a
21 big fan of that, too, because we don't want to have a party
22 that no one comes to, that if all the providers say, you

1 know, we envision that we want to be in the ACO space but
2 there isn't a similar recognition of the benefits to the
3 beneficiary, then I think we have a disconnect.
4 So, I would say that I would even encourage us to
5 go further in identifying how we can share with the
6 beneficiaries, and what I mean by that is I would even make
7 the sharing much more significant. I would encourage us to
8 even say an ACO is not an ACO is not an ACO, that the ACOs
9 that are either the most efficient or demonstrate the
10 highest quality have the even greatest degrees of freedom to
11 provide benefits to beneficiaries because it encourages them
12 to be even more efficient and higher quality and creates
13 even greater incentives for beneficiaries to seek them out
14 as the best providers.
15 So, I think there is great merit in the concept of
16 beneficiary benefit sharing and we just will need to figure
17 out how to effectively do that.
18 MR. KUHN: I'm a lot like Craig. I am a big fan
19 of the ACO model, as well, but when I look at all that we've
20 got up here today, it reminds me of a fingerpainting from my
21 niece that we have on our refrigerator right now. There's a
22 lot going on in that picture, I'm just not sure what it all

1 is.

2 [Laughter.]

3 MR. KUHN: And that's kind of what I think about

4 when I look at these kind of four areas that we're looking

5 at right now.

6 But, three things I'd like to just kind of focus

7 on. One, David, we were talking a little bit about the

8 types of ACOs out there and these one model that's coming

9 forward with these outside consultants coming in, perhaps no

10 capital requirements by the ACO itself. It's the other

11 group putting it up. I don't know whether it's a good or

12 bad thing. It reminds me a little bit of a model we saw a

13 decade or a decade-and-a-half ago with some of the

14 physician-owned specialty hospitals and some of the

15 development of those. What kind of -- are these becoming

16 pretty widespread out there, or what's kind of the take-up

17 rate of this particular model of ACO? Do we have much

18 information on it yet?

19 MR. GLASS: Well, there's one big group of these,

20 and they had over 30 and they have some additional ones in

21 the 123 that just came in, so that would be, I don't know,

22 35 or something.

1 MR. KUHN: Okay. I don't know whether it's a good
2 thing, bad thing, just curious about that.
3 MR. GLASS: Yes.
4 MR. KUHN: It's just an interesting kind of
5 phenomena here and we'll see how it works out.
6 The second thing, I, too, am interested in the
7 sharing success with beneficiaries, and I like all the
8 things that we're kind of enumerating as we go forward. I
9 will just say that a couple ACOs I know I'm familiar with,
10 the one I'm really interested in is the recommending post-
11 acute care providers, among all of them. I'm interested in
12 all of them, but that one. And the reason I raised that one
13 is I'm seeing more ACOs actually taking their staff from
14 their organization and putting them, say, in a long-term
15 care facility or other kind of post-acute care provider in
16 order to improve the quality so they don't get bounce-backs
17 from readmissions or whatever the case may be. They could
18 alleviate that problem if they could just recommend certain
19 high-quality providers out there, and it's a strange work-
20 around to make it work, but I think there's we can help that
21 through these set of recommendations, so I'm interested in
22 that.

1 And then, finally, what I'm interested in here,
2 too, is that since this continues to have its roots in the
3 fee-for-service world, unless Glenn has his way and thinks
4 about different other payments here, but I'm just wondering
5 if there are any program integrity issues that we need to
6 think about here as we go through these set of
7 recommendations. I don't know what those would be. I don't
8 think we've raised those. But are there any additional
9 program safeguards that we need to think about as we go
10 through the set of recommendations, and just something -- I
11 wanted to just make sure we fully vet those.
12 MR. HACKBARTH: On that last issue, Herb, I agree
13 with that, and one concept that we've introduced is that if
14 we were to move towards two-sided risk, then that would
15 allow potentially clearing away some of the regulatory
16 underbrush that is directed at cost increasing behavior, for
17 example, Stark rules.
18 Rita.
19 DR. REDBERG: Thanks for an excellent discussion,
20 and I also like the concept of ACOs but think the devil is
21 in the details and a lot of the changes that you've
22 suggested, I think, would improve the ACOs. I particularly

1 think it's important to focus on the beneficiary engagement,
2 because right now, and particularly -- maybe we could talk
3 about Medigap a little more, because we have before, but
4 particularly beneficiaries who have Medigap and don't pay
5 anything, there's not a lot in it for the beneficiary to be
6 in an ACO because they mostly have unlimited care whether
7 they need it or not. For whatever reasons, beneficiaries
8 currently think the more care they get, the better it is,
9 which isn't necessarily true, but that's a lot of the -- and
10 so the ACO doesn't have that kind of culture. But right
11 now, the way it's structured, there isn't a lot in it for
12 the beneficiaries.
13 So, I think the cost savings, the elimination of
14 cost sharing, getting away from and making it more favorable
15 for beneficiaries to participate, and, I think, additional
16 things besides just leaving the cost sharing, additional
17 perks for the program, things that beneficiaries clearly
18 want, you know, facilitated communication, ease of access to
19 their providers. I mean, I think those are things that
20 beneficiaries really value and are becoming harder and
21 harder to get and that would make ACOs -- give them a better
22 status in the marketplace compared to standard fee-for-

1 service plans, because otherwise, I fear there's just too
2 much leakage and there's no incentive. I mean, the provider
3 signed up. The beneficiary is going to get a letter from
4 the government saying, you're in this, and they have nothing
5 invested. So, I think those changes and more, as Craig and
6 others have said, would be a good -- a really important step
7 for the success of ACOs.
8 DR. CHERNEW: So, a few quick points. First, I
9 agree very much with John's comment that getting the
10 benchmark right is key. And, actually, in the chapter, it
11 alludes to the fact that we'll try and bite that off
12 separately, and I think that's probably right. There's a
13 lot of issues with how to do that. One is how to coordinate
14 with Medicare Advantage in a level playing field kind of
15 way.
16 Another one is when the system captures the
17 savings, on one hand, we want to capture the savings as the
18 ACOs become more efficient. On the other hand, you can't be
19 afraid of profits. They have to have an incentive to be
20 more efficient. And so, working through that requires some
21 thought.
22 I'm a little wary of sort of halfway tweaks to the

1 benchmark, in other words, don't rebase after two years for
2 those that are relatively efficient, because you're setting
3 up this whole other set of things. So, I'd rather wait,
4 bite it off as a big thing and figure how we want it to go
5 forward strategically as opposed to a few small things, and
6 I think the chapter actually notes that we'll try and do
7 that.
8 A few other things. I very much agree with these
9 points that have been made about administrative costs. In
10 general, I think we often ask organizations to spend less,
11 but then we impose a lot of administrative costs or other
12 restrictions that make it hard to do that, not just in ACOs,
13 incidentally. If we would have had more time in the
14 hospital sector, I would have said the same thing. We put a
15 lot of pressure on hospitals. We have to make sure that we
16 don't add a lot of costs to them at the same time in a bunch
17 of ways. So, I think, generically, that's a theme.
18 The one thing that's clear from your presentation,
19 and I would appreciate it if -- I very much appreciate it,
20 although it's depressing in some ways, is the aspects of
21 attribution is just a mess, and there's a lot of tweaks we
22 talk about, and thinking about how to work around that is

1 going to be very important. I think, despite a very
2 thorough and thoughtful presentation, in many ways, I feel
3 like we've just scratched the surface on how to get the
4 attribution right.
5 In response to Bill's point, we actually have a
6 paper that's under review now on how well the attribution is
7 working or not, and there's different types of people that
8 are getting misattribution -- I don't know, "mis" isn't the
9 right word, but you have problems with. One is you have
10 basically healthy people that don't go very much and so
11 their care patterns bounce around because there are just not
12 that many visits, and maybe that's not a big deal if you get
13 it wrong.
14 Then you have people that have serious events.
15 Something bad happens to them and they end up in a nursing
16 home and with rehab and they end up somewhere, or a lot of
17 different things, and those are people we really do care
18 about and there's issues with how that attribution goes,
19 too. It's sort of a version of the mortality story,
20 although it's not exactly that.
21 And so I really think it's important to think
22 about attribution, and honestly, my preference would be to

1 get away from some attribution thing, but there's all kinds
2 of other barriers, which we've talked about, about doing
3 that. I do worry a lot about it.
4 The last thing I'll say is I think some thought
5 about the role of a one-sided risk model is important, and
6 so let me say, I agree with where we've been collectively,
7 and I've said this, that I prefer a two-sided model for all
8 the reasons that have been said. So, I don't think it's a
9 huge question that the two-sided model in many ways is
10 better. The question is, that might not be for everybody.
11 So, it's not clear who the other folks are.
12 But then the question is, is there anything for
13 those other folks, and let me say, just in general, it's not
14 our job as a Commission, and I don't think it would be
15 advisable if we interpreted our job as to come up with
16 models that support the existing practice configurations and
17 infrastructures. You know, having them change in various
18 ways, I think, is fine. So, I don't think we should look at
19 a small practice and say it's really good and you always
20 have to be small and our job is to give you enough money so
21 you can stay small. Maybe that would be good, but
22 inherently, I don't think we have to support it.

1 On the other hand, we can't ignore the existing
2 infrastructure and just assume that everyone can transform
3 to some other configuration that we may or may not think
4 eventually could be better or not. And so I think there is
5 a struggle we have to come with about is there a role for
6 something in the transition or not, for organizations or
7 areas that won't fit well into a two-sided model if we think
8 those exist. And I have to admit, for many of the issues
9 that you raise in the chapter and some that I've commented
10 on, I am on the fence about how far to go and how it
11 ultimately plays out.
12 And I think, as I said in another meeting, the one
13 thing that is clear to me is finding some way to move away
14 from the fee-for-service -- you know, however bad this
15 looks, it looks more promising to me than where I think the
16 trajectory of fee-for-service would go for a whole variety
17 of reasons. So, I think it's crucial that we get this
18 right, but these are very hard issues that I don't have
19 necessarily strong opinions on yet.
20 DR. COOMBS: So, I think the benchmark is
21 important. I think the attribution is even more important,
22 because unless you get the assignment right, then you don't

1 know the baseline and you don't understand who is caring for
2 what in terms of -- not just in terms of cost, but in terms
3 of quality, and the quality piece is as important. And
4 that, combined with the risk adjustment, that was our
5 language with payment reform.
6 And another benchmark that I think is important is
7 the progression along the way, and the Secretary will be
8 able to assess how well we are doing in terms of ACOs, newly
9 adopted ACOs, over what period of time, so that there should
10 be a benchmark. In 2009, with the Payment Reform
11 Commission, we looked. It was 21 percent global payment and
12 it would progress to 40 percent and so forth within the next
13 time period. That's probably as important, because what it
14 tells you is that culture is changing in terms of providers
15 feeling like they have the support and going to the next
16 level.
17 And so I want to remind myself more than anything
18 else is that there's two things occurring at the same time.
19 There's health care delivery reform and then there's payment
20 reform. They should go together. They should be married.
21 And that's the piece that sometimes we talk about it as
22 though they're two different things. But the global payment

1 was a really important piece of where we went for health
2 care delivery reform.
3 I think the infrastructure, as mentioned before,
4 is really important for providers to see that they can do
5 it, and unless you address that, because of the percentage
6 of onesie, twosie providers, whether it's physicians or
7 nurse practitioners, you have to be able to have a heal that
8 is reachable. I mean, it has to be something that's
9 attainable, and it has to be perceived as fair, and it has
10 to be something that actually looks at the overhead for
11 providers in terms of being able to reasonably do something
12 in terms of this whole hurdle of understanding what your
13 patient panel looks like, what the risk adjustments look
14 like, and whether or not this is something that's
15 attainable. I think those are the important things going
16 forward.
17 And I have to say that I was pleasantly surprised
18 at the progression in Massachusetts in terms of where we've
19 gone from capitation in terms of percentage benchmark per
20 year, how many of the providers have transitioned. But one
21 key feature is that it's almost like a continuous pilot
22 study, where you're looking at issues that arise and you

1 have to be willing to deal with mid-course corrections along
2 the way. But you can't have just health care delivery
3 reform in the absence of payment reform. They go together.
4 They're married.
5 DR. HALL: I'll try not to repeat too much what
6 others have said. I think that the work we've done here is
7 terrific. I feel much better informed by this than anything
8 else that I've read about in terms of ACOs.
9 But, I think our discussion is pointing out that
10 we would all agree that the construct of the ideal ACO, or
11 constructs of ACOs, has yet to be determined, that there are
12 still some very basic integers that need to be filled in
13 here. For example, the whole issue of attribution that
14 everybody has mentioned here, whether it's retrospective or
15 prospective, we're now looking for labels to do attribution.
16 So, we're saying, well, anybody can be the designated
17 primary care provider to define membership in an ACO. That
18 has nothing to do with the definition of primary care, not
19 even the definition we used when we were trying to find ways
20 for paying for the sequestration. We were very, very
21 specific about who was a primary care provider.
22 So, it's kind of trying to monkey wrench names

1 into entities that we don't really know much about yet at
2 the present time. That says to me that this is such a work
3 in progress that we can make suggestions, but I think we
4 need to follow this much more closely.
5 And, in particular, I don't think any of this is
6 going to work unless both providers and patients have
7 confidence in these systems. It's not enough to just say
8 you're an ACO in a community. You may be an ACO in a highly
9 competitive urban community and your real purpose is to
10 steal market share from your competitors. Others may
11 really, truly want to embrace an entire State and say, we
12 can make this the best possible "X" that there is in the
13 world. But we need to urge people to take a look at some of
14 those factors, as well.
15 Do we know anything, really, about consumer
16 reaction? Do we know anything about what so-called primary
17 care providers feel about this? Unless we look at that, I
18 don't care -- we can come up with arguments that might be
19 more like how many angels dance on the head of a pin until
20 we really have some idea of what is the real human effect of
21 these things.
22 So, I think we should keep going, but I would be

1 very cautious for us to think that we have the answers here
2 and that we can make one suggestion on some of these
3 alternatives that come forward.
4 MR. HACKBARTH: Let me just pick up on Bill's
5 comment. Earlier, we talked about when data would be
6 available on the MSSP program, and Jeff boldly said, we have
7 it now.
8 [Laughter.]
9 DR. MARK MILLER: Just for the record, Jeff will
10 now clarify. We talked at lunch.
11 DR. STENSLAND: We have data on about 600,000 to
12 700,000 people in the MSSP, so we can --
13 DR. MARK MILLER: Pioneer.
14 DR. STENSLAND: In Pioneer, excuse me. So we can
15 track those Pioneer individuals.
16 MR. HACKBARTH: Just Pioneer.
17 DR. STENSLAND: Just the Pioneer. We don't have
18 the data yet, and we haven't got that all squared away on
19 the MSSP people. But to the extent that -- that's still a
20 pretty big sample of people that you could look at some
21 things and say, you know, what is the hospice use for the
22 people in the Pioneer and the year they were in the Pioneer

1 compared to other people in their same community. You could
2 do that kind of analysis with the stuff that we have. We
3 don't have the full five million.
4 MR. HACKBARTH: For this discussion, I'm actually
5 less interested in the Pioneer because they have, you know,
6 a more advance payment model, or "advanced" being defined as
7 one that I like.
8 [Laughter.]
9 MR. HACKBARTH: You know, I think Bill is right.
10 In a sense we're operating in sort of a vacuum and trying to
11 make decisions about these policy variables, and we don't
12 know much about what has, in fact, happened with the MSSP
13 program. And I think that is really critical.
14 My own hunch is that the MSSP program is so weak
15 that it's not a very effective tool for promoting the
16 delivery system reform that Alice seeks, and I agree, that's
17 the ultimate goal. But that's just my hunch. Maybe the
18 data prove me wrong. And so I would like to see how quickly
19 we can get a look at some of the MSSP data.
20 MR. GLASS: So we're hoping to at least hear about
21 MSSP performance in the next month or two. You know, but
22 that would be --

1 MR. HACKBARTH: Top-line numbers.
2 MR. GLASS: Yeah, top-line, did they make money,
3 lose money, you know, savings lost sort of thing.
4 DR. MARK MILLER: And in those types of analysis,
5 that won't be stuff that we'll have looked at independently.
6 It will be reported out. And if I could just get two other
7 clarifications here, the data that we have for Pioneer has
8 come by recently, like the last 48 hours. Is it claims
9 level data or blocks of expenditures, you know, like sort of
10 the rolled-up summary level stuff?
11 DR. STENSLAND: We have the beneficiary
12 identifying numbers, so we can link the --
13 DR. MARK MILLER: So it's more individual.
14 DR. STENSLAND: -- identification to the actual
15 claims and look at the individual claims of individual
16 people.
17 DR. MARK MILLER: Okay, and that's much ore
18 powerful. And then for Mike, you just described what you
19 guys had done, which is under review?
20 DR. CHERNEW: Just the stability issue, right, but
21 we [off microphone] --
22 DR. MARK MILLER: Sorry, I caught you --

1 DR. CHERNEW: No, I was hoping you would. We've
2 been looking at how many people stay in an ACO when, you
3 know, if you're assigned in one year, are you still in them
4 the next year? We weren't looking at them in the actual
5 ACOs because of the lag. We were looking in those types of
6 groups. So in big groups, how much movement is there across
7 those groups.
8 DR. MARK MILLER: Okay, that's what I wanted to
9 know [off microphone].
10 DR. CHERNEW: So that could all change when the
11 ACOs are keeping people in, but the underlying notion of the
12 basic care patterns are pretty noisy in a variety of ways.
13 DR. MARK MILLER: Right, and the thing I'm just
14 trying to clarify here and I need you guys to make sure I'm
15 asking the right question, you're not saying I have
16 beneficiary IDs assigned to this ACO; you're sort of looking
17 at how attached a beneficiary stays to a group?
18 DR. CHERNEW: In groups that are defined as ACOs,
19 but that's a longer discussion.
20 DR. MARK MILLER: Okay.
21 DR. HOADLEY: So I will echo what a number have
22 said. I think the research here you guys have done has

1 really been helpful in sort of setting us up. Having said
2 that, this is still a lot of hard questions, as, again, many
3 of us have said.
4 Thinking about the four topics that are up here,
5 I'm very convinced by a lot of comments here that the
6 attribution issues are really important. I'm also fairly
7 convinced that I don't have anything to add to that
8 discussion, so I won't try -- at least today.
9 I'm also convinced by Jon's and others' comments
10 that the benchmark is really important, and I totally get
11 that sort of comparison back to the early days of Medicare
12 Advantage. I don't think I have anything else that I feel a
13 need to add on that.
14 I have some thoughts on the two-sided risk, and I
15 partly was intrigued, Glenn, by your initial question,
16 trying to sort of say, well, how would your answer to that
17 question be different if you were under two-sided risk? I
18 mean, you're that same entrepreneur. There's still nobody
19 putting money in your hands.
20 MR. HACKBARTH: Actually that's the question I
21 meant to raise. We sort of simplified it as, oh, two-sided
22 is better than one-sided. But if it still all flows fee-

1 for-service, from the perspective of the fledgling ACO, it
2 may be worse.
3 DR. HOADLEY: Right.
4 MR. HACKBARTH: Because I don't have any more
5 tools, any more means to redistribute the dollars, but now
6 I've got downside risk. So that's the question I --
7 DR. HOADLEY: Yeah, and that's exactly the way I
8 thought about it. And then as I go deeper into the sort of
9 notion of two-sided risk, I started to try to think about --
10 and I don't know if there's experience at this point in the
11 Pioneers that have done this on sort of how the money -- you
12 know, what sort of happens with money, you know, if there's
13 a loss. You know, is this all a matter of what the contract
14 relationships are amongst the various players? Is there any
15 concern -- I mean, it's not like the beneficiaries are at
16 risk. You don't have sort of the insurance issues that you
17 might have on a provider-sponsored MA, you know, issues we
18 dealt with a few years back. But I am interested in sort of
19 what's the ability to put that money back in to cover that
20 and how all that plays out, and potentially more so when you
21 sort of think about the variety of kinds and some of those
22 smaller kinds of ACOs, ones that don't have a hospital

1 involved because the hospital has potentially deeper pockets
2 to sort of work with, both in terms of putting money up
3 front but also uncovering a loss. If you've got a
4 relatively small let alone not even the ones and twos, but
5 even a modest six physician practice trying to head up an
6 ACO, you know, what are the protections either for the
7 individual providers or for the entity as a whole in terms
8 of that downside risk? And how is that being played? I
9 know there were some references to reinsurance and some
10 other things in that.
11 So those are things that I think, you know, as we
12 think through the two-sided, I think it's really important
13 to think about and whether we're learning anything from the
14 relatively few groups, and maybe they're so atypical of the
15 rest of this universe that it doesn't help.
16 And then, last, on the beneficiary side, you know,
17 I've made points in other meetings about sort of the general
18 notion of how is it that a beneficiary is ever going to
19 understand what this is when we're having trouble explaining
20 them and understanding and thinking about attributions and
21 who's even attributed to be with let alone sort of with.
22 And I think, you know, these notions of improving

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

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

1 question.

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

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

20 DR. MARK MILLER: I guess the only thing I would
21 say is -- and we're up against time, so I want to -- there
22 are several things to say here, but I'll take this all

1 offline. We should look harder at this, because I think
2 some of what you said depends on whether you might be in
3 Pioneer versus MSSP. And I think it's more -- it might be
4 even more rigid than what you've said, depending on which
5 one you're talking about. And we keep jumping back and
6 forth in all these conversations, and I suspect people might
7 end up being confused. So we'll come back to you on that.
8 DR. BAICKER: So despite some of the gratuitous
9 potshots at economists -- which need to stop.
10 [Laughter.]
11 DR. BAICKER: -- I did want to follow up on --
12 DR. CHERNEW: Get more original [off microphone].
13 DR. BAICKER: Yes.
14 [Laughter.]
15 DR. BAICKER: That's really very much appreciated.
16 I wanted to follow up on the question -- that we may not
17 have the data now to answer -- of how often this
18 retrospective truing up is really a problem in practice, not
19 just in theory. I wonder if this doesn't actually happen
20 very often; or if you don't have the data to answer that
21 question, in practice you could see if this rule were in
22 placed based on beneficiary patterns, what's our best guess

1 at how often there would be -- how many people would move
2 based on prospective versus retrospective? And it may be
3 that it's particularly the problematic patients, very
4 expensive, hard-to-manage ones, so we care about who it is,
5 not just how many. But it would be helpful to have a sense
6 of how big that is.
7 That said, I do think that the prospective
8 assignment has a lot of attractive features, one of which is
9 giving providers a responsibility for those patients no
10 matter what, but also discouraging selective movement of
11 patients, where movement, I'm picturing a shove not a walk
12 out the door, and that suggests that you don't want
13 providers to have an incentive to say, "Wouldn't you be
14 better off across the street, Mrs. Very Expensive Patient?"
15 That concern goes over then to thinking about
16 beneficiary choices in moving. I wonder how often
17 beneficiaries who opt out would be doing so truly
18 volitionally versus some subtle encouragement of expensive
19 beneficiaries to opt out, not just -- I worry about that
20 less with data sharing than I would with actual --
21 MR. GLASS: They can't opt out now. They can't
22 opt out of the ACO now. They can only opt out of data

1 sharing.

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

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

21 MS. UCCELLO: So as the actuary who is more
22 typically the target of --

1 DR. BAICKER: I know. What's --

2 [Laughter.]

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

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

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

11 [Laughter.]

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

19 But I think what was still confusing after all
20 this is that we could not figure out how she got attributed
21 to this ACO. We got on the website and looked at the list
22 of providers, and she didn't really recognize any of the

1 names. And so it was just confusing -- it's still
2 confusing.
3 So I don't know if this is practical, but if these
4 letters could be a little bit more personalized to say how
5 it is what providers that they've been to that are in this
6 ACO I think would help. And I asked her if that would help,
7 and she said, "Oh, yes, it would." So she also said if you
8 need to call her for any information, she'd be happy to a
9 focus group of one.
10 [Laughter.]
11 MS. UCCELLO: On the other hand, you don't
12 necessarily want providers now to be listed on this that are
13 going to have to take all these calls from patients getting
14 these letters, but it might just make someone feel more
15 comfortable that they're just not out of the blue being
16 assigned to something that they have no idea what it is.
17 MR. GLASS: Well, some of the ACOs actually send
18 the letter out through the primary care provider so that
19 people know who they're being attributed on more or less.
20 MS. UCCELLO: That makes sense. Yeah, not my
21 mom's.
22 MR. GLASS: But that requires a lot of work to do

1 it.

2 MS. UCCELLO: Yes.

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

5 [Laughter.]

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

19 And I wouldn't discount the synergies with other
20 activities. Readmission rates, understanding medical
21 spending per beneficiary, palliative care -- a lot of things
22 that we're doing, they'd said, gee, we're doing those

1 things, they would help. And if there's some one-sided
2 savings, why not? And there are other payers it's working
3 for, too, so most states have moved or are moving toward
4 Medicaid managed care, so we look, for example, at frequent
5 flyers in the emergency department and what are their
6 characteristics and where are they going on their
7 discharges. Again, all of this kind of feeds into and is
8 really consistent with an ACO theme, and it just becomes --
9 you know, it does help. And the absence of other tools, you
10 still are working on these things.
11 Okay. So with respect to the discussion items,
12 I'm actually more of a one-sided guy, unlike a lot of you,
13 because I believe that if you are efficient, you will get --
14 you will opt to the Medicare Advantage plan. If, as Jon
15 says, the rates are set right, why wouldn't you just go into
16 Medicare Advantage as the option? And so I don't mind
17 keeping one-sided going. It has gotten 5.1 million people
18 in now learning a whole lot and not a big expense. Don't be
19 so quick to just kind of flip it to two-sided where there
20 would be all kinds of gaming and other things that get
21 introduced when you really want to go to Medicare Advantage
22 if you're efficient anyway.

1 On the sharing with the beneficiaries, you know,
2 I'm with Bill a little bit. Cash is real. I mean, maybe
3 this wouldn't work, but the ACA requires you to rebate money
4 above -- below 85 percent of the MLR. Is there some way to
5 take your end savings simply and rebate back? Maybe that's
6 way beyond what we can do, but that would get people's
7 attention, I think.
8 And, finally, on our lessons kind of learned
9 research piece, my calculation is that about 14,000 on
10 average in the 366 ACOs. Remember, we had the threshold we
11 wanted at 10,000, and they settled for 5,000. So the random
12 variation would be a good thing to understand under the MSSP
13 and whether that's a factor or not.
14 MR. ARMSTRONG: So there is a benefit and a
15 downside to being the last person in the round. I'm sitting
16 here feeling a little overwhelmed -- more than a little --
17 and kind of discouraged and trying to remind myself why the
18 ACO idea is actually a very exciting and powerful thing, you
19 know, that many of us have worked for a long time to try to
20 advance. And Peter started saying this. I do think it's an
21 experiment. You know, it's this space between a pure fee-
22 for-service payment structure and prepaid MA or something

1 like that. And it's a messy process, and it's not alone.
2 There's a lot of other things that are moving us forward,
3 and so I feel better having said that, and I just did that
4 for my --
5 [Laughter.]
6 MR. HACKBARTH: [off microphone].
7 MR. ARMSTRONG: I am reading a book called "The
8 Happiness Advantage," and I'm just really trying to apply
9 it.
10 With respect to the specific issues here, I think
11 it's a nice inventory of the issues we should be putting on
12 the table, and then I would really support moving our agenda
13 forward. I would just add a couple of comments.
14 One, I work for an organization with 80,000,
15 85,000 Medicare Advantage plan members. I know who they
16 are. They enroll every year. I have all the information on
17 their care and their claims payment and so forth. And I
18 still engage in endless debates about our attribution
19 methodology. So it's a hard thing. There are
20 organizations, though, that are experts at this and who have
21 been spending years trying to figure it out. It will never
22 be perfect, and so, I mean, I think maybe we just need to

1 acknowledge that.

2 I won't comment -- I agree with the point about

3 getting the benchmarking right, and not surprisingly, a real

4 advocate for the two-sided risk dynamic. I just think

5 that's the kind of incentive we're trying to create.

6 With respect to the beneficiaries and their

7 relationship to all this, I think we've actually understated

8 the importance of that, and that whether it's just, you

9 know, being in a relationship that's not scary or confusing,

10 like Cori's mother's relationship, and owning --

11 MS. UCCELLO: That was [off microphone].

12 MR. ARMSTRONG: I'm sorry. Cori's mother's

13 relationship. Sorry. But these ACOs need to be in a

14 relationship with the beneficiaries that are part of the

15 ACOs that not only gives them an incentive to but allows

16 them to actually be in a trusting relationship and engage in

17 a dialogue that recognizes their ability to meet the

18 benchmarks is, in fact, to a high degree a function of what

19 kind of behavioral changes can they make in those patients

20 when they're not actually sitting in the exam room or in the

21 hospital bed. And the way we built this is really impairing

22 our ability to do that.

1 Just one anecdote. I would say within the MA
2 program we now have accounts where beneficiaries had a very
3 poor record of having a relationship with primary care
4 providers or filling out Health Risk Assessment tools and so
5 forth. We have the flexibility -- we paid those
6 beneficiaries $25 cash if they showed up in the primary care
7 office in the first three months of being a member of this
8 plan. We pay them cash if they fill out the Health Risk
9 Assessment tool online and have a conversation with their
10 primary care provider about it.
11 You know, I just think ACOs are so impaired in
12 their ability by so many of these issues that are in the
13 design to actually fulfill our desire for this experiment to
14 teach us things that we just have to pay attention to it.
15 And in the end, and at the risk of sounding like, you know,
16 an insurance salesman, I think the Medicare Advantage
17 program solves these problems. And at the very least -- and
18 I remember we had this at some point. We should be asking,
19 as we line up all these issues, that we want to inform and
20 advise on with respect to helping the ACO experiment move us
21 forward. Line them up against the solutions that we've seen
22 in Medicare Advantage and just ask, Why is it so bad to make

1 sure MA really does what we want and fill in that space,
2 particularly, you know, MA plans that are provider focused
3 and, you know, engaged in care delivery and so forth? What
4 really is the hurdle that keeps us -- or what's the issue
5 that keeps us from filling the space between this ACO
6 experiment and really going for MA as a solution to some of
7 this stuff?
8 I'm sure that there's political answers and all
9 sorts of other reasons, but my hope is we can objectify some
10 of those differences in the analysis that we do going
11 forward.
12 MR. HACKBARTH: Okay. I had promised a Round 3,
13 but there will be no Round 3. I was thinking that we should
14 have a Round 3 because I thought that we might be close
15 enough to consensus on some issues that I wanted a Round 3
16 to crystallize that. I think actually we've moved away from
17 consensus compared to our last conversation. For example,
18 on the issue of two-sided risk, I think there's less
19 agreement this time than when we discussed this issue last
20 time.
21 Now, that's a healthy sign that people are really
22 wrestling with what's a complicated question, so I don't

1 have a problem with that, although we do have a fixed time
2 allotment to sort of come up with a view for the MSSP
3 proposed rule, which will come out sometime in the next
4 couple months, I think David said. So we've got some work
5 to do.
6 One last thought about this. I think there were
7 some really articulate comments about how you might want to
8 be careful about moving to two-sided risk prematurely
9 because the participation might fall off dramatically, and I
10 think that's probably a reasonable assumption. And so the
11 question that I'm starting to wrestle with, which is better
12 from the perspective of the Medicare program: to have a
13 much smaller program that involves providers that are
14 further along in terms of delivery system organization and
15 integration, or to have one that includes a lot of people
16 that are in a much earlier state of evolution? And hope is
17 -- I think Peter and some others described that in time, you
18 know, we'll get benefits, even though the incentives are not
19 all that strong, it's getting people to think about some of
20 the proper questions. And there's some intuitive appeal to
21 me in that, but I do think we need to take care to focus on
22 layering on complexity to the Medicare program for -- if we

1 don't think there's going to be a really big benefit,
2 because this one in particular, the more it expands, the
3 more beneficiaries we're going to have like Cori's mother,
4 "What in the world is this? I don't understand it." It's
5 such a, you know, sort of like a test tube idea that people
6 like us think up that a lot of Medicare beneficiaries find
7 it very, very difficult to relate to.
8 So there are costs to having a really big sort of
9 low-success program, a lot of regulatory costs and confusion
10 costs for beneficiaries, and we need to figure out how to
11 weigh that versus a much smaller, perhaps much more powerful
12 program.
13 I do think that having some data on how successful
14 MSSP is in changing behavior and getting people to start
15 doing things differently could be decisive in thinking this
16 through. So Jeff has promised us that we're going to have
17 data next week, and we'll look forward to --
18 [Laughter.]
19 MR. GRADISON: Glenn, may I make a brief comment?
20 Once before -- and I can't recall on which silo -- we
21 suggested that CMS had gone too far with the demonstration
22 in terms of how many people they brought into it. I think

1 we ought to give some thought to that in this instance as to
2 whether with all the things that aren't known and all the
3 variations as to whether there ought to be a moratorium on
4 new entries at some point in order to gain a little bit more
5 experience -- five million is a pretty good sample.
6 And the only other thing I want to say while I
7 have the floor is to apologize to Kate for what was meant to
8 be a self-effacing comment and to promise her I'll work on
9 some new material for next month -- for the next two months.
10 MR. HACKBARTH: Last word.
11 DR. CHRISTIANSON: Last word. All right. So most
12 of you are way too young to ever remember when Johnny Carson
13 was the King of Late Night TV, I'm sure, but he used to have
14 a bit called "Carnac the Magnificent," and he would take an
15 answer, and he would divine the question. So here's the
16 answer: "No Medicare-specific shared savings parameters."
17 So the answer to that is: "What are ACOs going to look like
18 in the future?" And we already see it in total cost of care
19 contracts now. The health plans are providing back-room
20 support to the provider systems. They also sell
21 reinsurance. It's much more efficient for ACOs to buy
22 reinsurance from health plans for their combination of their

1 total cost of care and ACO contracts than to engage in this
2 shared savings plus 7 percent minus 2 percent, all of this
3 stuff we're worrying a lot about. The larger ACOs are going
4 to want to do that very quickly, and so my point is: Where
5 does Medicare point to for its savings at that point? It
6 all depends on where you set the benchmark. It all depends
7 on where you set the benchmark at that point.
8 MR. HACKBARTH: Okay. Thank you, David and Jeff.
9 We'll now move on to dialysis.
10 [Pause.]
11 MR. HACKBARTH: Okay. Before -- where did
12 everybody go?
13 DR. CHERNEW: It's the after-lunch rush-out.
14 MR. HACKBARTH: Yeah, right. Well, once some
15 other Commissioners come back, I'm going to leave.
16 [Laughter.]
17 MR. HACKBARTH: I really am feeling crummy, and so
18 I'm about at the end of my battery for today. So I'm going
19 to turn the chair over to Mike. I apologize to people in
20 the audience. As I said earlier, this does not mean that
21 I'm not interested in dialysis or post-acute care, but I had
22 some food poisoning last night, and I'm just sort of totally

1 out of energy at this point. I didn't sleep much. So
2 please accept my apologies. But I will stay until we get
3 some more butts in the chairs.
4 Go ahead, Nancy, whenever you're ready.
5 MS. RAY: Good afternoon. Today's presentation on
6 assessing the payment adequacy of outpatient dialysis
7 services consists of four sections. First, I'm going to
8 answer some questions raised during the December meeting.
9 Then I will summarize the indicators of payment adequacy and
10 present the draft update recommendation for your
11 consideration. Lastly, I will discuss improvements to the
12 new Prospective Payment System that we discussed during the
13 December meeting and present a draft recommendation for your
14 consideration.
15 As background, in 2012, there were about 370,000
16 dialysis fee-for-service beneficiaries who were treated at
17 roughly 5,800 dialysis facilities. Total Medicare spending
18 for outpatient dialysis services was $10.7 billion in 2012.
19 So now I'm going to move to answer some of the
20 questions raised during the December meeting.
21 Alice and George asked questions about kidney
22 transplantation, and in response we have added a discussion

1 regarding access to kidney transplantation in the draft
2 chapter.
3 George asked about mortality differences by ESRD
4 modality. The adjusted rates are highest for hemodialysis
5 patients, second highest for peritoneal dialysis patients,
6 and lowest for transplant patients.
7 Alice raised the issue about bundling
8 transportation services into the payment bundle. In last
9 year's report, we discussed one approach for facilities to
10 provide transportation services to their dialysis
11 beneficiaries, but that it would require exceptions to the
12 anti-kickback statute. It could be an option that providers
13 could take if they deem it essential.
14 George also asked about facility ownership by the
15 two largest dialysis organizations in rural areas. We call
16 out in the chapter that these organizations comprise the
17 majority of facilities in rural areas as well as in urban
18 areas.
19 Now I will summarize our payment adequacy
20 analysis.
21 The indicators assessing payment adequacy for
22 outpatient dialysis services are generally positive, and you

1 have seen most of this material in December.

2 Regarding providers' capacity, the growth in the

3 number of dialysis treatment stations has kept pace with the

4 growth in the number of dialysis patients.

5 Regarding access, there are few facility closures

6 in 2011. Our claims analysis suggests that the few

7 beneficiaries who were affected continued to receive care at

8 other facilities.

9 Looking at volume of services, between 2010 and

10 2012, growth in dialysis treatment stations and facilities

11 matched beneficiary growth.

12 Looking at volume changes, we also look at volume

13 changes by measuring growth in the volume of dialysis drugs

14 furnished. Now that dialysis drugs are in the payment

15 bundle, providers' incentive to furnish them has changed.

16 Recall that under the prior payment method, these drugs were

17 separately billable. I'd like to highlight two findings

18 that we discussed last month: between 2007 and 2012, use of

19 the leading 12 dialysis drugs declined by 39 percent, and

20 that ESAs, erythropoietin-stimulating agents, that manage

21 patients' anemia declined by 45 percent.

22 There are quality implications concerning the

1 decline in the ESA per treatment use. The reduction is good
2 for clinical reasons. Between 2010 and June 2013, the
3 cumulative proportion of beneficiaries experiencing negative
4 cardiovascular outcomes associated with ESA use has
5 generally declined. As expected, lower ESA use is
6 associated with a decline in hemoglobin levels. Of concern
7 is the modest increase in the percent of dialysis
8 beneficiaries receiving a blood transfusion from a monthly
9 average of 2.7 percent in 2010 to 3.3 percent in 2013. This
10 contrasts with the relatively constant rate of the blood
11 transfusion rate over the last decade. I'll come back to
12 address this issue at the end of the presentation.
13 Other measures of quality that I'd like to
14 highlight: hospital admissions have declined between 2010
15 and June 2013, and there has been an increase in the use of
16 home dialysis, which has been associated with improved
17 patient satisfaction.
18 Regarding access to capital, indicators suggest it
19 is adequate, as suggested by the increasing number of
20 facilities that are for-profit and freestanding. The
21 aggregate Medicare margin for freestanding dialysis
22 facilities is 3.9 percent for 2012.

1 The Medicare margin in 2012 is higher for the two
2 largest dialysis organizations than other freestanding
3 facilities. The Medicare margin is higher for high-volume
4 facilities compared to low-volume facilities. That is, the
5 margin increases as total treatments increase. The lower
6 Medicare margin for rural facilities is related to treatment
7 volume. Rural facilities are on average smaller than urban
8 facilities.

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

22 This projection also includes the estimated small

1 reduction in total payments due to the ESRD QIP. And,
2 finally, the margin would be about 2 percentage points lower
3 if sequester cuts continue.
4 This leads us to our draft update recommendation.
5 The Congress should not increase the outpatient
6 dialysis payment rate for calendar year 2015.
7 Spending implications. This recommendation would
8 not change spending relative to current law over one year
9 and five years.
10 We anticipate no adverse impact on beneficiaries.
11 We anticipate increased financial pressure on some
12 providers, but overall a minimal effect on providers'
13 willingness and ability to care for Medicare beneficiaries
14 is expected.
15 So now I'd like to begin the last part of this
16 presentation. In December, we discussed three issues
17 concerning the new Prospective Payment System. I will
18 summarize each issue for you and present a draft
19 recommendation for your consideration.
20 The first issue concerns the change in anemia
21 management. As I previously said, the new Prospective
22 Payment System resulted in a reduction in the use of ESAs.

1 We are concerned about the incentive to undermanage anemia
2 under the new Prospective Payment System. Beginning in
3 2013, the ESRD Quality Incentive Program, the QIP, does not
4 assess anemia undermanagement. The Secretary has the
5 authority to include such a measure in the ESRD QIP. We do
6 not specify the measure, but envision that such as measure
7 could assess treatment outcomes such as rates of increasing
8 blood transfusions or rates of admission.
9 The second issue concerns the design of the low-
10 volume adjustment. For existing facilities -- those in
11 business in 2010 -- CMS does not factor the distance to the
12 next facility for determining the adjustment. In 2012,
13 nearly half of all low-volume facilities were within 5 miles
14 of another facility.
15 Cori, in December you asked about rural
16 facilities, and they are disproportionately paid under the -
17 - they disproportionately receive the low-volume adjuster,
18 and we have called that out in the chapter.
19 A low-volume adjustment should focus on protecting
20 facilities critical to beneficiary access. The Secretary
21 has the authority to redesign this adjustment by developing
22 a distance requirement that applies to all facilities.

1 The last issue concerns the accuracy of dialysis
2 facilities' cost reports. This sector has experienced a
3 major change. The accuracy of cost reports under the new
4 Prospective Payment System has not been examined. The last
5 audit was conducted more than 10 years ago. Prior ESRD
6 audits have found that facilities have overstated allowable
7 costs from 4 to 10 percent. If providers' costs are
8 overstated, then the Medicare margin would be understated.
9 It would be good fiscal management to assess the accuracy of
10 the cost reports.
11 So this brings me to Draft Recommendation 2. It
12 reads that the Congress should instruct the Secretary to:
13 include a measure in the ESRD Quality Incentive Program that
14 assesses anemia undertreatment; redesign the low-volume
15 adjustment to consider a facility's distance to the nearest
16 facility; and audit dialysis facilities' cost reports.
17 We expect that the spending implications of this
18 recommendation will be budget neutral.
19 Concerning implications for beneficiaries and
20 providers, we anticipate that this recommendation should
21 improve the quality of anemia management and help ensure
22 that beneficiaries' access is maintained at isolated, low-

1 volume facilities; that it would have a minimal effect on
2 providers' willingness or ability to serve beneficiaries;
3 and that it would decrease payments for facilities that
4 receive the low-volume payment adjustment but are in close
5 proximity to other facilities and would increase payments
6 for isolated low-volume facilities that do not receive this
7 payment adjustment.
8 That concludes my presentation. Thank you.
9 DR. CHERNEW: [Presiding.] Wonderful, Nancy.
10 Thank you.
11 So we're a tad behind schedule, so I'd just ask
12 you to keep that in mind as we go for clarifying questions,
13 and that said, are there any clarifying questions?
14 DR. HALL: In the slides we just looked at in
15 terms of assessing anemia, you used the term "anemia
16 undertreatment." In the narrative we were provided before,
17 the emphasis seems to be on transfusion being done
18 excessively, and I wonder if you could equate those two. I
19 think it's -- it makes a big difference.
20 MS. RAY: Right. The narrative was not intended
21 to give the impression that blood transfusions are being
22 provided too much. What we are trying to raise is that

1 there has been a trend under the new PPS and there's a small
2 trend for a modest increase in the rate of blood
3 transfusion.
4 DR. HALL: So that would be anemia overtreatment.
5 I guess I'm not making myself clear.
6 DR. REDBERG: I was confused by the same thing. I
7 think that they're calling it "anemia undertreatment"
8 because they're saying there's more transfusions because
9 hemoglobin levels are dropping. But my clarifying questions
10 are related to that issue.
11 DR. HALL: In Round 2 we can have a few more
12 points.
13 MR. GRADISON: I guess it's a similar subject.
14 Can't they get more frequent or do they get more frequent
15 readings, at least from the big companies that probably have
16 the data anyway with regard to, let's say, monthly figures
17 on transfusions or something of that kind rather than
18 waiting to do it once a year? I mean, I assume these
19 companies probably have it every week internally.
20 MS. RAY: Well, generally dialysis patients don't
21 receive transfusions in the dialysis facility. At least
22 historically they did not.

1 MR. GRADISON: Right.
2 MS. RAY: They received them in outpatient
3 hospitals. So that probably -- so the ability of the
4 facility and the nephrologist -- well, the ability of the
5 facility to know about the transfusion is probably going to
6 vary to the extent to which the facility and the
7 nephrologist are able to keep track of that information,
8 gather that information.
9 MR. GRADISON: Not to drive this into the ground,
10 but the nephrologists are usually the ones who say you need
11 a transfusion.
12 MS. RAY: Yes, that's correct. Well, if -- yes,
13 if it is ESRD related. But just to be clear, not all
14 transfusions are ES -- there are other reasons that a
15 dialysis patient may require a transfusion, is what I'm
16 trying to say.
17 DR. MARK MILLER: I might have heard the question
18 a little bit differently, Bill, so let me just ask. The way
19 we're looking at this, this comes out of the claims data.
20 MS. RAY: Yes [off microphone].
21 DR. MARK MILLER: And so at least our line of
22 sight on it is to know that a patient got a blood

1 transfusion and that patient is a dialysis-eligible patient.
2 That's how we have line of sight.
3 It may be that the dialysis organizations and
4 facilities have some other line of sight on this, and if you
5 want to tease that out in subsequent rounds, let's do it.
6 But for us, what we have line of sight on is claims.
7 MR. GRADISON: [off microphone] the annual?
8 DR. MARK MILLER: Well, I mean, the other way I
9 could have taken your question is: Is it possible to get it
10 any more frequently? Potentially we could get dumps of
11 claims more frequently, but, yes, we'll tend to be coming
12 back to you on an annual basis and saying this thing's
13 moving up or down.
14 The one thing I would say -- and I do want to move
15 this along -- this is such a rare event that it's a pretty
16 noisy measure, and getting it more frequently is even rarer.
17 I mean, you'll have even smaller N on a quarterly basis than
18 you will on an annual.
19 MR. GRADISON: Thank you.
20 MR. KUHN: Nancy, just a quick question or help me
21 get a clarification on the Draft Recommendation 2 where we
22 talk about the spending implications being budget neutral.

1 And one of the recommendations is to do more audits of cost
2 reports. From my time at CMS, there were a lot of things I
3 wanted to audit, but we just didn't have the administrative
4 dollars to do it. It does take a lot of money to do these
5 audits. So I'm just trying to understand where the offsets
6 are from the audits to make this budget neutral. This is
7 administrative dollars or are talking trust fund dollars, is
8 what I'm trying --
9 DR. MARK MILLER: Trust fund [off microphone].
10 MR. KUHN: Okay. So if it's trust fund, I
11 understand. Got it. Thank you.
12 DR. REDBERG: So back to the anemia
13 undertreatment, I was very troubled, you know, reading on
14 page 2, it says, "Hemoglobin levels have decreased from 11.4
15 to 10.6." And that's good because we were overtreating.
16 And the guidelines now are hemoglobin levels 9 to 11. So
17 we're still on the high side of those hemoglobin levels.
18 And then the next line says, "While blood transfusions
19 increased from 2.7 to 3.3 percent," which as I say that,
20 that was where I was guessing you were getting the anemia
21 undertreatment. But, first of all, as you said, that's a
22 very small increase, and there are a lot of reasons why

1 people get transfusions that have nothing to do with -- you
2 know, they come into the hospital acutely, and their
3 hemoglobin drops, or there's a lot of variability in
4 transfusion practice. And maybe we can get back to this in
5 Round 2, but I'm just wondering if there was any more basis
6 for this, because I have a lot of concern. You know, we've
7 spent billions of dollars trying to get people's hemoglobins
8 very high with very little benefit on outcomes -- no
9 quality-of-life benefits, no mortality benefits, very
10 little. And now, you know, we've seen tremendous drops in
11 strokes and heart attacks because we've kind of brought the
12 hemoglobin targets down. But I would be very careful about
13 trying to ramp it up again without having really good data
14 that there was some harm coming from this very tiny change
15 in transfusion when hemoglobin levels really are still on
16 target.
17 MS. RAY: Right. And it is not our intention to
18 ramp up hemoglobin levels again. Over the prior decade,
19 according to U.S. Renal Data System's data, rates of blood
20 transfusions were relatively constant. The new Prospective
21 Payment System has changed providers' incentives with ESAs
22 now in the bundle. We have seen, beginning in 2010 to 2011,

1 '12, and now for the first six months of 2013, you know,
2 this small increase in blood transfusions. So including a
3 measure in the Quality Incentive Program -- now, keep in
4 mind, I mean, there are already other measures that Medicare
5 holds providers accountable for: dialysis adequacy, another
6 measure is anemia. There is already an anemia measure in
7 the Quality Incentive Plan that holds providers accountable
8 for the proportion of patients with hemoglobin levels over
9 12. So this would just be another measure to counteract any
10 possible incentive that there could be under the new PPS
11 regarding anemia management.
12 DR. REDBERG: I guess I'm not clear. How are you
13 defining "anemia undertreatment."
14 MS. RAY: We are not specifying a measure. This
15 would be up for the Secretary to develop a measure. Such a
16 measure could be by looking at rates of hospital admissions.
17 And the Secretary discussed this in the regulatory process a
18 couple of years ago, saying that lower hemoglobin levels
19 could lead to higher rates of blood transfusions, higher
20 rates of hospital admissions, and those could potentially be
21 two measures that the Secretary -- and this is the Secretary
22 saying that she would look into down the road.

1 DR. CHERNEW: So my take on this is that there's a
2 number of pieces of evidence that just -- you know, in the
3 chapter, but the main point is when the bundle was expanded
4 and we saw the practice patterns change the way that you
5 document in your slide, there's always some concern that
6 you're going to go too far. And I take the spirit of -- I
7 think you're talking about the first point in the second
8 draft recommendation, that's the one under discussion, and
9 just again to clarify, I take that as saying with a lot of
10 flexibility to encourage the Secretary to try and make sure
11 that we don't go under. But the evidence that we provide in
12 the chapter isn't intended to specify what that type of
13 measure should be or what the thresholds are. It's just --
14 and I don't know if that's --
15 DR. REDBERG: I'm still not even clear of the
16 reason for the measure. We can get back to it.
17 DR. MARK MILLER: And maybe we are rolling into
18 Round 2, but just to add one other sentence to what he was
19 saying, nothing is intended to say we think we're observing
20 undertreatment. The trend was a concern to make sure that
21 we don't get there. And just to, you know, put a little bit
22 of a different tone on this, the last time we had this

1 conversation, there were several concerns expressed on this,
2 and we kind of crafted this in response to the concerns that
3 were expressed.
4 But, again, it's to his point, we aren't asserting
5 that undermanagement of anemia is occurring. It's a concern
6 over a possible direction.
7 DR. CHERNEW: And nor are we asserting that the
8 types of evidence presented, the number of transfusions,
9 should be in any way related to the measure that ultimately
10 is developed. It's more of a potential concern as you see a
11 dramatic reduction in the use of a service that I believe we
12 felt was overused to start with. You take a service you
13 believe is overused, you see it dropping, and for all the
14 reasons that were said in the presentation, there's a lot of
15 good things that seem to have happened because of that. The
16 question is: As you see things begin to drop, making sure
17 that they don't drop too much, because I would defer
18 clinically that I don't even know what that means. I can't
19 pronounce "dialysis." But my clinical knowledge is
20 basically limited to that. But I think the issue was
21 because there was some concern, we would encourage some
22 attention to it, but not that we think that we are either

1 observing it now or that we necessarily will observe it in
2 the future, or that we think that we should increase back to
3 where we were in any way.
4 DR. REDBERG: Just we saw a lot of good things. I
5 didn't see any data in here for bad things, so that's why
6 I'm confused about why we have this recommendation.
7 DR. BAICKER: I interpreted that to mean guard
8 against stinting.
9 DR. CHERNEW: Yes [off microphone].
10 DR. BAICKER: So we think levels were too high,
11 this is movement in the right direction, but we're cognizant
12 of the fact that that doesn't mean lower, lower, lower is
13 always better. There should be measures included to make
14 sure that there is not stinting as the flip side of the
15 overuse that we might have observed.
16 DR. CHERNEW: Yes, in a very non-prescriptive way
17 about how we would do that.
18 I'm going to go around now for Round 2 since we're
19 basically in Round 2, and I don't want Glenn to read the
20 transcript and see I failed.
21 [Laughter.]
22 DR. CHERNEW: Which is my main objective. So

1 since, Alice, your hand was up, why don't we start with
2 Alice, and we'll come around and end with Rita.
3 DR. COOMBS: I support the draft recommendations
4 with one caveat, because I had the same problem, being in
5 the ICU, our threshold for transfusion is 26. So, you know,
6 those are critically ill patients, and we have a lower
7 benchmark than what's described.
8 I think that what would make this easier is to
9 take out the word "undertreatment" and just put "anemia
10 treatment," because it presupposes that -- a whole bunch of
11 other implications. If you just put "anemia treatment,"
12 then that actually has a better approach so that it talks
13 about inappropriate transfusions versus indicated. And the
14 Secretary can get into the rest of it.
15 DR. CHERNEW: My understanding is there's already
16 an anemia treatment measure, and so the particular concern
17 here, in the spirit of what Kate said, was that because the
18 new incentives that were put in place include a potential
19 incentive to undertreat -- we're not claiming that's
20 necessarily going on, but so we particularly want to worry
21 about undertreatment. But it might be that as the measure
22 gets put in place, there's a whole other process of what

1 that measure would be. So I think my personal opinion is --
2 and, again, this is why it's Round 2 and we'll go around --
3 I think that calling out the concern that there might be --
4 that we have to guard against stinting in that way I think
5 is relevant. As the measure gets developed, the exact
6 measure would be -- I thought about in more detail as to
7 what it is. But in any case, sorry, I've got to learn to
8 talk less now.
9 DR. HALL: So I also think the chapter was
10 terrific and incredibly informative. Look, even though the
11 intention was not to say that we got to catch clinicians
12 doing something wrong, the perception, at least those of us
13 here who do this on a day-to-day basis, is that, in fact,
14 that's exactly what is being said here. So rather than make
15 these judgments about under- or overtreatment, we could just
16 say that we ought to be -- they ought to be monitoring
17 transfusion use, period, and not try to get so clinical at
18 this point. I don't know the necessity for that.
19 DR. HOADLEY: So I generally thought that this was
20 a really good analysis, and I support the direction of the
21 recommendations.
22 I also had reacted in reading this to the same

1 point about this provision on the anemia treatment.

2 And I guess -- Nancy, is there an existing measure

3 on treatment other than -- you had talked about the one that

4 was 2012 that they stopped using.

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

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

7 MS. RAY: In the quality incentive program right

8 now there's an anemia -- there are two anemia-related

9 measures.

10 The first one is designed to assess the proportion

11 of beneficiaries with hemoglobin levels that are considered

12 too high. And so that would be a bad outcome, and

13 facilities could potentially lose under the QIP. And that

14 hemoglobin level would be greater than 12.

15 The second measure is an anemia reporting measure

16 that requires facilities to report epo dose and, I believe,

17 hemoglobin levels.

18 DR. CHERNEW: I'm sorry. Am I correct in assuming

19 that first measure for an economist is a measure of over-

20 treatment?

21 MS. RAY: Yes, yes, yes.

22 DR. CHERNEW: So there exists a measure of over-

1 treatment essentially in there.

2 MS. RAY: Yes.

3 DR. HOADLEY: So, you know, I'm in this same sort

4 of dilemma of what's the right statement, and maybe part of

5 the answer -- again, no more -- as a political scientist,

6 I'm not more a clinician than the economist, and I hate to

7 try to practice medicine. So I won't try.

8 But maybe one part of the answer is let's just be

9 clear in the text around this that some of the points that

10 are made here are: We're not observing an existing problem

11 of under-treatment. We are concerned about the possibility

12 of stenting. And, thus, the measure should be -- you know,

13 if we stick with the recommendation, that the measure -- the

14 recommendation is there because of this concern and blah,

15 blah, blah, whatever.

16 But I think if we can surround it with text that

17 puts some of these other concerns and put it in context,

18 then I think it might be a place where people can be

19 comfortable.

20 DR. CHERNEW: Right. So part of the issue is the

21 wording, which I actually view as relatively weak, and the

22 other is the tone.

1 And so the tone is clearly one that I think was
2 not intended.
3 DR. HOADLEY: Right.
4 DR. CHERNEW: And we will have to go back. I
5 would defer to Nancy and the staff to worry about the tone.
6 And then -- well, we'll come around for the
7 recommendation.
8 Kate.
9 DR. BAICKER: So that's the difference between
10 political scientists and economists. We totally don't mind
11 overstepping our disciplinary bounds.
12 So I actually thought that it was helpful that the
13 recommendation calls out under-treatment rather than just
14 monitoring treatment in general. I think it builds into all
15 of this that we're monitoring what's going on.
16 But I thought it was helpful to acknowledge that
17 in a world where you're trying to discourage over-use you
18 must also be cognizant of potentially generating under-use.
19 So guarding against stenting in particular seems like a
20 helpful counterbalance to me given that we are pushing in
21 one direction. We just want to acknowledge being aware that
22 you can push too far in that direction without saying you've

1 actually observed anything like that.

2 So I thought the suggestion potentially to modify

3 the text to make it more clear that that's what we're

4 talking about would be really helpful, but I thought it

5 might actually unhelpful to take out the under-treatment

6 component of the recommendation.

7 MS. UCCELLO: Yeah, I agree with Kate.

8 I support the recommendations, and I do see the

9 need to protect against this potential stenting. You know,

10 the way the incentives are now could lend themselves to

11 under-treatment rather than over-treatment, which both are

12 not outcomes we want.

13 So, if the solution to this just making sure the

14 text surrounding the recommendation maybe needs to change in

15 tone and just clarify what we're trying to get at, but I do

16 agree that highlighting the under-treatment in this is

17 appropriate.

18 DR. CHERNEW: Peter.

19 MR. BUTLER: I was a psychology major and am

20 prepared to provide therapy to all of you struggling with

21 your identities.

22 [Laughter.]

1 MR. BUTLER: You could look towards the number 1
2 recommendation.
3 Well, you missed us, Mark.
4 DR. MARK MILLER: But when I came back into the
5 show --
6 MR. BUTLER: Well, put on recommendation 1,
7 please.
8 So this is a small point, but it kind of goes to
9 Glenn Hackbarth not here on sequestration.
10 We might -- we talked earlier in executive session
11 about changing the wording in the recommendations, and we
12 backed off of that. But here, where you say spending, no
13 change in spending relative to current law, you might say
14 Medicare law because someone would say -- you know.
15 So, when you look at these spending implications,
16 it's another opportunity to maybe clarify because I think
17 what this says is that actually it's 2 percent more than
18 would be in place if sequestration continues.
19 DR. CHERNEW: You're correct.
20 DR. MARK MILLER: That's right.
21 MR. BUTLER: Just a suggestion. We don't have to
22 vote on it.

1 MR. ARMSTRONG: First, I'm very happy with who I
2 am.
3 [Laughter.]
4 DR. REDBERG: [Inaudible comment.]
5 MR. ARMSTRONG: So I don't need Peter's help.
6 I support both draft recommendations number 1 and
7 2 as they've been written and won't repeat points other
8 commissioners have made.
9 DR. CHRISTIANSON: I also support both
10 recommendations, and I'm comfortable with Alice's suggested
11 change in wording or with the recommendation as is, either
12 way.
13 MR. GRADISON: I support both of them.
14 I'm just trying to figure out what I should try to
15 do when I finally grow up.
16 DR. NERENZ: Not much to add here. I think I just
17 might suggest in terms of some of the surrounding wording
18 around the second recommendation, since we do not have overt
19 evidence of a crisis in terms of under-treatment -- we have
20 hints; we have possibilities -- that maybe the text of the
21 recommendation can be as is, but some of the narrative
22 around it might also say something about whatever measure is

1 developed ought to be light in terms of data collection
2 burden and analytic burden, that sort of thing, because
3 measures can come in many different flavors.
4 And I think the burden of a measure should be
5 proportional to the severity and health impact and just
6 mathematical size of the problem, and maybe some words about
7 that could be added.
8 DR. NAYLOR: I really support the way in which
9 this has evolved to include current Medical law, to adjust
10 the text, and I support the recommendation.
11 MR. GEORGE MILLER: Michael, when Glenn reads this
12 transcript, you're in trouble.
13 DR. CHERNEW: Already figured that out. I've
14 already figured that out.
15 MR. GEORGE MILLER: In principle, I support both
16 of the recommendations.
17 And I certainly want to commend the staff on the
18 thoroughness of this chapter and particularly dealing with
19 the issue that I've raised several times, and they've done
20 an excellent job talking about race, demographics and
21 disparities.
22 What I'm a little, just slightly, concerned about

1 -- and we've brought this issue up, and I've brought it up
2 before. I'm really concerned about the lack of transplants
3 particularly among all ethnic groups, but particularly among
4 the African American population. And it is stark, and it is
5 a huge difference.
6 There is some explanation in the writing and the
7 literature about some of the reasons why that takes place,
8 but it doesn't explain all of it. And, while we've dealt
9 with other equality issues, I would encourage us to consider
10 addressing this, maybe not in a recommendation but in a text
11 box, to deal with the issue, to see in the chapter and to
12 talk about ways we can improve that.
13 The differences are stark, and Afro-Americans are
14 disproportionate users of these services, significantly
15 different than the population and dramatically different in
16 getting transplants.
17 So these providers are paid a lot of dollars, and
18 I'm wondering how we can incentivize or encourage a
19 resolution to this, in my mind, very glaring problem.
20 DR. CHERNEW: Craig.
21 DR. SAMITT: So I want to point out to everyone
22 that Scott said he's happy who he is and then about an hour

1 ago he said he was reading The Happiness Project. So I
2 think we all need to read what Scott is reading.
3 I support all of the recommendations.
4 MR. KUHN: I support both recommendations.
5 DR. CHERNEW: Rita.
6 DR. REDBERG: I support the first draft
7 recommendation and the second draft recommendation with the
8 proviso that I do think I would like to perhaps change the
9 wording to clarify as Alice had suggested.
10 I think it's important we look at instead of
11 anemia under-treatment, which I don't think is what we are
12 really trying to get at, but to have a more outcome-related
13 measure. Perhaps it's anemia-related hospitalizations we're
14 concerned, or something that looks at quality of life
15 related to end-stage renal dialysis treatment. But the
16 wording on calling it anemia under-treatment I don't think
17 captures what we were trying to get at.
18 DR. CHERNEW: So let me just ask a few other
19 questions or at least maybe ask in general of Nancy. I
20 don't perceive the recommendation or the text as advocating
21 any specific type of measure, including a process measure.
22 So I think everything that you say could fit into the

1 category of anemia under-treatment.

2 So the question I would ask to the clinicians

3 mostly is in the last time we met, I was under the

4 impression -- I think Glenn was and maybe the staff was --

5 that there was concern in the room broadly about the

6 potential, not the actuality, that people would be under-

7 treated for anemia.

8 That may not be happening. I don't know if there

9 is concern, but I think the feeling was that -- and again, I

10 may -- please correct me if I'm misreading the room, that

11 when the incentive changed there was concern that this might

12 happen and that some attention to worry about stenting,

13 since we already had a measure of over-treatment, would sort

14 of balance the scales, you know, in sort of an even-handed

15 way.

16 But a measure, for example, of under-treatment

17 that would focus on any of the things that you just

18 mentioned -- quality of life, hospitalization. I don't know

19 enough clinically to know what the right indicator would be.

20 I certainly wouldn't interpret either the

21 recommendation -- and I think we could clarify the

22 surrounding text to make sure that it's clear that we don't

1 intend to mean there has to be a particular process measure
2 related to you have to treat more for anemia because I think
3 your concern would be that if we put in such a measure we
4 would go back in the wrong direction.
5 And I think that's a legitimate concern, and at
6 least my read of the chapter is that is not our intent, but
7 maybe there are challenges there.
8 Craig.
9 DR. SAMITT: That's my understanding as well.
10 It may just require language. I mean, if we're
11 going to tweak the language, you know, we really want a
12 program that monitors the risk of anemia under-treatment.
13 We're not essentially saying there's anemia under-treatment
14 today, but what we've observed is a red flag that we want to
15 just pay attention to, that we're not seeing a continuous
16 decline or worsening of anemia, that we're monitoring for
17 the potential.
18 DR. CHERNEW: Right.
19 DR. REDBERG: What is the red flag?
20 DR. SAMITT: Well, just the -- you know, the
21 increased frequency of transfusions. And it may not be
22 statistically significant, but, in essence, it may enough to

1 say let's watch this.

2 DR. REDBERG: But we don't even know what levels

3 of hemoglobin those transfusions were occurring at because

4 the levels clearly are nowhere in the anemia range.

5 I mean, you know, transfusion is a very squishy

6 outcome, and that's why I don't think we can make a lot of

7 clinical conclusions based on a very small change in

8 transfusion rate. There are a lot of things that -- as I

9 said.

10 DR. CHERNEW: Right.

11 DR. REDBERG: And that's right I think it would be

12 good to clarify.

13 DR. CHERNEW: Okay, Alice.

14 DR. COOMBS: So I just want to say something. The

15 problem is the example that's given in the text of the

16 narrative of the chapter actually is consistent with over-

17 treatment, whether you use epo or whether you use

18 transfusion. Those chits are relatively robust.

19 And so, if a clinician -- and we were talking if a

20 nephrologist saw that there was this resolution to look at

21 under-treatment, based on the narrative in the text, they

22 would say: Under-treatment? You ought to be thinking more

1 along the lines of, as a clinician, over-treatment.

2 DR. CHERNEW: Right.

3 DR. COOMBS: So that's part of the issue.

4 DR. REDBERG: Right. And I did talk to my

5 nephrologist colleagues after this, and that was what they

6 reflected. They said the only thing that they could suggest

7 that possibly -- is that he told me sometimes insurance

8 coverage -- and he wasn't talking Medicare -- for epo lapse

9 is because you need prior authorization; so hemoglobin could

10 drift down.

11 But there wasn't, based on this, concerns about

12 under-treatment.

13 DR. CHERNEW: Since I can only say epo, I can't

14 say the full name of it, and I'm not completely sure.

15 DR. REDBERG: Erythropoietin.

16 DR. CHERNEW: Exactly. That will be for an extra

17 study session.

18 The broader question I have is -- so there are

19 several options on the table. One of them is -- and I hear

20 from a number of people -- the concern that the text in one

21 way or another has to be clarified to resolve this issue.

22 And I would encourage -- so that's sort of at a

1 minimum issue.

2 Then the next question is we could take that first

3 point in the draft recommendation 2 and either modify it or

4 strike it one way or another. I think the concern that it

5 was meant to address --

6 DR. REDBERG: Right.

7 DR. CHERNEW: -- was the concern, regardless of

8 the evidence in the chapter, that when we've given an

9 incentive to use less of certain types of things we've

10 actually seen a dramatic reduction in those things.

11 Although, by and large, we think so far it's been fine for a

12 number of reasons, there is a concern that it could go

13 overboard.

14 And so I think there is a general sense that we

15 have a measure of hemoglobin -- of over-treatment for

16 anemia. We don't have the corresponding under-treatment

17 measure in an era where that would be the concern.

18 So I am fine, in all honesty. I am not

19 tremendously wedded to that first point, and if people --

20 I've heard different things around the table of people's

21 views to that.

22 So I'm trying to figure out for those that feel

1 the most strongly and know the most clinically, how strongly
2 they feel about the first bullet point on recommendation 2.
3 If the solution is we want to strike it
4 completely, I'm mildly uncomfortable with that in part
5 because Glenn is not here, but in part I actually
6 substantively believe that there's a concern about under-
7 treatment -- that we would want to be sure we, at a minimum,
8 monitor it per what Craig said.
9 There might be a wording change, or it might be in
10 the text.
11 So, for those, I think Alice and Bill and Rita
12 feel the most strongly.
13 So we're in round four now.
14 Bill.
15 DR. HALL: You know, I'd hate us to not pass this
16 resolution or this -- I mean the recommendation. I think
17 it's important and time's a wasting.
18 DR. CHERNEW: Passing a good recommendation is
19 more important than passing a recommendation.
20 DR. HALL: I'll just speak for myself. I think we
21 will lose credibility as a Commission among physicians and
22 other health care providers who are very intimately involved

1 in analysis if we put this kind of value judgment in.
2 That's all.
3 I think --
4 DR. MARK MILLER: So, to that point, you've talked
5 about striking it. Does striking the one word change the
6 nature?
7 DR. COOMBS: Yeah, it does.
8 DR. HALL: I think it gets it a long way. I would
9 be happy with that.
10 DR. COOMBS: Yeah, treatment.
11 DR. CHERNEW: The word, under, is what --
12 DR. REDBERG: I think that we should focus more on
13 outcomes -- what is it we're worried about -- because anemia
14 -- we don't even have any signals, and anemia is a lab
15 value.
16 I mean, I really think we need to be thinking
17 about what are we worried about.
18 DR. CHERNEW: So I will just say my view of a
19 measure looking at anemia treatment could actually be a
20 measure that looks at outcomes.
21 So, for example, if I said we need a measure of
22 cholesterol treatment, that could be a measure of, you know,

1 either the cholesterol or some bad thing you think happened
2 if cholesterol wasn't managed well.
3 So it doesn't have to be --
4 DR. REDBERG: Well, that's why I said do you want
5 to say anemia-related hospitalizations -- because, to me --
6 DR. CHERNEW: My personal view is I am more wary
7 for a number of reasons of, at this stage, making a change
8 in the recommendation that is more prescriptive about the
9 type of measure that's included. So I would be less
10 comfortable picking something like hospitalizations or any
11 of the other things that would happen. I actually would be
12 more comfortable personally, if that were the case, of just
13 striking one.
14 I don't mind removing the word, under -- this is a
15 personal comment -- because that's -- you know, although I
16 do think that's the concern that I personally have. And
17 others expressed it, it seems, last time.
18 But I'm also cognizant of the concerns that the
19 folks have raised, and I certainly wouldn't want to, you
20 know, be the one to say Glenn left; so the Commission could
21 lose credibility on my watch.
22 But, no, I understand. I do take the point

1 seriously, and so of those people that are more familiar
2 with this area I'm happy to, you know, figure out what your
3 view is.
4 DR. MARK MILLER: The only other thing I would add
5 is that at least as it went around the room there were a lot
6 of people who were relatively comfortable with the concept,
7 if not the words.
8 And then we have a group here -- the clinicians
9 who, on this one, carry a lot of weight.
10 DR. REDBERG: [Inaudible comment.]
11 [Laughter.]
12 DR. MARK MILLER: Yeah.
13 DR. REDBERG: I have to clarify.
14 DR. MARK MILLER: I didn't want to finish the
15 sentence with that, but as long as you finished it that way,
16 yeah, okay. Fine.
17 I mean, here's one other take on it. There is
18 still striking -- is on the table. Okay.
19 But, if I listened to the last exchange, what if
20 it read as follows: Include a measure in the ESRD QIP
21 program measuring poor outcomes related to anemia?
22 Then I leave the measure open. I get to your

1 outcome. We're still --

2 DR. REDBERG: That sounds great.

3 DR. HALL: [Inaudible comment.]

4 DR. COOMBS: [Inaudible comment.]

5 DR. CHERNEW: Done.

6 In that spirit of eloquence of Mark, it is now

7 time to vote, and we will start on recommendation 1 if we

8 could have recommendation -- we have recommendation 1 up.

9 For recommendation 1, all those in favor?

10 [Show of hands.]

11 DR. CHERNEW: Opposed?

12 [No response.]

13 DR. CHERNEW: Abstains?

14 [No response.]

15 DR. CHERNEW: And now we'll go to recommendation 2

16 with the modified bullet 1 to read --

17 DR. MARK MILLER: As follows.

18 DR. CHERNEW: As follows.

19 DR. MARK MILLER: Include a measure in the ESRD

20 Quality Incentive Program related to poor outcomes -- oh,

21 sorry.

22 DR. CHERNEW: It was so eloquent before.

1 DR. MARK MILLER: I know.

2 DR. REDBERG: You wish you could read it back.

3 DR. MARK MILLER: Okay. Include a measure related

4 to poor outcomes -- oh, God, I don't think I can do this

5 now.

6 DR. REDBERG: It says poor outcomes related --

7 [inaudible comment].

8 DR. MARK MILLER: Measure that assesses --

9 DR. CHERNEW: Poor outcomes related to anemia.

10 DR. MARK MILLER: Yeah. Include a measure that

11 assesses poor outcomes related to anemia in the ESRD Quality

12 Incentive Program -- that's the language.

13 DR. CHERNEW: Are we -- well, we're going to find

14 if we're okay with that actually.

15 So all those in favor?

16 [Show of hands.]

17 DR. CHERNEW: Opposed?

18 [No response.]

19 DR. CHERNEW: Abstains?

20 [No response.]

21 DR. CHERNEW: Thank you very much and thank you,

22 Nancy.

1 And so now we will move, Carol and Evan, to PAC
2 payment reforms.
3 DR. REDBERG: Great job, Michael.
4 [Pause.]
5 DR. CHERNEW: Whenever you're ready.
6 MR. CHRISTMAN: We're starting this presentation
7 with a discussion of payment adequacy and rehospitalization
8 policy for home health agencies, and then Carol will discuss
9 the draft recommendation to gather common assessment
10 information across PAC settings.
11 The home health presentation will cover two areas.
12 I will deliver a brief review of the payment adequacy
13 framework we reviewed from last month and remind you of the
14 recommendations we have previously made for home health.
15 Recall that since we are reiterating our prior
16 recommendations, we will not be voting on payment
17 recommendations this year.
18 Our second item will follow up on a new topic we
19 introduced last month, a draft recommendation for an
20 incentive to reduce hospital readmissions for beneficiaries
21 in home health. As a reminder, Medicare spent about $18
22 billion on home health services in 2012. There were over

1 12,000 agencies and the program provided about 6.7 million
2 episodes to 3.4 million beneficiaries.
3 Last month, we reviewed and discussed the payment
4 adequacy indicators in detail, and you have more detail in
5 the papers. As a reminder, here is a summary.
6 Beneficiaries have good access to care. The number of
7 agencies continues to increase, reaching over 12,300
8 agencies in 2012. The number of episodes and rate of use
9 declined slightly, but after several years of rapid
10 increases. Quality shows improvement on most measures.
11 Access to capital is adequate. And the margins for 2014 are
12 projected to equal 12.6 percent. Margins would be two
13 percentage points lower if we included the sequester. I
14 recognize this is just an overview, and if there are any
15 areas that need clarification, please feel welcome to ask
16 during the Q and A session.
17 Since our indicators for 2014 are mostly
18 unchanged, the Chairman has proposed that we rerun our
19 payment recommendations from earlier years. As a reminder,
20 we recommended a more robust form of rebasing that would
21 address the historically high margins of home health
22 agencies. Our recommendation also addresses an incentive in

1 the payment system that may encourage more therapy. We
2 recommended that CMS eliminate the use of the number of
3 therapy visits provided in an episode as a payment factor in
4 the PPS. This change is budget neutral, but it would lower
5 payments for agencies that did more therapy, which typically
6 have had higher profits, and increase payments for agencies
7 that do less therapy, which have typically had lower than
8 average Medicare margins.
9 We have also advocated that CMS fully use its
10 authority to address fraud and abuse in the home health
11 benefit. There are many areas of aberrant utilization that
12 suggest investigation and enforcement efforts are needed.
13 Finally, we have also recommended that Medicare
14 establish a copayment for episodes not preceded by a
15 hospitalization or PAC stay.
16 Next, we turn to a new topic introduced last
17 month, establishing an incentive for home health agencies to
18 lower their rate of readmissions. As a reminder, there are
19 several reasons it would be appropriate for the Medicare
20 program to do this. First, reducing readmissions is a major
21 goal of many of the new models of payment in Medicare, such
22 as the Hospital Readmissions Reduction Program and others,

1 such as ACOs and medical homes. Many of the beneficiaries
2 in these new models will be served by home health. Home
3 health agencies are not usually holding financial risk in
4 these new models, so adding an incentive in fee-for-service
5 for agencies would align their incentives with those of
6 other providers seeking to reduce readmissions.
7 Second, extending an incentive for home health
8 agencies to lower readmissions might be appropriate because
9 home health is the most common site of post-acute care.
10 Under pure fee-for-service, agencies do not have a direct
11 incentive to reduce readmissions.
12 Finally, adding an incentive is also important
13 because readmission is a relatively common occurrence in
14 home health. About 29 percent of post-hospital home health
15 stays ended in a readmission in 2010.
16 The broad regional and provider-level variation in
17 readmissions rates suggests there may be substantial
18 opportunity for improvement. For example, the providers in
19 the top quartile of readmissions had a rate of 58 percent
20 while the rest of the agencies had an average of about 26
21 percent. Across the States, readmissions were highest in
22 four States that also had very high rates of home health

1 utilization. Providers in Texas, Louisiana, Oklahoma, and
2 Mississippi averaged a readmissions rate of 38 percent. If
3 providers in regions with higher than average rates were
4 able to lower their readmissions rates closer to those
5 achieved by better performing agencies, beneficiaries would
6 experience fewer readmissions and Medicare spending would
7 fall.
8 A home health readmissions policy would have
9 several parts to it. I would note that the elements I
10 propose here are based on the Commission's review of the
11 Hospital Readmissions Reduction Program that we included in
12 our 2013 June report. Under this policy, Medicare would
13 establish a fixed target based on performance in a prior
14 year, say, the rate of readmissions for the agency at the
15 40th percentile in a selected base year. Using the value
16 from a prior year would let agencies know in advance the
17 value they must be below to avoid penalties. Establishing a
18 targeted value like the 40th percentile would encourage most
19 agencies to improve. The rate would be risk adjusted and
20 computed at the agency level. Agencies with readmissions
21 rates in excess of the target would be subject to the
22 penalty.

1 The penalty could take several forms, but at a
2 minimum, it could be equal to the amount Medicare paid for
3 the home health services provided to the stays that resulted
4 in excess readmissions. The penalty would be collected
5 through a reduction to the agency's base rate. The key part
6 of this incentive is that the target readmissions rate an
7 agency has to be below is set in advance and does not
8 change. Agencies would assumedly know how their performance
9 in prior years compared to the benchmark, and those with
10 higher rates could avoid the penalty by lowering their
11 readmissions rate. In the future, Medicare could raise or
12 update the target as necessary as performance changes.
13 The policy should also include several safeguards.
14 Agencies that serve more dual eligibles generally had higher
15 readmissions rates, so it would be appropriate to compare
16 agencies to a peer group of providers that served a similar
17 share of low-income beneficiaries. This would lessen an
18 incentive to avoid these patients to improve performance.
19 The time period of the measure should include the
20 entire home health stay plus 30 days after discharge.
21 Including a post-discharge period would be appropriate,
22 given that a successful return to the community is the

1 typical goal in home health. I would note that our measure
2 includes post-hospital stays of home health only, which is
3 about 40 percent of all home health stays.
4 Finally, the measure should focus on readmissions
5 it would be reasonable to hold providers accountable for and
6 exclude those readmissions that are not necessarily
7 attributable to home health. In the hospital setting, we
8 have referred to these as potentially avoidable
9 readmissions.
10 To get a better sense of how this policy might
11 work in practice, we modeled its impact using 2010 data.
12 For this exercise, we identified agencies that were above
13 the 40th percentile on readmissions rates compared to other
14 agencies that serve similar shares of low-income
15 beneficiaries. We only had one year's worth of readmissions
16 rates to work with, so what we will show you is how many
17 agencies cross that 40th percentile benchmark based on 2010
18 data. Keep in mind that if the policy were in effect, those
19 above the target would likely work to lower readmissions, so
20 fewer agencies could be subject to the penalty.
21 Overall, 60 percent of agencies would be at risk,
22 a result of setting the target at the 40th percentile. The

1 shares would vary by group, but they broadly track the
2 trends in readmissions rates by agency characteristics.
3 More for-profit agencies would be above the target and under
4 pressure to change, while government and nonprofit would
5 have relatively fewer above the target. Freestanding
6 agencies would have more above the target compared to
7 facility-based. The rate for urban and rural was about
8 equal. Most strikingly, 74 percent of agencies in the four
9 States with the highest rates would be above the target,
10 indicating that pressure for improvement would be
11 particularly acute in these areas with the highest rates.
12 This slide provides a sense of the net financial
13 impact. Again, for simplicity, we have assumed no agency
14 lowered its readmissions rate to avoid the penalty. For
15 each year, Medicare would compute the number of hospital
16 readmissions an agency had over the target rate. For each
17 of these readmissions, Medicare would assess a penalty,
18 which in this example we have assumed would equal the
19 payments for the home health service preceding the
20 readmission. Medicare would reduce payments to an agency to
21 recover the total penalty amount. In practice, this
22 reduction could be implemented as a reduction to the base

1 rate for the agency in the following year. The policy would
2 likely want to include a stop loss provision so that
3 agencies would not incur unsustainably high penalties.
4 With these parameters, the table shows that the
5 total penalties incurred would be about $90 million a year.
6 Keep in mind that the primary goal of this policy is to
7 reduce readmissions, not collect penalties from agencies.
8 If agencies reduce the number of readmissions by ten
9 percent, the savings could lower inpatient hospital spending
10 by $300 million a year.
11 In sum, adding a home health readmissions
12 reduction policy would align agency incentives with those of
13 other providers seeking to reduce readmissions. It would
14 encourage providers with the highest rates to improve, and
15 it would recognize that avoiding readmissions is a primary
16 goal for post-hospital users of home health.
17 With these considerations in mind, we reviewed a
18 draft recommendation for your consideration. The
19 recommendation reads, the Congress should direct the
20 Secretary to reduce the payments to home health agencies
21 with relatively high risk-adjusted rates of hospital
22 readmission.

1 The spending implications are that this policy
2 would lower Medicare spending by $50 million to $250 million
3 in 2015 and less than $1 billion over five years.
4 Beneficiaries may experience fewer readmissions. The
5 recommendation should not adversely affect beneficiary
6 access or affect providers' willingness or ability to care
7 for Medicare beneficiaries.
8 This completes my portion of the presentation, and
9 now Carol will take you through a recommendation on post-
10 acute care data collection.
11 DR. CARTER: In December, we reviewed the current
12 status of the patient assessment information and the need
13 for common information across settings. Medicare requires
14 home health agencies, SNFs, and IRFs to use different
15 patient assessment tools, and LTCHs are not required to
16 submit patient assessment data. Each tool uses different
17 definitions, measurement scales, time periods, and methods
18 of assessment.
19 In 2011, CMS successfully completed a
20 demonstration that developed, validated, and tested a common
21 assessment tool but has not established a timetable for
22 implementing it across settings.

1 We also reviewed the benefits of having common
2 assessment items. Common assessment items would help us
3 compare patients treated in different settings, their costs
4 and outcomes. This comparative information would be
5 valuable for beneficiaries, discharge planners, and
6 physicians when selecting PAC providers. And having common
7 items would also facilitate narrowing the prices Medicare
8 pays for similar services to similar patients across
9 settings and, in the longer term, to develop and implement a
10 consolidated PPS that spans PAC settings.
11 Given the comments that several Commissioners made
12 about the urgency of this recommendation, the draft language
13 was modified to implement individual items rather than an
14 entire tool. A set of assessment items would be more
15 feasible to implement in the near term compared to an entire
16 tool.
17 The draft recommendation now reads, the Congress
18 should direct the Secretary to implement common assessment
19 items for use in home health agencies, skilled nursing
20 facilities, inpatient rehabilitation hospitals, and long-
21 term care hospitals by 2016.
22 Let me walk through one possible implementation

1 timetable which is discussed in the text under the
2 recommendation in the paper. In 2016, CMS could start
3 adding common assessment items as a supplement to existing
4 tools, beginning with items most important to understanding
5 differences in costs and outcomes, such as those measuring
6 functional and cognitive status. We're thinking a select
7 number of items in a couple of domains. For LTCHs, these
8 items would comprise their new reporting requirements.
9 Though diagnoses and comorbidities are also key, this
10 information is available on claims data.
11 During 2017, CMS would verify that these common
12 new elements could be successfully used in each PAC PPS.
13 The existing tools would remain in place for each setting.
14 In 2018, CMS could replace the items in the
15 original assessment tools with the new common items. The
16 existing tools would remain in place for each setting. CMS
17 may elect to add or to refine common item sets over time,
18 just as it revises existing patient assessments over time.
19 The implications of this recommendation are: The
20 recommendation does not directly raise program spending.
21 There will be administrative costs in the short term as
22 Medicare adds the new common assessment items to existing

1 tools and tests whether the new items can be used in
2 existing PPSs. For beneficiaries and their families, they
3 will have better comparative information that they can use
4 in selecting providers. And providers will have better data
5 to assist patients in making their PAC decisions and to
6 compare their costs and outcomes with other providers.
7 In the short term, providers will incur modest
8 additional costs to administer common items and to train
9 their staff on the new assessment items. In the longer
10 term, if assessment information shapes patient and provider
11 decision making, the mix of patients treated in different
12 PAC settings could shift.
13 And with that, we're going to put up this
14 recommendation to start your discussion.
15 DR. CHERNEW: Thank you, Carol and Evan.
16 Before we go around to do clarifying questions, I
17 want to do a little housekeeping from before.
18 Craig was out of the room during our vote on the
19 first recommendation, so I want to give him the opportunity
20 to vote. All in favor.
21 [Show of hands.]
22 DR. CHERNEW: Any abstentions?

1 [No response.]

2 DR. CHERNEW: Opposed.

3 [No response.]

4 DR. CHERNEW: So, Craig is on record as supporting

5 the first recommendation for the dialysis session.

6 And so with that, let's move to clarifying

7 questions. We'll start with David and we'll go around on

8 the post-acute reforms.

9 DR. NERENZ: Slide 14, please. I have two quick

10 questions, and I'm interested in the link between this slide

11 and the next slide. There's no -- there are no numbers here

12 on 14, no percent, no model, no calculation. And then in

13 15, we estimate a certain financial amount of change in

14 spending, and I think that was true in the chapter we got,

15 as well. Can you just tell me, what's the basis for, then,

16 the number estimates on 15?

17 MR. CHRISTMAN: It's basically this model here

18 that I ran on this slide. This slide shows that in the

19 first year, if no agencies change their behavior and lower

20 their readmissions rates, Medicare would collect about $86,

21 $87 million in penalties. And so we have this arrangement

22 with CBO where we put our -- we score our proposals in what

1 we call buckets, and because that one is about $90 million a
2 year or roughly $450 million a year, it falls into this
3 bucket, the $50 to $250 million in the first year and the
4 less than $1 billion over five.
5 DR. NERENZ: Okay. So, maybe I'm just obtuse and
6 it's late in the afternoon. Maybe we need to go to 12.
7 What is the penalty? What's the formula?
8 MR. CHRISTMAN: The penalty is, in this model,
9 every -- an agency would be on the hook to basically repay
10 the costs of the home health service for each readmission
11 that occurred in excess of the benchmark that was
12 established.
13 DR. NERENZ: I'm sorry. I -- all right. I just
14 missed it on the slides.
15 MR. CHRISTMAN: Sure.
16 DR. NERENZ: Okay. I get that.
17 And then very quickly on Slide 7, there are two
18 words or phrases here, worst quartile of agencies, lower
19 performing providers, and this question may, in part, be to
20 Mary. Is there actually evidence that some one or more
21 process measures of quality of care in home health are, in
22 fact, associated with ending up in a higher quartile of

1 readmission? Do we have that information?

2 MR. CHRISTMAN: So, you're asking sort of how are

3 these correlated with process measures?

4 DR. NERENZ: No, we're just -- we're using words

5 that are quite loaded. We're saying, you're a bad

6 performer, and I'm just curious, do we know independently

7 that these entities are bad performers by some process

8 measure?

9 MR. CHRISTMAN: I guess I have not looked at that

10 specifically. I mean, these are risk-adjusted rates, so

11 they are adjusted for differences in patient acuity across

12 the settings. These are areas where they do have some --

13 DR. MARK MILLER: This may be a more complicated

14 question and I just don't understand it. What -- all this

15 slide is saying is when you look at the quartiles of

16 readmission rates, these are the worst end of that

17 distribution. We're not making judgments about the rest of

18 their operation, right?

19 DR. NERENZ: Well, and that's actually another way

20 of saying what I'm saying. The language here is that you

21 are a low-performing provider. You performed badly. It

22 doesn't say, you are in the lowest quartile of end result,

1 and I think that -- to me, in my mind, that's an important
2 distinction. And I'm just curious, what do those words
3 really mean and what's the underlying evidence?
4 MR. CHRISTMAN: I guess we could easily -- I think
5 you could say the highest quartile of agencies and the
6 highest rate of readmissions, you know, that's who that
7 group is in the context of this project. We haven't looked
8 at them on other measures.
9 DR. CHERNEW: We're still going to start with you
10 for round two, so why don't you ask your clarifying question
11 and then we'll go to round two.
12 DR. NAYLOR: Surely. Slide 15, please. So, I
13 just wanted to -- Evan, if you could remind us of the
14 remodeling that was done, which you presented a number of
15 times, that talks about the intersection between the
16 Hospital Readmission Reduction Policy and the proposed --
17 this recommendation, particularly in those first 30 days,
18 since there would be, under the Hospital Reduction
19 Readmission Program, penalties assigned to hospitals and
20 then to the home health. So, I just wanted to make sure we
21 talked about that.
22 And in that same vein, in the modeling, how we

1 came to an understanding that this would not affect
2 beneficiaries' access to home health agencies, meaning would
3 home health agencies want to shy away from people who have
4 high readmission rates.
5 MR. CHRISTMAN: I mean, I think there's -- on your
6 first point, about the overlap between this and the Hospital
7 Readmission Reductions Program, you know, for those
8 readmissions that occur within 30 days and are considered
9 potentially avoidable by the definitions used in both the
10 Hospital Readmissions Reduction Program and the home health
11 program, both entities would be on the hook for a penalty,
12 different penalties. The hospital would be on the hook for
13 the cost of the readmission and the home health agency would
14 be, you know, in the model we've shown here, just on the
15 hook for the cost of the home health services.
16 The important thing to keep in mind is when we've
17 talked about this policy in the past, we've talked about it
18 as sort of an all condition applying to all home health
19 cases. Right now, the Hospital Readmissions Reduction
20 Program is only looking at six conditions, so unless the --
21 the Commission has leaned towards expanding the Hospital
22 Readmissions Reduction Program to all conditions. So,

1 eventually, this disconnect may disappear, but under current
2 policy, there might be some readmissions that the home
3 health agency would be on the hook for that the hospital
4 wouldn't, but it would be because of that difference in
5 definition.

6 And, I'm sorry, you had a second question --

7 DR. NAYLOR: Well, it just had to do with just,
8 you know, in terms of the implications that this would not
9 adversely affect home health agencies' willingness to accept
10 high-risk patients.

11 MR. CHRISTMAN: So, I think there's three pieces
12 to that, and one, of course, is we would want this to be
13 risk adjusted.

14 The second piece of this is that we've, again,
15 used a safeguard you guys talked about with the Hospital
16 Readmissions Reduction Program, where you're comparing
17 facilities to sort of peer facilities in terms of the
18 numbers of low-income patients they take. So the effect of
19 SES is kind of diluted by that in the sense that they're
20 just being compared to their peers, and if somebody has a
21 much better mix of more affluent patients, they're not going
22 to be penalized for that.

1 And then the third piece of this is we have talked
2 about having a stop loss policy, and that would put a limit
3 on how much agencies could lose. And I think all of those
4 things would combine to counterbalance some of the financial
5 risks that agencies would face in this model.
6 DR. NAYLOR: So, in terms of response, do you want
7 me to --
8 DR. CHERNEW: And now we are in round two. Notice
9 the difference in tone. Or, we can respond to round one.
10 DR. NAYLOR: So, I support the notion of the home
11 health readmission policy. It is very much in keeping with
12 the notion of alignment of these policies to promote a
13 continuum of services and shared accountability. Easier
14 said than done, but for what I just described about who's
15 going to be accountable for this. But, nonetheless, I think
16 that this is the direction that says all parts -- all silos
17 are responsible for what happens to Mr. Smith or Mrs. Jones
18 as they're going through an acute episode of illness.
19 One thing in terms of the text, or as we're
20 thinking about this, even, is to realize when the Hospital
21 Readmissions Reduction Program went into place, it went into
22 place along with programs that helped to position hospitals

1 to better get to community-based care transitions and so on,
2 so to think about this in the context of making sure we're
3 positioning home health agencies to be able to affect this
4 change is really important in recognition in the text.
5 In terms of the elements, I totally support a
6 common set of elements, so that would be the next
7 recommendation, that -- and the only question I'd have is
8 whether or not we should be more explicit in the
9 recommendation itself. Even though the text is very
10 explicit about the predictors of readmission, and you
11 mentioned them, function and cognition and so on, but
12 whether or not we should refer to -- as we're talking and
13 thinking about a common set of elements, it's to really
14 incorporate those domains that we know from evidence are
15 predictors of -- will help us to understand what can be done
16 to prevent poor outcomes, to promote positive outcomes.
17 And the second point on that, which is the notion
18 of you're going to have in the short term agencies
19 collecting -- some sectors collecting multiple measures of
20 functional status or cognition, and the notion that the
21 public beneficiary that gets to better information, I think
22 we need to really think that through in the conversation in

1 the text because it means the public might be confused,
2 having access to information about multiple measures of
3 something for the short term as we get to a final.
4 So, if there is any thinking that could be done to
5 say, we totally want to make this publicly available and
6 here's what we're doing, public, that would be very helpful,
7 if, especially, we want to use it to increase their
8 understanding of performance of the post-acute sector.
9 DR. CHERNEW: Thank you.
10 George.
11 MR. GEORGE MILLER: I have just one technical
12 question on Slide 15. Evan, did I understand you to say
13 that the buckets that are scored are -- the range is between
14 $50 million and $250 million? That is one bucket?
15 MR. CHRISTMAN: Yes. These buckets are --
16 MR. GEORGE MILLER: Huge.
17 MR. CHRISTMAN: Well, they're negotiated with CBO
18 about how much -- how wide a range they want to give us. I
19 don't really have too much of the history behind them. It's
20 part of how we sort of separate between our duties to make
21 recommendations and their duties to provide scoring.
22 MR. GEORGE MILLER: All right. Thank you.

1 DR. SAMITT: I support both of the
2 recommendations. I do have a question about the readmission
3 penalty. I'd be curious to hear your perspective on whether
4 there's any risk of screening out patients that could
5 potentially have a greater risk of readmission. So, as home
6 health agencies evaluate whether to accept patients to
7 provide care, would we envision that we will see agencies
8 that are concerned about the risk of readmission and,
9 therefore, don't accept care for those patients, and is that
10 a potential side effect of this readmission policy?
11 MR. CHRISTMAN: I suppose that it is. I think
12 we're kind of in the conundrum, also, that -- you know, this
13 is paired with Carol's recommendation for a reason, in that
14 we don't always know where people belong. So, when somebody
15 who is a higher readmission risk is moved to a, hopefully,
16 more intensive setting where, hopefully, their risk of
17 readmission will be lower, that is potentially what you want
18 to have happen. Now, it also may reflect those inpatient
19 PAC settings are more expensive and that's something you
20 have to deal with, but it -- when a patient who is higher
21 risk goes to a higher level of care, I can't always say that
22 that's the -- that might be what we want to have happen.

1 MR. KUHN: I support both recommendations. On the
2 readmission policy, we recommended here a year, a year-and-
3 a-half ago on long-term care, now to have one in the home
4 health area. So, we're capturing a greater part of the
5 post-acute care area, is critical and important, so I'm glad
6 this recommendation is moving forward.
7 In terms of the common assessment items for post-
8 acute care, these are going to be very helpful and, I think,
9 a useful movement forward.
10 Just to make sure that it gives us a stronger
11 platform to deal with post-acute care payment reform as we
12 go forward, if we can get these elements in place, it just
13 makes it easier to drive these future payment areas for
14 site-neutral payment systems in the future. So, I think
15 both of these are very important and strong movements
16 forward.
17 DR. REDBERG: I support both recommendations.
18 Hopefully, the risk adjustment would address some of the
19 issue Craig raised about the readmission, always a concern,
20 about avoid people with high risk of readmission. And,
21 again, I just wanted to reiterate that I think the common
22 assessment tool is really important and am very supportive.

1 DR. COOMBS: So, I support both recommendations,
2 and this was an excellent chapter. I really enjoyed reading
3 it.
4 One of the issues with this stop loss, is there a
5 way to carve out those agencies that are taking care of more
6 vulnerable populations, and I don't know if you could tailor
7 it so that those agencies would not be as adversely affected
8 in terms of their ability. I know that the margins, there's
9 some variability as to the margins in different regions and
10 different counties. I think I saw something about counties
11 and what it looks like. There's a chart in Table 6 that
12 actually goes through the rates of use for beneficiaries and
13 they used counties on that.
14 And so I was just concerned that with stop loss,
15 if the stop loss is too high for small functioning home
16 health agencies, they may be adversely affected.
17 And I think it's really good to now have the LTCHs
18 have a benchmark, because this is where the rubber meets the
19 road in terms of being able to say that we do either a
20 better job or we do the same job. Thanks again.
21 DR. CHERNEW: Thanks, Alice.
22 Bill.

1 DR. HALL: I'm strongly in favor of both
2 recommendations.
3 DR. HOADLEY: I'm also in favor of both
4 recommendations. The only point I wanted to bring up was
5 almost more of from a clarifying thing, but the context of
6 the readmissions policy, and you said it at one point, this
7 applies to just those home health stays that are post-
8 hospital, and I think in the chapter, that point -- the
9 first time I read through, it kind of got lost, and I think
10 to make that very clear at the front, including the
11 quantification. I think you mentioned a figure of 40
12 percent of all home health episodes were post-hospital, but
13 I also saw, I think, in a table in the chapter, there was a
14 number that said 34 percent were preceded by a hospital or
15 another PAC stay.
16 So, I mean, you can deal with the numbers, but, I
17 mean, putting that right in the context of the
18 recommendation will just kind of help remind everybody of
19 the context and that this isn't all home health stays we're
20 talking about, it's this particular set. I mean, you could
21 have a policy for ones not preceded by a hospitalization,
22 about how many of those end up in a hospitalization, but

1 that's obviously not rehospitalizations and that's not the
2 area we're in.
3 DR. CHERNEW: Thank you.
4 Kate.
5 DR. BAICKER: I support the recommendations and I
6 echo Mary's enthusiasm for the creation of an arc of
7 responsibility over the whole course of treatment.
8 DR. CHERNEW: Cori.
9 MS. UCCELLO: I support both recommendations, and
10 I just want to highlight again the finding in the chapter,
11 how striking the variations in readmissions are across these
12 different agencies. I mean, it really shows that there's a
13 lot of area for improvement, that something needs to be done
14 here. And I also want to thank you for including the little
15 couple sentences about the QIOs.
16 DR. CHERNEW: Peter.
17 MR. BUTLER: So, could you put up Slide 14. I
18 don't want to be difficult here. So, 60 percent of the
19 agencies would be subjected to the penalty if they didn't
20 lower their readmission rates, right?
21 MR. CHRISTMAN: Right. We're showing that as the
22 -- perhaps I should have used these words. I mean, that's

1 the illustrative policy that we showed, yes.

2 MR. BUTLER: Right. So, what I'm struggling with

3 is this says, should direct the Secretary to reduce payments

4 to home health agencies with relatively high risk adjusted

5 rates. You could be better than average and you're

6 subjected to the example that you show. So, I wonder

7 whether it's not more accurate to say, the Congress should

8 direct the Secretary to reduce payments to home health

9 agencies based on high risk adjusted rates of hospital

10 readmission, so you're not -- if you follow me. I just

11 don't like the adjective, "relatively high risk," because

12 that says, well, it may be 20 percent of the institutions

13 are impacted, when we're really kind of showing an example

14 of where it's 60 percent. Or, if we just drop the words and

15 said, to reduce payments to home health agencies based on

16 risk adjusted rates of hospital admission.

17 DR. BAICKER: I wouldn't interpret --

18 MR. BUTLER: I don't feel -- okay. You don't

19 interpret it --

20 DR. BAICKER: I was interpreting that to mean

21 based on having high rates, where relative was meant to be

22 broadly cast. It doesn't mean above average. It doesn't

1 mean above the median. It just means the payments would
2 apply based on having rates that are too high where we're
3 not taking a stand on what too high is.
4 DR. CHERNEW: Yeah --
5 DR. BAICKER: Is that -- that was my
6 interpretation.
7 MR. BUTLER: Well, I'm just giving you my
8 interpretation. It looks like not that many are going to be
9 impacted. That's how I read that.
10 DR. CHERNEW: That wasn't how I read it, but I
11 think if you get rid of the word "relatively" or just put it
12 "based," then it just seems like based on -- it strikes me
13 as harder to read if it just says with high risk adjusted
14 rates, because you have to end up defining high. So, we're
15 defining high sort of relative to some other group, and I --
16 I don't mean to be defensive in the recommendation, so I'll
17 let Mark and Evan jump in. I think where the threshold gets
18 drawn, whether it's 40 percent, whether it's 60 percent, or
19 where it is, is something to, you know, not specify it in
20 the exact recommendation, and so we used that
21 illustratively. I must admit, I'm a little --
22 MR. BUTLER: Well, I'll vote for it as is. I just

1 think -- I read that to impact a small percentage of the
2 home health agencies when our example impacts 60 percent.
3 DR. CHERNEW: Right. No, I understand, and I
4 think that's a -- right. That's a valid point, so we'll --
5 my view is we would deal with that in the text, about what
6 that word means, but in any case, if it's okay, I'll go to
7 Scott.
8 MR. ARMSTRONG: I'm prepared to vote in favor of
9 these recommendations. I don't have anything more to add.
10 DR. CHERNEW: Well, let me just -- because I still
11 have to go around to get back, so I have Jon.
12 DR. CHRISTIANSON: Okay. I also support the
13 recommendations, but I share some of Craig's concerns about
14 hospital discharges not randomly distributed to home health
15 agencies. Discharge planners work with different home
16 health agencies and I think they tend to try to put patients
17 with agencies that do a particularly good job with certain
18 types of patients, and so risk adjustment is critical and I
19 am not somebody who has a great deal of belief in the
20 ability of risk adjustment to deal with these types of
21 issues.
22 DR. CHERNEW: Bill.

1 MR. GRADISON: I support both recommendations. I
2 want to say with regard to the common risk assessment tools,
3 that my best understanding is that we have a much better
4 reason to be confident in them than we did when we adopted
5 the DRGs, which had been tested, if that's the right word,
6 in a slightly different form in just one State and did have
7 to be modified from time to time to improve them. So, I'm
8 very comfortable with that.
9 With regard to -- and I will support both
10 recommendations. But the question that I would like
11 somebody to help me answer in case it gets asked, if we
12 believe that there can be steps taken in PAC settings to
13 reduce hospital readmissions, then why don't we apply this
14 simultaneously to all PAC settings rather than just picking
15 this one out?
16 DR. CHERNEW: I'll leave that -- Evan, do you want
17 to take that not quite clarifying question, and thank you
18 for saving that for round two.
19 MR. CHRISTMAN: I mean, we have recommended it for
20 skilled nursing facilities, and I believe it's something
21 we're thinking about with the IRF. I think we -- I think
22 it's -- coming up with a common policy -- right now, these

1 silos are administered separately. That may not be a
2 completely correct answer to your question, but I think that
3 that's definitely -- I think the one area where we haven't
4 recommended it yet, technically, is IRFs, and I think that's
5 something we're working towards.
6 DR. CHERNEW: I read that as we're moving in that
7 direction.
8 DR. NERENZ: If I could just speak for a minute on
9 this issue of disincentives for caring for low-income
10 beneficiaries and the related text on page 33, the text is
11 quite accurate in describing the current NQF and CMF policy
12 suggesting against including variables like race and income
13 in adjustment. I would say that the actual text of where
14 that is currently in writing does not identify specifically
15 race and income. It describes the broader category of SES
16 variables, and if you talk about race, you're actually
17 talking about an even broader set that we'd call socio-
18 demographic.
19 The NQF, as I think you know, has established
20 quite recently an expert panel to help it think through this
21 position, and although the report of that group is not out
22 until June of this year, the meetings are open to the

1 public. The transcript is a matter of public record. And I
2 think the signals indicate that the NQF position will
3 probably change to a more positive, more affirmative
4 statement about including socio-demographic variables in
5 risk adjustment models, and that certainly would be
6 applicable here.
7 So, with that in mind, when we look at 14, we may
8 just have in our minds, without changing any of the wording,
9 that a future risk adjusted model may include some SES or
10 socio-demographic variables that would not currently be put
11 in on the basis of current NQF policy. That's -- so, we may
12 choose to have some special position about that, but just --
13 it's kind of the background of what that phrase might mean
14 in the future.
15 The other thing is that we do specifically mention
16 on page 33 one approach that does not actually adjust the
17 measure, but it does take income into account when applying
18 a penalty. I would ask us that, as this moves to final
19 form, we use text that says, this is one approach, it is an
20 example, but it is not necessarily a suggested or
21 recommended approach in the sense that we collectively have
22 considered ten or 12 different alternatives and selected

1 this one as the best. Could we do it that way, because I --

2 DR. MARK MILLER: The only reason I'm going to

3 hesitate here, and you and I had some of this conversation

4 this morning, is the Commission did come to this posture for

5 dealing with the SES issues as it related to the hospital

6 correction, or penalty. And what we've basically said in

7 both the SNF and in now building out to the home health is

8 we're saying that's our reference point for what the

9 methodology is.

10 And I think, philosophically, you're opening a

11 much -- while you're saying this is just something to change

12 in text, philosophically, you're sort of taking the

13 Commission back to a point where you could be opening the

14 door on saying the basic measure should be adjusted for SES,

15 and the Commission kind of hassled through that for a couple

16 months to get where it was on the readmission penalty. In

17 some ways, I do think it's bigger than just an editorial

18 point.

19 Now, what I would be willing to say, to try and

20 reach, is to say, you know, in the environment, there are

21 people who are thinking of different definitions, and sort

22 of put it that way. But saying that it's the Commission's

1 position that you could just do it this hundred different
2 ways, I would feel that we may have moved off of a position.
3 DR. NERENZ: Okay. Let me just try to clarify it.
4 Ninety percent of what I just said is just describing
5 changes in the environment that I think we should be aware
6 of. I am not asking the Commission --
7 DR. MARK MILLER: No --
8 DR. NERENZ: I am not asking the Commission to
9 revisit its basic policy. Two years from now, we may choose
10 that. But I'm just saying, this is a change that is in the
11 environment that may affect this.
12 Still, though, on the issue of this specific
13 approach, I would just say, for example, I don't know, at
14 least not at the level of the full Commission discussion,
15 that we have seen data suggest that income is the most
16 important variable that should be included in a model of
17 this type, which is not specifically an adjustment model.
18 It's a payment application, or a penalty application model.
19 Now, have we actually done that?
20 DR. MARK MILLER: We have, when we went through
21 the hospital --
22 DR. NERENZ: No, no, no, but here, because what's

1 good for the hospital is not necessarily best for here.

2 DR. MARK MILLER: I understand what you're saying,

3 although I'd be willing to bet you your paycheck that it

4 probably is, but --

5 [Laughter.]

6 DR. NERENZ: I might take that deal, Mark. I

7 might --

8 [Laughter.]

9 DR. MARK MILLER: I just wanted to run it past you

10 and see if it happened.

11 No, I do see what you're saying. It could be that

12 suddenly in home health, the strength of income relative to

13 some other variable is suddenly very different than what you

14 find in hospital, although, in all seriousness, I'd tend to

15 bet against it.

16 But what the Commission has been doing through --

17 and this is why I think this is something of a bigger change

18 -- through hospital, SNF, and home health, is sort of said,

19 that's the approach that we saw the most evidence for and

20 that's what we built our house on. I understand what you're

21 saying. Maybe that's different here. But I think that the

22 Commission has had a position up to this point that income

1 is the most dominant factor when you get into these areas.

2 DR. NERENZ: Well, and I guess, again, this is not

3 in the wording of the recommendation. It will not affect my

4 vote on the recommendation. But, I guess, then, I would

5 like to see the data that led to that, and maybe this

6 preceded my time on the Commission. I'm not convinced,

7 based on what I do know, that income necessarily matters

8 most here because it matters most in hospital. Maybe it

9 does. I'm happy to be convinced.

10 DR. MARK MILLER: I'll have the -- at least

11 immediately have the link sent to you for the June 13, 2013

12 chapter that went through that analysis for hospital.

13 DR. NERENZ: I've read it ten times over in the

14 last week. That, I've got. It's okay. For hospital.

15 DR. MARK MILLER: Okay. Well, that's the basis of

16 it.

17 DR. NERENZ: Well, but -- okay. I understand.

18 We're not talking hospital here.

19 DR. CHERNEW: Right. So, we can continue to sort

20 and discuss through that, but I think I get the point, and I

21 think the general view which I've heard is there is concern

22 about some issues related to making sure that people aren't

1 avoiding high-risk folks, and I think, as in all our
2 recommendations, monitoring how that is playing out and how
3 it's affecting these agencies as we go forward will continue
4 to be an important thing, and I think that's part of the
5 normal course of business, is that we follow what happens.
6 And so none of the recommendations we ever make are always
7 set in stone as we go through. And monitoring for quality
8 effects, et cetera, I do think are important.
9 Mary, did you have something to say before we
10 vote?
11 DR. NAYLOR: No.
12 DR. CHERNEW: Really?
13 DR. NAYLOR: Really.
14 DR. CHERNEW: Okay. So, if we can have
15 recommendation one. So, it is, in fact, time to vote. How
16 many in favor of recommendation one.
17 [Show of hands.]
18 DR. CHERNEW: Opposed.
19 [No response.]
20 DR. CHERNEW: Abstentions.
21 [No response.]
22 DR. CHERNEW: And -- okay. And so, recommendation

1 two, the common assessment items. All right. All those in
2 favor.
3 [Show of hands.]
4 DR. CHERNEW: The votes are getting up before the
5 question is called.
6 Opposed.
7 [No response.]
8 DR. CHERNEW: Abstentions.
9 [No response.]
10 DR. CHERNEW: All right. That passes, as well.
11 Thank you both very much. It's an important area.
12 That brings us now -- notice that not only are we
13 on time, we're a little ahead of schedule. I take all
14 credit.
15 [Laughter.]
16 DR. CHERNEW: No, seriously, thank you all. Those
17 actually were very important discussions on both of those
18 chapters and so I appreciate that.
19 It is time now for public comment, and let me just
20 say, as I try and channel Glenn, I will try and keep track
21 of two minutes, but you should know, this is certainly not
22 your only opportunity to make remarks or even your best

1 opportunity to make remarks, and I encourage anyone who has
2 comments to contact the staff and Mark, but I'm waiting to
3 see. There were no comments this morning, either.
4 [No response.]
5 DR. CHERNEW: Seeing none, we are adjourned.
6 Thank you all.
7 [Whereupon, at 5:04 p.m., the meeting was
8 adjourned, to reconvene at 8:00 a.m. on Friday, January 17,
9 2014.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 17, 2014
8:02 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [8:02 a.m.]

2 MR. HACKBARTH: Okay. It's time to get started.

3 We begin this morning with a series of -- is this on? Okay.

4 We begin this morning with a series of votes with brief

5 presentations. This is a new thing that we're doing this

6 time around. These are all issues on which there was no

7 controversy when we discussed the draft recommendations in

8 December, and in order to save time for other work, we

9 decided to take this approach of very brief presentations,

10 followed by votes.

11 Okay. It didn't sound like it was on. Is this

12 on? The people in the back can't hear me.

13 There we go. Now we're live. Okay. Starting

14 again, we're going to have a series of votes on

15 recommendations preceded by brief presentations. This is a

16 new procedure that we're doing this time on these issues on

17 which there was no controversy when we discussed them in

18 December.

19 We're using this approach to save some time for

20 other issues. You'll recall that we missed a meeting in

21 October this year because of the shutdown, and so our scarce

22 resources, our face-to-face time together, and we needed to

1 make some adjustments in order to make the best possible use
2 of our group time.
3 Before we turn to those votes, I want to say just
4 a little bit about the sequester, and I apologize to people
5 in the audience who were here yesterday for having to listen
6 to this again, but there has been much discussion about how
7 the sequester affects MedPAC's decisions or does not affect
8 them, and so I want to just quickly walk through our
9 approach.
10 Could you go to the next slide?
11 So this slide depicts the world as we see it. The
12 yellow line represents the increase in the base rate paid to
13 providers under one of the many payment systems within
14 Medicare, and for sake of illustration, this graph assumes a
15 current law update of 2 percent per year, so the yellow line
16 goes up in 2 percent increments each year.
17 The green line signifies the effect of the
18 sequester. The sequester at the beginning of each of those
19 years reduces the base rate by 2 percent; then at the end of
20 that same year, the rate pops back up again. The important
21 point here is that the sequester is a temporary adjustment
22 and it is not cumulative. In fact, the sequester law is not

1 part of the Medicare law. It's a completely separate issue.
2 And so what we do -- and could you go forward to the table?
3 So what we do is focus our recommendations on what the
4 change should be in the Medicare base rate, focused on the
5 Medicare law, and this table provides a simple illustration
6 of that.

7 So in 2014, the base rate for this particular
8 provider type is $100, and because of the sequester the
9 amount the providers are paid falls to $98 at the bottom of
10 that column. In 2015, if we assume that this is a category
11 that has a current law update of 2 percent, all other things
12 held constant, the base rate would go from $100 to $102 I n
13 2015.

14 Let's say MedPAC does its analysis of payment
15 adequacy, looks at access to care, access to capital,
16 quality of care, margins where that data is available, and
17 we conclude that the appropriate base rate is a 1 percent
18 increase, so that's the 101 circled in red. The sequester
19 amount -- and for this example, let's just assume that
20 Congress doesn't accept our recommendation; they leave the
21 current law in place, which provides for a $102 base rate.
22 The sequester would then take that down to $100. Because

1 $100 is less than the $101 that we recommended, we disagree
2 with the sequester. We are focused on what the base rate
3 change should be. We're not ignoring the sequester. What
4 we are doing is recommending what we think the Medicare law
5 should say, which is our responsibility. So that's how it
6 works.
7 Now, there are cases where our recommendation
8 might actually be high -- or lower, rather, than what
9 providers would be paid even after the sequester. And so
10 you might say that, well, in some instances we like the
11 sequester, in some instances we don't. That's not the way
12 we look at it. We're focused on what the right rate should
13 be under the Medicare law and think that there are better
14 ways to achieve Medicare savings than an arbitrary, across-
15 the-board 2 percent cut in everybody's payment rate. We are
16 in principle opposed to the sequester as a way to achieve
17 Medicare policy goals.
18 It isn't our call though. The Congress obviously
19 is the decisionmaker on this. All we can do is recommend
20 what we think the appropriate rate should be in the Medicare
21 law, which is our responsibility.
22 So that's how it works. We will take a look at

1 ways that we can reframe our recommendations or present
2 margin information to take into account the fact that the
3 sequester now has been extended through 2024. And so it
4 seems a more or less permanent part of our lives now, and we
5 will try to make some adjustments or consider some
6 adjustments in how we present -- package what we do. But
7 the substance of it is going to stay the same.
8 So with that, let's turn to our presentations, and
9 we're beginning with ambulatory surgery centers, I think.
10 MR. WINTER: Good morning. So with regards to the
11 ASC update, the questions that you asked us at the December
12 meeting, we have tried to address them in the draft chapter
13 that we mailed to you.
14 Just to review a couple of key facts, in 2012,
15 Medicare payments to ASCs totaled $3.6 billion. There were
16 over 5,300 ASCs that treated 3.4 million Medicare
17 beneficiaries.
18 To summarize our measures of payment adequacy for
19 ASCs, access to ASC services continues to increase, as shown
20 by growth in the number of beneficiaries treated, volume per
21 beneficiary, and the number of ASCs. There has been strong
22 growth in Medicare payments per beneficiary. And, in

1 addition, growth in number of ASCs suggests that access to
2 capital has been adequate. However, our analysis is limited
3 because we lack cost and quality data.

4 CMS began collecting data on five quality measures
5 in October of 2012, but they have not yet released the data
6 that ASCs have submitted. In addition, the Commission has
7 recommended several times that ASCs be required to submit
8 cost information. But CMS does not collect cost data and
9 has not announced plans to do so.

10 So the draft recommendation reads: The Congress
11 should eliminate the update to the payment rates for ASCs
12 for calendar year 2015. The Congress should also require
13 ASCs to submit cost data.

14 In terms of the implications, under current law,
15 ASCs are projected to receive an update in 2015 of 1.4
16 percent. Therefore, relative to this statutory update, this
17 draft recommendation would produce small savings.

18 We estimate savings of less than $50 million in
19 the first year and less than $1 billion over five years.
20 Our smallest savings category for five years is $1 billion;
21 the savings would actually be substantially less than that.

22 Because of growth in the number of ASCs and the

1 volume of services, we do not anticipate that this draft
2 recommendation would diminish beneficiaries' access to ASC
3 care or providers' willingness or ability to furnish
4 services. ASCs would incur some administrative costs to
5 submit cost data.
6 And with that, I'll turn the discussion back over
7 to Glenn.
8 MR. HACKBARTH: Okay. Thank you.
9 Any questions about the recommendation before we
10 proceed to vote?
11 [No response.]
12 MR. HACKBARTH: Okay. All in favor of the
13 recommendation?
14 [Show of hands.]
15 MR. HACKBARTH: Opposed?
16 [No response.]
17 MR. HACKBARTH: Abstentions
18 [No response.]
19 MR. HACKBARTH: Okay. Thank you.
20 So next is?
21 MS. KELLEY: Long-term care.
22 MR. HACKBARTH: Okay.

1 MS. KELLEY: Good morning. The Commission made a
2 recommendation yesterday that would significantly change
3 Medicare's payments for LTCH services. Today I'm going to
4 ask you to switch gears and focus on the payment update for
5 LTCHs in 2015 in the current policy environment. Our update
6 recommendation is relevant if Congress does not mandate LTCH
7 reform for fiscal year 2015, and it will be relevant for
8 payment for CCI cases if Congress did mandate our
9 recommended policy change. Also I'd like you to note that
10 the pathway for SGR reform does mandate changes to LTCH
11 payment policy, but those changes do not begin until fiscal
12 year 2016.
13 Last month we presented the findings from our
14 update analysis for LTCHs. Those findings are summarized
15 here. Our indicators of payment adequacy are generally
16 positive.
17 We looked first at access to LTCH services.
18 Remember that many beneficiaries live in areas without LTCHs
19 and so receive similar services in other settings with few
20 apparent differences in quality or outcomes. Remember too
21 that from 2008 through 2012, Congress imposed a moratorium
22 on new LTCHs and LTCH beds. Not surprisingly, given this

1 moratorium, we saw little growth in supply in 2012. The
2 number of facilities and beds remained stable, and there was
3 little change in volume.
4 We considered changes in quality. We lack patient
5 assessment data in this area, and there are no available
6 quality measures as yet, so we're forced to rely on
7 aggregate mortality and readmission rates. Those have been
8 stable.
9 We then considered access to capital. The current
10 availability of capital for LTCHs says more about
11 uncertainty regarding possible policy changes than it does
12 about Medicare payment rates. Both the industry and the
13 financial markets have been taking a wait-and-see approach
14 to growth and expansion.
15 Finally, the 2012 margin was 7.1 percent.
16 Our projected margin for 2014 is 6.5 percent.
17 This decrease is due to a couple of factors: the PPACA-
18 mandated adjustments to payment updates in 2013 and 2014,
19 and CMS' budget neutrality adjustment corrects for an
20 underestimate of how much LTCH spending would increase in
21 the first year of the LTCH PPS. We also expect aggregate
22 payments in 2014 to be reduced by changes in CMS' short-stay

1 outlier payment policy. Overall, we expect cost growth to
2 continue to be below market basket levels, but we do think
3 it will be somewhat higher than payment growth. If the
4 sequester remains in effect, the estimated aggregate margin
5 would be two points lower.
6 We make our recommendation to the Secretary
7 because there is no legislated update to the LTCH PPS. The
8 draft recommendation reads: The Secretary should eliminate
9 the update to the payment rates for long-term-care hospitals
10 for rate year 2015.
11 CMS historically has used the market basket as a
12 starting point for establishing updates to LTCH payments.
13 Thus, eliminating the update for 2015 will produce savings
14 relative to the expected regulatory update, even assuming
15 PPACA-mandated reductions. Savings are estimated to be
16 between $50 and $250 million in 2015 and less than $1
17 billion over five years. Medicare patients will continue to
18 be profitable in 2015, so we don't anticipate that
19 eliminating the update will have adverse impact on
20 beneficiaries or on providers' willingness or ability to
21 care for patients.
22 And now I'll turn the discussion over to Glenn.

1 MR. HACKBARTH: Okay. Any questions about the
2 recommendation?
3 MR. BUTLER: One comment. I know that yesterday
4 we voted on the change in the payment here. We probably
5 haven't done a lot of modeling on who might get impacted in
6 terms of the changes in payment. Or maybe you have, because
7 it's so significant and it won't fall equally across these
8 institutions. But do we know much about where the impact's
9 going to fall?
10 MS. KELLEY: Well, as you would expect, the impact
11 depends mostly on the LTCH's share of CCI cases. We expect
12 overall, when the policy was fully implemented, for payments
13 to drop 36 percent, and we found in our modeling that
14 proprietary LTCHs and LTCHs in LTCH-saturated markets would
15 have relatively greater impacts.
16 MR. HACKBARTH: Any others?
17 [No response.]
18 MR. HACKBARTH: Okay. Ready to vote. All in
19 favor of the recommendation?
20 [Show of hands.]
21 MR. HACKBARTH: Opposed?
22 [No response.]

1 MR. HACKBARTH: Abstentions?

2 [No response.]

3 MR. HACKBARTH: Okay. Thank you.

4 MS. SADOWNIK: Good morning. I will discuss the
5 adequacy of Medicare payments to inpatient rehabilitation
6 facilities, or IRFs. Questions from the December meeting
7 have been addressed either through direct communication or
8 as indicated on the cover letter to the mailing materials.

9 In summary, in 2012, 1,166 IRFs treated 373,000
10 fee-for-service cases totaling over $6.7 billion in
11 spending. Our indicators of Medicare payment adequacy for
12 IRFs are positive. Beneficiaries generally maintained
13 access to IRF services in 2012, with the number of cases
14 increasingly slightly, by half a percent. In terms of
15 provider supply and capacity, the number of facilities was
16 almost unchanged from 2011 to 2012, a shift from declines in
17 previous years. Occupancy rates decreased slightly to 62.8
18 percent. Occupancy rates have been stable in recent years,
19 changing by less than one percentage point overall from 2008
20 to 2012. Together, these measures suggest that capacity
21 remains adequate to meet demand.

22 In terms of access to capital, one major

1 freestanding chain has very good access. We are not able to
2 determine the ability to raise capital of other freestanding
3 facilities. The parent institutions of hospital-based IRF
4 units have maintained reasonable access to capital.
5 Quality of care has continued to improve in recent
6 years on measures of functional outcomes, discharge to the
7 community, and rates of readmission to an acute-care
8 hospital. Due to changes in our cost growth assumptions, we
9 revised the projected 2014 margin from the one we presented
10 in December. Aggregate margins averaged 11.1 percent in
11 2012, and we project margins will grow to 11.8 percent in
12 2014. If the sequester is in effect for the full year of
13 2014, the projected margin would be about two percentage
14 points lower.
15 The draft recommendation for your review is: The
16 Congress should eliminate the update to the Medicare payment
17 rates for inpatient rehabilitation facilities in fiscal year
18 2015.
19 Future work will include addressing trends in
20 financial performance among sectors of the IRF industry.
21 Recall from the discussion in December the differences in
22 financial performance between hospital-based and

1 freestanding IRFs. While 2012 margins in hospital-based
2 facilities averaged 0.8 percent, margins averaged 24 percent
3 among freestanding facilities, which provide care for 45
4 percent of all IRF discharges. With very high margins among
5 providers for almost half of Medicare discharges, payments
6 may no longer accurately reflect providers' costs. In
7 future work, we plan to consider options for rebasing IRF
8 payments.
9 On the basis of our analysis, we believe that IRFs
10 could absorb cost increases and continue to provide care
11 with no update to the current payment rate. We estimate
12 that this recommendation will decrease federal program
13 spending relative to current law. We do not expect this
14 recommendation to have adverse impacts on Medicare
15 beneficiaries.
16 This recommendation may increase the financial
17 pressure on providers, but overall we expect a minimal
18 effect on providers' willingness and ability to care for
19 Medicare beneficiaries.
20 This concludes the presentation, and I will now
21 turn discussion over to the Chairman.
22 MR. HACKBARTH: Any questions?

1 [No response.]

2 MR. HACKBARTH: Ready to vote? Okay. All in

3 favor of the recommendation?

4 [Show of hands.]

5 MR. HACKBARTH: Opposed?

6 [No response.]

7 MR. HACKBARTH: Abstentions?

8 [No response.]

9 MR. HACKBARTH: Okay. Kim.

10 MS. NEUMAN: I'm going to talk about hospice and

11 summarize indicators of hospice payment adequacy that we

12 discussed in December and that are described in detail in

13 your mailing materials.

14 In 2012, more than 1.2 million Medicare

15 beneficiaries received hospice care furnished by more than

16 3,700 hospice providers, and Medicare paid those hospices

17 about $15 billion.

18 Our indicators of access to care for hospice are

19 favorable. The supply of hospice providers continues to

20 grow, increasing nearly 4 percent in 2012. For-profit

21 providers account almost entirely for this growth.

22 Hospice use has also increased. About 46.7

1 percent of Medicare decedents used hospice in 2012, an
2 increase of 1.5 percentage points over the prior year.
3 Average length of stay among decedents also
4 increased -- from 86 days in 2011 to 88 days in 2012.
5 Median length of stay has been fairly steady at 18 days in
6 2012 and 17 or 18 days since 2000.
7 Different from most other sectors, we do not have
8 publicly available quality data to examine for hospice
9 providers currently.
10 In terms of access to capital, the continued
11 growth in the number of providers suggests capital is
12 accessible.
13 So that brings us to margins. As you'll recall,
14 our margin estimates assume cap overpayments are fully
15 returned to the government and exclude non-reimbursable
16 bereavement and volunteer costs. For 2011, we estimate an
17 aggregate Medicare margin of 8.7 percent. For 2014, we
18 project a margin of 7.8 percent. That projection is before
19 the sequester. The margin would be roughly two percentage
20 points lower after the sequester.
21 So that brings us to the draft recommendation. It
22 reads: The Congress should eliminate the update to the

1 hospice payment rates for fiscal year 2015.

2 The implications of this draft recommendation are

3 a decrease in spending relative to the statutory update of

4 between $250 million and $750 million over one year, and

5 between $1 to $5 billion over five years.

6 Since we expect that hospices would be able to

7 cover their costs in 20115 without an update to the payment

8 rates, we would not expect the draft recommendation to have

9 an adverse on beneficiary access, nor would we expect it to

10 affect providers' willingness or ability to care for

11 Medicare beneficiaries.

12 So that concludes the presentation, and I turn it

13 back to the Chairman.

14 MR. HACKBARTH: Thank you.

15 Any questions?

16 [No response.]

17 MR. HACKBARTH: Okay. All in favor of the

18 recommendation?

19 [Show of hands.]

20 MR. HACKBARTH: Opposed?

21 [No response.]

22 MR. HACKBARTH: Abstentions?

1 [No response.]

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

3 So now we move on to status report on Part D.

4 [Pause.]

5 MS. SUZUKI: Good morning. In this presentation,

6 I'm going to give you a status update on Part D with a focus

7 on program costs and the driver of the growth in spending.

8 Here's a quick overview of the Part D program.

9 Spending totaled about $62.5 billion in 2012, up 4.4 percent

10 from 2011. About $59 billion of that was for payments to

11 Part D plans, and a little over $3 billion was for the

12 retiree drug subsidy. The rest of the presentation will

13 focus on the $59 billion.

14 In 2013, over 35 million, or nearly 70 percent of

15 Medicare beneficiaries, were enrolled in Part D. For 2014,

16 the base beneficiary premium increased by four percent to a

17 little over $32. This reflects the plan's expectations

18 about the costs per beneficiary rather than the actual

19 premiums paid by enrollees. Enrollees filled, on average,

20 four prescriptions at $240 per month in 2011. Surveys

21 indicate that Part D enrollees are generally satisfied.

22 First, I'll provide a quick summary of Part D

1 enrollment and plan offerings for 2014. Then, we'll look at
2 costs of the program, with a focus on understanding the
3 drivers of the growth in spending, including how changes
4 made by PPACA to close the coverage gap has affected program
5 spending. Finally, I'll summarize key evidence from program
6 spending on insurance risk and plan incentives and discuss
7 our ongoing and future work related to the topics we discuss
8 today.
9 There hasn't been a dramatic shift in Part D
10 enrollment patterns from year to year. In 2013, about 64
11 percent of Part D enrollees were in stand-alone PDPs and the
12 rest were in MA-PD plans. As in previous years, most LIS
13 enrollees continue to enroll in PDPs.
14 In 2014, we're seeing a modest increase in PDP
15 offerings, with over 1,100 plans available, up from a little
16 over 1,000 plans in 2013. There are between 28 and 39 PDPs,
17 depending on the region, and the typical county has between
18 three and ten MA-PDs.
19 In 2014, fewer PDPs are offering coverage in the
20 gap. The phase-out of the coverage gap may have affected
21 plans' decision to provide coverage in the gap.
22 Now, I'm going to talk about trends in program

1 spending. This chart shows Medicare's payments to Part D
2 plans. Between 2007 and 2012, payments grew from $43
3 billion to $59 billion, a 38 percent increase over this
4 period. Part D enrollment grew by 29 percent during this
5 period, which is nine percentage points lower than spending
6 growth.
7 I want to call your attention to two figures in
8 this chart. First, payment for LIS for the low-income
9 subsidy continued to be the largest component, accounting
10 for 38 percent of payments to plans. Most of the spending
11 is used to help LIS beneficiaries with their cost sharing.
12 In Part D, plans set their own cost sharing amounts. For
13 example, a plan may charge $40 for preferred brands and $90
14 for non-preferred brands. For LIS beneficiaries, their cost
15 sharing is set by law. In 2014, for the majority of them,
16 it is a little over one dollar for generics and $3.60 for
17 brands. The difference between the plans' cost sharing
18 amount and the amount set by law is picked up by Medicare,
19 and plans are not at risk for this spending.
20 Second, payments for individual reinsurance
21 continue to grow rapidly, growing by 95 percent between 2007
22 and 2012. As you know, a typical Part D plan benefit has

1 three distinct phases: Initial coverage, where plans cover,
2 on average, 75 percent of the cost; gap phase, where, until
3 recently, there were no coverage unless you were in enhanced
4 plans with some gap coverage; and the catastrophic phase,
5 where plans cover 15 percent of the cost, enrollees pay five
6 percent in cost sharing, and the remaining 80 percent is
7 paid for by Medicare's reinsurance. So, plans have some
8 risk in the catastrophic phase, but a limited risk, and
9 spending for reinsurance may continue to grow rapidly as the
10 coverage gap is phased out, and we'll come back to this
11 issue in a few minutes.
12 The three key things to keep in mind as we go
13 through the next few slides are that Part D spending has
14 been growing faster than enrollment. Payments for the low-
15 income subsidy continue to be the largest component. And
16 payments for individual reinsurance continue to grow much
17 faster than other components.
18 To understand the sources of this growth, we
19 looked at various data and aspects of the program, including
20 per capita spending, prices of drugs, trends in plan
21 formularies, and, finally, the effects of closing of the
22 coverage gap.

1 Since not all growth in program spending can be
2 explained by enrollment growth, we looked at per capita
3 spending and use. This is total spending that includes
4 enrollees' out-of-pocket. We found that per capita spending
5 for LIS enrollees grew faster than for non-LIS enrollees,
6 growing by 4.8 percent annually between 2007 and 2011,
7 compared with 1.8 percent for non-LIS enrollees. The growth
8 in number of prescriptions filled was comparable between LIS
9 and non-LIS enrollees, indicating that growth in prices per
10 prescription account for the difference. Average price per
11 prescription filled by LIS enrollees grew by ten percent
12 between 2007 and 2011, while the average prices decreased
13 for non-LIS enrollees.
14 The mix of drugs can have significant effects on
15 the cost of medications, as we'll see in the next slide.
16 Some of the difference is likely due to the structure of the
17 cost sharing subsidy that limits plans' ability to encourage
18 generic use among LIS enrollees. Moreover, because of
19 subsidies not part of the benefit, plans have no incentive
20 to manage that part of the spending.
21 Overall, Part D drug prices based on individual
22 drug products rose 29 percent between January 2006 and

1 December of 2011, and that's the gray line, solid gray line.
2 However, when generic substitution is taken into account --
3 that's the dotted line in gray -- prices rose by only three
4 percent. Here, the shift in volume from brand name drugs to
5 generic alternatives have resulted in a dramatic difference
6 in prices.
7 Another way to see how the use of generics has
8 kept prices low is to look at brand and generic prices
9 separately. The red line at the top shows that the prices
10 of single-source brand name drugs grew by 66 percent, while
11 the blue line shows that the prices of generic drugs
12 decreased to about 40 percent of the average prices in 2006.
13 So, encouraging enrollees to use generic drugs
14 when appropriate can slow the spending growth by keeping
15 prices low.
16 The use of generic drugs has increased over time,
17 from 61 percent in 2007 to 77 percent in 2011. However, the
18 rate of generic drug use varies across beneficiaries. For
19 example, generic use has been consistently higher among MA-
20 PD enrollees compared to PDP enrollees and higher among non-
21 LIS enrollees compared to LIS enrollees. The difference
22 between LIS and non-LIS enrollees have grown from two

1 percentage points to five percentage points between 2007 and
2 2011.
3 As we just saw, the prices for brands are growing
4 rapidly while the prices of generic drugs have, on average,
5 decreased. So, that difference in generic use rate has a
6 significant effect on the average prices of drugs covered by
7 Part D and a significant effect on Medicare spending for
8 Part D.
9 Spending on the low-income subsidy may also be
10 affected by the structure of formularies' plans' use. In
11 recent years, an increasing number of plans have added a
12 non-preferred generic tier, in some cases with a
13 substantially higher cost sharing relative to the preferred
14 tier. In 2014, on average, about 75 percent of all
15 formulary generic drugs are placed on non-preferred tiers
16 and the share is even higher if weighted by enrollment.
17 But, as we just discussed, cost sharing amounts for LIS
18 enrollees are set by law and that amount is the same for all
19 generics. So, the higher cost sharing required for drugs
20 placed on non-preferred tiers are paid for by Medicare.
21 From beneficiaries' perspective, their cost sharing is the
22 same whether they take medications on preferred or non-

1 preferred generic tier.

2 We're also seeing an increasing use of tiered

3 network pharmacies that further stratifies cost sharing so

4 that the amounts are lower if one filled medications at a

5 pharmacy that is designated as preferred. We are concerned

6 that some enrollees may not have access to preferred

7 pharmacies. We are also concerned that while the costs may

8 be lower at preferred pharmacies, if LIS beneficiaries do

9 not use those lower-cost pharmacies, it could increase

10 Medicare spending for the low-income subsidy.

11 Finally, as we saw earlier, reinsurance has been

12 the fastest growing component, growing by 95 percent between

13 2007 and 2012. Growth was particularly high between 2010

14 and 2011. This is when the phase-out of the coverage gap

15 began, which was accomplished partly by manufacturers' offer

16 of a 50 percent discount for non-LIS enrollees while they

17 were in the gap phase. That discount is treated as

18 beneficiary out-of-pocket for the purpose of determining

19 when an individual has met their annual out-of-pocket

20 threshold and enter the catastrophic phase. That is, if a

21 drug costs $100 and a beneficiary paid $50 and the

22 manufacturer discount paid the other $50, the beneficiary

1 still got a credit for $100 as their out-of-pocket spending.
2 Because non-LIS enrollees who filled brand name
3 drugs now had to spend less in out-of-pocket to meet the
4 threshold, it was expected that more people would reach the
5 catastrophic phase, further increasing spending for
6 reinsurance. From beneficiaries' perspective, it may make
7 financial sense to choose brand name medications if they
8 think they'll have high enough expenses, and the limited
9 cost sharing required in the catastrophic phase may not
10 provide strong enough incentive for them to use generic
11 drugs.
12 Our analysis of the Part D data for 2010 and 2011
13 shows that the number of non-LIS enrollees who reached the
14 catastrophic phase of the benefit increased by 28 percent
15 and spending for these high-spending enrollees increased by
16 38 percent. In the past, number of non-LIS enrollees who
17 reached the catastrophic phase of the benefit remained
18 stable, at around 400,000. If discount did not count
19 towards the out-of-pocket threshold, most likely would not
20 have reached the catastrophic phase as quickly, and some
21 likely would not have entered the catastrophic phase at all
22 and spending for reinsurance would have grown more slowly.

1 This is different from saying that these people
2 would not have reached the catastrophic phase without the
3 discount. Many of them likely would have, but given that
4 now we have a discount that reduces their out-of-pocket by
5 half during the gap phase, if the discounts were not treated
6 as their out-of-pocket, it would take them longer and
7 possibly many more prescriptions before they can meet the
8 out-of-pocket threshold. That also means that if the
9 discounts did not count towards the out-of-pocket threshold,
10 many would have likely incurred a much higher out-of-pocket
11 cost.
12 So, one issue we'll be focused on is how this
13 manufacturer discount should be treated. Should it continue
14 to be treated as beneficiary out-of-pocket when determining
15 whether one met the out-of-pocket threshold?
16 So, to summarize, program enrollment and plan
17 offerings remain stable, with generally high satisfaction
18 among enrollees. Spending is growing faster than
19 enrollment. Higher use of brand name drugs used by LIS
20 enrollees is contributing to higher growth in spending. Use
21 of non-preferred tiers and tiered pharmacy networks may
22 increase Medicare's costs. And closing of the coverage gap

1 is accelerating the growth in Medicare spending for
2 reinsurance.
3 In 2012, the Commission recommended changes to the
4 low-income subsidy cost sharing structure to encourage the
5 use of generic drugs. If implemented, this policy could
6 lower Medicare spending for Part D because the average
7 prices would be lower, the spending for LIS would be lower,
8 and some LIS enrollees may not reach the catastrophic phase
9 of the benefit or have lower spending in the catastrophic
10 phase because more of their medications would be for generic
11 drugs.
12 We have also reported on the preliminary findings
13 from our analysis of the relationship between Parts A and B
14 and Part D spending. If spending for Part D continued to
15 grow, we'd need a better understanding of the relationship
16 and whether there are drug classes or conditions for which
17 Part D provides higher or lower value.
18 Our focus on cost is because we need to ensure
19 that the program is sustainable. Medicare spending for
20 prescription drugs accounts for over a quarter of total
21 national spending on prescription drugs and it has been
22 growing faster than overall spending, partly due to

1 enrollment, but also because of other factors, like more
2 people reaching the catastrophic phase.
3 We are also concerned about fraudulent or abusive
4 prescribing as well as overuse of medications that could be
5 harmful. CMS has announced in the recent proposed rule that
6 they are considering changes to allow them to more easily
7 identify fraud and exclude prescribers who engage in fraud
8 or abusive prescribing. We'll monitor this issue and we'll
9 come back to you if we think more needs to be done.
10 We'll also continue to monitor changes in plan
11 formularies and their effects on program spending and we'll
12 revisit them, if necessary.
13 In the future, we plan to focus on the effects of
14 the manufacturer discount on program spending and we'll come
15 back to you with policy options.
16 We'll also be looking at the effects of insurance
17 risk on plan incentives and consider ways to strengthen plan
18 incentives to manage costs.
19 Finally, we plan to come back to you with an
20 updated analysis of the relationship between Parts A, B, and
21 D spending later this spring.
22 And that concludes my presentation.

1 MR. HACKBARTH: Okay. Thank you.
2 So, this status report on Part D will be included
3 in our March report, and as Shinobu indicated, in the
4 future, we may consider some specific recommendations.
5 What I'm thinking is that we ought to go for three
6 rounds here: Round one clarifying questions. Round two
7 monitored by the light -- give everybody two minutes. Don't
8 feel obliged to use the full two minutes if you don't need
9 to. And then a third round that we focus in on some
10 particular issues.
11 So, round one clarifying questions. I have Dave
12 and then George and Rita and Scott.
13 DR. NERENZ: Okay. Slide 8, please. Just a
14 question of how we interpret the top red line. Is this the
15 same market basket of drugs from 2006 to 2011, or does it
16 include the new entry of drugs during that period?
17 MS. SUZUKI: It actually is chain weighted, so it
18 does evolve over this period. But if you look at time
19 period that's closer to each other, it has a lot of
20 overlapping drugs.
21 DR. NERENZ: So for those who are not technical
22 term oriented, chain weighted means --

1 MS. SUZUKI: Chain -- umm --
2 DR. MARK MILLER: One way to -- if you kind of
3 understand a Paasche and Laspeyres, this is like blending
4 two of those.
5 [Laughter.]
6 DR. NERENZ: That didn't get better.
7 [Laughter.]
8 DR. CHERNEW: I think the answer is, it's more
9 analogous to the same drugs' prices going up than it is to
10 more expensive drugs coming into the market, because in any
11 given period, they keep the drugs the same and get inflation
12 between that period. Then they do the next period with a
13 new basket and they connect them. But the way to think
14 about it is -- I believe -- is that it's the same drugs'
15 prices rising as opposed to more expensive drugs coming in,
16 driving up the average price.
17 DR. NERENZ: That was exactly the distinction I
18 was after, yes.
19 DR. CHERNEW: I am not sure I'm right, but I think
20 of those two choices, that's the one I think is probably
21 closest.
22 DR. MARK MILLER: [Off microphone.] But it does

1 allow for substitution over time. It's just -- it's not all
2 -- like, a Paasche and Laspeyres is either all one set at
3 the beginning -- and this is kind of takes both of the
4 change in the price and substitutes drug change over time.
5 That's what chaining does.
6 DR. SOKOLOVSKY: For those who aren't more
7 technically oriented, it is a Fisher index. But the key
8 thing is that before something is added for the next period,
9 it has to be in the previous period. There has to be a
10 certain amount of use in the previous period before it gets
11 included in the next period.
12 MR. GEORGE MILLER: I'm not sure if I should
13 follow that with a question.
14 [Laughter.]
15 MR. GEORGE MILLER: I've got a different question
16 on Slide 13,and in the chapter -- and it was just
17 fascinating reading -- I'm struck by the notion that if we
18 do better education, we can help drive the cost down,
19 particularly around generic drugs. My question may not have
20 an answer to it, but I wonder how much is being spent on
21 education, and I contrast that on every TV station there's
22 some advertising for some kind of drug to make your hair

1 grow and your warts go away and you become more beautiful
2 and all of that stuff.
3 [Laughter.]
4 MR. GEORGE MILLER: I mean, it's just the barrage
5 of drugs versus the amount of money we're spending on
6 education. That just struck me as a parallel. I mean, are
7 we in the -- by referencing, that would help drive costs
8 down, are we spending -- I'm not sure I'm framing this right
9 -- are we going to spend enough money to make education
10 overcome the amount of money the drug manufacturers are
11 spending in advertising? I don't know if that's a good
12 question, but it just struck --
13 MR. HACKBARTH: That's a great question, but more
14 a round two question than a round one.
15 DR. MARK MILLER: [Off microphone.]
16 MR. HACKBARTH: Right. Bill.
17 MR. GRADISON: Maybe I need another cup of coffee,
18 but could you explain to me why the use of tiered pharmacy
19 network is pushing prices up? I have a little trouble
20 understanding that.
21 MS. SUZUKI: So, one way we were thinking about
22 this is -- so, non-preferred pharmacies typically have cost

1 sharing that are higher than at preferred pharmacies, and
2 all of that difference is going to be picked up by
3 Medicare's low-income subsidy for LIS beneficiaries. And so
4 if low-income subsidy enrollees don't have access to
5 preferred pharmacies or don't know that there are different
6 types of pharmacies and continue to use the non-preferred,
7 that may result in higher spending for the program.
8 MR. GRADISON: So, the increase in the cost is
9 through the use of the non-preferred rather than the
10 preferred.
11 MS. SUZUKI: Right.
12 MR. GRADISON: Thank you.
13 MR. ARMSTRONG: On Slide 6 -- oh, I'm sorry.
14 [Off microphone discussion.]
15 DR. REDBERG: -- having an identity crisis.
16 [Laughter.]
17 [Off microphone discussion.]
18 DR. REDBERG: That was yesterday.
19 [Laughter.]
20 DR. REDBERG: Shinobu, that was an excellent
21 presentation. My question is about what percentage of
22 enrollees use mail-in pharmacies and does that differ by LIS

1 and non-LIS.

2 MS. SUZUKI: So, we have not recently looked at
3 the mail order pharmacy use, but my understanding is that it
4 continues to be low. The last time we looked at it, I
5 believe, was in 2007, when it was less than ten percent of
6 the prescriptions were through mail order, and it could have
7 been much lower than ten percent.

8 DR. MARK MILLER: And the other part of her
9 question was LIS and non-LIS, and what I remember, and it is
10 a number of years ago, we kind of looked at it urban and
11 rural, but I don't remember that --

12 MS. SUZUKI: I don't think we have that.

13 DR. MARK MILLER: Okay.

14 DR. SOKOLOVSKY: We did look at it urban and
15 rural, and rural actually used it a little bit less than
16 urban. But it was ten versus nine and it wasn't growing.

17 DR. REDBERG: Because, I mean, it just seems like
18 an opportunity for people that don't have access to
19 preferred pharmacies that everyone has access to mail order.

20 My other question is can you estimate what
21 percentage of Part D spending is for biologics versus other
22 drugs?

1 MS. SUZUKI: I can get back to you on the overall
2 share, but for the people who reach the catastrophic, it's
3 less than ten percent.
4 MR. ARMSTRONG: So, I'm looking at Slide 6, but I
5 think there are references to the trends in Part D prices in
6 several places. What I don't really understand is that I
7 think the way you describe the increase in prices, it's
8 really a function of the relative use of generics versus
9 non-generics. It's kind of the net price. But what do we
10 know about the trends in the price per pill, or price per
11 unit of service that underlies that? Is that a different
12 number than the way in which you're using this term, trends
13 in Part D prices?
14 MS. SUZUKI: So, the one place where I do talk
15 about prescription prices is where I compare the LIS and
16 non-LIS enrollees and said that between 2007 and 2011, price
17 per prescription for LIS enrollees grew by ten percent while
18 the prices for non-LIS enrollees actually decreased by about
19 two percent.
20 MR. ARMSTRONG: But my understanding is the
21 difference is largely a difference in the percentage of
22 generic drugs that the non-LIS versus LIS patients are

1 using. It really has no -- there's no impact of the
2 underlying price per drug. It's just really the ratio of
3 low-cost to high-cost drugs --
4 DR. BAICKER: Doesn't Slide 8 show us what's going
5 on with branded drugs versus generic drugs that's not
6 affected by the mix of branded and generic that people are
7 taking? This is about the prices of a basket of drugs,
8 where the basket is evolving over time in a chain weighted
9 kind of way to let new drugs enter, but it's -- from period
10 to period, it's showing for a basket of drugs, how did the
11 price for that basket change. So, I thought that spoke to
12 that question.
13 DR. CHERNEW: It's sort of analogous to a case mix
14 kind of question, and I believe the right way to look at the
15 slide that Kate's talking about is that it is case mix
16 adjusted, although I would defer to them, but I think that's
17 the question that --
18 DR. BAICKER: But the initial question was branded
19 versus generic and the mix of that, and these lines separate
20 that out. So, it's not adjusted. So, this shows you what's
21 happening to the price of branded drugs. The basket of the
22 branded drugs that you are pricing is evolving over time

1 based on utilization. So, as new drugs enter, if they're
2 more expensive, that would, over time, make this move up,
3 although from period to period, you're saying, what's the
4 CPI for this basket of drugs.
5 MS. SUZUKI: But the utilization is reflected in
6 the dotted line.
7 DR. MARK MILLER: But the solid line right above
8 the dotted line, that's net across all drugs and it's a
9 price measure that doesn't take into account the generic
10 substitution.
11 MS. SUZUKI: Right.
12 DR. MARK MILLER: Does not. Right. That's what
13 I'm trying to say. So, to Scott, what I think I would be
14 saying is if you wanted to look at a price effect across the
15 entire program, if that was your question, which I've in
16 some ways lost a little bit of sense of --
17 MR. ARMSTRONG: Yeah.
18 DR. MARK MILLER: -- I think it's the solid white
19 line. Are you guys okay there?
20 DR. SOKOLOVSKY: The solid red line is what
21 happened to the price of the branded drugs.
22 DR. MARK MILLER: Well, that's single source, and

1 if he is asking branded, then I would push him up to the red
2 line. But the white line is across everything, right?
3 MS. SUZUKI: Mm-hmm.
4 MR. ARMSTRONG: Okay. So, then, my related
5 question is, I'm not exactly sure -- I probably should know
6 this, but how is the price per drug determined? Are those
7 negotiated by the plans with bulk purchasing organizations,
8 or does MedPAC set those prices, and then how does that --
9 like we do for so many other services, but --
10 [Laughter.]
11 MR. ARMSTRONG: -- and then later -- anyway, I'll
12 stop there.
13 MS. SUZUKI: So, the prices are negotiated between
14 the plans and the pharmacies. So, we have that side of the
15 payment. Plans also negotiate rebates. That's not
16 reflected in the prices we're measuring for using the claims
17 data.
18 MR. ARMSTRONG: Okay. And so CMS has no role in
19 setting those prices?
20 MS. SUZUKI: No.
21 MR. ARMSTRONG: Okay.
22 MR. HACKBARTH: Any other clarifying questions?

1 Jon.

2 DR. CHRISTIANSON: So we don't actually -- if I

3 understand what you just said, we don't actually know what

4 the plans paid for the drugs because we don't know the

5 rebates.

6 MS. SUZUKI: Correct. Well --

7 DR. MARK MILLER: And just to be clear, it is

8 known; it's not known by us.

9 DR. CHRISTIANSON: We don't know.

10 DR. MARK MILLER: We don't know. MedPAC does not

11 know.

12 And I guess I would ask for one other

13 clarification.

14 To the extent that CMS or whoever knows, do they

15 know drug by drug, or do they just know this is the spend

16 and these are the rebates?

17 MS. SUZUKI: The trustees' report puts out an

18 aggregate rebate amount, and I can't remember the percent.

19 I believe it is by drug. Or, manufacturer?

20 DR. SOKOLOVSKY: I think it's by manufacturer.

21 MR. SUZUKI: It may be by manufacturer.

22 DR. BAICKER: So while we're on this chart, which

1 I found really helpful, is this just standalone Part D, or
2 is it MAPD plus?
3 MS. SUZUKI: It's both.
4 DR. BAICKER: It's both. So it would be
5 interesting to see how those -- how the chart looks
6 different for each of those in that we think there might be
7 different management tools available in the MAPD.
8 I think it would also be -- and I don't know if
9 you know the answer to that offhand.
10 It would also be interesting to know how the
11 bundle used by Medicare Part D enrollees overall compares to
12 other populations, ideally, you know, somewhat similar
13 commercially insured populations, but I know they're never
14 going to be quite the same and that you're not going to have
15 the claims data.
16 But it would be interesting to know how the
17 program is influencing the bundle overall compared to not
18 the program as well as the MAPD versus the standalone.
19 DR. SAMITT: So, while we're also on this graph,
20 I'm curious again to get clarification on the difference
21 between the solid white line and the dotted white line. I
22 assume the solid line represents reality whereas the dotted

1 line represents what the incremental cost would be, assuming
2 full generic substitution had been applied where all
3 opportunities for that existed. No?

4 MS. SUZUKI: So the dotted line is the closest to
5 reality. We're taking the actual weights of brand versus
6 generic and coming up with a price index.

7 The white line is showing that if you just measure
8 the growth in drug prices over time but not considering that
9 some people would switch from Lipitor to a generic statin,
10 then what would the price growth be?

11 DR. CHRISTIANSON: So, I mean, I always think of
12 price as what we pay for things, and this really isn't what
13 is being paid for things.

14 How much are we to take away from this graph? The
15 line -- what's actually being paid for stuff may look
16 different, quite a bit different than that, right?

17 I mean, I'm just trying to get some clarification
18 on this.

19 DR. SOKOLOVSKY: It's what beneficiaries are
20 paying in the coverage gap. It's what Medicare is paying
21 for, say, LIS and what they're paying in catastrophic. It's
22 not the net price for the plan.

1 DR. MARK MILLER: Well, you're absolutely right
2 because then there's this discount, or rebate transaction,
3 that occurs all behind this.
4 And you're right; it is what a person faces at a
5 counter, you know, when they're standing at the counter.
6 I suppose over time, to the extent that rebates
7 drive down the cost of the plan, the plan might reflect that
8 in a premium, but again, that's a different signal than the
9 price signal here.
10 But you're absolutely right; it's in some ways not
11 the actual net price when all is said and done.
12 MR. HACKBARTH: We're going to be really clear
13 after this round what we --
14 [Laughter]
15 DR. REDBERG: Your presentation was very clear.
16 It's just an additional question on table 13 in the mailing
17 material.
18 I'm assuming I'm looking at the average number of
19 prescriptions per enrollee. I'm assuming this is just for
20 the Part D enrollee; so it doesn't include beneficiaries who
21 are not part of Part D.
22 MS. SUZUKI: Right, this is just for Part D

1 enrollees.

2 DR. REDBERG: And then do you have any data now or

3 later on median and range? I'm just interested.

4 These are average, I assume, but I'm assuming some

5 people have very low and some people might have very high

6 use.

7 Thank you.

8 MR. HACKBARTH: Any other round one questions?

9 [Pause.]

10 MR. HACKBARTH: I'm going to kick off round two

11 with sort of a rhetorical question. I don't expect an

12 answer to this, but -- during Shinobu's presentation about

13 the gap and interaction with the reinsurance, I couldn't

14 help but wonder how the approach to Part D compares to what

15 we do with Part A in terms of plans assuming risk. And

16 since yesterday we were talking about ACOs assuming risk,

17 that's still another model.

18 And it seems to me that there ought to be some

19 logical reason if we differ our approach to risk-bearing

20 across different elements of the program. There ought to be

21 some rationale for why we do it differently in Part D versus

22 MA versus ACOs.

1 And I don't think that people have looked at it
2 that way across the different elements of the program. So
3 that may be just a way to think about some of these issues.
4 My impression is Part D plans assume a lot less
5 risk than MA plans, and I recognize that there may have been
6 a reason for that initially -- that this was a new type of
7 insurance. As Tom Scully famously said, this is a type of
8 product that doesn't exist in nature.
9 But now we're pretty well into this. And, does it
10 make sense to have dramatically different approaches to
11 risk-bearing across the different parts of the program?
12 So that's a rhetorical question for maybe future
13 consideration.
14 Jack, do you want to take us from here?
15 DR. HOADLEY: Sure. And I really want to thank
16 Shinobu for a great analysis. There's all kinds of good
17 data points.
18 And I've talked to her separately about some
19 technical questions that I have and don't want to take the
20 Commission's time on those.
21 I would observe, sort of as a starting point,
22 that, as she pointed out, there's about $60 billion worth of

1 spending in Part D. And, if you think about the 4 sectors
2 we talked about this morning and the 2 we talked about
3 yesterday afternoon, they actually add up to about $60
4 billion. So what we're talking about today is a piece of
5 the program as big as the last six sectors that we talked
6 about.
7 Now it's a little apples and oranges because here
8 we're counting subsidies to low-income beneficiaries as well
9 as the direct coverage. So, I mean, you can quibble about
10 whether it's a direct comparison, but I just thought it's
11 helpful to think of it.
12 And because we don't have -- we don't work on the
13 prices, to Scott's question. You know, we don't have an
14 update thing. So we don't sort of automatically, routinely
15 sort of look at recommendations in the same way. So -- and
16 I do think there are some things that are worth talking
17 about
18 I think there -- I identified a half-dozen or so
19 different policy issues that come out of this presentation,
20 and a couple of them we've discussed in the fall
21 presentation -- the low-income penalty issues that Shinobu
22 mentioned, and the exceptions and appeals, the need for

1 greater transparency and data.

2 And I don't think it's worth sort of repeating
3 that discussion, at least for me, although I would note that
4 the new Part D rule that raises some potential changes to
5 the protected classes, I think, kind of ups the ante on the
6 exceptions and appeals. If that were to go through the
7 importance of exceptions and appeals could become even
8 greater, and so the need to understand that process only
9 increases.

10 The LIS sort of co-pay issue was addressed by the
11 Commission a couple years ago. I think that's still an
12 important issue, but I won't sort of say more about that
13 right now.

14 The three that I wanted to focus on -- and one of
15 them relates to the question Glenn just asked. But starting
16 with the tiered pharmacy networks, you know, this is really
17 an area that's jumped up quite considerably in the last
18 couple of years, and there are a number, I think, of
19 important issues.

20 There's a transparency issue. Do people who are
21 buying these plans really understand the differentials in
22 the network, the differential co-pays?

1 CMS has done some things to make the plan finder
2 operate better because they now really push you to put your
3 pharmacy into the plan finder and, therefore, get the prices
4 that are linked to your pharmacy. Otherwise, you tended to
5 get the preferred pharmacy price even if it turned out the
6 only preferred pharmacy was, you know, 15-20 miles from your
7 home.
8 And the question of how close the preferred
9 pharmacies are -- Shinobu showed numbers that said in some
10 plans it's as few of 10 percent of all network pharmacies
11 although in other plans it's considerably higher than that.
12 I'm trying to do some work to look at sort of distances to
13 these preferred pharmacies.
14 And there are some pretty big cost-share
15 differentials. So, even just for the general beneficiary,
16 access and standards -- I think there's an issue there.
17 And then, as Shinobu points out and it came up in
18 response to one of the questions, the extra cost that can be
19 triggered for the LIS beneficiaries that goes to the program
20 is a program cost.
21 Plus, CMS has identified that the prices being
22 used at the preferred pharmacies are not always less than

1 the prices being used at the nonpreferred pharmacies, the
2 other network pharmacies. And so, in those cases also, the
3 program loses money even though the beneficiary saves on a
4 co-pay.
5 So I think there are some important issues to
6 address there.
7 And this is also addressed with one particular
8 policy approach in the new Part D proposed rule. It's a
9 form of an any-willing-pharmacy rule that may or may not be
10 the best solution to that, but it's going to trigger this
11 issue to have some policy discussion in the near term.
12 The second one I would go to is the reinsurance
13 question, and I just want to reemphasize the numbers that
14 Shinobu pointed out.
15 I mean, 80 percent of the benefit in the
16 catastrophic phase is reinsured by the government. So
17 beneficiaries are on the line for 5 percent of the payment.
18 That means the plan is only on the line for 15 percent. So
19 that's a very extreme version of reinsurance and really does
20 seem to change the incentive.
21 So anytime you've got an expensive beneficiary or
22 a very expensive drug, the plan's incentive to try and

1 manage that drug is much reduced.

2 And, again, it's not completely obvious what the
3 right answer is, but I think it's an area that does very
4 much justify some discussion. It's also much less of a
5 reason for plans to try to negotiate prices or negotiate
6 those rebates for the expensive drugs.

7 And, while the biologicals, many of them, are
8 covered under Part B -- so it's not relevant to this part of
9 the program.

10 And so far, the expensive drugs don't seem to be a
11 big part driving the expensive enrollees, but they are
12 likely to become a bigger role in the future. And so, if
13 plans have minimal or less reduced incentive -- much reduced
14 incentive -- to negotiate hard on those drugs where they're
15 going to tend to be single-source and hard to negotiate
16 anyway, I think it's something where, you know, it's worth
17 some attention.

18 And related to that, sort of my third issue is the
19 risk-sharing corridors, which are very tied in.

20 But, in addition -- and it goes back to just the
21 logic that Glenn put out there -- in order to encourage
22 plans to get in, not only did we do risk adjustment, which

1 we always think is important, but we did this very extreme
2 version of reinsurance and we added risk-sharing corridors.
3 So substantial profits or substantial losses are mooted in
4 the program.
5 And so a plan -- again, it reduces significantly
6 the incentives to really manage the expensive cases, and I
7 think that's something that really does justify some further
8 look.
9 You know, I think the only other one I would add -
10 - and I don't want to take any more time -- is the issue of
11 the protected classes, which is going to be a point of
12 discussion in the policy community. It is already since
13 Part B announced changes -- proposed changes -- in the rules
14 of how the protected classes -- this is the six classes of
15 drugs where plans must include all drugs on their formulary
16 and can't exclude any drugs.
17 So it's basically the mental health drugs,
18 antidepressants, antipsychotics, the HIV drugs, the cancer
19 drugs, the immunosuppressives for transplant patients and
20 anticonvulsants. It's those six protected classes that have
21 existed to date, and if you're a plan, you have to list
22 every drug in those classes on formulary.

1 And Shinobu had some analysis in the chapter on
2 the fact that the price curves are very similar to the ones
3 that are up on this graph.
4 Whether those protected classes should be
5 continued -- CMS is proposing to eliminate some of them in
6 its proposed rule.
7 So, again, it may be an area where we want to
8 think about and address.
9 And I don't have a clear view on what's the right
10 answer there other than to link it back to the exceptions
11 and appeals because if we do change and take antidepressants
12 or antipsychotics off the protected class and, therefore,
13 off some plan formularies, there is going to be a lot more
14 people asking for exceptions to maintain drugs that they're
15 using or to pick particular drugs that are off formulary.
16 So those are the issues that I wanted to
17 highlight.
18 DR. BAICKER: There's a lot of interesting
19 material here, and I'll take the chance to focus on one of
20 my favorite topics -- the insurance value provided versus
21 the incentives that are created at a number of different
22 levels.

1 For beneficiaries, we clearly want to provide good
2 insurance protection against these potentially very
3 expensive medical opportunities.
4 And the goals of filling in part of the donut hole
5 or insulating, in particular, low-income beneficiaries from
6 excessive cost-sharing are laudable goals, but we clearly --
7 Shinobu has documented some instances where the incentives
8 to use high value products, the least costly alternative to
9 be able to get the health goals people are striving for, is
10 so undermined in the service of improving the insurance
11 value that we have some utilization that clearly seems low
12 value.
13 So opportunities to think through the unintended
14 consequences of some of the filling-in, especially for low-
15 income beneficiaries, while preserving adequate insurance
16 value, seems like an important area for us to consider.
17 On the insurer side, the reinsurance that Glenn
18 brought up also seems like a case where our efforts to
19 insulate others from risk have gone so far as to undermine
20 any incentive to manage value in an aggressive way or at
21 least in an appropriate way.
22 And, for insurers, I'm less concerned about their

1 exposure to risk than I am for low-income beneficiaries.
2 They should be able to take on a fair amount of risk given
3 that they're insuring pretty large pools of people and
4 individual variability is bound to get wiped out for the
5 most part.
6 So it seems as though the reinsurance is
7 excessively insulating and, therefore, undermining those
8 incentives.
9 So across those areas the common theme of
10 thinking, yes, we want to be sure the program is providing
11 good insurance value, but we want to do that in a way that
12 provides incentives to steer patients, pharmacies, insurers
13 towards the most valuable medicine seems a good opportunity
14 for us to explore.
15 MS. UCCELLO: So I think this was a great chapter,
16 and I'll focus on risk corridors and reinsurance.
17 So, just as a reminder, risk corridors protect
18 against pricing uncertainty.
19 So, when the program began, this was a new, you
20 know, standalone drug benefit that wasn't covered before,
21 and insurers didn't have a lot of data with which to
22 estimate premiums. That's no longer the case and argues for

1 removing the risk corridors.

2 But -- and I think this is a huge but -- the risk

3 corridors are resulting in plans actually paying the

4 government these days instead of the other way around. It's

5 protecting the government from these windfall profits of

6 insurers versus protecting the insurers against pricing too

7 low. So, if we remove it, we need to think of something

8 that could act similarly to limit these windfall profits.

9 Now the new MLR requirements for Part D plans -- I

10 think we need to look into what the parameters of that

11 requirement would be to see if that could act similarly --

12 have a similar result as the risk corridors are. So, before

13 we would want to take away these corridors, since they are

14 actually resulting in payments to the government instead of

15 from the government, we need to look into that.

16 In terms of reinsurance, I'm thinking that it may

17 be worth considering using some type of reference pricing to

18 act as how we pay the insurance plans.

19 So, you know, one idea would be if a generic is

20 available and appropriate for someone, to use that as the

21 price when making the payment as opposed to the brand price,

22 or some other type of price that then could be used to put

1 more pressure on the plan to manage their costs better and
2 maybe negotiate their prices more.
3 MR. BUTLER: So, following Jack and Kate and Cori,
4 I almost want to be an economist and actuary and all in one.
5 This is ripe territory for this kind of thing, and
6 so my question actually is along the line of so much of what
7 we're talking about is once you've picked a plan, the
8 behaviors in the plan.
9 I'm always struck still by the health exchange-
10 like apparatus that you have to go through to make your
11 selection the first time, which is not insignificant. It
12 doesn't get the same attention as the health exchange
13 because the benefit is so good; people found a way to do it.
14 But then I get the sense the likelihood of
15 changing in year two or year three is not great unless
16 something is flashing that is so obvious a reason to change.
17 So, my question. Really, there's not too much in
18 the chapter around the impact of different premium prices
19 and benefits and how frequently and reasons for people
20 switching from one Part D plan to another.
21 So, if you could just comment a little on what the
22 experience is -- I know the turnover among plans is not

1 great, but tell me some more.

2 MS. SUZUKI: So we've looked at the switcher issue
3 last time around, and we found that about 13 to 14 percent
4 of the people switch plans. And this wasn't due to a plan
5 exiting the market or other reasons. So this seemed like a
6 voluntary switching.

7 When I looked at the average spending before and
8 after, it seemed like switchers, after switching, seemed to
9 be, on average, using more drugs. So maybe that was one of
10 the factors they considered -- better coverage of the
11 medications they need.

12 And I think, Jack, you had looked at premiums a
13 little.

14 DR. HOADLEY: In our switching analysis, we looked
15 at the impact of premiums. If somebody's premium was
16 scheduled to go up next year, yes, they are more likely to
17 switch than somebody whose premium is stable or scheduled to
18 go down next year. But many people, even facing a pretty
19 substantial premium increase, still did not switch.

20 So it was maybe from 13 percent jumps up to 25
21 percent of the people facing, say, a $10 a month premium or,
22 you know, on a base that might be typically $30 a month. So

1 they might be facing a one-third increase in their premium,
2 or it may double the rate of switching, but still the
3 majority don't make a switch in that circumstance.
4 Again, maybe some of that is logical. They like
5 their plan. They like other aspects of it.
6 We also think they're more sensitive to switching
7 based on premium than really total cost because premium is
8 the most visible part even though they can look at total
9 cost.
10 It's harder to do that. It's a more complicated
11 analysis, but to the extent that we could look at that, we
12 think they're more sensitive to the premium than to the
13 overall cost -- the out-of-pocket cost for them.
14 DR. CHERNEW: Can I add one thing just briefly?
15 There's a growing body of literature that suggests
16 that the beneficiary choices aren't optimal for the
17 beneficiary in a whole variety of ways.
18 I'll just leave it at that for now.
19 MR. HACKBARTH: I read somewhere, Mike, that there
20 are at least some pieces that say that it looks like the
21 choices have gotten more optimal over time. Is that true?
22 DR. HOADLEY: There was one study that drew that

1 conclusion, but I actually think that study is significantly
2 flawed.
3 There's another analysis that Jon Gruber with
4 Abaluck did that actually shows the opposite. It showed
5 that people making later decisions are not necessarily
6 improving the optimal nature of the selection.
7 DR. CHERNEW: I think that point remains
8 controversial.
9 DR. HOADLEY: Yeah.
10 DR. CHERNEW: But the first point, I think even in
11 the ones who worry about whether it's getting better or
12 worse would still argue it's still not very good for a
13 variety of reasons.
14 DR. MARK MILLER: Can I just check on one thing?
15 I hate to do things by memory.
16 But when we did this, when we did the switching
17 thing, we found that the beneficiary was getting more drugs
18 and that it kind of was a good -- you could understand why
19 they were switching, but it wasn't necessarily working out
20 that the program was benefitting from the switch.
21 MS. SUZUKI: Right. So it seemed like they were -
22 - so their out-of-pocket spending generally went down after

1 the switch even though the total spending had gone up on
2 average.
3 DR. MARK MILLER: The anomaly is -- and I
4 definitely want you in on this because I'm sure you have --
5 but, you know, you kind of think of switching as driving
6 people into less expensive plans over time, and at least
7 some noise in the data suggested they may have come out with
8 a better deal -- the beneficiary. And that's a good thing,
9 but it didn't necessary translate over.
10 DR. BAICKER: And my reading of the literature,
11 which is less in depth than yours, I'm sure, is that the
12 switchers make sense. They're switching to get a better
13 deal for themselves, as well as they should.
14 It's the nonswitchers that are a mystery, where
15 you can calculate the amount of money left on the table by
16 people who have available to them plans that would cover
17 their basket of drugs at substantially lower costs and don't
18 switch. That's the mystery.
19 DR. MARK MILLER: And that would explain --
20 [inaudible comment.]
21 DR. CHERNEW: And that's a nontrivial number of
22 people.

1 DR. BAICKER: And a nontrivial amount of money.
2 It doesn't -- there is something interfering with the choice
3 process, one suspects.
4 MR. BUTLER: Part of the reason for asking the
5 question is when we looked at our -- what do we call them?
6 Premium support? Competitive premium?
7 MR. HACKBARTH: Price contributions.
8 MR. BUTLER: Yeah. We looked for lessons learned,
9 and as we did, when we looked at that. You know, what are
10 the lessons learned here in terms of choices at the front
11 and that may apply to other sectors in Medicare as we evolve
12 from a fee-for-service system.
13 DR. SOKOLOVSKY: Can I just add one thing?
14 We, MedPAC, actually did a lot of work on this, a
15 lot of it with Jack, at the beginning talking about how
16 people chose their plans, and the one thing we heard --
17 well, then it was certainly a focus on premiums, but the
18 other thing we heard consistently was how hard it was and
19 how many hours they spent.
20 And the thing that we hear year after year in our
21 focus groups, when we go over this, when we ask about
22 changing, is the majority say it was so hard to begin with;

1 we don't want to look at it anymore.

2 MR. BUTLER: That was my point.

3 DR. SOKOLOVSKY: Yeah.

4 MR. ARMSTRONG: So, first of all, I feel that Part
5 D is part of the overall program that I'm much less familiar
6 with than a lot of other parts, and so in some ways my
7 questions are borne out of just not knowing things I
8 probably should do.

9 But I do -- I'm really impressed by the analysis
10 and agree on the final slide, when you describe ongoing
11 future work, that this looks like an agenda that is a great
12 focus for us and that, I think, is really an important topic
13 and one I'm eager to spend more time really learning much
14 more about.

15 Glenn, your comment about, you know, we talk about
16 the different parts of the Medicare program and we
17 distribute risk and we try to control costs in a variety of
18 ways so that we really ought to be thinking about how is
19 Part D set up in ways different or analogous to whether it's
20 the MA plans or it's ACOs or bundled payments and, you know,
21 various themes there. And I think that's also really worth
22 exploring.

1 In particular, just as I think about this, in MA,
2 we leverage the purchasing power through fee-for-service to
3 get lower MA rates because MA plans use those fee-for-
4 service rates as a point of reference. And it just strikes
5 me that that's a real difference in Part D, where we're just
6 completely dependent upon the Part D plans to negotiate the
7 best rates possible. There's never any opportunity to
8 leverage the full Medicare program for lower-per-unit
9 prices, I think.
10 So, if that's the case, then I would be interested
11 in learning more about that if it's not already covered in
12 one of the bullets for the work plan going forward.
13 DR. SOKOLOVSKY: And you remember that that is in
14 statute, that the Secretary not get involved in negotiating
15 prices for drugs. So it actually would require a big change
16 in the Medicare law.
17 MR. ARMSTRONG: Well, no, that was not clear to
18 me. I guess that would make that a short analysis.
19 [Laughter.]
20 MR. ARMSTRONG: I'd be interested to learn more
21 about what we can do and/or not do.
22 Thanks.

1 MR. HACKBARTH: So, as was pointed out, this was a
2 part of the fundamental design of Part D -- it not have
3 government-determined prices but, rather, market-determined
4 prices.
5 But this also interacts with some of these other
6 issues that we've been talking about -- reinsurance and risk
7 corridors and all that.
8 If you're going to rely on competitively
9 determined prices, but then take away a lot of the risk,
10 that's not a combination that necessarily works together.
11 So, if we want a competitive program, we need to look at
12 some other features in that same light to support that goal.
13 MR. ARMSTRONG: I also just was thinking; how do
14 we know if we're getting a good deal for the Medicare
15 program?
16 We know for MA how much we spend relative to what
17 our prices for fee-for-service are. But, in Part D, how do
18 we know?
19 You know, someone mentioned maybe we should
20 compare more to some of the other private plans, or there
21 are other points of reference. It doesn't have to be, you
22 know, the government setting rates.

1 But I think that's a legitimate question for us to
2 be exploring, and hopefully, there are ways within the
3 statute that we could explore that.
4 DR. REDBERG: I think people also compare to the
5 VA formularies for prices.
6 DR. HOADLEY: But the absence of full transparency
7 on the rebate side of the prices, whether it's in Medicare
8 or in the private sector, further prevents us from doing
9 that.
10 And, while CBO or the actuary can look sort of in
11 the aggregate at the magnitude of rebates, even they are
12 pretty constrained in what they can do on sort of a drug-by-
13 drug basis.
14 DR. SAMITT: Although it's not just a pricing
15 issue we want to look at. We want to essentially look at
16 total drug cost per beneficiary versus a similar market
17 basket on the commercial side, and when we look at that
18 comparatively, how much is Medicare spending for drugs per
19 beneficiary versus how the commercial population is doing
20 that.
21 DR. CHERNEW: I'll waive my turn [off microphone].
22 DR. CHRISTIANSON: Okay. Four quick, I hope,

1 suggestions or observations. I think getting the risk-
2 sharing rate, as you folks are talking about, is very
3 important. I'm more convinced of that after hearing Cori's
4 comment. It's just complicated. There's a lot of moving
5 parts here, and we need to spend some time talking about and
6 focusing on that with some help from the Commission staff in
7 terms of framing different alternatives.
8 I'd like to suggest that the language starting on
9 page 43, there be something in there that really clarifies
10 that the prices in those drafts are, I think if I understood
11 what you said, prices faced by beneficiaries, they're not
12 net prices paid by -- net prices that are received by drug
13 manufacturers and suppliers for their product.
14 And then another general comment on the chapter is
15 I think it starts out talking about, you know, the general
16 status of Part D, including stand-alone plans and Medicare
17 Advantage plans. And I think as you go forward there, there
18 were places where I wasn't clear that the data were just
19 applying to stand-alone Part D plans, if I understood some
20 of your comments right. And so just being very clear about
21 when you switch over from this general discussion of Part D
22 coverage to here's some data but the data only apply to

1 stand-alone plans.

2 And then finally the other Part D issues there,
3 the second bullet point, abusive prescribing. The other
4 stuff there seems to have been supported by discussion in
5 the chapter. I didn't see any discussion in the chapter on
6 that. Maybe I missed that. There's a page at the end that
7 talks about quality measures. It doesn't really deal with
8 abusive prescribing. So how do we define abusive
9 prescribing? How would we know it when we saw it? Why is
10 it a Part D issue? I didn't see the support in the chapter
11 for that as another Part D issue. I'm not saying it isn't.

12 DR. MARK MILLER: I'll take responsibility for
13 this.

14 DR. CHRISTIANSON: Good, good. That's good.

15 DR. MARK MILLER: Just to defend myself for a
16 moment --

17 [Laughter.]

18 DR. MARK MILLER: I wanted this chapter to bring
19 you guys up to speed on the whole landscape out there, and
20 there's been some recent work, ProPublica, that said they
21 took the claims data and they looked at these providers, and
22 I just wanted to make sure that everybody was aware of that

1 in case it triggered any interest.

2 There isn't a lot in the chapter. It was a late

3 arrival based on my suggestion.

4 DR. CHRISTIANSON: In the next version of the

5 chapter --

6 DR. REDBERG: In your defense, Mark, on page 10 in

7 Tab A, it's the ProPublica story on some of the abusive

8 prescribing, which was remarkable. I mean, a physician

9 claimed that someone had gotten hold of his physician

10 license and written -- $3.8 million had paid for -- Medicare

11 had paid in one year for this one physician's drugs, which

12 he claimed was all fraudulent. So I think that was --

13 DR. CHRISTIANSON: Yeah, I just didn't think that

14 we should have this as another Part D issue at the same

15 level as these two things without any discussion of it in

16 the chapter. It just kind of got dropped in there.

17 DR. MARK MILLER: You're right. It was dropped

18 in. That was my doing. Shinobu told me not to do it.

19 [Laughter.]

20 DR. MARK MILLER: Just for the record, Shinobu was

21 right. Okay?

22 MR. GRADISON: I want to thank all of you for

1 working so hard to try to foster my understanding of a field
2 that I really don't know that much about. I am intrigued by
3 the very broad issue of whether we could -- what we can
4 learn, if anything, about how market pricing in this area
5 could more broadly be applied to other parts of our
6 responsibility, and vice versa.
7 The only thing that I've seen that might be a
8 little additional way to figure out what we're buying --
9 whether we're getting value for money is to look at the
10 organizations which buy pharmaceutical products and then
11 provide them to nursing homes and various assisted living
12 facilities. There's some very big for-profit companies in
13 this field. It's not exactly comparable because most of
14 them provide additional services. Specifically they often
15 provide the service of taking a look at each new nursing
16 home patient to review what prescriptions they're on, which,
17 by the way, on average means reducing the number by two when
18 the people come into the nursing homes. But it's just a
19 suggestion. There may be something there that would -- I
20 can't be specific about what it might be -- that might give
21 us -- these are other large purchasers who do provide -- who
22 negotiate prices with nursing homes, often with very big

1 chains, for the drugs and certain services in addition to
2 just providing the drugs.
3 Thank you.
4 DR. NERENZ: Could you put up Slide 11, please?
5 In many chapters there are things that pop up that are
6 clearly problems, and then our task is to try to figure out
7 if there's some sort of a set of recommendations. My core
8 question here is: Is this a problem? So let me just
9 elaborate a little bit. I think, first of all, it's
10 interesting, but the question is: Is it a problem?
11 If I'm tracking this correctly -- and there's text
12 on this on page 36 of the chapter as well -- in the
13 Affordable Care Act there's some language that changed the
14 rules of the game here, and as a result of that, some fairly
15 striking things happened in the 2011 to 2012 period that had
16 not been happening before. And the key thing on this slide
17 is that percent of people who moved into this catastrophic
18 phase. The numbers here are about percent rather than -- or
19 the additional percent or the changes, how many more got in,
20 rather than absolute numbers. So one question is just what
21 are the absolute numbers.
22 But the second sub-bullet there seemed to me, as I

1 read it, the key thing, that the manufacturer discounts are
2 now counted against this out-of-pocket requirement, which
3 strikes me as an interesting thing. It's different. I'm
4 not sure I heard of this before, but, okay, I think I
5 understand it. As a result then, what I think I can imagine
6 happening is that as a year goes by and as spending occurs,
7 the beneficiary who's moving through this up to the
8 catastrophic phase spends less time in this doughnut hole or
9 gap phase and also incurs less truly out-of-pocket expense
10 and then hits the catastrophic threshold faster. Okay. So
11 probably a little better for the beneficiary, all else
12 equal.
13 What I can't quite understand then is between the
14 manufacturer and the Medicare program who wins and loses
15 when this happens, because the manufacturer presumably has
16 contributed in some way this discount, but then the person
17 runs through to the point where now the government, per
18 Jack, is picking up 80 percent of the cost and maybe the
19 manufacturer thinks net out all this is -- actually they
20 come out ahead.
21 And sort of on the other side of the coin, the
22 Medicare program is picking up 80 percent of the expense

1 more quickly than would otherwise have happened or more
2 often.
3 So, finally, is this a problem? Should we worry
4 about this? Or is this good? Is this all okay?
5 MS. SUZUKI: So I'll answer the easy one first.
6 We have been tracking a number of people who reached the
7 catastrophic, and for non-LIS enrollees it has been about
8 400,000 for the last few years. In 2011, when the
9 manufacturer discount began, it was 500,000, so it was a
10 pretty big jump that we hadn't seen before. And I can
11 probably figure out how much the manufacturer discount
12 accounted for from the claims data. But it's hard to figure
13 out how much of the reinsurance spending was because of the
14 manufacturer discount.
15 MR. HACKBARTH: I may be confused here, but one of
16 the things that struck me about this was it seems
17 inconsistent with the true out-of-pocket concept. Elsewhere
18 what we're saying is it's -- to get to the catastrophic cap,
19 it has to be true payments out-of-pocket. If it's covered
20 by some other insurer, et cetera, it won't count. But here
21 we're saying, well, this particular type of protection from
22 another party is okay. Is there some inconsistency?

1 MS. SUZUKI: That was an explicit law.

2 MR. HACKBARTH: Right. I understand that. But it
3 seems inconsistent with the original philosophy of Part D.

4 DR. NERENZ: I'm sorry. I guess -- is it a
5 problem or not a problem?

6 DR. MARK MILLER: The way I would answer that --
7 and some of this comes back to what Cori and the people over
8 there said.

9 [Laughter.]

10 DR. MARK MILLER: I always look for an opportunity
11 to hassle those guys.

12 But I would link this thought back to the risk
13 discussion, okay? That what's happening in that gap may be
14 beneficial to the beneficiary, and I think everybody wants
15 to help the beneficiary. I think there are some questions
16 about how much it drives people into the catastrophic cap
17 and whether on balance, if we step back and listen to all of
18 these comments that people are making about what is the risk
19 structure here, I would link the thought back to that. And
20 problem or not a problem, the point is I think we should be
21 -- I'm hearing the Commission wants to step back and revisit
22 the risk structure of Part D, and this is decidedly feeding

1 into that. That's what I would say. So I'm not litigating
2 problem/not a problem, but I'm kind of blowing it up to a
3 bigger question that I think you're all tracking on.
4 DR. CHERNEW: I would say it's a problem to the
5 extent to which you believe that more generous coverage
6 encourages more use, and that's true in a whole range of
7 things across the program, that there's a good side of it,
8 more generous coverage in a variety of ways, and a bad side
9 of it, it encourages more use and effectively then more
10 government spending.
11 DR. NAYLOR: So I also echo everyone's comments
12 about how beautiful this work is, building on the work that
13 you provided in the past. And I would love to build on this
14 notion of the problem. And as I understand the problem, it
15 is we are seeing rising Medicare costs. We're wanting to
16 make sure that the reason the program particularly focused
17 on low-income groups is to make sure that they had
18 appropriate, adequate access to prescription services.
19 We're watching that their use of the services seems to be --
20 that they are using the services, in fact, their drug use
21 per month is higher than non-income, and they're using more
22 brand relative to the lower income. So we're trying to say

1 how do we get that, and all of the wonderful comments from
2 colleagues before about risk sharing and the whole notion of
3 insurance and the network preferred pharmacies and so on I
4 think is really important.
5 I do want to get back to George's comment at the
6 beginning because we also have tackled this in earlier work
7 to say isn't a huge part of this going to be about getting
8 clinicians to change behaviors for a group of people that
9 often are on way too many incorrect, inaccurate medications
10 and getting beneficiaries to be better positioned. So I'm
11 wondering as we go forward if we can continue the terrific
12 work that you've done about literacy, engagement, shared
13 accountability, and clinician behavior. I see this as
14 central in solving this problem -- not that these other
15 components are not important, but I think that they're part
16 of a whole package which says we rely way too much on
17 medications, and an elderly population doesn't do well under
18 the burden of all of the prescription drugs that they are
19 now on.
20 MR. GEORGE MILLER: All right. So I can ask this
21 question now. I just want to bring that up as an issue.
22 You talked about really trying to drive appropriate behavior

1 and appropriate use, and we say education would help with
2 the correct selection of the appropriate drug based on
3 price, dealing with the generic versus the brand name, how
4 do we make that happen, particularly with the large amount
5 of marketing dollars spent on driving folks to certain
6 drugs. And Mary just raised an appropriate question, that
7 is, is it appropriate the type of drugs, the amount of
8 drugs, and the use? Rita talks about this all the time.
9 She finds patients being overmedicated and shouldn't be on
10 some of the drugs.
11 The other issue that Scott mentioned I wanted to
12 bring up as a point, and I think it was so eloquently
13 detailed on both days by the Chairman dealing with the
14 sequester versus law and what we think is appropriate. So
15 to Scott's point, is it appropriate today that the Secretary
16 does not have the right to negotiate prices? It made sense,
17 as Cori said, in the beginning of the program, but now that
18 we have data and information, should we recommend that the
19 Secretary have that power to look at the best value for the
20 dollars that we're investing in the program? And if that is
21 true, then we as a Commission should say that they give --
22 repeal the law and give the Secretary that power if we can

1 get better value by evaluating the value for the dollar,
2 looking at what the other programs are doing as it relates
3 to pricing for drugs and use that as the methodology to
4 determine if that's appropriate.
5 MR. HACKBARTH: On this issue, which has now come
6 up a couple times, of the Secretary negotiating, I have a
7 vague recollection that at one point CBO was asked to do an
8 estimate of how much money it would save if the Secretary
9 were empowered to negotiate, and they came up with a
10 surprisingly small number. Was it actually zero? And as I
11 recall, CBO's logic was that the power to negotiate without
12 also having the power to set the formulary is of little
13 value. You have to be able to say we're going to steer
14 patients to particular drugs in order to have real
15 negotiating leverage. Am I remembering that correctly?
16 DR. HOADLEY: [off microphone] Yeah, in their
17 statement.
18 MR. HACKBARTH: And so it isn't just negotiation.
19 It is also the establishment of a formulary that would have
20 to go with it.
21 DR. HOADLEY: Or some similar kind of leverage
22 point.

1 MR. ARMSTRONG: But, Glenn, isn't that analogous
2 to setting hospital payment rates without the ability to
3 manage care?
4 DR. HOADLEY: It's partly the difference between
5 Medicare paying hospitals directly, which it can just vary -
6 - I mean, the underlying questions are certainly relevant,
7 but in the context of Part D where the payments are made
8 from private plans to -- between private plans and
9 manufacturers, I think that's the context in which CBO's
10 statements were made. How do you give the Secretary
11 authority in the context of a privately delivered benefit?
12 DR. BAICKER: But --
13 MR. HACKBARTH: And to go back to my Part D/MA
14 comparison, so in MA the Secretary isn't setting the
15 hospital prices that Scott pays. That's a privately
16 determined transaction, as well as the networks, et cetera.
17 And so, again, you know, I think there needs to be some
18 consistency and logic.
19 DR. BAICKER: Yeah, I wanted to echo that idea
20 that if the goal is to use market competition to drive down
21 prices, if you had central pricing by the Medicare program
22 and they weren't able to say this drug is on the formulary

1 and this drug isn't, there's no mechanism to get the prices
2 right and to negotiate. There's no negotiating stance. And
3 the analogy to MA I think is pretty strong in that the goal
4 of MA is to try to get higher-value bundles of care by doing
5 more aggressive management, more discriminating contracting,
6 all of the mechanisms that MA has that the fee-for-service
7 program does not. The analogy then to Part D is let them
8 negotiate what things are on formulary, what things aren't,
9 what things are in which tier, and try to, therefore, get a
10 higher-value package. And that to me seems like -- if we're
11 in favor of moving towards more sophisticated management
12 tools through ACOs or MA, the analogy is moving less towards
13 government centralized pricing and more towards the
14 flexibility to design higher-value packages that doesn't
15 really work with our fee schedule.
16 But then that augments the importance of what
17 Glenn was saying about, okay, so if we're going to rely on
18 these plans to do a more sophisticated package, putting them
19 together and let people choose among them and find the
20 highest-value ones, then they have to be real competitive
21 actors. We can't say, "But we'll take away all the risk,
22 don't you worry about that." Those two have to go hand in

1 hand if this has a hope of moving in that direction.

2 DR. CHERNEW: So let me just say one other thing,
3 if I can. The first thing is, as interesting and important
4 as this discussion is, I think there's a lot of nuances to
5 it, and my fear is that if we got too distracted by it, we
6 will miss opportunities to actually really make the program
7 broadly better.

8 MR. HACKBARTH: What is the "it"? If we get
9 distracted --

10 DR. CHERNEW: If we get distracted by worrying
11 about whether the Secretary should set prices, we'll get --
12 which I don't think has much of a -- I'm actually not so
13 convinced for a variety of reasons it's a good idea, just to
14 be clear. I do think we could have an interesting debate
15 about whether it's a good idea, but a lot of it hinges on
16 how well you think the Secretary would actually do that.
17 And so I think there's a lot of areas in Medicare where the
18 Secretary or the government has the power to do a lot of
19 things, and they actually do it really badly, despite the
20 things that we might say, and I guess that is on the record
21 now, so I did actually just say that.

22 [Laughter.]

1 DR. CHERNEW: But in any case, I do think there's
2 a lot of examples where the government has the opportunity
3 to set prices in areas, and the prices don't end up being
4 the prices you would want for a variety of reasons. And I
5 think often the proponents of negotiation assume it's going
6 to work really well, and I think for a variety of reasons it
7 might not.
8 But regardless of where you come out, because I
9 think there's legitimate arguments on both sides, I think
10 that in terms of the productivity of recommendations we can
11 make, there's a lot more fruitful ways that we can make a
12 positive difference than trying to take on something that
13 was really central, frankly, to the fundamental design of
14 where Part D was. And so it strikes me that that goes to
15 the heart of relitigating the philosophy behind Part D as
16 opposed to an approach to how to make it better. And I
17 guess I'm in the latter camp of let's try and make the basic
18 thing work within the philosophy that won the day, whether
19 that was good or bad, as opposed to relitigate where Part D
20 was. But that's just my opinion.
21 MR. GEORGE MILLER: While I appreciate the
22 analogy, if I go buy a widget and Walmart goes and buys a

1 widget, there's no difference between pricing?

2 DR. CHERNEW: I'm not sure I--

3 DR. MARK MILLER: Who were the two actors in that?

4 MR. GEORGE MILLER: Me and Walmart.

5 DR. CHERNEW: Company X.

6 MR. GEORGE MILLER: Okay, excuse me. Company X.

7 DR. BAICKER: Yes, but suppose you --

8 MR. HACKBARTH: I'm not sure -- go ahead, Kate.

9 You're the economist.

10 DR. BAICKER: The analogy isn't I individually try

11 to go buy something versus a giant purchaser tries to go buy

12 something. The analogy is, you know, the giant purchaser

13 can negotiate among different providers, but I have to go to

14 all providers and say, okay, I'll take anybody -- I have no

15 -- whatever kind of widget you want, whatever size you think

16 is appropriate. It's not an analogy of individual

17 purchasing power in the same operating space as giant

18 purchasing power. It's, you know, medium purchasing power

19 with the ability to pick and choose versus even bigger

20 purchasing power with one hand tied behind its back. That

21 wasn't a very helpful analogy either. I take [off

22 microphone].

1 DR. CHERNEW: George, I guess I would just say it
2 is certainly possible that with more pricing power in the
3 government they could, should they choose, given all the
4 politics and everything, they could, I believe, probably get
5 lower prices. There's a whole range of issues related to
6 that, some of which relate to innovation and a bunch of
7 things that, you know, we don't want to go through; some of
8 it relates to the politics of how we're going to get there.
9 My only point is I would love to have that
10 discussion with you. I just think if that discussion
11 replaces the discussion about how to redesign the
12 reinsurance program or what to do about some of the other
13 issues, we'll miss out on solving what those other problems
14 are, because I don't think at the end of the day we're going
15 to be able to solve the merits of free market economies
16 working versus political economy.
17 MR. GEORGE MILLER: Great. Then why was it put in
18 statute that the Secretary couldn't do it? That's just my
19 question.
20 DR. CHERNEW: Yes, exactly --
21 MR. GEORGE MILLER: Political, okay.
22 MR. HACKBARTH: To favor a competitive approach

1 over a government-administered price approach.

2 DR. CHERNEW: This debate was had. For better or
3 worse, it was had. And it come out a particular way, for
4 better or worse.

5 MR. ARMSTRONG: Can I make just one more brief
6 point on this? I don't want to debate the statute and all
7 that, but to Kate's point, I do think it's constructive for
8 us to really try to compare how does MA work versus fee-for-
9 service versus Part D. And the way you were making that
10 comparison, I would argue with you, and add that, in fact,
11 the fact that there is a Medicare fee schedule does give MA
12 plans real leverage. I mean, it really does, I think, makes
13 -- I think makes that different than MA -- or Part D plans.

14 Anyway, I would just really want to make sure we
15 explore those things, not because I want to change the
16 statute necessarily. I just think we need to understand
17 that.

18 DR. SAMITT: So I'm not going to join in and
19 become embroiled in the discussion of price, because I want
20 to go back to the discussions we had yesterday about the
21 fact that some of the key drivers of excessive cost really
22 have little to do with price and have more to do with

1 efficient utilization. And, frankly, I think that's where
2 the opportunity lies in the drug space as well.
3 So I would jump on to the notion of evaluating the
4 risk structure of Part D. In fact, I'd go further to say
5 it's not just the risk structure. I think we need to
6 evaluate the overall incentive structure of Part D. I
7 really like a lot of the ideas about re-evaluating
8 reinsurance because it's an escape valve right now to really
9 not effectively manage efficiently prescribing. Transfer
10 pricing was another really good idea. The thing we really
11 haven't talked about is what's being done to align
12 incentives with the providers, and I don't recall, for
13 example, whether of the 33 ACO quality measures, generic
14 prescribing is a measure that really looks at provider
15 effectiveness in prescribing and encouraging efficient
16 prescribing, whether it's generic or other potential
17 alternatives.
18 I think we didn't talk a lot about the concerns
19 specifically in the LIS population, and that the inability
20 to affect the cost sharing is really neutralizing the effect
21 of the tiers as well as neutralizing the effect of the
22 preferred versus non-preferred, if I really understand it.

1 And what do we do about that? I know it's wired into law,
2 but are there other things that can be done? For example,
3 can we require forced generic substitution when that
4 opportunity exists? Or is there something different about
5 the LIS population that the pricing differential for non-
6 preferred pharmacies does not apply for the LIS population?
7 Or other more creative thinking about how to de-neutralize
8 the incentives at the user level.
9 So I like this. The chapter was exceptional and
10 very clear, but I think there's a lot of future work to do
11 that we can make more progress here.
12 MR. HACKBARTH: In Medicare Advantage, MAPDs, we
13 have a single entity that has responsibility for Part A and
14 B and D costs. In the freestanding Part D plans, we've got
15 two different insurance pockets. The Part D plan has
16 responsibility only for drug costs, and then Medicare is
17 bearing the risk on Parts A and B. It seems to me that they
18 create very different incentives. So if you're running a
19 Part D-only plan, your objective is to hold down Part D
20 costs. If you're running an MAPD, your objective is to hold
21 down total cost. And it could lead, at least in the
22 abstract, it could lead to differences in prescribing

1 behavior and how you think about managing drug costs.

2 Can we look at the differences in patterns between

3 MAPDs and freestanding Part D plans? Have we done that?

4 And do we see differences? I think I've asked this question

5 before, and the answer was there really isn't that much

6 difference. But --

7 MS. SUZUKI: Typically we're seeing lower spending

8 on average among MAPD enrollees compared to PDP enrollees,

9 but some of that is driven by the fact that most of the LIS

10 enrollees are in PDPs, and they're the higher -- they tend

11 to have higher costs. So it's hard to disaggregate how much

12 of it is maybe health status-related difference versus maybe

13 there's something about MAPDs that manage the drug spending

14 better.

15 MR. HACKBARTH: Yeah, actually I would have

16 thought maybe it would go the other way, that the MAPDs

17 would spend more on drugs and make sure people -- all the

18 people who need their meds get them and really follow up

19 because they have an interest in controlling total costs;

20 and the freestanding plans would say, "I'm really only

21 interested in the drug cost, and if people don't use their

22 prescriptions, hey, that's not too bad."

1 MS. SUZUKI: And part of it is that generic use is
2 very different between MAPD and PDP, so when you talk about
3 spending, some of the difference is also driven by the fact
4 that generic use is higher among MAPD enrollees.
5 DR. SAMITT: I mean, I would encourage a similar
6 analysis. I think your exact hypothesis plays out at Health
7 Care Partners when we look at specific disease states and we
8 influence before to after when we manage populations. In
9 certain instances, drug costs are the only cost category
10 that rises, and perhaps primary care services. But, in all
11 the other areas, costs fall, and so you would imagine that
12 that would be the right trade-off and why looking at
13 aligning the incentives between A and B and D makes
14 significant sense.
15 DR. HOADLEY: And to that ACO point you raise, I
16 mean, the request for information that's out on the table
17 now does ask, is there a way to bring the Part D plan, the
18 stand-alone PDPs, into some kind of relationship with an
19 ACO. I mean, it's complicated and that's why they're asking
20 for ideas about it.
21 MR. KUHN: There's been a lot of good issues
22 raised, and the ones I wanted to focus on were in the

1 proposed 2016 rule that just came out here a week or so ago.
2 And one, a question, and a second, an observation.
3 The question, in the area of negotiated rates. I
4 understand as I read summaries and information I have found
5 that they are going to revise the definition of negotiated
6 rates, and so I'm just curious, is that revision significant
7 enough that it's going to be hard to do future analysis in
8 terms of savings as we go forward? You know, is it going to
9 be where we are going to continue to be able to have an
10 apples-to-apples comparison, or is it going to be apples-to-
11 oranges comparison?
12 MS. SUZUKI: So, just to be sure, you're talking
13 about when plans use non-preferred pharmacies, that whatever
14 rebates they're getting, or --
15 MR. KUHN: Correct.
16 MS. SUZUKI: -- from the preferred pharmacies,
17 that's reflected in the claims rather than on the back end,
18 maybe through lower premiums or something.
19 MR. KUHN: Yes. That was the revision I was
20 curious about, and is that going to impact any kind of
21 future analysis? Is that a --
22 MS. SUZUKI: So that piece, we didn't talk about

1 in detail. We knew that CMS had found that maybe about a
2 third of the plans that they looked at that had tiered
3 network pharmacies had higher per prescription costs at
4 preferred pharmacies, even though they are offering lower
5 cost sharing in those pharmacies. But we were actually
6 focused on low-income subsidy --
7 MR. KUHN: Okay.
8 MS. SUZUKI: -- portion of the cost.
9 MR. KUHN: Okay. Thank you.
10 And the second issue is on the category of
11 preferred pharmacies. And, like Jack, I'm interested in the
12 "any willing pharmacy" provision that's there. And then,
13 also, in kind of the redefinition there, in the reduction of
14 copayments and coinsurance for the preferred pharmacies, and
15 was wondering as we go forward how that might be impactful,
16 particularly in rural areas. Would that mean we would have
17 fewer or the same or more preferred pharmacies in rural
18 areas, and I was just worried about an access issue and the
19 concern that the folks in rural areas always have is that
20 you don't want to create medical deserts in certain parts of
21 the country or certain communities and just wanted to make
22 sure that we follow that one along to avoid those kind of

1 issues.

2 DR. REDBERG: Thanks. I think a lot of my fellow
3 Commissioners have made really important comments, which I
4 concur, so I was going to concentrate on the clinical part
5 of it and really build a little bit on what Mary said. You
6 know, clearly, a lot of drugs are very helpful and are
7 treating chronic conditions that to our beneficiaries'
8 benefit. But I have to say, also, that every week, I see a
9 lot of Medicare beneficiaries in my practice that are on way
10 too many drugs. That's why, when we can see the averages
11 have certainly gone up and gone up higher for LIS versus
12 non-LIS, but routinely, you know, once people -- anyone is
13 on more than three to five drugs, you start to get a lot of
14 interaction.

15 And I have started routinely, and actually,
16 patients often ask me, "Can't I get off some drugs?" And
17 you look at the list of even healthy Medicare beneficiaries
18 and they're often on anti-depressants, PPIs, statins,
19 biphosphonates, chronic pain meds, and that's another thing
20 we haven't really talked about, but there is a lot of over-
21 prescription or overuse of narcotic pain medication for
22 chronic long-term low back pain, other things. People get

1 started and then somehow it just doesn't get stopped and
2 that's a very large problem because of the risks of those
3 medications.
4 But, as I said, certainly, some of these medicines
5 are beneficial, but some of them, people feel much better
6 when they come back the next visit and say, "I feel so much
7 better now that you stopped some of my medications," which,
8 for example, proton pump inhibitors are often prescribed
9 acutely for gastric distress but are really supposed to be
10 used for two weeks for most people and then stopped, but
11 they're not stopped. And there are risks to all of these.
12 So, I guess I think if we can include in the
13 tiering kind of the value to our patients. You know, right
14 now, we look at tiering for other reasons. But is this a
15 medicine that we know the benefits outweigh the risks for
16 the patient, and create incentives for both patients and
17 physicians to look at this more. I mean, there are
18 guidelines, and I will say one drug you might be shocked to
19 know I frequently stop because it's not -- I don't feel the
20 benefits outweigh the risks are statins. And the recent
21 cholesterol guidelines did suggest that statins should be
22 stopped for primary prevention for most people over 75 years

1 old except for some very specific groups, people with known
2 coronary disease and diabetes.
3 And so I think trying to incorporate the value
4 into the tiering and other incentives would be a great
5 benefit, because right now, we're spending a lot of money on
6 drugs that some, of course, are helping our beneficiaries,
7 but a lot of them are making them worse.
8 MR. HACKBARTH: [Off microphone.] Aren't there
9 quality measures that get at this problem?
10 DR. SOKOLOVSKY: So, quality measures don't really
11 get to this issue. They're more on the sense of there's a
12 list, a controversial list of drugs that shouldn't be
13 prescribed to the elderly, and it's a quality measure if
14 they're being prescribed, although, generally, the
15 literature says that people are going to hospitals and
16 having adverse effects because they're taking too many
17 drugs, not because they're taking the drugs that are on this
18 particular list.
19 MR. HACKBARTH: Yeah.
20 DR. SOKOLOVSKY: But the Medication Therapy
21 Management Program is supposed to deal with these kinds of
22 issues. We -- it hasn't worked very well so far the way

1 it's set up, but there is a preliminary evaluation that did
2 come out which, to the extent that people actually had this
3 management, overall, they seemed to add drugs to people.
4 They switched some people to cheaper drugs, but there was
5 much less taking people off drugs. But, again, this was
6 very preliminary numbers and there were lots of questions
7 about --
8 MR. HACKBARTH: So, my recollection is that plans
9 are required to have a Medication Therapy Management Program
10 --
11 DR. SOKOLOVSKY: Yes.
12 MR. HACKBARTH: -- but that's pretty much it. You
13 have to have a program in place, is that --
14 DR. SOKOLOVSKY: Well, every year, CMS increases
15 the things that they -- in order to try to get it moving
16 more, it increases the responsibility of what plans are
17 supposed to do, and this year, in the 2015 rule, they're
18 limiting the number of drugs somebody has to be eligible and
19 they're doing some other things to try to get more people
20 involved. But, again, this preliminary analysis showed that
21 the majority of people that plans contacted, and there's no
22 clear way of knowing exactly how they contact them, but the

1 majority opt out.

2 MR. HACKBARTH: So, there aren't any established

3 metrics of this is what a good Medication Therapy Management

4 Program looks like. Here are the results that they produce.

5 DR. SOKOLOVSKY: Well, now, you have to actually

6 provide a listing of -- a comprehensive listing of what

7 drugs the person is taking. So, again, they keep adding

8 requirements, but it's still not the way you might want.

9 MR. HACKBARTH: Yeah.

10 DR. CHERNEW: My sense, sort of in the spirit of

11 that, or more broadly, what makes this area so hard is there

12 is -- this is an area where there is a lot of under-use,

13 where people are not taking drugs that we want them to take

14 for a variety of reasons. They're not managing their

15 chronic disease particularly well. In certain cases, and

16 I'll defer to Rita, there's places where medical therapy

17 could substitute for other invasive therapy. So, I don't

18 know about medical therapy versus stenting or whatever it

19 is, but there's areas where there's a very good --

20 It's also an area where there's a lot of overuse.

21 So, we think people are taking too many drugs and we think

22 they're buying the drugs that they're buying inefficiently.

1 They're using the brand, not the generic. They're spending
2 more than they need to use. It's always difficult to manage
3 an area where you have both under-use and overuse, because
4 you try and put something to reduce use and you exacerbate
5 one problem, you know, or do -- it's just very hard, and
6 it's particularly hard because so many of these things are
7 important for quality of life in a variety of ways that are
8 hard to get at and measure.
9 And so I do think there's a long history of trying
10 to do a good job through medication management, for example,
11 and we have struggled with what the right polices are,
12 despite recognizing a lot of problems. We are doing a study
13 now looking at the use of Beers List drugs, which are drugs
14 you shouldn't be using, in nursing homes, where you would
15 think people would be managed well, or in other places, and
16 we find patterns that you would both not expect to see and
17 it's not clear we have the tools to get at it at that micro
18 level.
19 So, I guess my first point would be, there's a
20 certain set of things we can control that are -- because the
21 system is set up a little bit removed -- that I think are
22 important. So, I would focus where it seems like we're

1 doing, on aspects of the basic program design -- how we deal
2 with reinsurance, how we deal with the coverage gap issues,
3 how we deal with the basic things that might make the design
4 better and get some of the incentives right. In some of
5 these places, we're going to have a discussion that's going
6 to be incredibly important later about disparities and low-
7 income things, and the concern is, of course, when you try
8 to get the incentives right and charge people more, you
9 create other types of problems. So there's a lot of trade-
10 offs.

11 I do believe there are other tools that we might
12 focus on, performance benchmarks for plans in certain areas.
13 So, the solution might not be to make people pay more in the
14 reinsurance, but to make -- you know, have a benchmark for
15 how you have to behave if you're a plan in that area, and
16 I'm not advocating that, but I would consider that.

17 And I do think quality measures, to the extent
18 that we can figure out good quality measures for overuse or
19 bad things -- I'm not the guy to do that, there are others
20 that might -- I do think those types of things are very
21 important.

22 The other areas which we haven't talked about as

1 much but I do think is important is, again, in the paradigm
2 of Part D, it was set up with this structure of the belief
3 that we're going to let plans compete and we'll let industry
4 sort out all of these problems, basically so we don't have
5 to. Different people have different views about the merits
6 that private industry can solve those things relative to the
7 government, and right now, it's not so important. But I do
8 think there's increasing evidence that the markets don't
9 work as well as economists would like, and as an economist,
10 I feel bad taking a pot shot at economists, but nevertheless
11 --
12 MR. HACKBARTH: Go ahead.
13 [Laughter.]
14 DR. CHERNEW: -- that remains, I think, true, the
15 evidence of choice. And I do think there's a growing
16 literature in economics about ways you might improve choice.
17 So, I think thinking about auto assignment to people or
18 putting them in plans or sending -- you know, there's
19 actually a lot of tools now that researchers, at least, have
20 used to identify people that could save significant amounts
21 of money if they were in a different plan, a mechanism if
22 said to somebody, you could save $300 if you switch to this

1 plan versus that plan, basically, ways to proactively help
2 search as opposed to what the standard economic paradigm is,
3 which is send them to a website and they'll pick what's
4 right for them. I think that latter view doesn't work as
5 well, in general, and certainly for this population.
6 So, I do think it's worth some attention to figure
7 out how we can make that type of choice better to encourage
8 switching, and I think that it will be frustrating because
9 we don't in this plan, in the Part D program, have the
10 ability to go in and micromanage the same way that -- and I
11 think we find it hard in other areas, too, but we certainly
12 don't have that ability here. A lot of these important
13 decisions are, by the structure of the program, deferred to
14 the Part D plans or the MA-PD plans.
15 DR. COOMBS: So, I was thinking of all the
16 comments around the room and this has been a real learning
17 session for me. Thank you, Jack, especially, because I can
18 understand now why I get aggravated by the Physician Health
19 Organization that sends me a note, why are you using this
20 drug as opposed to this drug?
21 So, I would think that there are a couple of
22 things that, clinically, that I can think about, of having

1 the right people on the bus. If you have the prescription
2 plan and you have the providers and you have the patients
3 and you have all these things that are hooked together and
4 we have the payer, one of the key components of that is this
5 whole notion of what happens between the different pieces of
6 the puzzle. And recently, there's a lot of literature out
7 on protocolized care, and when it comes from within the
8 organization, some component says, here's a benchmark, this
9 is an algorithm, we would want the providers to be adherent
10 to these guidelines, and there can be exceptions to the
11 rule, my concern is how well have we looked at the
12 prescription plans, Part D plans, in terms of looking at
13 whether or not they have protocols for the main cost
14 drivers, the mental health, the hypertension, the
15 cardiovascular, because once you have this invoke now
16 monitoring response, that in and of itself actually changes
17 behavior.
18 And I know it changes my behavior, first of all,
19 and most of the physicians in terms of someone saying, well,
20 you're using this drug. You realize that the data just came
21 out. This is no good anymore. I mean, I just -- I was just
22 at the critical care meeting and they said, hypothermia is

1 changing in terms of 36 degrees versus 34 degrees. There
2 was a conversion of the whole room, because that was
3 information that was put out there. And how much better
4 does it work to have what we see as an Accountable Care
5 Organization within the Part D plan, so it's almost like
6 transforming it into a mini-house or mini-medical home
7 within the Part D plan.
8 I think that that kind of creativity lends itself
9 to real adaptive challenges that move the meter in terms of
10 changing DNA for the people on the bus. And so that's one
11 of the things.
12 I think about one of the things that Rita said,
13 which is really important, is this whole notion of people
14 winding up on drugs. I can honestly say that people who
15 come to the hospital who have some mental, maybe it's
16 agitation, confusion, they get placed on certain drugs and
17 they will stay on those drugs as a part of med
18 reconciliation. When you get ready to discharge a patient,
19 you say, well, this is what has stabilized this patient
20 right here. They won't have an appointment with their
21 doctor for maybe for two to three months, and they won't
22 even understand -- the doctor in the office setting won't

1 understand why they were placed on those drugs and they will
2 go into a chronic corridor of having this medication on for
3 months until someone deciphers that this is not a medicine
4 that they need to wear for the rest of their lives.
5 So, I think that's really important, is how
6 patients actually wind up on the medications. Was it
7 related to a hospitalization or not? Was it part of a
8 medical reconciliation? And I think these are the important
9 things.
10 MR. HACKBARTH: Alice has opened up another
11 dimension of this that we haven't really focused on, and
12 that is the relationship between the individual physician
13 and the plan, the drug plan, in this case. To what extent
14 have Part D plans -- let's set aside the MA-PDs because
15 they're a special case here -- to what extent have the
16 freestanding PDs tried to influence physician prescribing
17 patterns? How do they do that? What tools do they use?
18 And does it work? And what does it feel like from the
19 physician's perspective inasmuch as their patients may have
20 five or six or ten different plans that they're working
21 with?
22 DR. SOKOLOVSKY: I can only report from what the

1 physicians tell us in focus groups, and for them, it's a
2 pretty adversarial relationship, that they don't feel that
3 the plan is really -- knows the clinical condition of their
4 patient.
5 But, on the other hand, the switch to generic
6 drugs, which happened particularly for the non-LIS
7 population so quickly, happened a lot because the physician
8 said, well, if I prescribe a generic drug, they're not going
9 to hassle me. And so it really led to this very big switch.
10 On the other hand, the physicians will tell us
11 that some plans are easy to deal with and they can talk to
12 them and work out how to deal with it and other plans really
13 don't want to deal -- and I think we talked about this a
14 little in the grievance and appeals place. They will say it
15 has to be the physician on the phone. It's the same number
16 as for customer complaints, and the physician would have to
17 be on the phone for 45 minutes on hold.
18 So, it's not -- they get papers from the plans a
19 lot, they tell us, but they don't -- they see it as an
20 adversarial relationship.
21 MR. HACKBARTH: Not much effective engagement
22 between physicians and drug plans.

1 DR. SOKOLOVSKY: On the other hand, there was --
2 in the Innovation Center, they did a project with an ACO
3 doing its own medication therapy management and they
4 reported very good results, so --
5 MR. HACKBARTH: Rita.
6 DR. REDBERG: I would certainly agree with what
7 Joan said about the relationship, and probably if it does
8 come from within or you feel like you had some part of the
9 helpful suggestions, you're more receptive to them. But
10 just getting letters or being told that your choice wasn't
11 good for your patient is not generally well received.
12 But what I do think has been helpful, you know, we
13 have electronic health record, as most hospitals and
14 practices do, is that now the patient's plan is inputted
15 into the electronic health record, so if I am choosing a
16 drug, it tells me what's preferred, what's non-preferred,
17 and so that has been, I think, more helpful. So, it's easy
18 for me to choose the drug that is preferred by that
19 patient's particular drug plan, because you're right.
20 Patients have so many drug plans, there's no way -- and they
21 all have different formularies and cover something different
22 and no way you can track it. But the electronic health

1 record has been helpful with that.

2 DR. HOADLEY: Yeah. I was just going to add, I

3 mean, I think where it's a drug class and it's a particular

4 drug to choose within the class, that's the part that's

5 gotten a lot easier in the new world. But, otherwise, the

6 tools are the prior authorizations and the step therapies

7 and the off-formulary. And so if you're trying to really

8 address, does a person need to be on this drug, maybe you

9 put a prior authorization flag in, but that goes into that

10 adversarial, we're going to say "no" until you push back and

11 it's going to be a huge hassle to get the one that needs the

12 "yes," and maybe you get the "no" only because you just

13 accept that it's too much hassle and if you do it it's in

14 that adversarial framework, rather than some kind of

15 educational outreach.

16 DR. CHERNEW: A lot of what goes on, and I think

17 this is true in the Part D plans, but it's certainly true

18 otherwise, is it's not just the plan. They often contract

19 out the specialists. So, this is an area where there's,

20 like, a pharmacy benefit management firm, which isn't

21 necessarily the plan. So there are, in general, specialist

22 people that think through and try -- there's just an

1 enormous amount of work in this area and there are still all
2 of the problems that we have. It just turns out for all the
3 reasons said to be very hard to get right, because there's a
4 lot of art in getting the right mix of medications for
5 somebody, which I think makes it very hard to know from any
6 distance what the right thing to do is, even though there
7 are some guidelines.

8 DR. COOMBS: I think it might be interesting to
9 look at successful or best products out there with the plans
10 in terms of what kind of formulation do they have in terms
11 of engagement with providers, to go the other way.

12 DR. HALL: Well, I don't want to add too much to
13 the clinician mafia here, but we do seem to sing in the same
14 choir all the time.

15 [Laughter.]

16 DR. HALL: I think there's an opportunity right
17 now to make some real progress in this quality area in
18 addition to all of the good things they did in this report.
19 It's an area of the literature that I follow, and this year,
20 there's been an unprecedented interest in articles talking
21 about adverse drug episodes, more than I've seen in a very,
22 very long period of time. So, I asked myself, why is that,

1 and it's probably the unintended consequence of a plan that
2 works really well to give access to Medicare patients to
3 legitimate pharmaceutical agents, and the flip side of that
4 always is that there's no free lunch, and so there are going
5 to be some side effects.

6 But, linking this to other things we've talked
7 about, when people are looking now at attribution of why
8 patients are being readmitted to hospitals within 30 days,
9 what they're finding is that they are, more often than not,
10 not admitted for the same diagnosis that was the initial
11 diagnosis. We've talked about that a bit. And when one
12 looks at these readmissions, a substantial portion of them,
13 maybe even 20 percent of them, are related to some kind of
14 drug misadventure, not because of incompetence or because
15 people didn't do the right thing, nor of access, but really
16 because there were complications of the drug. And we've all
17 known this for a while, and it is complicated.

18 Mike, you mentioned, let's do -- every good idea
19 should be looked at in its time. I think this is the time
20 because I think this is going to become a really big issue
21 in looking at attribution of readmissions. So, here we have
22 an industry that's providing a service and we say, listen,

1 we're going to give you a 30-day guarantee on our service.
2 We're that confident. But, by the way, one out of every
3 five people we harm. You probably wouldn't buy that product
4 for very long and it wouldn't work in the military -- well,
5 I mean, it would work in the military. But in other areas,
6 it just isn't going to work.
7 So, I think this dovetails with a couple of other
8 issues that we're talking about that I think somebody -- CMS
9 -- should say, what is -- see, nobody is responsible for
10 this. We've all talked about, well, somebody could do
11 something. Somebody could do something. But it's not
12 happening. And so I'm kind of wondering whether we should
13 emphasize this a little bit as we continue to look at
14 improvement of Part D management, that this is a big problem
15 and somebody has got to be responsible for this.
16 DR. MARK MILLER: [Off microphone.] Just to make
17 sure I understood where you were going with that, are you
18 saying that there should be some contract or guarantee
19 between a manufacturer and the --
20 DR. HALL: [Off microphone.] -- analogies that
21 limp pretty badly, but the point is --
22 DR. MARK MILLER: I didn't --

1 DR. HALL: The point is that we are -- the product
2 we're delivering in aggregate, not pointing the fingers at
3 any one group, fails one out of every five times. The
4 therapeutic regimen after hospitalization leads to some sort
5 of bad problem that it results in a rehospitalization.
6 Everybody is interested in this right now, so this is a
7 pretty good time to start talking about why is this the case
8 and how do we straighten that out.
9 MR. HACKBARTH: Kate.
10 DR. BAICKER: A couple of comments that the
11 clinicians have made, I think, highlight something Glenn
12 said and something that you've been working on, which is the
13 important connection between Parts A and B and Part D, and
14 along with our theme of breaking down silos, there's the
15 opportunity for better use of medicines to reduce
16 hospitalizations. There's the possibility of inappropriate
17 overuse or under-use of medications to increase
18 hospitalizations. And we're concerned with the whole
19 patient and the whole program, so this is a great
20 opportunity to think about the cross-silo effects of the
21 whole course of treatment.
22 DR. HOADLEY: And one area where we need Medicare

1 Advantage claims data to do the comparison.

2 [Laughter.]

3 MR. HACKBARTH: Okay. So, we're at 10:20, have

4 ten minutes remaining for this session. I actually

5 accomplished -- you accomplished already much of what I

6 wanted to do in round three, which was to have more of a

7 free-flowing interchange among Commissioners as opposed to

8 just going person by person.

9 DR. HALL: [Off microphone.]

10 MR. HACKBARTH: Yeah. Right. Right. Okay. I'll

11 let that go.

12 [Laughter.]

13 DR. SAMITT: We weren't supposed to say anything.

14 DR. CHERNEW: I was, like, the substitute teacher.

15 MR. HACKBARTH: Right.

16 [Laughter.]

17 MR. HACKBARTH: So, what we do want to accomplish,

18 though, is have a relatively clear agenda for staff on work

19 going forward from here. Mark, do you have any concluding

20 comments or need for clarification on some issues to build

21 that agenda? And I would add Shinobu and Joan into that, as

22 well.

1 DR. MARK MILLER: I think Joan and I should throw
2 Shinobu under the bus in short order.
3 [Laughter.]
4 DR. MARK MILLER: Shinobu? So, this is what I
5 took from it, and I'm not just saying this. I thought that
6 was a really healthy and pretty complex and interesting
7 exchange, so good job, guys. That's it.
8 [Laughter.]
9 MR. HACKBARTH: Well done.
10 DR. MARK MILLER: Thank you.
11 [Laughter.]
12 DR. MARK MILLER: All right. Shinobu?
13 [Laughter.]
14 DR. MARK MILLER: So, this is what I took out of
15 it, if it were me and I was thinking about priorities, and I
16 will cut through this fairly fast. I think we all -- I
17 think we all agree that probably the first thing that is in
18 our work, you know, more natural for our work, is to step
19 back and think about the risk structure of the plans, okay,
20 and I think that runs in a lot of directions, how the gap is
21 being filled in and what's going on there, what's going on
22 with the corridors, the catastrophic cap design, that type

1 of thing. And I think that's almost first and foremost
2 because it's the most natural thing that the Commission
3 would be about.
4 I think that and another point I'm just going to
5 make in a second links back to some of this discussion we've
6 been having where we've been saying, we've got to be
7 thinking about fee-for-service, ACOs, Part C, and how they
8 all relate to one another, and I think as we think through
9 that, the risk structures here, I think we should also be
10 looking back over our shoulders at these other items. So
11 that's one thought, and probably if somebody said, quick,
12 what's your highest priority, which I think he just did,
13 that's what I would say.
14 A second thing that I think -- and then this is
15 pretty high on there -- is that we have this tiered -- at
16 least the tiered network and the protected classes issue
17 being pushed forward because of the regulatory process, and
18 so I think we've got to pay some attention to that, and we
19 will do that.
20 Now, let me just say two other quick things, and
21 I'll stop. I think there's a set of beneficiary issues that
22 got teased out here, one of which is the choice issue and

1 money being left on the table or optimal choice, that type
2 of thing, and we can do some thinking about that. And here
3 again, I think we have to think about how beneficiaries
4 choose things, even if we're going to step back to this
5 question of fee-for-service, ACO, managed care, you know,
6 that type of thing.
7 Now, the more complex ones that I feel very --
8 that we've made runs at and ended up being fairly
9 disadvantaged on are things like we -- and I've got to tell
10 you, Shinobu and Joan have been on this issue for a while,
11 you know. The overuse and concern about over-medication is
12 something they have raised and we've discussed many times.
13 Exactly how to get to it, I've always felt encumbered, and
14 the MTM program, I think, is a word, but I just don't think
15 it's functioning well. But, I would say that we'll take
16 another run at it, see if we can't tease some things out
17 that captures a lot of comments around the table.
18 Then, you guys -- this is coming up to my last
19 comment -- raised the whole issue of the very structure of
20 Part D and government versus market price. Thanks a lot for
21 bringing that up. But, you know, the way, in all
22 seriousness -- in all seriousness -- the way that I thought

1 that that conversation finished in a real constructive way,
2 and the final transaction there -- and I just wanted to say,
3 I wrote it down before you guys said it -- I think it raises
4 a broader question of stepping back and saying, well, if we
5 have some parts of Medicare that are market-driven and some
6 parts of Medicare that are government-driven, then should we
7 step back and start thinking about the benefits and the
8 flaws in both of those, and at a minimum at least start
9 thinking about better alignment across them and perhaps
10 asking the question much more broadly than just litigating
11 the piece of legislation that arrived at that particular
12 decision when it created Part D. I think it does implicate
13 broader and more interesting -- or broader questions, and
14 you don't have to go right at that piece of legislation.
15 That was kind of my take-away.
16 MR. HACKBARTH: And on that last issue of the
17 government's role versus the private sector's role, I do
18 think that, at a minimum, we can try to say, if you want to
19 use a competitive model, then to make it work, you need to
20 pay closer attention to A, B, and C issues. If you don't
21 want to use a competitive model, then you've got another set
22 of issues that you have to deal with. But what strikes me

1 about Part D as it's currently structured is that, in some
2 ways, it's at war with itself. It isn't as completely
3 pursuing that competitive model as it might.
4 So, good discussion. Thank you, Shinobu and Joan.
5 And now, we will move to our last item of
6 financial assistance for low-income beneficiaries.
7 [Pause.]
8 MR. HACKBARTH: Christine?
9 MS. AGUIAR: Today we will discuss assistance with
10 Medicare out-of-pocket costs for low-income beneficiaries.
11 Before we begin, we would like to thank Carlos Zarabozo and
12 Joan Sokolovsky for their help on this project
13 I'll begin with an overview of the issue. As you
14 recall, the Commission recommended a series of redesigns to
15 the Medicare fee-for-service benefit package in 2012. The
16 redesigned benefit package includes better protection
17 against high out-of-pocket spending, deductibles for Part A
18 and B, and co-payments instead of co-insurance. The
19 Commission's recommendation on the fee-for-service benefit
20 design tried to protect beneficiaries against high out-of-
21 pocket spending while at the same time create financial
22 incentives for them to make better decisions about their use

1 of discretionary care.

2 However, even with the improved fee-for-service

3 benefit package, low-income beneficiaries may have

4 difficulty paying their out-of-pocket costs. During today's

5 presentation we will explain how a recommendation the

6 Commission made in 2008 to raise the income eligibility

7 criteria for the Medicare savings programs, or MSPs, would

8 help low-income beneficiaries afford their out-of-pocket

9 costs under the redesigned fee-for-service benefit.

10 Please note that this presentation is largely

11 informational, and it is in tended to highlight the

12 connection between the 2008 and 2012 Commission

13 recommendations. Over the next few slides, I will go over

14 background information on the MSPs and the 2008

15 recommendation.

16 This slide shows the Medicare Part A and B

17 assistance under the MSPs and the Part D assistance under

18 the low-income drug subsidy, or LIS. As you can see,

19 beneficiaries receive varying levels of assistance based on

20 their income. Beneficiaries must also meet asset limits in

21 order to be eligible for the MSPs and LIS. The asset limits

22 for both programs are 300 percent of SSI.

1 Beneficiaries in the middle two income categories
2 on the table -- the 100 to 120 percent of poverty and the
3 120 to 135 percent of poverty -- are eligible only for Part
4 B premium assistance. These two income categories
5 correspond to the SLMBs and the QIs. Beneficiaries with
6 incomes up to 100 percent of poverty are eligible for
7 assistance with their Part A and B deductibles, co-
8 insurance, and co-payments, in addition to premium
9 assistance. Of the three MSP categories, only the QI
10 program is fully financed by the federal government. The
11 QMB and SLMB programs are jointly financed by the federal
12 government and the states.
13 Note that in the final column on the slide, there
14 is a gap between MSP and LIS assistance for beneficiaries
15 with incomes between 135 and 150 percent of poverty. These
16 beneficiaries are eligible for reduced Part D co-payments
17 under LIS, but are not eligible for Part A and B financial
18 assistance. This is because the income eligibility for the
19 MSPs ends at 135 percent of poverty.
20 In 2008, the Commission recommended that the
21 Congress align the MSP and LIS income eligibility criteria.
22 If this recommendation were implemented, the gap we saw on

1 the previous slide between MSPs and LIS for the 135 to 150
2 income category would be closed, and beneficiaries with
3 incomes up to 150 percent of poverty would receive Part B
4 premium assistance.
5 Note that the Commission also recommended in 2008
6 that Congress align the MSP and LIS asset limits. Congress
7 adopted that portion of the recommendation in 2008.
8 The 2008 recommendation was based on an analysis
9 of out-of-pocket spending. The main findings are listed on
10 this slide. The Commission found that, compared to non-
11 Medicare beneficiaries under age 65, Medicare beneficiaries
12 age 65 and older were more likely to be poor or near poor
13 and they spent a larger percentage of their income on out-
14 of-pocket health costs. To some extent, this finding is
15 expected. A third was that beneficiaries eligible for but
16 not enrolled in the MSPs were more likely than MSP enrollees
17 to report avoiding needed health care because of cost.
18 Since the recommendation in 2008, these findings
19 remain generally true. For example, relative to non-
20 Medicare individuals under age 65, Medicare beneficiaries
21 are still more likely to be poor or near poor.
22 The illustrative example for the 2008

1 recommendation assumed that the MSPs would be aligned with
2 LIS by raising income eligibility criteria for the QI
3 program. This slide highlights some of the implications of
4 that. For one, unlike the other MSP categories, the QI
5 program is fully financed by the federal government.
6 Therefore, increasing the income eligibility for this
7 program would not increase state spending. However, it
8 would increase federal spending. One way to possibly reduce
9 the cost would be to provide a partial, rather than a full,
10 Part B premium subsidy, or to set the Part B premium subsidy
11 on a sliding scale.
12 Cost-sharing incentives at the point of service
13 would be maintained because the beneficiaries would not
14 receive assistance with their deductibles, co-insurance, or
15 co-payments. Moreover, the Part B premium subsidy would
16 free up income that could cover beneficiaries' other cost-
17 sharing expenses. Finally, financial assistance for low-
18 income beneficiaries would be directly targeted to those
19 individuals.
20 I'm going to pause now for a moment to continue
21 with the last point from the previous slide about directly
22 targeting financial assistance.

1 The Commission stated in its 2008 report that the
2 MSPs are a direct and efficient way to target low-income
3 supports. But less targeted approaches have arisen in
4 policy discussions. For one, some believe that higher
5 payments to Medicare Advantage plans are a way of providing
6 assistance for the low income. However, the Commission has
7 argued that MA payments are not a direct or efficient way to
8 target assistance because all enrollees in a given plan
9 receive the same extra benefits whether or not they are low
10 income.
11 In addition, during the Commission's discussions
12 on the effects of supplemental coverage, some argued that
13 Medigap plans are important for protecting low-income
14 beneficiaries from catastrophic financial liability.
15 Although Medigap plans fill in some or all of Medicare's
16 cost sharing, their premiums are much higher than their
17 expected benefits. Moreover, cost-sharing incentives at the
18 point of care may not be maintained under supplemental
19 coverage. For these reasons, Medigap plans are neither a
20 targeted nor efficient way to provide assistance to low-
21 income beneficiaries.
22 Moving on now, this slide shows the relationship

1 between the Commission's 2008 and 2012 recommendations. The
2 2008 recommendation would effectively provide a Part B
3 premium subsidy to beneficiaries with incomes up to 150
4 percent of poverty. For 2014, the Part B premium subsidy
5 would amount to about $1,300 a year. This additional
6 premium subsidy is a direct and targeted form of assistance
7 to low-income beneficiaries. This additional assistance
8 would free up discretionary income to help beneficiaries pay
9 the remainder of their out-of-pocket costs under the
10 Commission's redesigned fee-for-service benefit. For
11 example, the average cost-sharing liabilities for
12 beneficiaries enrolled in the QI program were about $1,900
13 in 2011.
14 To summarize, the MSPs are a direct and targeted
15 way to provide financial assistance for low-income Medicare
16 beneficiaries.
17 Moving forward, the Commission should keep in mind
18 this issue of financial assistance for low-income
19 beneficiaries as you continue work on synchronizing fee-for-
20 service, ACO, and MA payment policies. For example, should
21 financial assistance be in the form of premium assistance?
22 If so, should the premium assistance be a full or partial

1 subsidy? Or should additional cost-sharing assistance with
2 deductibles, co-insurance, or co-payments be provided? Note
3 that cost-sharing assistance raises the issue of whether
4 states would continue to pay the cost sharing on behalf of
5 Medicare beneficiaries or whether the federal government
6 would fully subsidize the cost sharing. Again, these are
7 not issues for you to resolve today, but for you to keep in
8 mind as the Commission's work moves forward.
9 This concludes the presentation, and we look
10 forward to your questions.
11 MR. HACKBARTH: Round 1 clarifying questions.
12 MS. UCCELLO: So on Slide 5, the third bullet says
13 that folks in the MSPs were less likely to avoid care than
14 those not enrolled. And I was wondering whether and how
15 that may have differed across the different types, whether
16 it was more with the QMBs that also offer the out-of-pocket
17 cost-sharing assistance, or was it also true when just
18 premium assistance is provided.
19 MS. AGUIAR: We could go back to the original
20 study to see if they actually looked at it that way. The
21 way that the study was reported in the 2008 chapter and how
22 we summarized it here did not have that level of detail, but

1 we'll go back to the original report to see if it does.

2 DR. HOADLEY: On Slide 3, on the LIS section, I

3 think your X's refer to where there's a full premium

4 subsidy, so I think it's important to clarify that in the

5 next to the last row there under the 135-150 it is a partial

6 premium subsidy, and that, of course, relates to some of

7 what you say thereafter.

8 MS. AGUIAR: You're right, yes. So those --

9 exactly right. The details of exactly what -- under the LIS

10 program what each income group is eligible for is

11 highlighted specifically in the paper. But you're exactly

12 right for the slide that that is what that means.

13 DR. COOMBS: So on page 7 you actually give a good

14 estimate of the third category, the QI. But for the fourth

15 category, what's the number that that involves, the number

16 of beneficiaries for the last row?

17 MS. AGUIAR: I'm sorry, for the QI --

18 DR. COOMBS: No, not for the QI. For the 135-150

19 percent of the federal poverty level. I'm sorry, column.

20 DR. CHERNEW: Last row [off microphone].

21 DR. COOMBS: I mean the last column. I'm sorry.

22 DR. LEE: So using 2011 numbers of all Medicare

1 beneficiaries, it's about 4 percent are not duals but Part D
2 LIS. So it's the 135-150.
3 DR. COOMBS: Okay. Is there a cost projection for
4 what that would be? I know it's hard, but based on 2011
5 data?
6 DR. LEE: The cost in terms of what part of the
7 cost?
8 DR. COOMBS: The part of actually increasing it to
9 the 135-150 --
10 DR. LEE: That is actually multiplying two
11 numbers. The increase in the benefit is just Part B, the
12 premiums, so that's Part B premiums for 2014 is about $105 a
13 month, and 4 percent of Medicare beneficiaries is a little
14 under two million.
15 DR. NERENZ: On this slide, is there any simple
16 way in which we should think about information on this slide
17 and the concept of dual eligibles? How do these go
18 together?
19 MS. AGUIAR: Sure. Again, in the interest of
20 time, we explain that a little bit more in the paper, but
21 didn't want to have to go through that here. So if you look
22 at it, so we'll start with the income bracket of up to 100

1 percent FPL. Those are the QMBs. Everyone in this program
2 is eligible for the cost-sharing assistance that you see on
3 that slide.
4 Now, there are some people within the QMB program
5 that meet their state's eligibility for full Medicaid
6 benefits, and that differs by state, as you know. So those
7 QMBs that are eligible for full Medicaid benefits we call
8 QMB-plus because they are full-benefit dual eligibles. The
9 QMBs that are eligible only for the cost-sharing assistance
10 you see here, we refer to those as QMB-only's, and they are
11 the partial-benefit dual eligibles.
12 DR. NERENZ: Okay. So you may have already
13 answered without having to walk through. So what we're
14 displaying here are federal programs and --
15 MS. AGUIAR: Yes.
16 DR. NERENZ: -- the question of whether someone
17 then goes into the category of dual eligible is really
18 somewhat a separate issue based on state criteria for
19 Medicaid eligibility. Is that a fair statement?
20 MS. AGUIAR: Well, not entirely, because everyone
21 in the QMB, the SLMB, and the QI program here, whether they
22 are eligible for full Medicaid benefits or not, are

1 considered dual eligibles. We just break them up into
2 partial benefit because they only get the cost sharing or,
3 you know, full benefit because they're eligible for more.
4 MR. HACKBARTH: Any other clarifying questions?
5 DR. CHRISTIANSON: Yeah, here and there in this
6 chapter you actually present the numbers, here is what the
7 deductible, here is what the Part B premium would be and so
8 forth. It would be helpful to have a table that had those
9 so we could put this in perspective. So what does it mean
10 to cover the Part A premium? What's the size of the Part A
11 premium? You've got Part B, $1,300, you've got some co-pays
12 and stuff.
13 MS. AGUIAR: Sure. Yes, I agree with that, and
14 that could be a change that we'd be happy to --
15 DR. CHRISTIANSON: [off microphone] -- how
16 important it is to a beneficiary. What is the Part A
17 premium?
18 MS. AGUIAR: Right. We do have that in the
19 appendix.
20 DR. CHRISTIANSON: Okay. But what is the Part A
21 premium?
22 DR. LEE: The Part A premium is -- for Part A

1 premium, there is -- if you have 40 quarters, if you have
2 ten years of a work history, that Part A premium is zero for
3 the beneficiary.
4 DR. CHRISTIANSON: That's what I thought, and
5 that's the kind of stuff that when you look at this, I don't
6 -- okay. So do we know how important that is, how many
7 people would --
8 DR. LEE: For the low-income, there are many
9 beneficiaries who do not satisfy that requirement. So in
10 that case, the state actually buys -- or has the option of
11 paying for part --
12 DR. CHRISTIANSON: Do we know how many [off
13 microphone]?
14 MR. HACKBARTH: So how many people pay a Part --
15 are liable for a Part A premium?
16 DR. LEE: Actually I do not have that number.
17 MS. AGUIAR: We don't have that in front of us,
18 but we will go to see if we could calculate that. I believe
19 that we can.
20 DR. MARK MILLER: And it sounds like the other
21 piece of this question is -- and when that happens, there's
22 been a calculated Part A premium that somebody has to pay

1 when they fall in that bucket.

2 MS. AGUIAR: Yes.

3 DR. MARK MILLER: And it sounds like he's saying,

4 "I want that number, too." He can speak for himself, but I

5 think we need to --

6 [Laughter.]

7 DR. LEE: Yeah, that number is 426 a month.

8 DR. MARK MILLER: Well, there you go.

9 MR. HACKBARTH: Any others?

10 [No response.]

11 MR. HACKBARTH: Okay. Let's see. Dave, do you

12 want to lead off Round 2?

13 DR. NERENZ: You caught me by surprise there.

14 MR. HACKBARTH: That was my goal [off microphone].

15 DR. NERENZ: I'm sorry?

16 MR. HACKBARTH: That was my goal.

17 DR. NERENZ: Okay. Well, it worked.

18 I have this very general question about

19 administrative burden that perhaps you could speak to,

20 because when we think about these various programs, they're

21 driven by information that must come from somewhere about

22 income, and then in a couple of these places assets are also

1 part of the issue. And presumably we're asked to think
2 about how these might evolve in the future and where they
3 need to be expanded or perhaps contracted or whatever. And
4 it seems to me part of that discussion is how hard is it,
5 either on the beneficiary or on the Medicare program, to
6 actually administer these? What information bits are
7 required? How often? How much hassle is it for everybody
8 who has to work with it? Can you speak to that just a
9 little bit?

10 MS. AGUIAR: I can speak to that a little bit. I
11 do knot that Joan has done far more research on this, so
12 after my comments, Joan, you are welcome to come up if you
13 have anything to add.

14 We touched a little bit about this in the paper.
15 With the MSP program, the income and eligibility criteria
16 and the benefits are set by the federal government, but they
17 are administered by the states. So in the 2008 report,
18 really one of the impetuses of making the recommendations
19 that they did was concern over the fact that a lot of
20 beneficiaries that were eligible for the MSPs were not
21 actually enrolling. And because of all of these, the
22 administrative requirements but also confusion about whether

1 or not they were eligible and that sort of thing, and, you
2 know, some individual state processes that might have made
3 it difficult for them or discouraged them from actually
4 enrolling.

5 And so since -- I believe that one of the
6 recommendations in 208, the first one, was to increase
7 funding for the SHIPs, and since -- sort of for them to help
8 to reach out to these beneficiaries, to help point out that
9 they are eligible for these programs and to enroll them.
10 And we have seen -- actually enrollment since 2008 in the
11 MSPs has gone up a little bit, but, yes, you are completely
12 right to focus on that, that there are administrative
13 difficulties, and on the beneficiary perspective, just a lot
14 of confusion about whether or not they're eligible and, you
15 know, sort of where to do. You know, as I said, since state
16 processes vary across states, it is a very confusing -- my
17 understanding is that it is a confusing program to actually
18 really implement.

19 DR. NERENZ: I guess that leads to a question I
20 didn't anticipate in the first thing. Because these are
21 administered by the states, does that make them sort of
22 outside our purview? Or can we still speak to them because

1 of how closely this is all linked and it is essentially a
2 means of administering a Medicare benefit or a Medicare --
3 MS. AGUIAR: Right. So there's sort of two parts
4 to that that I'll answer. The 2008 recommendation, which
5 was, as you know, to increase the QI program, income
6 eligibility criteria, from 135 to 150, that is fully
7 financed by the federal government. So the federal
8 government appropriates that and gives out a block grant.
9 DR. NERENZ: Okay. Just a quick aside. My only
10 concern here is just this issue of the administrative
11 expense and process, not where the cutoff is set. I mean,
12 that, I realize it's an issue, but whether it's 135 or 150,
13 somebody still has to document the income or document a
14 change in income, and it's more that that I'm thinking
15 about.
16 MS. AGUIAR: Oh, I see, yeah. I don't believe --
17 and, Joan, if you want to come up here? I do not believe
18 that we anticipated any burden, extra burden on states by
19 that recommendation.
20 DR. MARK MILLER: I think the reason that she's
21 mentioning that, different of these columns are financed
22 differently. So QI is completely federal, but SLMB and QMB

1 actually have a state share.

2 MS. AGUIAR: Yes, that was the second part that I

3 was going to get to that.

4 DR. MARK MILLER: So let me just get there. So I

5 know you started to say, "But that's not what I care about."

6 Your question was: Can we speak to it? So even on the

7 administrative front, if we say either the state needs to do

8 something or the federal government needs to do something to

9 make it simpler, we have to be cognizant of anything that we

10 do imposing or relieving the state of, you know, federal --

11 or I'm sorry, the --

12 DR. NERENZ: Yeah, yeah.

13 DR. MARK MILLER: And that's why I think she

14 originally started and said, well, understand that the

15 state's involved in some of this and not in others. And

16 that's why --

17 DR. NERENZ: Okay, okay.

18 MS. AGUIAR: So I'll just quickly finish the

19 second point. So if the Commission were to think about, for

20 example, expanding the QMB program from 100 percent FPL to

21 120, 135, 150, that really implicates not only state

22 administrative costs or processes, but it implicates state

1 financing. It implicates whether or not that will continue
2 to be jointly financed between states and the federal
3 government, or the federal will assume the cost. And so
4 it's much more complicated there. But I'll let Joan...
5 DR. SOKOLOVSKY: So in terms of the administrative
6 issues, right now these programs are federal Medicare
7 programs, and they're set -- the standards, like income and
8 how you measure them, are set in law. But states have the
9 flexibility to disregard some income -- in the law, $25 a
10 month is disregarded, but states can do that higher. They
11 can disregard all assets, and there are five states that
12 don't do an asset test at all. QIs, you have to follow the
13 federal guidelines, but for the others there's a lot of
14 state flexibility.
15 One of our recommendations, one that was not fully
16 taken by the Congress, was if people are applying for the
17 low-income subsidy and they apply there to Social Security,
18 let Social Security also screen them for eligibility for
19 these programs and enroll them if they're eligible. Well,
20 what Congress did was have Social Security screen them, but
21 then give the names to the states. And the result is that
22 some states, it's a fairly smooth process; but other states

1 who are not anxious, presumably for fiscal reasons, to
2 enroll more people will then give you a full Medicaid
3 application that you must fill out. And they can be very
4 administrative complex for both state workers and the
5 beneficiary. But the states that want to make it easier,
6 you put it down as kind of presumptive, and then the IRS
7 checks.
8 MR. HACKBARTH: Let me just make explicit
9 something that I think is implicit in what we've discussed
10 to this point, and that is, if we're going to make
11 recommendations in this area, I think we ought to make
12 recommendations about the federal government's
13 responsibility and not make recommendations that would
14 increase state financial responsibility.
15 Now, it is worth noting that this is an area
16 where, again, Part D sort of took a different approach. You
17 know, Part D basically federalized the responsibility for
18 the low-income people as opposed to shared it with the
19 states. A and B, it's still this mixed federal-state
20 responsibility. But given that we are a federal advisory
21 body, I think we really ought to focus our recommendations,
22 if we have any to make, on what the federal government

1 should do.

2 MR. GRADISON: I'm struck that these break points

3 -- a couple things about the break points. First of all,

4 there are four of them. I have to imagine people move back

5 and forth now and then, maybe rather often, between them. I

6 was wondering about grouping, whether there might be some

7 administrative merit and certainly some simplification in

8 general about combining them.

9 A second related point is that this doesn't seem

10 connected to the new option of going to 138 percent of

11 poverty for Medicaid, and I kind of wonder whether we ought

12 to be maybe thinking about two categories here. One would

13 be, let's say, 100 to 138 and the other might be above 138,

14 so that to tie it in and saying, for example, that in the

15 states which go to 138 -- and it's still their option --

16 that then would have implications in terms of the federal

17 subsidy for people in those categories.

18 I'm just raising the question. I'm not trying to

19 suggest an answer. But these break points seem like they're

20 -- I understand why they're there. But I think they're sort

21 of from the past rather than in terms of the structure that

22 we're gradually moving towards.

1 More generally, I know a lot of us and certainly I
2 have been concerned with our lack of success in altering the
3 fee-for-service package. I was involved, maybe some of you
4 were, too -- it was years ago -- with the attempt to add a
5 catastrophic benefit, something we certainly would like to -
6 - I think we all would like to see added one way or the
7 other. And I am intrigued by the question as to whether
8 getting this right, modifying it, would in any way help to
9 move the decisionmakers in the direction of the kind of fee-
10 for-service package -- the packages that we've talked about.
11 I don't know. That's sort of a judgment call.
12 More specifically, since I'm on that point -- and
13 I won't take long to develop this, but as I think about the
14 idea of an alternative package, my recollection is that the
15 notion, whether you're talking about Medicare catastrophic,
16 the ill-fated legislation, or our own proposal in more
17 recent times, it was sort of an all-or-nothing thing, we're
18 going to move this program from this to that. I've been
19 wondering what would happen if we said we're going to have
20 two fee-for-service options. You can stay with the one we
21 have, with the deductibles and the various different
22 deductibles for different kinds of expenditures and lack of

1 catastrophic, or you can move to an actuarially equivalent
2 package which -- take your choice. Something just to think
3 about maybe for the future.
4 MR. HACKBARTH: Bill, on your first point, at the
5 hearings that I testified at on the benefit redesign
6 recommendation we made, a common question was, well, what
7 about low-income people, and is there some way that we can
8 better address their needs? And so that's one reason that
9 we're going back to this issue.
10 DR. CHRISTIANSON: I don't have much to say about
11 this other than to thank you for bringing me up to date. I
12 was unaware of what the Commission's previous positions on
13 this were and how they came to them, and I think it is an
14 important issue.
15 It would be helpful to me to actually translate
16 some of this into dollars. Even in the appendix there's no
17 -- I don't have in my mind immediately what the federal
18 poverty level is, for instance, and that's nowhere in the
19 chapter. So I would like to sort of see some information
20 that says in those categories here's the dollar income level
21 we're talking about, here is what the dollar impact is of
22 providing this coverage and this coverage and this coverage,

1 and then net, what does that mean for the beneficiary in
2 terms of actual dollars. Just in terms of educating me and
3 helping me get my hands around this issue, that would be
4 helpful.

5 MS. AGUIAR: We're happy to do that. The one
6 caveat that I just want to give is where when we do try to
7 quantify this -- and we do quantify this in the paper --
8 this is, again, specifically for the deductibles and the co-
9 insurance for Parts A and B. We are only able to calculate
10 those beneficiaries' cost-sharing liability, but not how
11 much was paid for the QMBs. So just so you are aware of
12 that. We're not actually able, because of limitations in
13 the data, we won't be able to say to you the liability was
14 this and what the state paid was that.

15 DR. CHRISTIANSON: That's fine. Yeah, I saw Table
16 3 that had the average liability, and just anything that
17 would even put that in context would be helpful to me.

18 MS. AGUIAR: Sure.

19 MR. ARMSTRONG: Just very briefly, I want to
20 affirm I think the work is excellent. I think what we're
21 trying to do is strike a balance between creating access in
22 a program that right now is pretty complicated and as much

1 as we can, simpler terms, and I really applaud that. And I
2 look forward to supporting this work going forward.
3 MS. UCCELLO: First, I just want to thank you for
4 the really nice discussion in the chapter laying out all the
5 different QMB, SLMB, all that stuff, and dual, you know,
6 plus and all that. It's very complicated, and I've never --
7 I've looked before to find something like that, and so I was
8 so pleased that it was there, and you did just a fabulous
9 job. And it is very complicated.
10 In terms of, you know, what's the best way to
11 address some potential access problems for low-income folks,
12 I agree that our charge should be to try to look at things
13 from the federal side and not try to impose anything more on
14 the state side. But I'm just trying to understand better
15 what the behavioral impacts and what the true impact on
16 access is for a premium reduction or elimination versus an
17 at the point of service cost-sharing reduction, because in
18 theory, yes, not having to pay the premium frees up some
19 money. You can use that for something like your cost
20 sharing. You could also use it for something else.
21 And maybe some of this is already in that 2008
22 chapter, I don't know, but I think it's something that I

1 need to understand more to really assess what the right way
2 to go is.
3 DR. CHERNEW: I think Kate was reaching for her
4 button, too. Maybe we were going to say the same thing.
5 But in any case, I think the evidence would suggest that if
6 you give someone just a lump sum, reduce their premiums by
7 $100 but still charge them at the point of service, they
8 respond to the higher price. So that's, in fact, how the
9 RAND Health Insurance experiment worked. They gave people
10 money to participate, but they didn't -- you know, they
11 still responded to the price of service at the point of
12 service.
13 MS. UCCELLO: And that's exactly what I'm
14 concerned about with just focusing on the premium side.
15 DR. BAICKER: I really also appreciated the
16 distinction drawn between subsidizing -- the subsidy for
17 premiums versus cost sharing. My reaction was a little
18 different from Cori's in that especially in light of our
19 discussion about Part D, thinking about ensuring that low-
20 income beneficiaries still face some cost sharing to steer
21 them towards higher-value services, I think argues for
22 subsidizing premiums more and leaving some cost sharing in

1 place. But then what's the right level of cost sharing?
2 That clearly depends on income, the level, the dollar amount
3 that helps steer low-income beneficiaries towards higher-
4 value services might be a much smaller dollar amount than
5 what's appropriate for higher-income people. So it's not
6 that income shouldn't be taken into account. I think it
7 should. But I think that it should -- we should work to
8 ensure that we maintain appropriate incentives across
9 different types of care.
10 MR. HACKBARTH: So we've talked about premium
11 subsidy and cost-sharing subsidy. Another potential
12 variable here is an out-of-pocket limit on cost that is
13 income related. Have we thought at all about that and what
14 the implications are? I think that could be done through
15 the federal -- a federal change only.
16 Julie has a skeptical look on her face.
17 DR. MARK MILLER: That's just because you're
18 looking at her [off microphone]. I was a bit unclear how to
19 take that, too. So why did you think that that just had a
20 federal piece to it?
21 MR. HACKBARTH: Well --
22 DR. MARK MILLER: Because I was looking at --

1 MR. HACKBARTH: Just consider that an assertion as
2 opposed to a logical thought. So you could say the Medicare
3 cost-sharing liability is income related, and after some
4 point, the beneficiary incurs no additional cost-sharing
5 liability so there's nothing for the state to contribute.
6 It would reduce state burden. It wouldn't increase state
7 burden in any way.
8 DR. LEE: Actually I thought what you were saying
9 was that it's out-of-pocket maximum that's income related.
10 And so, for example, low-income beneficiaries would have a
11 lower out-of-pocket maximum.
12 MR. HACKBARTH: Yeah.
13 DR. LEE: And there would be -- once they reach
14 that maximum, then all the cost-sharing liability will be
15 paid --
16 MR. HACKBARTH: By the federal government.
17 DR. LEE: By the federal. So we had -- on our
18 discussions on the benefit redesign, we have not discussed
19 this particular form of that design. I think a proposal
20 from Urban Institute actually takes on this flavor but we --
21 MR. HACKBARTH: I remember that.
22 DR. LEE: As a Commission I don't think we had

1 discussed that. I think the kind of argument for the
2 redesign was -- or discussion on the benefit redesign was we
3 actually took the low duals out of that particular
4 discussion in the recommendation. But the kind of main
5 argument for the redesign was for all Medicare
6 beneficiaries, the basic benefit, what should that look
7 like?
8 MR. HACKBARTH: Right. And I understand all that.
9 I agree with that. But if we're concerned that simply
10 relieving low-income beneficiaries of the premium burden may
11 still -- and leave them with the same cost sharing as
12 everybody else, may have a disproportionate impact on their
13 use of services because of their low income for the reasons
14 that Mike just stated. I'm trying to think of other
15 variables that you can adjust to deal with that.
16 One of your slides said, you know, if you relieve
17 them of the Part B premium, that's a $1,300 annual savings,
18 and the average cost-sharing liability is $1,900. Well, one
19 of the issues, though, is there's lots of variability around
20 that $1,900 average. And so the low-income people that are
21 also burdened by illness would be particularly hard hit,
22 and, you know, the out-of-pocket maximum is a variable that

1 could address that.

2 Please don't count this as advocating that. I
3 really haven't thought through it, but it just occurred to
4 me based on this conversation.

5 DR. LEE: The one I think that will have a
6 different effect is actually the conversation between Cori
7 and Kate on -- for the -- what you are doing is you are
8 making the basic cost sharing in place for a narrower
9 spending range, so low-income beneficiaries are still going
10 to face the same incentives as before, but now at a lower
11 spending level, now you are taking away all of their
12 financial incentive. So then you are facing the problem of
13 not having incentives early on. So it's kind of a shifting
14 that you are going to -- it has different implications than
15 the behavioral response.

16 DR. HOADLEY: I had thought about bringing an
17 issue like that up. If you layer that onto the current
18 system, of course, you've got a lot of administrative
19 issues, especially with the different ways states fill in
20 cost sharing and the different -- if you're sort of going to
21 a complete rethinking, including all the QMB, SLMB, and all
22 the kinds of things there, than you might be able to go

1 along the lines we just had.

2 I think one of the things that's frustrating is,
3 as, you know, the point was made on Table 3 in the text, you
4 know, they can show us the cost-sharing liability for these
5 people. They can't actually show us how much people are
6 paying, so we can't even look empirically at -- unless maybe
7 somehow with some of the joint data with the Medicaid data
8 there's a way to do this. And I don't know if there's any
9 of that. But, you know, even to illustrate sort of what
10 people under the current structure are actually paying as
11 opposed to what they're liable for, because what they're
12 liable for is pretty huge compared to the income levels
13 we're talking about, which also goes to Jon's point about
14 being able to relate those to dollars and incomes and help
15 to understand what a $1,900 liability would mean, if they
16 were actually paying it, which we think many -- some of
17 them, many of them -- some number of them aren't.

18 I don't know if that helps to think about it at
19 all, but I was going to make a different point, which
20 actually goes back to the question that -- oh.

21 DR. MARK MILLER: Just before you go on, could we
22 have a couple of reactions. When you were saying about the

1 complexity of this, you know, and so we'll call it the
2 Glenn-Jack idea, since you both have taken such a strong
3 stand on this. But in all seriousness, to give it a second,
4 you're absolutely right that as it currently stands in the
5 system, you would have all -- it would be very complex. But
6 if you were to pursue something like this, I would think you
7 would immediately move to a federal determination and pull
8 that out of all of the state, otherwise it would be
9 unadministerable or --
10 DR. HOADLEY: Yeah, I mean, I think -- and you'd
11 have to have it -- I mean, I think it would be very hard to
12 layer it on the current QMB cost-sharing support that we
13 don't even know how much happens. But if you rebuilt that
14 and either federalize it all like the way you do in LIS or
15 something in between --
16 DR. MARK MILLER: This is getting complex fast.
17 But one other thing. Christine, did I notice that you
18 wanted to react on whether the dual-eligible data -- I don't
19 want to put you on the spot, but --
20 MS. AGUIAR: Sure. This is not a major point, but
21 I did want to let you know that we have been working for the
22 duals data book with MACPAC, and we do have a combined --

1 now it's 2009. We'll be working on 2010 MSIS and Medicare
2 claims data set. And we have really looked at this issue
3 closely, and we'll hopefully be able to continue to, but we
4 have not yet been able to verify whether or not the
5 variables in the MSIS that say how much states are actually
6 paying are accurate. There's just a lot of concerns with
7 that.
8 So we've looked and we've tried to calculate how
9 much states actually are paying, and sometimes it just
10 really doesn't reconcile with what the liability should be.
11 So it's something we are still going for, but just so that
12 you know with that data set we haven't yet been able to.
13 DR. HOADLEY: And I know there are other issues
14 under the current rules with the states that won't pay the
15 co-pay that exceeds what they would normally pay in
16 Medicaid, and then that may never be collected, but it may
17 show up somewhere sort of as if collected, and that's
18 obviously a further limitation. I get that.
19 The other point I was going to come back to was
20 the point where Joan jumped in and said part of what I was
21 going to say. I mean, I think there is a role to think
22 about to sort of go back to that issue of saying, you know,

1 when somebody right now comes into the Social Security
2 Administration to sign up for Part D, and they're judged
3 eligible for MSP, and, you know, we previously recommends,
4 as I understand it, that that might then become relatively
5 automatic, completely automatic, something, a federal
6 action, it doesn't now. The states don't fully follow up on
7 it. We could go back and sort of repoint that, but
8 particularly if we align, as was all part of, I guess, that
9 2008 recommendation, then there is a real logic to deeming
10 the full eligibility once you come in on either program of
11 getting in, so you create both some administrative
12 efficiency and actually a more effective result.
13 So I think it was actually thought through pretty
14 well by the Commission's recommendation. Unfortunately, it
15 hasn't all happened.
16 MR. HACKBARTH: And why did the Congress take part
17 of the recommendation and not the other part? Maybe that's
18 a question for Joan or --
19 MS. AGUIAR: Do you mean for the one about the
20 income and the asset limits or the one for the SSI -- I mean
21 Social Security Administration.
22 MR. HACKBARTH: The Social Security

1 Administration, when we said that there ought to be -- when
2 people are determined eligible for LIS, we ought to also
3 make a determination about MSP eligibility.
4 MS. AGUIAR: It is a question for Joan. She's
5 coming up.
6 DR. SOKOLOVSKY: I can't give you a definitive
7 answer, but my impression -- because it wasn't made public,
8 but my impression was that the states had objections to
9 that.
10 DR. HOADLEY: The states are liable for part of
11 the cost.
12 DR. SOKOLOVSKY: Yeah.
13 DR. HOADLEY: That would be the logic, I would
14 think.
15 DR. SOKOLOVSKY: Yeah.
16 MR. HACKBARTH: Yeah. Okay.
17 DR. HOADLEY: And the only other point I was going
18 to add on that general theme is, I mean, there really is a
19 further issue with outreach and education on this. The
20 point has really been made, I think, but, you know, the
21 number I always like to point to on the LIS where it is a
22 more federal role, of the people who are not automatically

1 LIS eligible based on their Medicaid or SSI eligibility, the
2 ones who need to apply on their own for LIS, the best data
3 we still have from CMS says less than half of the people who
4 we think are eligible actually apply. And, you know, there
5 may be a lot of reasons underlying that, but that does
6 suggest an area where we really need to do better, and we
7 know the MSP take-up is also very low. In some cases I've
8 seen numbers even lower, well below half.
9 DR. HALL: Thank you. This is news to me, most of
10 this. Linking premium support to the federal poverty level
11 is causing some problems in administration of insurance
12 exchanges for a younger population, but I assume that most
13 of these Medicare-eligible people don't have that much
14 income change year to year, so that's -- I mean, how much
15 migration is there between the eligibility for these levels
16 of support?
17 DR. SOKOLOVSKY: When we looked at this
18 previously, there wasn't that -- there's some change, but
19 not a great deal of change.
20 DR. HALL: Right.
21 DR. SOKOLOVSKY: The biggest issue is if you have
22 to reapply, a lot of these people don't remember to reapply

1 when it's due, and that's where you lose a lot of people.
2 New people come on, and people who are still eligible didn't
3 reapply and lose eligibility.
4 DR. HALL: So you wonder if we gain much by -- or
5 CMS gains much by categorizing this each time you go up by a
6 20 percent or 15 percent increment. I don't think there's
7 much change. Once people qualify, that's probably where
8 they are the rest of their lives. But I don't know. I'm
9 just trying to simplify things if we can.
10 DR. LEE: I think for a large number of Medicare
11 beneficiaries that their income is Social Security benefit.
12 DR. HALL: Right.
13 DR. LEE: So that is pretty constant over time.
14 However, unlike exchanges where the subsidy is based on the
15 IRS definition of AGI, whereas here it's based on the SSI
16 definition of income, which includes, you know, other
17 assistance that people may receive. So empirically I don't
18 know how much fluctuation or variation that exists over
19 time.
20 DR. HALL: Thank you.
21 MS. AGUIAR: And I would just quickly add to that,
22 when the fluctuation that we have heard in terms of people

1 falling in and out of these categories is much more on the
2 side of whether or not they qualify as a full dual for full
3 Medicaid benefits within their state, it really seems to be
4 -- that's a little bit more of an issue than -- and, again,
5 this was in our joint data book analysis that we did with
6 MACPAC, was where we saw some of the more shifts between
7 partial and full dual as opposed to between, you know, dual
8 and non-dual, that sort of thing.
9 DR. COOMBS: So as I read the chapter, one thing I
10 would have loved to maybe had this kind of information, and
11 that is, how well does support, partial/full support
12 correlate with things like ED visits or outcome-driven kind
13 of analysis on -- because we all assume that the more
14 Medicare D support you might have in terms of not having
15 barriers to get your medications, you know, the admission
16 rate may be altered by some of the policies that you have in
17 the drug plan and things like congestive heart failure, but
18 also emergency room visits which don't reach the bar in
19 terms of as much of a cost driver as a full-blown admission,
20 but it would be interesting to see if there's some data out
21 there that ties those two things together.
22 MS. AGUIAR: I just want to clarify that. Is your

1 question more that those in the MSP program who get this
2 financial assistance then -- is it an access-to-care issue?
3 Or is it how does their utilization change?
4 DR. COOMBS: How does their adherence and
5 utilization change as a result of their position that they
6 have -- we move them on the curve in terms of their wealth,
7 their element of wealth.
8 MS. AGUIAR: Okay. So, again, not to keep
9 promoting this data book, but in that data book we do have
10 data for, you know, all duals. We break it up between
11 partial and -- and, you know, as one would expect, it is
12 very high. We have not yet, though, looked at -- done sort
13 of a longitudinal analysis and looked at people who were,
14 you know, pre-duals and then became duals, and then to sort
15 of see how that changed. And that is something that we
16 could do.
17 DR. COOMBS: That's really a persuasive argument
18 for the support.
19 DR. CHERNEW: So a few basic things.
20 First, this issue of point of service versus
21 premium subsidy is important to me for a variety of reasons.
22 One of the issues sort of just as a general theme is that

1 you worry about cost sharing at the point of service because
2 it discourages the use of care, and you worry about cost
3 sharing at the point of service because it increases -- it
4 can increase care. So, for example, it's another
5 underuse/overuse thing.
6 What we'd like to do, if we could do it
7 administratively, is target the subsidies to the people for
8 the things you really think are important, but allow cost
9 sharing, higher cost sharing for the things that we don't.
10 That just turns out to be very hard to do. That's sort of a
11 value-based insurance design kind of notion, which sounds
12 good in meetings like this, and if we could figure out a way
13 to at least at the margin make it work, that would be better
14 than not. But I recognize it's hard.
15 So that gets to this question -- the first
16 question I have is about the administrative burden of doing
17 anything at the point of service. We've been talking a lot
18 about the administrative burden of enrolling people into
19 plans, and I believe that's administratively burdensome in
20 general. But the question I sort of have is: If you were
21 trying to set differential co-pays or deductibles or even
22 out-of-pocket maxes based on income, that somehow has to be

1 known and adjudicated in a much more complicated way than
2 just whether you get into a plan or not, because it changes
3 over the course of the year. And that's even before you
4 worry about value-based insurance design. That's just a
5 whole separate thing.
6 So I would like to know more about administrative
7 challenges of doing things at the point of service, which I
8 believe is important, particularly for high-value things,
9 because I worry that as lower-income people have to pay
10 more, some work we did suggested that charging lower-income
11 people more for high-value services led to disparities in
12 access to high-value things. And we were very worried about
13 that. But finding the solution in a way that doesn't lower
14 the co-pays for everything, creating the LIS story before
15 where they don't use generics, you know, is, I think, just a
16 fundamental and very difficult problem, but that doesn't
17 mean that it's not a very important problem.
18 My second comment is really just a question about
19 -- just showing complete ignorance. Do people on Medicare,
20 if they can't pay, go bankrupt? Is there a big -- and this
21 isn't, incidentally, just low-income people. You could be a
22 moderate-income or high-income person. There's no out-of-

1 pocket max, which is a concern we've raised in the past. So
2 anybody with a severe enough illness could conceivably, you
3 know, go bankrupt, or at least not be able to pay. So do we
4 think people don't use the services? Do they go bankrupt?
5 Or are providers writing off these expenditures? So I'm low
6 income, this person can't pay whatever it is, we're just
7 going to put that into charity care or bad debt or something
8 like that. I would just be interested to know broadly about
9 what happens across the income spectrum, although I think
10 it's clearly more often the case for lower-income people
11 when they have high expense -- when they're liable for high
12 expense relative to their income, what happens? Do they go
13 to collection agencies? I just don't know, and I would love
14 to know relative to this.
15 MS. AGUIAR: So I have only a partial answer to
16 that. What I do know is that some of the pathways, that
17 people become full duals, so an example of this is
18 SLMB-plus, are people who normally have income and assets
19 that would exceed -- that would prohibit them from becoming
20 -- from being eligible for Medicaid benefits to begin with.
21 And then they do have high health care costs, for example,
22 let's say a hospitalization, then followed by a nursing home

1 stay, a long nursing home stay, and they exhaust their
2 income and their assets to the point that they then qualify
3 for Medicaid benefits.
4 DR. CHERNEW: So just to be clear, what I hear you
5 saying is if I'm not Medicaid eligible now, and I have no
6 supplemental insurance, just for the purposes of this
7 discussion, and I get hit by a bus or something, and I have
8 very high expenses, at some point I would then become
9 eligible and then all my expenses after that point could
10 qualify for some of these other --
11 MS. AGUIAR: Exactly. You would qualify for that
12 program. And so that -- and, again, so I can't answer as to
13 whether or not people go bankrupt. I don't know. But I
14 just do know this is one pathway where people incur -- one
15 situation where people incur very high costs and then end up
16 needing Medicaid assistance.
17 DR. CHERNEW: And just a Jon Christianson-type
18 question in this regard. Roughly where is that in the
19 income threshold? In other words, would I have to spend
20 down to -- it's sort of an absolute threshold, so I'd have
21 to spend down to 150 percent of poverty? Is that the way I
22 should think of it?

1 MS. AGUIAR: So, again, because those individuals
2 would become full-benefit dual eligibles, that threshold
3 varies by states. In some states it's called "medically
4 needy." In some states I believe it's 300 percent SSI. But
5 it does vary by state.
6 DR. CHERNEW: So let me just -- I guess I'll just
7 ask my last and more complicated question. Are there asset
8 tests related to that, so I have to spend down not just as a
9 share of my income but I have to spend down my assets in
10 order to get to that point?
11 MS. AGUIAR: Yes, there are assets tests for that
12 as well, but as Joan had alluded to before, there are some
13 states that do tend to waive those asset tests. So, again,
14 it varies state by state.
15 DR. HOADLEY: And aren't there some states that
16 don't do any kind of a spend-down?
17 MS. AGUIAR: Yes, there are some states where you
18 couldn't even qualify for Medicaid under that scenario. We
19 could give you more information on this if you'd like.
20 DR. CHERNEW: My concern just broadly speaking is
21 I'm very concerned about the protections. One of the issues
22 I would ask is my sense -- and you can correct me if I'm

1 wrong -- is there's an odd sense of patchwork things that
2 are in place to try and protect people in a variety of ways
3 that aren't codified in a presentation as clear as yours.
4 And it's possible -- and I could be wrong -- that that is --
5 complicated and as frustrating as that patchwork of stuff
6 is, that it's actually doing okay and it's not as big of a
7 problem. Or it's possible that it's a disaster and there's
8 a lot of people that are losing their houses, going
9 bankrupt, whatever it is, that we should know about. And
10 I'm just not sure of how that's all playing out, and that's
11 what I was asking about.
12 MS. AGUIAR: You're right. it is very
13 complicated. But we could come back to that if you would
14 like to.
15 DR. MARK MILLER: I would have said part of the
16 ability to get back to the how many people and whether the
17 house was lost was complicated by the fact that these
18 decisions are so eccentric across the state for both income,
19 asset, and whether they do it at all. If I were in your
20 position, I would be very nervous that I could answer your
21 question in the end.
22 MS. AGUIAR: Well, with the --

1 DR. MARK MILLER: [off microphone].

2 [Laughter.]

3 MS. AGUIAR: In the instance of housing recovery,
4 again -- and I'd have to go back to refresh my memory about
5 this -- my understanding is that -- I wouldn't say all
6 states or most states -- some states do have policies that
7 say that if you enter a nursing home and then you become on
8 Medicaid, then basically that they are able to get your
9 house, for lack of a better word. But I have -- and there's
10 a term for it which is --

11 MR. GEORGE MILLER: Spend-down.

12 MS. AGUIAR: Spend-down, right -- a term that's
13 escaping my memory right now. "Housing recovery" I think
14 it's called. However, if that's on paper, it is also my
15 understanding that for the states that have that policy, it
16 is not always actually implemented, to further complicate
17 it.

18 DR. CHERNEW: I wasn't asking for some pristine
19 number that you have to defend. I was trying to get a
20 generic sense about how good or bad this informal safety net
21 system is, and also, frankly, how much it's burdening
22 providers. In other words, another part of the safety net

1 is providers just don't collect whatever it is, and so you
2 just never had to pay it.
3 DR. CHRISTIANSON: If I could just quickly jump
4 in, I agree we don't need a pristine answer.
5 It would be really helpful to me to have you run
6 two or three or four hypotheticals and just say, here's how
7 these -- for this person, here's how these different
8 programs would interact in this state.
9 Just, it's so complicated, and keeping it all in
10 mind is very hard.
11 So the hypotheticals don't need to be based on
12 what you think would be the average or, you know, we don't
13 need to pin you down to that, but just something that
14 illustrates how all of this works together or doesn't work
15 together.
16 DR. REDBERG: Thanks for a very helpful chapter.
17 I have been like, I think Bill, just trying to
18 think of ways to simplify, but the more I think I understand
19 it the more I don't know how much is possible for us because
20 so much of this is related to varying state requirements and
21 how states -- but it did occur, and I think Bill Gradison
22 mentioned this.

1 If it's possible to change -- and again, QMB and
2 SLMB have state components and QIs are only federal. But
3 with the ACA and the 138 percent of federal poverty level,
4 at least -- is it -- 25 of the expansion states will use
5 that criteria. If it was possible to simplify this in any
6 way, I think it would be helpful for me.
7 No, I think it would be helpful.
8 DR. SAMITT: I want to just come back to some of
9 the comments about, you know, striking the balance here
10 because, obviously, the challenge here is we want to enable
11 greater accessibility to the impoverished for the Medicare
12 programs, but we also want to align incentives with that
13 same population to choose value-based care alternatives.
14 So I'm interested in the comments in your future
15 work about aligning or evaluating across fee-for-service,
16 ACO and MA, and you know, the chapter was beautifully done.
17 And I think where I was going next with questions
18 is, is there a way to see a comparative analysis on how this
19 population is managed across these various sectors?
20 So, for example, how do D-SNPs or other MA plans
21 strike the same balance about accessibility versus alignment
22 of incentives?

1 And do we see different scenarios regarding drug
2 utilization or access, or use, of other services in MA plans
3 versus in fee-for-service or ACO, which I would imagine are
4 the same fee-for-service and ACO today?
5 So I'd be interested in the future work really
6 helping us look not just with the scenarios that maybe Jon
7 had suggested but also looking across to the various corners
8 of the Medicare program to see if we can learn anything from
9 that as well.
10 MR. GEORGE MILLER: Again, I will just add to what
11 my colleagues have said, that this is just a fascinating
12 chapter and great work.
13 As I read the chapter, I was struck by the
14 differences in the different states and the amount of
15 subsidies provided, or lack thereof.
16 And I'm wondering; because of that, is there any
17 movement from state to state because of a better or richer
18 benefit as we see in other programs in this particular case,
19 and does that impact federal spending?
20 And is there a way, if that is the case, to make
21 this simpler so that the impact is not as -- so that it's a
22 better benefit to the patient and aligns the incentives?

1 DR. CHERNEW: There was actually a recent paper
2 that came out that found there was not movement.
3 MR. GEORGE MILLER: Okay.
4 DR. CHERNEW: This wasn't in Medicare, but just in
5 general there was not movement across states in Medicaid, to
6 get better Medicaid as a general rule.
7 MR. GEORGE MILLER: Medicaid, okay.
8 DR. NAYLOR: So thank you for teeing up a great
9 conversation with your great work.
10 One question now that this generates for me -- and
11 it really was stimulated by Jack's comment about education
12 and outreach. And we have seen this so many times in terms
13 of even accessibility of existing opportunities and people
14 not knowing about them or finding it too complicated to be
15 able to get to them.
16 And I'm wondering; on your table 3, on page 8 in
17 the chapter, when you talk about the percentage of
18 beneficiaries who are current, I'm assuming -- and this is
19 excluding the duals who are currently receiving -- is that
20 those who are actually using it or those who are eligible?
21 DR. LEE: Those are people who are actually
22 currently participating in those programs.

1 DR. NAYLOR: All right.

2 DR. LEE: So, presumably, the --

3 DR. NAYLOR: It would be much greater given --

4 DR. LEE: It would be larger --

5 DR. NAYLOR: Larger.

6 DR. LEE: -- given that not all eligible
7 beneficiaries are participating.

8 DR. NAYLOR: Okay. I don't know if your data book
9 or others can help uncover how many potentially eligible and
10 how many are actually using. I think that would be very
11 helpful, if there's any way to try to peel away that part of
12 the onion.

13 MR. HACKBARTH: [Inaudible comment.]

14 DR. NERENZ: Caught you by surprise.

15 DR. MARK MILLER: It's fairly thin, but a couple
16 of things that could potentially come out of this
17 conversation because remember what the purpose of this was.
18 It was this is a very complex and important area. It is
19 hard to keep in mind for, you know, any moment.

20 And we wanted to bring you guys back up to speed
21 and also to bring you back up to speed on something that had
22 happened in the Commission a while back because it does kind

1 of fold into some of the conversations about benefit
2 redesign. In that sense, that's really all it was about.
3 A couple of things that I could take away from
4 this.
5 One is there was a couple of requests for
6 information to understand better.
7 And I admit that I kept thinking, God, it would be
8 really hard to get to an average number of X, Y, or Z, but
9 the notion of scenarios does kind of lend itself to -- and
10 it might be something of a public service to kind of lay out
11 a few things and say: By the way, mechanically, this is how
12 this works. Now, if you took another state, this is how it
13 would work in that state.
14 And it would be representative to the extent that
15 it was one person, one state, one thing.
16 And, even there, I swear there will be caveats.
17 If the state actually does X, then -- but there might be
18 some public value there.
19 The other thing that occurred to me -- and this
20 has potential to be wildly misunderstood if we were to do it
21 and present it in public -- would be to take one scenario.
22 So, for example, Glenn and Jack were talking about this

1 notion of income relating to the stop-loss. And, use that
2 to illustrate how many different directions the policy would
3 go in.
4 Okay, these are all the administrative issues.
5 You could -- you know, federal, state and then implications
6 for all of that.
7 These are all the issues for financing that start
8 to get implicated -- federal, state, that type of thing.
9 And not say we're doing it but say, this is when
10 you think about an idea like this; this is how many
11 different directions it runs in and the issues that get
12 implicated.
13 Again, more as a public service to try and
14 illustrate for people how these things hang together.
15 That was one thought. Now that doesn't take you
16 to a policy or anything, but hopefully, I've given you
17 enough time to say something more.
18 MR. HACKBARTH: Yeah, but you have not succeeded
19 in giving me enough time to say something better.
20 DR. MARK MILLER: I gave it a shot.
21 MR. HACKBARTH: But say something, I will,
22 nonetheless.

1 So this is sort of overwhelming in its complexity,
2 but if you go back to basics, I think what I hear here, as I
3 heard in 2008, is it doesn't make sense for there to be less
4 generous support for low-income people under Parts A and B
5 than under Part D; so we ought to move towards equalizing
6 assistance.
7 If we accept the constraint that we should not be
8 recommending increases in state fiscal burden, that really
9 limits our options and may limit it to just premium support
10 contingent on this analysis of the issues raised by income-
11 related catastrophic limit.
12 Now we acknowledge that maybe just the premium
13 support will --
14 DR. BAICKER: [Inaudible comment.]
15 MR. HACKBARTH: Yeah. Premium assistance.
16 Premium assistance, yeah.
17 We acknowledge that maybe the premium assistance
18 would still leave us with some issues about impaired access
19 to care for low-income beneficiaries because of the cost-
20 sharing that they would still face.
21 But, if it compared to the status quo, it's
22 clearly better. It may not be better than some perfect

1 model that we can't achieve in this complex web of federal
2 and state responsibilities, but it would be better than the
3 status quo.
4 And so, I support all of this and our analysis and
5 all of that, but I think there are still some basics here
6 that we probably agree on, and I just don't want them to be
7 lost in all of the discussion.
8 DR. MARK MILLER: That was good, Glenn.
9 MR. HACKBARTH: Not bad, okay.
10 Okay. Thank you very much, Christine and Julie
11 and Joan.
12 Okay, we are now to our public comment period.
13 [Pause.]
14 MR. HACKBARTH: Seeing none, I think we are
15 adjourned until next time.
16 [Whereupon, at 11:38 a.m., the meeting was
17 adjourned.]
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