MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 6, 2014
10:10 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [10:10 a.m.]

MR. HACKBARTH: Okay. Welcome to our guests and the audience.

We have two sessions this morning -- the first, site-neutral payments for select conditions treated in inpatient rehab facilities and skilled nursing facilities. For those of you who follow our work, you will recognize this as a recent theme of MedPAC's work, moving towards more site-neutral payments.

And then, before lunch, we turn to measuring quality across delivery systems.

So let's begin with site-neutral payments.

Carol?

DR. CARTER: Good morning. As Glenn just mentioned, this is a presentation that continues the Commission's conversation about site-neutral payments.

Past work, as you know, has focused on inpatient and outpatient services with the objective of eliminating price differences based simply on the setting.

Today, we are shifting our focus onto post-acute care. For some conditions requiring rehabilitation after a hospital stay, there is overlap in the beneficiaries for

some treated in IRFs and SNFs. We are exploring a policy that would base payments to IRFs on the payments made to SNFs for select conditions.

The Commission is not alone in its interest in this topic. Many of the past president's budgets, including the one released this week, have included proposals to narrow the price differences between the two settings for select conditions.

Today, we will begin with some background on how those two settings differ, and then we are going to review some criteria we use to select the conditions that we are exploring. Then we compare beneficiary characteristics and their outcomes, and we have estimated the impacts of paying SNF rates to IRFs. And, finally, we will end with a short discussion -- and there is more in the paper -- about waiving certain IRF program requirements.

The services typically offers in IRFs and SNFs differ in important ways.

First, IRFs are licensed as hospitals. They have greater physician oversight and are required to have more nursing resources available compared to SNFs.

IRFs are required to use multidisciplinary teams

led by physicians, and SNFs are required to do that.

IRF patients must require three hours of therapy a day. In SNFs, patients assigned to the highest case-mix group receive less -- about 2.4 hours a day.

Compared to SNFs, IRF stays are shorter on average, and the patients receive more intensive services.

We acknowledge that the services in these two sites are different. The question is whether the program should pay for these differences when the patients admitted and the outcomes that they achieve look similar.

Aside from program requirement, each setting has its own prospective payment system. SNFs are paid on a day basis, and IRFs are paid on a discharge. IRFs also receive add-on payments for teaching, high shares of low-income patients and outliers.

In the fall, we discussed criteria for selecting conditions, and we settled on three. The conditions make up a sizable share of IRF volume and spending. The conditions are frequently treated in SNFs. And we looked at conditions that had been included in studies comparing IRF and SNF costs and outcomes. Based on these considerations, we selected the three conditions on the right -- stroke, major

joint replacement, and hip and femur procedures, which includes hip fracture.

For the analysis in the paper, we have used DRGs as a convenient way to identify patients treated for the same condition. We show three conditions as illustrations but used a broader set of eight DRGs throughout the analysis.

In terms of payments, we summed the SNF daily payments to a discharge basis to make this comparison.

And the payments on this slide for IRFs include the add-on payments.

You can see here that IRF payments range from 40 percent higher for major joint replacement, without major complications or comorbidities, to about the same made to SNFs for hip fracture patients.

We examined many different characteristics of beneficiaries going to IRFs and SNFs, and you see that in the paper.

When we were comparing patients, we looked at patients that were admitted to facilities in markets with both types of facilities. We thought if there was some sorting going on between IRFs and SNFs, we would be more

likely to see it in those markets where patients had the option of going to one setting or another. The paper notes where our findings differed for all markets because we also looked at that.

Here, we show the mean risk scores measure using their HCC scores, ages, shares of duals, minority and female beneficiaries.

Especially for the orthopedic conditions, the second and third on the slide, the differences are pretty small.

There are larger differences with the stroke patients. For example, look at the risk score. You can see that the mean risk score of patients going to SNFs was 1.8 versus 1.5 for IRFs.

Across all the conditions, the shares of female beneficiaries were higher in SNFs.

We wanted to look behind the averages, so we compared the distributions of some of the characteristics. One measure of the overlap is to calculate the share of IRF values that fall within the 10th and 90th percentiles of the SNF distribution for that same parameter, say, the risk scores.

By definition, 80 percent of SNF patients fall within the 10th and the 90th percentiles. So, if there was a lot of overlap in these distributions, we might expect to see 80 percent of IRF patient values also falling within those 10th and 90th percentiles.

Here, we show the results of looking at risk scores and ages, and you can see that the overlap is considerable. For risk scores, it was between 72 and 82 percent, depending on the condition, and of the age beneficiaries there was slightly more overlap.

Another way we looked at whether the patients were similar was to look at indicators of patients' care needs, and we compared their predicted nontherapy ancillary and therapy costs that we use in the alternative SNF payment design, and that alternative design is described in the paper.

IRF stays had higher predicted mean costs per day compared to SNF patients, reflecting their higher intensity of services furnished to those patients given their shorter stays. Despite this, the overlap in the distributions was still considerable for NTA and therapy costs.

The relatively low overlap for therapy costs for

hip and femur procedures reflects the larger differences in the SNF and IRF lengths of stay that translate into higher IRF costs per day and, therefore, less overlap in the distributions.

Here, we compared the prevalence of comorbidities using HCCs. We are showing here the most frequent ones, and the columns show the three conditions, and each row is a comorbidity.

In general, the shares of patients with comorbidities were fairly similar, especially for patients recovering from orthopedic conditions.

Let's focus on the middle column for a minute. These are for major joint replacement patients, and you can see that across the board the shares of patients with these comorbidities are very similar. There were larger differences for the stroke patients. That is the first pair.

Patients treated in SNFs were more likely to have several of the comorbidities. The higher prevalence of them in SNFs may reflect that patients couldn't tolerate three hours of therapy in an IRF, and so they went to a SNF.

Here, we turn to some results from CMS's post-

acute demonstration because they looked at functional status at admission. You will remember that demonstration collected uniform patient assessment information using the CARE tool, and so the data are comparable.

Shown are the mobility and self-care abilities for admission to patients going to SNFs and IRFs, and these are data for all conditions, not our three select ones.

Going up the side is functional ability, and then you can see pairs for comparing the SNF and the IRF for both mobility and self-care.

This chart indicates that patients who went to IRFs and SNFs were very similar in terms of their incoming functional status, at least measured by mobility and self-care.

Now we're going to turn to outcomes.

Risk-adjusted readmission rates were not possible for us to do because of the lack of common patient assessment information. We compared the observed readmission rates during the IRF stay and the SNF stay and then 30 days after discharge. For these conditions, the unadjusted risk SNF readmission rates were higher than the readmission rates for IRFs.

However, when we look at the readmission rates from the PAC demonstration, which allowed for risk adjustment, we see that the differences were not statistically significant between these two settings. And that study looked specifically at a group of patients with musculoskeletal conditions, and nervous system, and that includes -- about half of those patients are stroke patients, and again, the readmission rates were not statistically different.

The PAC demonstration also looked at risk-adjusted measures of functional change. And for the two patient groups that we're focused on, what we see is that there were no statistically significant differences in change in mobility for either of the patient groups. For self-care, what the study found was that there were no significant differences for the musculoskeletal patients, but it did find higher rates of improvement for the stroke patients, just for the self-care.

The project did not establish thresholds for understanding whether the larger differences were sort of clinically meaningful.

Finally, we wanted to look at the 30-day spending

after the SNF or the IRF stay. While program spending on IRF stays is often higher than SNFs, what we wondered was whether spending after the stay was less or how it compared. We wondered whether their trajectories, if you will, for SNF patients and IRF patients were similar.

This shows the 30-day spending on all Medicare services. Spending on the second PAC site use, such as home health care or for IRF patients -- maybe they're discharged to a SNF -- is in yellow. The readmissions are in green. And the spending for Part B services is in gray.

We found that IRF stays continued to have higher spending in the 30 days after discharge compared to SNF stays. Additional PAC spending for IRFs was almost 50 percent higher compared to SNF stays. However, IRF stays had lower readmission spending.

When we combined the spending for PAC stays and the 30-day spending, IRF spending was 9 to 38 percent higher than SNF spending.

Okay, now Sara is going to go over our findings about the impacts of paying IRFs, SNF rates.

MS. SADOWNIK: To assess the financial impact of paying IRFs the same rate that SNFs would be paid, we

compared base payments to IRFs under current IRF policy for 2014 with 2 SNF scenarios -- payments using the current SNF PPS and payments under a MedPAC-recommended alternative SNF PPS design, as Carol mentioned. We used this alternative design because the Commission has long criticized the shortcomings of the current SNF PPS.

The alternative design bases payments on patient and stay characteristics rather than the amount of therapy furnished and better targets payments for patients with high care needs for nontherapy ancillary services such as drugs.

Under each SNF scenario, we modeled the payment that the case would have received based on the characteristics of each individual case. To do so, we had to address a few differences in the IRF and SNF payment systems.

First, we converted the SNF day-based payment to an IRF discharge-based payment, as described earlier.

Also, the IRF PPS includes add-on payments per case, which the SNF PPS does not, for indirect medical education, share of low-income patients and high-cost outliers. We assumed that IRFs would continue to receive full add-on payments for the cases paid under a site-neutral

policy. The site-neutral policy would only affect the base payment.

Our estimates do not factor any changes to IRF's patient admission practices or changes in spending in the 30 days after discharge in response to the policy.

We modeled impacts at the individual DRG level and impacts to total payments at the facility level.

For the DRGs we examined, both SNF payment scenarios resulted in a substantial decrease in payment for stroke, and hip and knee replacement, and then increase in payment for hip fracture. The table here shows impacts on the base rate for three DRGs and reflects some corrections from your mailing materials.

Under SNF current policy for 2014, payments for IRF discharges would decrease by about 22 percent for stroke DRG 65 and 23 percent for hip and knee replacement DRG 470 while payments would increase by about 5 percent for hip fracture DRG 481. The impacts under the SNF alternative design were similar to those for current SNF policy.

Impacts on IRF payment rates were fairly consistent across the broader definitions of the conditions -- the larger set of eight DRGs we examined, not shown here.

Based on the per-discharge payment differences, we estimated the total financial impact on IRFs of site-neutral payments for our select conditions, with both the more narrow set of three illustrative DRGs and the broader set of eight DRGs we examined for these conditions.

For the three DRGs, we found that paying SNF rates under current SNF PPS policy in 2014 would save a net of about $300 million, which would represent about 4 percent lower total IRF payments, including add-on payments.

For the broader set of eight DRGs, the payment impact was larger because more cases are included. In this case, Medicare savings would be about $415 million, or a 5 percent decrease in total IRF payments, including add-on payments.

We found that the total payment impacts were smaller with the SNF alternative model.

Overall, the impact of site-neutral payments on total IRF revenue was similar between provider types. Non-profit, for-profit, hospital-based and freestanding IRFs all had Medicare payments decrease by around 4 percent under site-neutral payments for the 3 DRGs. Payments for rural facilities decreased slightly more, by around 5 percent.

Site-neutral payments would decrease the total base payments slightly more for non-profit and hospital-based facilities compared with for-profit and freestanding facilities as non-profits and hospital-based IRFs have higher shares of patients with the three conditions. However, site-neutral payments in our model did not change add-on payments, which typically add about 9 percent to all IRF-based payments on average.

Non-profit and hospital-based facilities receive more of these payments than for-profit and freestanding facilities, and receiving these add-on payments lessens the total financial impact of site-neutral payment policy for these providers. In essence, while these providers have larger shares of patients with our select conditions, add-on payments make up a larger share of total revenue for these providers, and this revenue source is not impacted. Therefore, overall, the financial impacts of site-neutral payments on total revenue are similar between these provider types.

In establishing narrower prices between IRFs and SNFs, we need to consider whether IRFs should continue to be required to meet IRF regulations for the selected case

types, such as the provision of 3 hours of therapy a day, the frequency of physician supervision and the 60 percent compliance threshold. Medicare could waive some of these requirements for IRFs when they treat beneficiaries who could be appropriately treated with less intensive care, which would allow IRFs the option of functioning more like SNFs in treating those conditions and, thus, leveling the playing field with respect to regulatory requirements.

While we recognize that IRFs face some fixed costs in their requirements, such as having a medical director of rehabilitation, IRFs could choose to provide less intensive therapy or medical care for individualized patients based on the patients' particular needs. For example, IRFs could have the flexibility to not provide three hours of therapy each day or to vary the number of physician face-to-face visits each week as IRF clinicians deem necessary.

If these requirements were relaxed, Medicare would need to carefully monitor outcomes, such as readmissions and improvement in functional status, to ensure the quality of care is not eroded.

Options regarding how to factor site-neutral payment cases in the 60 percent compliance threshold are

described in the mailing materials, and we are happy to discuss this on questions.

We have outlined options for Medicare paying similar rates when IRFs and SNFs treat similar patients and have similar outcomes.

Next steps include refining which conditions should qualify for site-neutral payments, including potentially exempting specific case types. For example, patients who require IRF-level medical or rehabilitation care, such as patients with particular comorbidities that require 24-hour nursing or frequent physician oversight, may not be appropriate candidates for site-neutral payments and perhaps should be exempted.

We also plan to identify the key factors that predict where patients are discharged to further assist the overlap in patients.

While a few IRF conditions, such as burns, spinal cord injury or traumatic brain injury, may always typically require hospital-level care, many other conditions could likely be found to be appropriate for care in a SNF and, ultimately, be applicable for site-neutral payments.

This analysis also reinforces the PAC-PRD

conclusion that a common payment system may be possible for patients who could appropriately be treated in different settings. Even if estimated savings are modest, the approach begins the process of considering a common payment system across PAC settings.

We look forward to the Commission's input on site-neutral payments in IRFs and SNFs, in particular, which cases and conditions to focus on, whether there should be exemptions and which, and whether some IRF requirements should be waived to create a more level playing field between IRFs and SNFs for these cases.

This concludes the presentation, and we will take your questions.

MR. HACKBARTH: Okay. Thank you.

Clarifying questions? I have Peter. We'll go down the row here. Inquiry? We'll get Peter.

MR. BUTLER: Slide 11. Just to make sure I understand the -- the first one, I understand, and you have specific -- in the chapter, the differences in the rates. And then the second said, which are unadjusted -- am I drawing the right conclusion to say once you adjust for risk, there is no difference, at least for those

musculoskeletal and nervous system? So the first point really is not something we should worry about, or should we worry about the differences in readmission rates?

DR. CARTER: I guess personally, I would put more emphasis on a risk-adjusted rate, but because they were broader groups of patients, they're not exactly comparable, because the musculoskeletal includes a broader mix of patients, as does the nervous system conditions. So we don't have the data on the three conditions narrowly that were -- the rest of the paper is focusing on, but I would place more weight on a risk-adjusted measure.

MR. BUTLER: Okay. On Slide 13, it's somewhat related, but make sure I understand what you're trying to convey here. Let's look at stroke. So that's one where in the chapter, there's a 15 percent readmission rate in SNF versus 11 percent in IRF, which I think accounts for the difference in the size of the green bar, right? And the yellow is any post-acute care spending. It could be home care. It could be in fact ISNF, or it could be anything that we consider in the post-acute care bundle, and the gray is part B, right?

DR. CARTER: Right.

And so, for example, if somebody was readmitted, it would include the readmission also to the SNF, for example, because it's looking at post-acute care spending after the discharge from the SNF of the IRF. So if somebody was readmitted to a hospital and then went back to a post-acute care setting, it's picking that up. It's also picking up any home health care spending or -- I mean, there's very little LTCH referral, but there could be an occasional one of those as well.

MR. BUTLER: Yeah. I'm trying to -- I understand kind of the blame, if you will, related to the green bar and the readmission rate. I'm less clear in my mind to what extent the setting and how it's managed affects the yellow bar, you know, and that's just a little -- a little less clear to me how we should look at that.

DR. CARTER: Well, one thing that I think about is because the IRF's days are so much shorter, they're about half, you know, ball park. So you might thing that they have another PAC use after that, and it turns out a lot of them do. And so even -- so that was one of the things I was interested in was how, given that the lengths of stay are so different for these two settings, how does the 30-day

spending after that compare.

DR. BAICKER: And does the yellow bar then include this PAC use subsequent to a second readmission -- I mean to readmission. So some of that kind of goes with the green bar, and some of it might be straight from one PAC to another PAC.

DR. CARTER: That's right.

MR. BUTLER: Not to divert us too much, but this is an important slide.

So my simple mind says what's the tradeoff between the site-neutral and the readmission part. I can make that calculation pretty well. I get less clear about how to make the calculation when you include the total bar difference.

MR. HACKBARTH: So on this same slide, as I understood what you said in response to Peter's first question about Slide 11, the risk adjustment here is this information is all drawn from the PAC demonstration. None of our analysis is risk-adjusted, so --

DR. CARTER: It's only risk-adjusted to the extent that like this stroke is a specific DRG. So it's not the strokes with the major complications and comorbidities. So to the extent that you think that the DRGs are somewhat

sorting patients by their complexity of their comorbidities and complications at least while they are in the hospital, that is controlled for.

MR. HACKBARTH: Yeah. But as risk adjustment, the term is used on page 11. "This graph" --

DR. CARTER: This is not. Right.

MR. HACKBARTH: -- "is not risk-adjusted."

DR. CARTER: That's right.

MR. HACKBARTH: Okay. Cori.

MS. UCCELLO: So I can't remember if this was discussed in the chapter, but can you talk about why the savings would be smaller under the alternative SNF payment?

DR. CARTER: We haven't analyzed that completely. I mean, one reason is because the alternative design is not basing payments on therapy but on their comorbidities, to the extent that IRF patients have more of those things coded, they will pick that up.

The other thing is the way that we -- and probably -- and more importantly, the way that we estimated the spending for IRF cases was we calculated a cost per day, and because IRF services are more intensive, they end up with a higher cost per day, and then we multiplied it by the SNF

length of stay, and so they sort of have a higher cost per day that then gets multiplied out through the SNF length of stay, which we assume for the IRF patient.

One of the things we had to think about was, well, IRF stays are much shorter than SNFs, would they continue to be under this policy. So at least for this go-around, we assumed that the length of stay would mirror more like the SNF length of stay, but that's why you see the differences. It has probably more to do with length of stay differences and how the costs that are higher in IRFs on a daily basis get multiplied through.

DR. COOMBS: I had a question on 11 as well, but now I understand, Carol. Thank you so much. You're basically saying that's a whole bunch of little DRGs dumped into the second risk-adjusted one, is that correct, on Slide 11?

DR. CARTER: Right. Well, to the extent that the musculoskeletal includes a range of patients, yes.

DR. COOMBS: Right, right. So the variability of those DRGs in terms of prognosis and how they fare is going to be very different from the three, very three specific DRGs and the first unadjusted bullet, right?

DR. CARTER: Before I agreed with that, I would need to look at the mix of cases in that broader condition definition and see.

Like the nervous system, I think 47 percent of those cases are stroke patients, and so it's true -- 53 percent aren't -- but stroke is going to be a major factor in that readmission rate.

I haven't looked at the musculoskeletal bucket, if you will, to see sort of the mix of things that's in there, and to the extent our -- the conditions we focused on, over how much overlap there is in there.

DR. COOMBS: And then the second question is, What is the value of the balance that we see here between the readmission rates and the cost of the secondary PAC stay? What value -- I know that you said it was a 4 percent savings, 5 percent savings later on in paper. What is the value of that? What are we giving up? What is our opportunity cost here if we switch, take away the 3 hours of intensive therapy in the IRF? Is that in and of itself something that's going to reduce cost by itself in terms of being more selected? Is there a -- is there a conversion factor for what we're going to see combining the readmission

and looking at the savings that are accrued because of the different -- changing the protocol or regulation?

MS. SADOWNIK: We didn't look at any changes in spending after, in the 30 days after discharge from -- from the IRF or from the SNF when we looked at the payment impact. So that 4 percent is just for payments for that stay. We did not assume any changes in the days after discharge.

And actually, to your earlier question, it's worth noting that in the PRD, for example, when they talk about stroke or musculoskeletal conditions, et cetera, the DRGs that we looked at do not -- so let's say the three DRGs for stroke that we looked at in the broader set do not constitute necessarily all of the stroke cases in an IRF, there could be some subset of other smaller DRGs that we didn't look at. There could be they didn't have -- they had a different DRG in the hospital but stroke was the most important impairment when they got to the IRF, et cetera, so that's an important distinction.

DR. COOMBS: So thank you very much. That's very helpful.

I can go to the second round. Thanks.

MR. KUHN: On Slide 4, you list the three conditions there: stroke, major joint replacement, and hip fracture. Carol, also in your opening comments, you mentioned that the administration, their budget that they released this week, also has a proposal out, and they've kind of talked about this before. Did they define specific procedures in their budget proposal, or did they just say let's try to align as many of these as we can?

DR. CARTER: They specifically mentioned -- I haven't looked. I forget -- I haven't seen sort of the detail behind what was in this year's budget.

In the past, they've looked at hips and knees -- and I think that's literally the language, which now we can see could mean a few things -- pulmonary and then others to be determined by the Secretary.

MR. KUHN: Okay. Thank you.

DR. CARTER: We looked at respiratory, because we knew that that had been on their radar screen, but the case counts in the IRFs just isn't high, so we didn't pick it for that reason.

MR. KUHN: Thank you.

MR. ARMSTRONG: Last month when we were -- or in

the late couple of meetings when we were setting rates and evaluating the performance overall of the industries, I just didn't have a chance to go back and look at this. Could you remind us how are -- what's the financial performance of IRFs in our most recent analysis?

MS. SADOWNIK: The overall, the marginal cost --

MR. ARMSTRONG: Margins, yeah.

MS. SADOWNIK: -- all industries, about 11 percent.

MR. ARMSTRONG: About 11 percent.

MS. SADOWNIK: In 2012.

MR. ARMSTRONG: Yeah. Thanks.

MR. HACKBARTH: Clarifying questions?

DR. REDBERG: Thank you.

On Slide 13, again, do you know what the mortality rates were for SNF and IRF? Because anytime I look at readmissions, I find it helpful to know the mortality, because obviously dead people don't get readmitted, and we'd want to know that that was not what was driving the lower readmissions.

DR. CARTER: Right. So at least for our paper and this entire analysis, because I knew we were looking at the

30-day spending, we excluded people who died.

DR. REDBERG: But do you have that data?

DR. CARTER: I think I can get it. Yeah.

DR. REDBERG: Great. Thank you.

MS. SADOWNIK: For IRFs, anyway, it's about 0.2 percent died during their stay.

DR. REDBERG: Just during the 30-day period is what I'm interesting in.

MS. SADOWNIK: Oh, no. I'm sorry. Sorry. Just during their stay.

DR. REDBERG: Thank you.

MR. HACKBARTH: George.

MR. GEORGE MILLER: Yes, please. On Slide 13 -- I'm sorry. 9. 9. I'm sorry. Thank you.

I noticed that on the -- as you pointed out, more comorbidities on the SNF side, especially under stroke, could you remind me with that, what the outcomes were for stroke, compared to the IRFs, between the SNFs and the IRFs? It would seem -- if I remember, you're saying that the outcome is still the same --

MS. SADOWNIK: Yes.

MR. GEORGE MILLER: -- even though the

comorbidities may be more --

MS. SADOWNIK: Right. So the outcomes for mobility were the same, and for stroke, for self-care, IRFs had slightly -- they had significantly better improvement in self-care.

MR. GEORGE MILLER: Okay. Okay. And then Slide 17, please. What's the difference? Why would rural IRFs have 5 percent versus urban 4 percent? Can you just give me the math why it's higher?

MS. SADOWNIK: I think the reason for the difference that we're seeing is that rural facilities do take higher shares of the -- of patients with the three conditions that we looked at.

MR. GEORGE MILLER: Oh.

MS. SADOWNIK: And their add-on payments are almost exactly the same as urban. So you don't have that offsetting factor.

MR. GEORGE MILLER: But it seems that would be just the opposite. I thought you said that the add-on payments were not impacted, but it's the larger share is the mathematical issue then, the larger share. Okay. I got it.

MS. SADOWNIK: That's right.

MR. GEORGE MILLER: It's the larger share. Okay. Thank you.

DR. CHRISTIANSON: So on page 32 on the bottom, you're kind of dropping the idea that looking at this for broader clinical categories might have some merit, and then it does seem like it might -- and then you suggest that further research would need to be done. Is that something you're planning on doing, or is that something that you're hoping other people will do or what? How do you plan on proceeding with that suggestion?

MS. SADOWNIK: I think the challenge there in drawing a direct comparison to SNF patients gets into more challenging research issues to draw a direct comparison.

With DRGs, it's considerably easier, because you are comparing patients. You have sort of a common unit between IRFs and SNFs of what did they -- what did the hospital -- what did they have in the hospital, what did the hospital define them as before they left and went to their post-acute care. And because patients may be categorized differently once they get to the IRF and the SNF, in IRFs the condition that you have is very important to your unit of payment, and in SNFs much less so. So sort of drawing a

more exact circle between those patients would be challenging for that reason, so --

DR. CHRISTIANSON: I get that it's challenging. You sort of put out there that further research needs to be done, and my question was, Is that on your agenda?

DR. CARTER: Not immediately, no.

MR. GRADISON: It's a powerful argument here that we're overpaying for certain sets of services that are performed in both types of institutions from which on Slide 16, you derive some estimates of potential savings. My questions -- my question, really, goes to what is the significance of -- what would be the significance of that move to the financing within the IRF?

Now, let me explain what I mean. If IRFs receive less money than they do now for patients that are less expensive to treat, will it be necessary to reevaluate the amount that they are paid for the patients that they will continue to treat, which are more expensive? In other words, is there a significant degree of cost shifting within the IRF or income shifting, however which way you want to think about it, from the money they receive going -- perhaps some of it, a significant number, arguably, going from the

less expensive cases to the more expensive?

Another way to phrase the question is, Are there significant fixed costs that the IRF will continue to incur mainly because of the requirements, the hospital-based requirements that the SNFs do not have to -- that would argue that if they do, if we do what's recommended here that we're going to -- as part of the analysis take a look at what we paid the IRFs in the future for the cases in which they have a particular niche and will continue to be paid under the current rates?

DR. MARK MILLER: I think if I can just interject, I think there's probably two or three things that the Commission would have to think about in answering that question.

Scott asked the question of what's their overall financial performance now, and that's probably something to keep in mind.

Another question is implied -- I think by your question is, well, there's a certain fixed cost here, and we have to cover it, but the other thing that could happen is how these patients start to be treated might change and the IRF's approach to the patients that they either continue to

take under this payment system or substitute other payments could change. There were changes made in the IRF through the 75, 65, 60 whatever percent rule, and the IRFs did respond to that and actually changed some of the underlying mix of their patients. So some of the answer to your question also gets behavioral. Do they stay right in this space, or do they actually respond by going to different mixes of patients, that type of thing?

MR. GRADISON: I guess what this really comes down to is a suggestion. You might want to take a look at what the implications, if any, are within the financing of the IRF. I acknowledge the 11 or 12 percent. I'm not trying to say that's not a factor, but I still think it would be interesting to say, "Okay. Granted that, how much would that come down if this change is made?" I think that's a meaningful question for us to ask.

Thank you.

MR. HACKBARTH: Just to pick up on that, when we talked about site-neutral for LTCH, my recollection -- and correct me if I'm wrong about this -- is that we were able to say that the patients that we were cutting payment for were not disproportionately profitable relative to the

others, and so I think Bill is correctly asking what do we know about the relative profitability of cases within IRFs right now.

Can we say anything at this moment about that, or is that just something we have to examine?

MS. SADOWNIK: That is something that we would have to examine.

MR. HACKBARTH: Okay.

MS. SADOWNIK: But you're raising some very good points about, I think, making sure that in the case of if it became -- if regulations were waived and it became less costly for IRFs to treat these site-neutral payments, what impact would that have on the relative payments for other cases and making sure that we wouldn't inadvertently pay more for the other ones? Because IRFs --

MR. GRADISON: Paying too much or too little.

MS. SADOWNIK: Right. Pay too much or too little, but because it's sort of a relative value, it's scaled now, so those sort of points.

DR. COOMBS: But isn't that the reason why the joints were -- seemed as low resource input compared to some of the other orthopedic procedures like the hip fractures

and the knee fractions, and that's the reason -- especially the knee replacements, they come in with less comorbid conditions, and even their comorbid conditions are not as advanced. So they were seen as more profitable, and therefore, I thought that was why the restriction on the percentage of patients in those institutions was input.

MS. SADOWNIK: The restrictions were not due to profitability but -- because that's where -- it may be -- you know, they are lower cost than, say, a stroke patient and paid less than a stroke patient. But I can't comment on the profitability, you know, the payment to the IRF versus their own cost but --

MR. HACKBARTH: The profitability is a function of payments and costs. We can say they're less costly, but we don't know how the relationship between payment and cost goes.

MS. SADOWNIK: Right. But those restrictions in terms of the 60 percent rule were commenting more on the need for intense rehabilitation and being treated in an IRF sort of medical necessity -- you know, need for intensive rehab compared to -- you know, there are select conditions that have been identified as needing intensive or deserving

of intensive rehab. So stroke, yes, and hip and knee, no.

MR. HACKBARTH: But what I hear you saying is that it is feasible to do the analysis that Bill and Alice are referring to, look at the relative profitability of cases that we might be moving, or is that an unrealistic expectation?

MS. SADOWNIK: That would be a very long -- I think a long-term endeavor to do that --

DR. MARK MILLER: Yeah, and I think I'd like to take this offline and have a discussion and see what we can do about that.

MR. HACKBARTH: Bill, a clarifying question?

DR. HALL: Yes. I really thought this was a terrific chapter, corrected a number of biases that I think I've had for years on this subject.

A couple of clarifying questions. Why did you pick 30 days as the time frame post-discharge to evaluate whether there were some adverse consequences of IRFs versus SNFs?

DR. CARTER: It does mirror the Medicare spending per beneficiary measure, so --

DR. HALL: For acute-care hospital --

DR. CARTER: Yeah, yeah.

DR. HALL: And maybe it --

DR. CARTER: Were you thinking something longer, or --

DR. HALL: Well, I think there's significant clinical differences between the expected rate of improvement post-hospitalization than post-SNF or SNF. And if it were feasible to look at 60 and 90 days, I'd be much more reassured that we haven't overlooked a benefit of one of the two venues for care, if it wouldn't be too much trouble.

And the other is there was a very tantalizing paragraph at the very end of the material you handed out that mentioned there's some industry interest in creating what might be called "super SNFs." Do you have anything more to say about that or that is available?

DR. CARTER: I can get you information. Some of the publicly traded firms have been -- talk about their business strategy and have developed -- they call them different things. One change calls them "sub-acute," another chain calls them "transition care." And they really are focused on sort of high-intensive, mostly Medicare, but

rehab services.

DR. HALL: So it sounds like someone thinks that if a SNF looks more like an IRF, there might be a market for it. Is that fair?

DR. CARTER: Well, we know that--

DR. HALL: I'll just withdraw that. Okay. I'm fine for now.

[Laughter.]

MR. HACKBARTH: Okay. Let's move on to Round 2. Herb, do you want to start Round 2?

MR. KUHN: So one question I just have before I get into a couple observations here is: Are we seeing anything in the data that shows different movement between SNFs and IRFs as a result of ACOs? Or is it too soon to tell? Because the incentive is to constrain costs, and so our -- when they get to discharge, are they moving folks more to a SNF, a lower-cost setting, or even to home health for that matter? And so I'd be curious if we're seeing, beginning to see any changes there.

DR. CARTER: We haven't looked at that, and I would defer to our ACO folks. Evan and I separately have been talking to some companies about how the private sector

manages post-acute care, and we are seeing -- we are hearing, at least, anecdotally that in an effort to control post-acute-care spending, they focus on two things: one, shortening the SNF stays, and the other is avoiding the high-cost post-acute-care settings. But I don't know specifically about ACOs.

MR. KUHN: It would just be interesting to see as we continue to go forward.

MR. HACKBARTH: Yes. So I think at the last meeting Jeff --

DR. MARK MILLER: Yeah, I got it.

MR. HACKBARTH: -- mentioned that we were starting to get ACO data that we can begin looking at.

DR. MARK MILLER: Yeah. I don't know that we can slice the data at this point into that kind of detail, but what I will tell you is the conversations with some of the ACOs, they have different strategies, and one of the strategies is to focus on post-acute care, and the sentences are very similar to what Carol just said.

MR. KUHN: Okay.

MR. HACKBARTH: And if Craig were on the ball, he would also ask about the Medicare Advantage data.

DR. SAMITT: I was going to do that [off microphone].

MR. KUHN: The encounter data.

DR. MARK MILLER: A preemptive strike [off microphone].

MR. KUHN: So a couple additional thoughts. One, in terms of waiving the regulatory requirements, I understand that. That makes sense. It sounds to me, I guess, and the only way that I can kind of frame it, it almost sounds like a swing bed-type program in the IRF world, like we have for rural hospitals where they can have an acute-care bed and then the next day it's kind of a SNF bed, for intents and purposes. So I don't think it's out of bounds in any stretch of imagination. It's been done in Medicare before.

But the final two things kind of is where we go forward on this. So I understand the conversation. I understand what were trying to accomplish here. But I'd like to think of it more in the terms of kind of a bridge to a post-acute-care bundle, because this is -- does this really take us, move us in that direction to get us to that stage of where we need to be? Because ultimately I think

where we'd all like to see this is where we have good case management, where they're making the decisions to put the patient in the right place, and do these policy decisions we're contemplating now move us in that direction? Or does it veer us off to one direction or another? And I want to just make sure we've got good alignment as we think about that going forward.

And in that same vein, we're mostly talking about post-acute care here, but would it be also helpful to look at procedures that are admissions from the community? Are we just looking at folks that have been hospitalized and then moving to the post-acute-care setting? Are there a different set of conditions that could be an admission from the community? Of course, that raises the whole issue of waiving the three-day prior hospitalization for SNFs and all those things. But I'm just wondering, again, thinking about this notion of a bridge to a post-acute-care bundle, are we limited in our thinking, or are there some other areas that we could be looking at?

MR. HACKBARTH: So here's my thinking about that. We've had over the years several different discussions about moving towards a post-acute-care bundle or bundling post-

acute care with inpatient admissions and the like. The most recent of those was -- I don't know.

DR. MARK MILLER: Carol, do you remember?

DR. CARTER: June of this past year we had a chapter.

MR. HACKBARTH: June last year.

DR. CARTER: Yes.

MR. HACKBARTH: And each time we've addressed that, it has been inconclusive, shall we say. Commissioners have been divided about whether that's a path that we wish to pursue or at least put -- let's put it this way, wish to pursue until the current demonstrations are complete. So as everybody knows, CMS has set up some demonstrations and various models for bundling either admissions with post-acute care or just post-acute care by itself. And those, are they actually up and running yet? They are up and running?

DR. CARTER: Yes.

MR. HACKBARTH: But the results from those are years away, so the demos will run for several years, and then it'll be years of evaluation. So that track is not immediate.

So our thinking has been that, given that bundling is not going to happen quickly, given that Commissioners have said, well, we don't want to press ahead absent information from the demos, the question then becomes: Well, what do we do in the meantime in the non-bundled Medicare fee-for-service program? And that's the question that we're trying to address here or with LTCH site-neutral payment, et cetera.

MR. KUHN: That's helpful to get that additional background, Glenn, and I recall those conversations now. But I just want to make sure whatever we think about it doesn't -- are we thinking about things -- does this align with those demonstrations? Does it go in a different direction, the demonstrations so we have a different result for maybe where the demonstration -- I just want to think -- just make sure there's some alignment there.

DR. COOMBS: If you wouldn't mind putting up Slide 9? Thank you so much for this chapter, and it was almost like, Carol and Sara, you anticipated some of the questions that I had, so it was really neat going through the chapter.

One of the things that if I thought of one group to do this project with, it would be the center group,

because many of the major joint replacements and knee replacements that I deal with on a daily basis are coming in elective. No one really has an elective stroke. And, I mean, your whole presentation is very different, so that when these patients leave the hospital, they leave quite differently from many standpoints.

The problem with the stroke category is that there is such large variability in a stroke, and the recovery, as Bill has kind of alluded to, is so variable. You can come in with, you know, hemiparesis and someone over maybe 45 days or 60 days gets to the point where they're more functional, and your graph that shows mobility and how someone gets to the place where they can ambulate, maybe with a walker -- all of those things become very important past that 30-day period. So I think that stroke is a very vulnerable category, a DRG to deal with because of the wide variability of presentation.

So if I were going to try this project with -- it would be the middle category, which has -- they may have comorbid conditions, but they're coming in electively, you know, and so that makes that patient very different in terms of their overall presentation. And to be honest with you,

I've seen patients stay a few days in the hospital and even go home with physical therapy at home. So this is a reachable goal for that group in the middle. I think that's where I'd go with that.

MR. HACKBARTH: And so just to pick up on Alice's point, which I think is a good one, if you were going to do a category of patients which has this inherent variability, you would only want to do that if you felt confident you could risk-adjust very accurately within the category to address those differences.

Now, we talked earlier in the presentation about how this analysis has not been risk-adjusted, the payment part of it. But the PAC demo did do risk adjustment for comparison, comparison outcomes.

My question is: Should we think about this pay policy now as having risk adjustment beyond the DRGs? Or is the DRG classification going to be the extent of the risk adjustment? Is that clear?

DR. CARTER: Yeah. So the DRGs were just a convenient way to draw a circle around patients that were leaving the hospital for the same condition. When they come to the SNF, they're not going to be paid on a DRG basis.

MR. HACKBARTH: Right.

DR. CARTER: If it's current policy, they're going to get assigned to a RUG group for each day.

MR. HACKBARTH: Right, right.

DR. CARTER: And I'll remind you that -- you, gosh, of anybody remembers that the SNF payment system is really driven by therapy, much less so than diagnoses, which is one of the things we like about our alternative design, which is really basing payments on patient characteristics. And to that extent, if you thought that the -- under that scenario, there is a risk adjuster based on comorbidities and the clinical condition of the patient.

MR. HACKBARTH: Okay.

MS. UCCELLO: Okay. I think this is really great work, and I think it's a natural extension of other things that we've been doing to pursue site-neutral payments. And when we think about conditions to look at beyond people who know a lot more about this in terms of clinical things, just thinking about, you know, patients who have similar needs and at different sites offer similar outcomes. And it is worth doing if there are meaningful spending differences between the two, or whether it facilitates better this move

to a site-neutral payment, even if the spending differences are a little less.

Kind of building off what Herb's discussion was about, I know we can be frustrating in that we want to go fast, except when we don't. And, you know, sometimes when I look at this stuff, as well as some other of our site-neutral payments, sometimes I feel like we're micromanaging on these very narrow things. But, on the other hand, I think about how, you know, even when we will kind of eventually move to these broader units, we still have to kind of have the payments right in the first place to be able to do that. So I think this is, you know, still very worth doing.

One thing that was interesting in the output here, results, was that the spending for the IRF was actually less than the SNFs for hip fractures or something, and so, I mean, I think we should think about going both ways, not just all going to the SNF. If it is actually less than IRF, I think there's argument to be made to make those the same as well.

In terms of the requirements, I think it makes sense to relax some of those, similar to what we did for

LTCHs, if we're paying the same, then we should relax some of those. And we didn't really talk about it, but the chapter talked about in terms of the threshold, perhaps lowering it or tightening, if that seemed to make sense.

DR. MARK MILLER: Just to the extent that the preliminary cost savings or spending savings, they assume both the up and down, right? And so we laid out the fact that in two instances it went down but in one it went up, and the impacts are the net. So we actually raise the payment in the third case.

MS. UCCELLO: Right. And I'm saying we shouldn't do that. We should go the other way.

DR. MARK MILLER: Okay. That's what I wanted you to try and see what you were saying. So far we've just assumed the chips fall where they may.

MR. HACKBARTH: Yeah. Just one other thought about this relationship of this work to, say, future bundling. You know, another way to think about these things is as a potential catalyst, you know, when you sort of shake things up, and it's a reason for people to say, well, maybe moving into a bundled payment system would be a better model. And so that's, frankly, how I think of some of these

things, as just get the system moving, shake it up a bit, create some dynamism.

DR. HOADLEY: So on the broader policy issues, I think, you know, I'm pretty in sync with these last couple of comments in terms of how we go. I wanted to just zero in on a couple of more specific things that partly were triggered by some of the first-round questions in one case.

When you talk about Slide 13 about the 30-day spending and it's higher in the IRF, and you said part of that may be as a result of the fact that the stays are shorter in the IRF, so we're at a sort of different point post-hospital. Does it make sense to look at spending 30 days or 60 days, or whatever, from the original hospital discharge as a way to balance out that kind of look? Is that something that would make sense as another analytical line?

DR. CARTER: I understand your question. I don't think we could do it sort of for this round of analysis, but, yeah, in that sense it would -- you're right that 30 days added to a 14-day stay is different from a 30-day stay added to a 25-day stay. You're sort of capturing different recovery periods, if you will, and we could do that down the

road if we decided to pick up on it.

DR. HOADLEY: Okay, yeah. And the other thing, I guess when I started reading this chapter, which was really very helpful in going through this issue, I started to think, well, given the requirements, what am I expecting? You're going to make these comparisons of the different sets of patients in the two settings. And I realize, you know, there's this interesting contradiction in the IRF requirements that you're saying somebody needs to be -- you know, should be in a situation where they've got the presence of the doctors and all the facilities of the hospital. On the other hand, they've got to be healthy enough to withstand this longer, potentially longer amount of therapy every day. And, you know, you come out with a very consistent set of measures done lots of different ways, which is very powerful, that overall these patients aren't very different, a little bit here, a little bit there and different things. But the net stories is that they're not very different.

You know, is that just the contradiction? Is any of that the result of this contra -- I mean, I don't know if this is an answerable question, but the contradiction in

these requirements that on some dimensions they have to be healthier, in some dimensions in a sense they have to be less healthy. And is there anything else to sort of capture if there's a subtle difference in there somewhere to capture that?

MS. SADOWNIK: I think one thing that has been a caveat in a lot of the research comparing outcomes in IRFs and SNFs is also the factor of motivation to be able to meet the IRF requirements, that you have it in you to be doing three hours of rehab a day.

Also, one other point on the spending that relates to both your first question and your second, you know, maybe in terms of motivation or other external factors, is that some -- is that some SNF patients are also going back to a nursing home more than IRF patients would, so maybe you go home with home health, you have someone at home, and that home health spending would be recorded for the SNF. But, you know, your nursing home spending would not be recorded for the SNF. Did I say that backwards?

DR. CARTER: No.

MS. SADOWNIK: Good.

DR. MARK MILLER: I think there probably is

something to what you're saying. I think probably some of the patterns do reflect this puts and takes, given what the patient has to be able to do in the IRF, and I think some of that drives one of our concluding points that we want to unpack I think the stroke group a bit and try and figure out whether there are some distinctions in there, even below the -- I know we've tried to look at this orthogonally, a number of different ways, but whether there's even yet another pass through this, and I think some of it is driven by exactly what you're saying.

DR. NAYLOR: So, first, I also echo everyone's comments about this was a terrific analysis, and I think it's invaluable in helping to determine what might bundle payment or could it look like in the future. And so I would say down the road, I would start even a little further back. I mean, I think it would be interesting to know when the index hospitalization started and whether or not this provided an alternative to earlier discharge, knowing it was to the IRF, and then what the patterns are. So you have this amazing opportunity here to kind of help understand the trajectories of the entire experience with care.

I do want to echo people's comments about

mortality rates I think are going to be very important here. Carol and Sara know about a report, we've just become aware of, where adverse events in SNFs are very high, 22 percent while in the SNF experience adverse events, another 11 percent experience temporary problems as a result of that, and an estimate 60 percent are preventable. So knowing what the experience of care is like, the quality, and whether or not that -- I mean, certainly, we should be taking that into consideration.

The other thing I was interested in was the whole notion -- and I don't know if we have any data on this -- on the experience with care. What's it like to be in someplace 15 days versus twice that in another in terms of the beneficiary's experience with care?

Last couple comments. I think a later chapter on risk adjustment says, well, first, how important it is and, secondly, how it doesn't always do as well, even with the advances in it, in predicting the costliest of patients. And as you look at these data, it really does suggest that maybe the best opportunity here is with the costliest of patients for whom there is the biggest differential between SNF and IRF, and yet they may be the hardest for us to

really understand, the stroke patients. And I especially think that's a challenge because, as you point out, a very high percentage, much higher percentage go into SNFs who are over 85 and are likely not going to ever benefit from the IRFs, et cetera.

So I think it's a really amazing opportunity, and I think we have some more understanding. We need more knowledge to better understand what the policy options might be here.

MR. BUTLER: So I think I'm next. Yeah.

So one observation I have is that this site-neutral issue seems to have a little clearer path to me than some of the other ones that we've been on.

If you think about it, for example, something like the ambulatory surgery centers would get clouded by the fact that they're often a physician down, and they don't take much Medicaid, so we somehow factor that in indirectly, or the HOPD issue, we're worried it disproportionately impacting some, and we're conscious of the incentive to employ physicians. It's another variable to consider.

I think in this case, everybody is more aligned with fewer extraneous variables, and when you think about

it, the MA plans have a high incentives to put them in the right place and the ACOs do, and even every single hospital that now is getting the medical spending per beneficiary data should be -- so you got alignment to kind of make this right, and that by itself should help make this adjustment.

And even the bundled payments, for example, in joints, I don't know anybody that would be submitting a bundled payment and say, "Guess what? A key part of my bundle for the joint is an IRF stay." It just wouldn't be in there.

So I think this is pretty well aligned, and then not the least of which, Scott asked the -- reminded us of the economics. You recall that the freestanding for-profits are more like the 20 percent margin, not the 11 percent average for IRFs overall. So it's an area that's pretty profitable as it is.

Now, getting more directly to the questions at hand, I think Alice articulated very well, better than I would have, the elective joints as being kind of a very easy place to go ahead and deploy this, and I also think that, secondly, the relaxing of the standards for IRFs for those that are getting paid the same rate ought to be done. So

I'm pretty comfortable with that, and I, too, get a little less comfortable with strokes, both because of that readmission rate issue -- and frankly, my -- Rita will probably slap me because it's not science-based, but my general sense that the variability and quality in the nursing homes and the number of adverse events kind of that occur there, I just feel a little less secure about that for a stroke, for example, versus IRFs. And I don't have the data to support that, but it's a sense of the settings I've been in and the markets I've been in, there is a difference.

MR. HACKBARTH: Peter, on your first point, are you saying that you think that there are enough other forces pushing towards thinking carefully about appropriate use of IRFs versus SNFs, that this is not something that we should be worried about, or just what's your conclusion from that observation?

MR. BUTLER: I'm less worried about it. In fact, I even thought this is a chapter that's not only good for Congress; it's great for everybody that's trying to -- we've got other customers that should be grabbing on and saying let's run with this.

So I feel definite, though, that still going ahead

with some component of this like joint at the same time would be -- just our demonstration, we can bite off something and show that it can work, but we don't have to stretch too far, because the market and these incentives will move along as well.

MR. HACKBARTH: Was it on this point?

MR. KUHN: Yeah. And just to chime in on that a little bit, one of the other market forces, as Peter was talking, I was thinking about, if I understand right, there is a number of LCD policies out there that are pushing pretty hard in terms of kind of to restrict, I think, some of the movements to some of the ultra-high RUGs, therapy RUGs that are out there.

Also, I think we need to think about some of the policies regarding the RACs as well and how that's just changing the nature out there. So I think there's a lot of movement out there, in addition to what Peter said, also kind of narrowing the difference here too.

MR. HACKBARTH: Yeah. On Peter's gut instinct about variability and quality and SNFs versus IRFs, in the chapter, it talked about some analysis that you did of SNFs in markets with IRFs versus SNFs in markets without IRFs,

and there are bit swaths of the country where there aren't IRFs. And so these patients, presumably, are all being cared for in SNFs. Does that sort of analysis shed any light on this?

DR. CARTER: So we did look at whether the differences look the same in markets with both types of facilities.

I was also interested in whether the SNF patients looked different in markets where you didn't have an IRF, and I was pretty surprised. You just don't see big differences in the patients in terms of their characteristics.

Now, I am still waiting for the outcomes data sorted by that, so -- and some of the risk-adjusted outcome from the PAC demonstration, I won't be able to do, but I can look at readmission rates and the 30-day spending, and I plan to do that.

DR. HALL: So I think we're coming to kind of a convergence of opinion around the table that this is an important aspect of the care system that you've dissected out for us, and I guess I have two kind of hopes out of our discussion and further analysis.

One is I hope we will rationalize payments systems for both of these systems, but if we're going to do it by eliminating the IRFs, I think I would be very cautious. A well-run IRF -- I realize they are not in every geographic area -- can make an enormous difference in a wide variety of patients. It's probably the outstanding paradigm of interdisciplinary care. It works, and I don't know whether it's ever within the scope of MedPAC and the staff, but I wonder if a visit to a really well-functioning IRF would be quite revealing to you. And there are plenty in the D.C. area. I think you would see something there that is -- while it's intangible and can't be described statistically, it just simply makes a lot of sense.

But I think the IRFs, their hands have been tied by impossible forms of regulation, the 60 percent rule, the time limitations, but somewhere in the health care system of the future, we need an IRF or an IRF-oid or a SNF on steroids that would allow us to provide the kind of care, particularly for this huge population of older people who end up with a tremendous amount of frailty. And unless we do something about that, then they are going to be readmitted not within 30 days maybe, but in 60 or 90, or

they're going to die, as has been mentioned here. So let's not throw the baby out with the bathwater as we move along.

MR. GRADISON: I think this is a really groundbreaking piece of work, and I congratulate you for it. I join with others who see the benefits that it may have to decision-making outside of the Medicare program or at least outside of the fee-for-service part of the Medicare program, which leads me to this observation. That I wonder, as in this instance there are others, what opportunities or responsibilities MedPAC may have to try to get this sort of thing out to people who are the decision-makers, let's say, within the MA plans or within the ACOs who have to make decisions with regard to this. This simply raises questions, which they may or may not have considered before in terms of appropriate placement.

I don't have an answer to that question, and I know that's not what we're created to do, but I think when we come across work of this quality, it's worth at least raising the question of whether we're keeping this hand on or under a barrel or bushel or whatever it is.

MR. HACKBARTH: You're suggesting, Bill, that not everybody reads our red books?

[Laughter.]

DR. CHRISTIANSON: So I also was impressed with the work, and I was a little bit overwhelmed with all of the different things that you had to do to try to make sure that you were comparing apples to apples as you were doing this.

And then Alice's comment focus on major joint replacement, there seemed to be some sort of consensus around that, I thought.

I worry that we've got this general principle that we all support, which is equal payment by site of care, but when you start focusing down and narrowing down on when is it feasible, when do we feel comfortable doing it, when can it really work, we get narrower, narrower, and narrower. And so we really -- I just worry whether we can implement this principle in any broad scale. Given the discussion that we had today, maybe this gets to your point, Glenn, about providing a demonstration around one major joint replacement or a prelude to moving towards bundled payment. But in terms of actually implementing the principle, it gets more and more complicated in my mind whether we can actually do something major in this area.

Also, I wonder whether the staff or Commission has

talked about given that we're looking at this across different kinds of care, whether we are using a common analytical assessment approach in terms of -- you guys did a great job of laying this all out. Now, is that same kind of approach used every time we look at comparing different sites of care? Is there an implementation part of that, that the implementation was kind of woven?

And your discussion I think throughout -- well, my point I made under clarifying questions was you said, well, it would be great if we could do this in broader care bundles, and we could probably -- there's some real advantages, that we need more research, we're not going to be doing it. I don't know where that leaves us, but is there an implementation part of this assessment as well? Is there a common approach that we're using that will allow the Commission to look across these different analyses done by different staff members and sort of feel like, yeah, everything is sort of analytically on the same plane, so that the results we're getting are not due to sort of different analytical approaches that are being used by staff across different reports? That's just a question.

DR. MARK MILLER: I mean, we have thought about

this and talked about it as a staff and to you, and the answer is we're certainly trying. So the way I see it is we did some work in the ambulatory setting where we asked questions like does this happen a lot in these two different settings, physician and the OPD, and we asked other questions, but we also said and are the risks between these two different -- the risk profiles of these two different populations different.

And in a sense here, this is part of what they've done. They went and looked at procedures that were done frequently in two different settings, and then all that layer of data, one after another, is our attempt, because there's no common assessment and ability to look at a risk score to try and ask the question are the risk profiles of these two people different.

Now, obviously, what you have to work with and how you can implement the framework varies from setting to setting, but they're certainly an attempt. And in the LTCH acute care conversation where we went to a site-neutral payment, it was kind of the same drill, looking at the complexity of the patients using the CCI type of approach, which I won't bore everybody with. But the attempt is to

look through the lens consistently and then pull the tools together that we can pull to.

DR. CHRISTIANSON: And I appreciate that.

So I'm wondering whether we have explicitly said here is the framework and at the end can say we can't really apply this part of the framework for this particular comparison we're making. We don't have the data, or the risk adjustment isn't there or something else. So at the end of the analysis, imagine a table with the cells in it that says, okay, this cell we just can't do here, as compared to this other time, we tried to apply the framework and we could actually do reasonable risk adjustment for this kind of care. That's an example for this kind of care.

For me, just keeping this sorted out in my mind with something like that would be helpful.

DR. MARK MILLER: And we can certainly do this, and this response is not intended to sound in some ways the way it might sound.

[Laughter.]

DR. MARK MILLER: Remember, it's intent. It's intent.

[Laughter.]

DR. MARK MILLER: Yeah, it's going to be much less dramatic. I mean, part of that is what we're asking you to grapple with. We're trying to like lay things out in cells and get our clinicians and our economist types and so forth to look at this and kind of go, "Is this one hitting the mark or not?" And so I think we're kind of -- that is exactly what we're trying to do, but pulling this together in a summary fashion, here is the framework, here is how we think we're addressing it. We can decidedly do that and to move the conversation along.

DR. BAICKER: So my comment was along the same line as John's, but I wonder -- my interpretation of the narrowness with which we are applying these is that, really, it's pretty reassuring that it could be done more broadly in terms of the lack of differences in patients, the patterns of differences in outcomes. To me, it suggests the potential for much wider applicability, but we start with the most conservative, narrowest bucket, and I leave it to those with more clinical knowledge to define better what that bucket is. But you start with something where there is really the strongest evidence that it's apples to apples and that you're equalizing equal things. But that's a proof of

concept. That I think the evidence supports doing it much more broadly, but there's reason to be cautious in starting too broadly.

So even though we're struggling with the specific place to apply it here, to me that is a product of being very conservative appropriately in thinking about where to start, not a limitation in potential applicability if the proof of concept plays out well.

MR. GEORGE MILLER: With that said, I would agree with Alice's statement that, certainly, the major joint replacement makes sense, the selective procedure, but stroke has so many different things. And I think Mary mentioned the fact that we may want to start back with the admission and look at it from that standpoint and maybe in the 60 days afterward to see the total spend. So that moving forward, if apples to apples, we feel comfortable and the major joint makes some sense and maybe even hip and femur procedures -- it's just those are not always elective. But I'm not so sure I would move forward with the stroke at this point.

DR. REDBERG: Well, I also want to compliment you on an excellent chapter, and my sort of major takeaway was I was impressed with how similar sort of the patients were

between IRFs and SNFs and how similar the outcomes were, which made me feel that this certainly was an area to think again our principle of site-neutral payments.

And actually, I'm less concerned about the differences, because from a beneficiary point of view, I feel like there are some advantages not to have been shuttled to one or another, because people change during the course of their rehab, and somebody who might have not been able to get 3 hours of therapy when they started might after a week be able to get that. And so from a beneficiary point of view, I think there's also a lot of advantages for not having it so separate, the way we do now.

DR. NERENZ: I would just be interested in your thoughts on how the dominoes might fall if this policy were implemented in one particular area.

If these patients that we're talking about stayed in the IRF setting, but then the rules were modified and less therapy was provided and whatnot, one result then is that the IRFs and the SNFs would look more like each other than they do today -- their staffing, what happens on a daily basis -- and so that's one track.

But it could go the other way, that the IRFs could

decide or the referring physicians could decide that the patients for this payment rate really belong in SNFs, and in that case, the IRFs and the SNFs would less like each other than they do today.

Do you anticipate it going one way or the other? Should we care if it goes one way or the other?

MS. SADOWNIK: I think that's a very central policy question for discussion, and we would value your input on that. I think you have done a good job of laying out two paths and reasonable implications of those paths. So I think it's an open question. Would you want those two facilities to look more different and more specialized and IRFs to be -- sort of probably have a smaller patient base, or would you want, as Rita said, a system where you can have more variability and continue to have that, that overlap?

DR. CARTER: I think that IRFs have shown some ability to change their mix of patients over time, and so we don't know that that wouldn't happen again.

This policy would retain IRFs and the key role that they play for the types of patients that Sara mentioned before. So we're not saying their whole mix needs to change, right? We're just saying for these types of

patients that probably could be treated in a SNF, we're just going to pay you like a SNF.

Now, would IRFs respond by changing their staffing and having maybe a wing, so that that's actually -- there really would be some efficiencies there? I don't know.

One thing we did look at was whether -- let's say IRFs stopped taking these patients, because even at the margin, they weren't -- it wasn't advantageous to take them. So I looked at whether -- because SNFs have a reasonably high occupancy rate. It's about 83 percent, but there actually aren't that many patients we're talking about, and so the average occupancy, taking all of these patients into SNFs, would add about a half a percent on the occupancy rate.

So we have adequate capacity on the SNF side, and I guess it remains an open question whether IRFs would opt to continue to treat these patients with the flexibility of changing the way they practice, and I don't know about that.

I guess -- and one last thing. Some of the IRF industry has been interested in sort of this continuing hospital concept where the patient stays in the bed, but what they do to them changes over time. And this is kind of

like that. I mean, that they're talking about an episode payment, that's not this really. It may include less things, depending on how you define that, but at least that tells me that there's been some interest to treat a less complex mix of patients, given some relaxing of regulatory requirements.

But you raise a good question.

DR. NERENZ: And I don't have my own preferred answer to it. I just observed that this comes up anytime we have the site-neutral discussions. As we think about how the dominoes fall, are the patients going to stay in the setting they're currently in, but then that setting adjusts what it does to adjust to the lower payment, or the patient is going to move, and do we want it to go one way or the other? And I don't -- in this case don't have a clear sense myself.

DR. SAMITT: So three quick things. Great chapter. Thank you.

In terms of selecting new cases -- and I apologize if this is a predictable answer for me -- I don't think we need to start from scratch. I think we should look out to see where there are examples of more accountable models of

care to determine what they are doing with these cases, and it's not just MA. It's MA. It's ACO. It's the value-based private sector models. I'd be curious to know when there is closer accountability to the provider level, how are they deciding differently between IRF admission versus SNF admission by diagnosis, and it may highlight for us where the next round of opportunities would be.

The second is I absolutely would support the waived IRF requirements. I think if we will do this, we need a way to allow the IRFs to variabilize their costs. So if they don't require 3 hours of therapy or what have you, that we need to allow them the freedom to preserve these patients in those facilities.

And the third thing is, while I know we may not be ready for post-acute care bundles, it was striking to me, this side in particular, would we ever think about a penalty for a second post-acute care stay? So instead of -- so kind of like a readmission penalty of sorts, but that if there is a second post-acute care stay after an IRF stay, that there is a penalty for that, so that we don't encourage that type of additional 30, post-30-day cost.

MS. SADOWNIK: There is actually a payment penalty

for IRFs for going to discharge to another -- to a SNF if the patient has stayed below a minimum number of days. I think below the average.

DR. CHERNEW: Yes. So I also liked this very much, and I'm very supportive of the general direction, largely for two reasons. I think it's an issue of fairness, and I think it's an issue of stewardship of resources.

And let me just say one thing about that. As a general principle, my view is if the outcomes are similar, payments should be similar, even if the cost of treating folks or the resources used are different, and therefore, that makes the fundamental question, which we've had some discussion about, of whether or not the outcomes are similar. And there's issues about the time horizon. There's issues about heterogeneity.

The one thing I don't know a lot about is there's probably, although I wouldn't know, a pretty good -- and maybe that's just optimistic. I'd like there to be a better -- surely literature -- on the cost effectiveness of these types of services. This is really a debate about giving certain types of services to certain types of people, and I think it should be more a debate about that and less a

debate about the setting in which they get those particular types of services.

And the fact that some markets don't have IRFs demonstrates that you can get certain types of services in other settings. So I'd rather see it, broadly speaking, be more about service and less about site.

So per David's question he asked a minute ago is I don't think it matters if you get people who are in the IRF to go to the SNF and get a sort of set of services or people that were in the IRF, staying in the IRF, and getting a sort of set of services. It's about the service and the treatment more than the site, and I think the challenge that we have to face, which we don't really discuss very much, about site is whether there's economies of scale or scope of somehow putting these types of patients together. And that arises across a whole bunch of things.

So would there be a big problem for people that are getting services that have to be in an IRF if you pulled out a certain type of patient and sent them to a SNF? That would be a problem.

I think in this setting, there's not a lot of evidence on that. I don't think that's really a big

concern. I think that the IRFs now are quite profitable, so I'm not worried that at the margin, we're going to do something horrible that's going to be bad, and I don't see a lot of evidence, although several people have asked, that the payments are too low for these other types of services that we're not putting in here. And it seems relatively modest in the starter set of services that Kate mentioned as a way to begin.

So I think given the basic principle of paying similarly, if the outcomes are the same and ensuring people get the right amount of services that matters, but I'd much rather see the debate be about the cost effectiveness and value of particular types of services for particular types of people than a debate about where those people should be.

MR. ARMSTRONG: Just very briefly. I don't have anything new to add. I do want to affirm, though, that I think the work is excellent. That the two policies that this advances, this equal payment for comparable services and this notion that there's a better way of bundling post-acute care services, this helps with both.

I think it helps, frankly, reinforce the importance of equal payment for comparable services much

more than it helps advance this notion of rationalizing payment for well-managed post-acute services, which is why I do want to reiterate a point Craig made that there are a lot of questions about.

So what would the implications of this be? I think there are a lot of organizations we could spend just a little bit of time with and imagine or feel much more confident about. There is a kind of a rational way of looking at this, and this can come together in I think really smart ways.

Finally, I also agree that the IRF requirements should be lifted in order to make sure this is a level playing field and that we should look at what exactly that means, but I think that's the right direction to head in.

MR. HACKBARTH: Okay. Good job, and look forward to hearing more about this.

So we will now shift gears and have a discussion about measuring quality across Medicare's delivery systems by which we mean traditional Medicare, free choice of provider, fee-for-service, ACOs, Medicare Advantage Plans.

John?

MR. RICHARDSON: Thank you. Good morning,

everybody.

At its November 2013 meeting, the Commission discussed whether and how to significantly streamline Medicare's quality measurement strategy. Today we will summarize the key points from that discussion, which considered refocusing Medicare's quality strategy on using population-based outcomes and other metrics to synchronize quality measurement across Medicare's three delivery and payment systems at the level of local health care market areas.

Then for the main event today, we will present the results of two analyses that illustrate another quality concept the Commissioners asked us to explore, which is measuring the potentially inappropriate use of services. The idea here is to explore the feasibility of using existing data sources, such as fee-for-service claims, to cast light on potentially unnecessary or even harmful service use.

Last, we will tee up several discussion questions and look for your guidance on the directions you'd like us to take this work.

This slide summarizes the Commission's concerns

with the current quality measurement activity in fee-for-service Medicare, which we discussed at length in November, in the mailing materials, and at the meeting, so I won't dwell on them here. But, of course, we can come back to these issues as needed during the discussion.

In light of these concerns, we started discussing an alternative strategy in November that would measure quality at a population level across fee-for-service Medicare, Medicare Advantage, and Medicare accountable care organizations in local health care market areas. This alternative strategy would use a small set of outcome measures that are listed on the slide. I wanted to take a moment and call out one of the measures, the Healthy Days at Home measure, which we did not talk much about in November.

Staff is actively developing this concept, which involves capturing at a minimum how many days that a beneficiary stays alive and out of the hospital. We are starting the development with a combined mortality and readmissions measure and also exploring other permutations, such as how to include the use of post-acute-care services, and we hope to have more to report on this measure in the next report cycle.

Another significant area of discussion in November amongst you was whether Medicare's quality strategy should also include measures to monitor the undesirable responses to the financial incentives in each of the three major payment systems, for example, being able to detect the overuse of services in fee-for-service Medicare and underuse in Medicare Advantage and in ACOs, at least those that operate in a two-sided risk model.

This idea of measuring potentially inappropriate use of services is the main topic of our session this morning, and we will return to it in just a moment. But before I do that, I wanted to acknowledge one other major issue that we aren't planning on discussing today but will return to in April, which is how to delineate the local areas within which Medicare could measure quality across fee-for-service Medicare, MA, and ACOs. We talked about this a little bit in the mailing materials, and I just wanted to acknowledge it here.

The ideal technical solution would be areas that perfectly matched local health care delivery markets within which we could identify MA enrollees, Medicare patients that are attributed to ACOs, and fee-for-service beneficiaries.

But until we can refine this idea, we have to use alternatives, such as core-based statistical areas and metropolitan statistical areas, which were used in the illustrative analyses that Ariel and Kevin are going to present in a moment.

In April, we will return with a revised version of the population-based admission and ED visit rate analysis that we presented in November, which, as you might recall, used the Dartmouth Atlas Hospital Service Areas. We'll use this as an opportunity to tee up further discussion of this whole issue. We don't want you to think we're ignoring it.

All right. Back to the main topic today, which, as I mentioned a couple of times now, is measuring the potentially inappropriate use of diagnostic and therapeutic services.

The concept of potentially inappropriate use includes both underuse and overuse. Underuse measures are designed to detect the inappropriate withholding of clinically indicated care. Overuse measures monitor the use of services that have little or no benefit for patients or may even expose them to risk of harm.

Most of the quality measure and activity in the

U.S. health care system to date has been focused on detecting underuse, best exemplified by the Healthcare Effectiveness Data and Information Set, or HEDIS, which most of you are very familiar with and has been used to measure quality in managed care organizations for a number of years, including, of course, in Medicare Advantage.

However, as several of you have pointed out, underuse measures may not be the best way to evaluate quality in a payment system where providers are reimbursed for every single service that they perform. Instead, overuse measures may be better indicators of quality for that kind of payment system.

Ariel and Kevin will now present two types of analyses to illustrate the potential applications of overuse measurement.

MR. WINTER: Okay. CMS has developed six measures of the appropriate use of imaging in hospital outpatient departments, and these are all listed in your paper.

The purpose of these measures is to: limit beneficiaries' unnecessary exposure to radiation and contrast agents; improve providers' adherence to evidence-based guidelines; and reduce unnecessary spending by the

program and beneficiaries. These measures are based on claims rather than medical records.

CMS publicly reports scores on these measures at the hospital, state, and national level. But hospitals are not subject to financial penalties or rewards based on how well they perform on these measures.

An important issue is whether hospitals, physicians, or both parties should be held accountable for the appropriate use of imaging studies performed in outpatient departments.

On the one hand, hospitals provide the facility, the imaging equipment, and the staff, and they may also employ the radiologists who interpret the studies. On the other hand, physicians determine whether or not to order an imaging study and what type of study to order.

So we selected three of CMS' imaging measures for further analysis: patients with low back pain who had an MRI without first trying conservative treatments; CT scans of the chest that were combination, or double, scans; and patients who got cardiac imaging stress tests before low-risk, non-cardiac outpatient surgery. We only used the CMS measures that have been endorsed by the National Quality

Forum.

The measures we selected represent three different types of imaging: MRI, CT, and cardiac stress tests. We included all ambulatory settings in our analysis -- OPDs, physicians' offices, and independent diagnostic testing facilities, or IDTs -- whereas CMS applies its measure only to OPDs.

We examined geographic variation in these measures using CBSAs, as John described earlier. Before presenting our results, I'll go over some background on each of the measures that we analyzed.

So the first measure is MRI for low back pain without evidence of prior conservative treatment. Several specialties recommend against the use of imaging for low back pain except for certain conditions, such as neurological deficits or cancer. Inappropriate use of imaging for low back pain leads to higher spending and may induce a cascade of additional procedures, such as surgery.

CMS' measure calculates the share of patients in OPDs who received MRI of the lumbar spine for low back pain without first trying more conservative treatment, which is defined as physical therapy, chiropractic treatment, or an

E&M service.

The measure excludes patients with serious conditions that may warrant immediate use of MRI, such as cancer, trauma, neurologic impairments, or spine surgery. A lower score on this measure suggests that a provider is using MRI for low back pain more appropriately.

The second measure we looked at was CT scans of the chest that were combination scans. In a combination scan, a patient receives one scan without contrast, followed by a second scan that uses contrast.

According to clinical guidelines, combination CT scans of the chest are not appropriate for most conditions, and they may be appropriate for only one condition: solitary pulmonary nodule.

Combination scans increase spending because they are paid higher rates than single scans, and they also expose patients to additional radiation and the risk of contrast agents.

CMS' measure is the share of all CT scans of the chest performed in OPDs that were combination scans. A lower score suggests that a provider is using CT scans of the chest more appropriately; whereas, a higher score may

indicate that the provider has a protocol that calls for routinely giving patients combination scans of the chest when they only need a single scan.

And the third measure we looked at was patients who got cardiac imaging stress tests before low-risk, non-cardiac outpatient surgery. Clinical guidelines recommend against using cardiac stress tests in the preoperative evaluation of patients before they have low-risk procedures because these procedures put very little stress on the heart.

Inappropriate use of cardiac stress tests leads to higher spending. And in the case of cardiac nuclear tests, it also leads to unnecessary radiation exposure

CMS' measure is the share of all cardiac stress tests in OPDs that were received by patients during the 30 days prior to a low-risk, non-cardiac outpatient surgery. A lower score on this measure suggests that a hospital is using cardiac stress tests more appropriately.

So here was have the national rates for these measures from our analysis across all settings for 2010 through 2012. And, again, a lower rate indicates that the service is being used more appropriately, and a higher rate

indicates that the service is being used less appropriately.

The rate for MRI for low back pain without prior conservative treatment was 36 percent across all three years. This means that nationally 36 percent of MRIs for low back pain were not preceded by conservative treatment, like physical therapy.

The rate of CT scans of the chest that were combination scans declined from 5.1 percent in 2010 to 3.6 percent in 2012, which means that, overall, providers have improved their performance on this measure.

The rate of cardiac stress tests that were provided before low-risk outpatient surgery was stable at 5 percent in each of the three years. And it is important to mention that there are inappropriate uses of cardiac stress imaging other than the one mentioned here. For example, the American College of Cardiology recommends against performing annual cardiac stress imaging as part of routine follow-up in asymptomatic patients.

The advantage of the specific measure of that we've shown here is that it can be calculated with claims data. Other studies that have used medical records and look at additional indications find higher rates of inappropriate

use of cardiac imaging, in the range of 13 to 24 percent.

This slide shows the rate for reach measure by setting in 2012. The rate for MRI for low back pain was higher in OPDs than in offices or IDTFs, meaning that these tests were more likely to be inappropriate when provided in OPDs.

By contrast, the rate for CT scans of the chest that were combination scans was higher in IDTFs and physicians' offices than in OPDs. The rate for the cardiac imaging measure was similar across settings.

It is important to remember that the settings are based on where the imaging study was provided. The ordering physician may practice in a different setting than the one being measured and probably bears at least some responsibility for the appropriate use of imaging.

This slide shows the geographic variation in the rates of these measures in 2012. For MRI for low back pain, the CBSA at the 5th percentile had a rate of 29.1 percent, and the area at the 95th percentile had a rate of 44.6 percent. This means that in a high-performing area, 29 percent of the MRIs for low back pain were provided to patients who did not receive more conservative treatment

first. The rate for the first quartile was about 33 percent compared with about 39 percent in the third quartile.

Next, looking at CT scans of the chest that were combination scans, we find significant variation. The CBSA at the 5th percentile had a rate of 0.4 percent compared with a rate of 10.7 percent at the 95th percentile. The rate in the third quartile was over four times as high as the rate in the first. CBSAs with much higher rates probably have providers who routinely give patients combination scans when they only need a single scan.

There was also variation in the rate of cardiac imaging before low-risk outpatient surgery, which is the last column. The CBSA at the 5th percentile had a rate of 3.6 percent compared with a rate of 6.3 percent at the 95th percentile. The rate for the first quartile was 4.3 percent compared with 5.3 percent in the third quartile.

Collectively, the variation in the rates of these measures suggest that there are opportunities for providers to use these imaging services more appropriately, which would reduce unnecessary spending and potentially reduce radiation exposure.

Now I'll move on to Kevin.

DR. HAYES: Inappropriate use of services can take two forms. First, a service can be furnished to too many patients. Second, too many services can be furnished to the same patient.

While most research on inappropriate use has focused on the first category, two studies for the Commission are in the second category: repeats of diagnostic tests furnished to Medicare beneficiaries.

Both studies were led by a physician. The results were published in the Annals of Internal Medicine and the Archives of Internal Medicine -- now JAMA Internal Medicine. Commentaries accompanying the articles expressed the view that the repeat testing found represented "unjustified testing" or "overuse."

The first study considered repeat use of certain imaging services, tests, and diagnostic procedures that I will list in just a moment. The second study focused on repeat upper endoscopy: its frequency, the diagnoses reported on Medicare claims with the procedure, and whether those diagnoses suggested that a repeat endoscopy would be expected, uncertain, or not expected.

In the interest of time, I will not go over this

second study, but can say more on question. It was summarized in your mailing materials.

Looking at the first study, six services were considered: echocardiography without a stress test, nuclear medicine and echocardiography stress tests, chest CT, and the others you see listed here. All are services for which uncertainty exists about whether to repeat them and how often. Medicare claims data for six years -- 2004 through 2009 -- were analyzed to determine rates at which beneficiaries receive repeats of these tests and the intervals between an index -- or first observed -- test and a repeat test.

One finding was that repeat testing is common: depending on the test, one-third to one-half repeated within three years of an index test. For the physician leading the study, this finding raises the question of whether some physicians are routinely repeating tests even though little is known about appropriate thresholds and intervals for doing so.

The other finding was that geographic variation in repeat testing suggests decisions to repeat tests are influenced by factors other than disease burden. To

understand this finding, let's look at an example.

Here we see data for the 50 largest metropolitan statistical areas on one of the services in the study: imaging stress tests. You can see across the bottom we have the proportion of beneficiaries receiving any of these tests, whether repeated or not. On the vertical axis, we have the proportion repeated.

The hypothesis was that the proportion of beneficiaries receiving repeat tests would exhibit little variation. If physicians have similar thresholds for diagnostic testing, the proportion receiving any test would vary in accord with disease burden. Meanwhile, the proportion repeated would be similar across geographic areas owing to homogeneity among those receiving at least one test.

As you can see, the findings were not consistent with this hypothesis. Across these MSAs, the proportion of beneficiaries receiving repeat tests varied widely, depending on the test. For example, with this service, on the vertical axis you can see the proportion receiving repeats within three years. It ranged from 30 percent, which is in Portland, Oregon, to over 54 percent in Orlando,

Florida.

The additional finding was that the proportion receiving a repeat test was positively correlated with the proportion who received any test. The correlation coefficient for the statistical relationship between the proportion tested and the proportion repeated was fairly high as these things go. On a scale of 0 to 1, the correlation was 0.62.

We expected to see no correlation between the proportion of beneficiaries receiving an initial test and the proportion receiving a repeat test. While the proportion receiving an initial test might vary somewhat because the incidence and prevalence of disease varies geographically, we thought the proportion repeated would exhibit little variation if physicians have similar thresholds for deciding whether to conduct a test.

If there was any expectation about the correlation, it was that it would be negative. In an area with a high rate of initial testing, a high proportion of beneficiaries who received an initial test would include many found to have no disease. Therefore, the area would have a low proportion receiving a repeat test. The finding

of a positive relationship suggests that areas prone to do many initial tests are also prone to do many repeat tests.

The example we looked at was imaging stress tests. Except for one of the diagnostic procedures in the study, the same pattern -- a positive correlation between proportion tested and proportion repeated -- was found when we examined the other services.

Stepping back and thinking about the results of the two repeat testing studies together, they illustrate a way to study potentially inappropriate use and, say, compare fee-for-service, ACOs, and Medicare Advantage. The available indicators include the length of the interval between the initial test and a repeat test and the frequency of repeat tests.

John will now summarize issues for your discussion.

MR. RICHARDSON: All right. For your discussion, we are concluding with the following questions you may wish to consider. These include: the strengths and challenges of measuring potentially inappropriate use at all; your thoughts on applying both overuse and underuse measures, like HEDIS, in all three delivery systems or, as we

discussed in November, selecting one or the other type of inappropriate use measures to target each payment system's incentives; if it would make sense to apply these kinds of measures at a population level, a provider level, or both; and your vision of how over- and underuse measures would fit into the larger Medicare quality strategy we have been discussing, which, as a reminder, centers on having fewer measures focused on population-based outcomes and having a higher priority placed on synchronizing quality measurement with the private sector.

Thank you very much, and we look forward to your questions and discussion.

MR. HACKBARTH: Okay. Thank you.

So when we get to round two, I am really going to want people to address these questions at the end, so think about them when you are waiting for your turn to talk.

The order in which -- the first one is sort of a technical question, if you will, about the challenges of measurement. I'm really interested myself, since I don't have anything to contribute on the first, the last three questions, and I sort of think of them, the last ones first. How do they fit into our overall strategy that we've been

talking about? And then second would be, Do we apply these measures across the board in all payment systems, or do we try to target them based on the weakness, perceived weakness of the system? And then third, are we just talking population level or also provider level? I think those are three really important questions, and I hope people will try to take a crack at them.

So first, round one, clarifying questions. Kate and then Craig.

DR. BAICKER: So I was a little unsure about the denominator for the three measures that we were looking at. So for example, the stress test, the way I understood it from the reading materials and the presentation was that you looked at all the stress test and said what share are before one of these procedures where it wouldn't be required, but that share could change, because the other tests are changing. And the concept I thought you were getting at is it's inappropriate to use this when people have one of these procedures coming up that doesn't require it, so wouldn't we want to look at the share of the people having one of those procedures who get a stress test inappropriately? Because in some ways, I worry that the measures we are looking at,

while the numerator is the thing that we want to look at, the denominator may not be the right denominator to perfectly capture what we're trying to get at.

If suddenly a hospital or a provider starts doing a lot of stress tests for other stuff, they would suddenly look better on this measure, even though it doesn't indicate less appropriate use. It might indicate more inappropriate use. I'm saying that not clearly. If that denominator goes up because they're suddenly giving everyone in the world stress tests, that's not a good thing, and so is the measure really capturing overuse, or do we need maybe this and another measure?

MR. WINTER: It's a really good question, really good point, and in fact, there is another NQF measure, which is not the one CMS uses, which uses a denominator as the patients who get a low-risk outpatient surgery, exactly as you suggested. And we can try to take a look at that and see if we can apply that with claims data.

The reason that we used the measure that CMS has been using was as an initial step, it made sense to pick ones that have sort of been tested and -- or we have data that we can validate our results against, but for the

future, we can certainly think about using the type of a denominator that you suggested.

DR. BAICKER: And an alternative denominator could be -- you could just look at the number of stress tests per capita if you're not able to capture situations in which a stress test may or may not be appropriate. You could say, "Are they just using a lot of stress tests, and that's why this share looks kind of low, or is it" --

MR. WINTER: And that can obviously change, depending on the unit of measurement. Is it a CBSA? Is it a hospital? Is it a physician practice?

Another thing to think about in terms of the alternative measure where the denominator is the low-risk outpatient surgery is if you're trying to attribute it to a setting, then it can get sort of complicated. Should it be the setting where the surgery happened or the imaging study happened? And the way CMS has done it is attribute it based on where the imaging study occurred.

DR. COOMBS: Because if you do it per capita, the problem with that is you have a high-volume, low-risk surgery, that's going to change from geographic area to geographic area. So you make the mistake if you do it per

capita, not considering the frequency of low-risk surgery that occurs in that given area. So that if someone has an area that has lots of low-risk surgery and the screening may be less threshold to get the stress test preoperatively, then they may actually do better in some areas than others.

MR. HACKBARTH: Was that your point, Jon?

DR. CHRISTIANSON: It was on geographic areas -- [off microphone].

MR. HACKBARTH: But it was on Kate's measurement point. I will get you that.

I have George, Rita, Craig, Jon. Who do I have on this side with clarifying questions? Anybody?

Okay. George, Rita, Craig, Jon.

MR. GEORGE MILLER: Yeah. As you were doing this analysis, did you look at also access, if appropriate folks were getting access to these services? Is that one of the measures as we were looking at this? Is access an issue at all?

And secondarily -- second -- I'm sorry -- do we look at the demographic information for each one of these? Especially in the overuse category, were you able to break down demographically to see if one part of the population

may be getting overuse disproportionate to as it relates to the other?

MR. WINTER: All right. So in terms of access, we did not explicitly address that with regards to the analysis that I presented. I'll let Kevin talk about the analysis he worked on.

We do use -- in terms of examining quality in the physician sector for the update analysis, we do look at measures of underuse, which we called the MACIs, and that is part of what factors into our analysis of access and quality, but for this specifically, we did not address that. And I'd be interested if you have specific ideas for how we should apply these to access questions. That would be helpful.

And then the second question on demographics, we did not look at demographic characteristics of the patients who were caught up in these measures, but it's certainly an interesting analysis for the future.

The one thing I will say is that there was a paper published by my colleagues in 2009 which looked at overuse of imaging for low back pain based on an NCQA measure, which is not very different from CMS's measure, and they found

that African Americans are actually less likely to get MRI when it was not recommended. In other words, they got MRI more appropriately than other racial categories, so that's interesting. I'll just throw that out there.

MR. GEORGE MILLER: Yeah, yeah.

MR. WINTER: If Kevin has anything to add, I'll turn it over to him.

MR. GEORGE MILLER: Okay.

DR. HAYES: Just that when the Commission has defined access, we have defined it in terms of use of appropriate services, and so what we're looking at with respect to this set of analyses would be that part of the definition where, well, is the service appropriate or not in trying to develop a kind of an information base and set of capabilities that would allow us to do this.

Specific to the repeat testing work, we did not look at the demographic characteristics. It's something we could do, but here, it was more of an exploratory study to just see what we could find.

MR. GEORGE MILLER: Well, obviously -- well, I shouldn't say obviously, but part of my question is if tests are being done and they're appropriate, is a set of the

population getting access to have those tests done that are appropriate? And then conversely, if they're inappropriate, demographically, are we measuring and making sure that it's consistent across to the population?

DR. REDBERG: Thank you. Excellent presentation.

My question, I guess on Slide 13, where you separated according to the site of the imaging, were you able to look at who ordered the test or issues of self-referral?

MR. WINTER: We did not -- we did not look at it by ordering physician, and one of the issues there would be you could get down into small numbers pretty easily, and then it's hard to look at statistical validity.

But we could think about trying to do this at a practice level, maybe larger practices, and try to compare the rates of appropriate use of imaging at that level, but for this initial analysis, we did not look at it by ordering physician.

In terms of self-referral, that gets more complicated, because then you have to come up with a definition of self-referral, because it's not always listed on the claim, and what if a physician refers to someone else

in their practice? Is that considered self-referral if they're eventually benefitting financially from that?

So we've looked at this in the past, and we have developed some work and some models and some definitions, and we can think about applying it to this, because it's certainly an important issue to think about, but that would be for future work.

DR. REDBERG: And where are they publicly reported? It said Slide 17 as publicly reports these.

MR. RICHARDSON: It's on Hospital, Hospital Compare.

DR. REDBERG: Hospital Compare-dot-gov. That's what I was trying to find. Thank you.

DR. CHRISTIANSON: I'd like to go back to Slide 5, and this is just to make sure that I understand what the idea is.

So with the ideal I'm trying to imagine in my mind, there's a map, and we've drawn a circle or something, and then within -- and you raise the appropriate issue, how do we draw the circle, how do we get -- so within that circle, are we talking about -- okay. Let's say there's two MA plans and three ACOs, so we would construct the quality

measure individually for each ACO and for each MA plan and for netting out the people that are attributed to ACOs and the people that are enrolled in MA plans? The rest are in the fee-for-service system, and then we would construct a measure which would be our fee-for-service quality measure in that area?

MR. RICHARDSON: Right. So you -- to your first question, this is envisioning Medicare Advantage as a sector or a delivery --

DR. CHRISTIANSON: It's not divided into the plan?

MR. RICHARDSON: Not divided in the plan

I think Craig brought this up in November, which is that you definitely could -- first of all, Part C or CMS already does that for individual MA plans.

DR. CHRISTIANSON: And they are a population that you can --

MR. RICHARDSON: Exactly.

DR. CHRISTIANSON: -- use as a popular measure.

MR. RICHARDSON: I think, especially for MA where the population -- you know, you're enrolled in a plan or that plan -- and specifically, it's easy to say you're either in MA or you're in that MA plan. That's easy to --

DR. CHRISTIANSON: Wouldn't the same be for ACOs, that are attributed in ACOs, where there's an organization that has to think in a population --

MR. RICHARDSON: Yes. Again, you could do it. The question would be if in a particular geographic area, you had enough in there, you had enough observations, but assuming you did, you could go as far down as you wanted to, even within -- anyway, yes, within the organizations.

DR. CHRISTIANSON: So the idea would be -- I'm just trying to review what we talked about last time and get it straight in my mind. So the idea would be let's say a beneficiary in fee-for-service, not in an ACO or attributed ACO or an MA plan, would look at their number and say, "Well, if I assume I'm an average fee-for-service beneficiary, I would be better or worse off had I been attributed for" -- and then this quality measure -- "had I been in a particular ACO or a particular MA plan."

MR. RICHARDSON: Right.

DR. CHRISTIANSON: I mean, that would --

MR. RICHARDSON: I mean, if the --

DR. CHRISTIANSON: Is that what the --

MR. RICHARDSON: If the purpose of the

measurement, which is a question, was to give the beneficiaries information about where to go, it would be, I think, more helpful if he knew a specific MA plan.

DR. CHRISTIANSON: So we're probably going the second route, so I think I understand what the -- the way you're thinking about it.

MR. RICHARDSON: You could do it either way.

DR. CHRISTIANSON: Okay.

MR. HACKBARTH: Okay. Let's go to round two, and Craig is going to go first.

DR. SAMITT: Great presentation. Thank you.

I'll go question by question in terms of the discussion. I certainly have strong feelings about each of these.

This is certainly something that -- I'm going to actually do the last question first. I think this absolutely fits within our quality strategy. Overuse, underuse must be a part of that.

The concern that I have about the measurement of inappropriate use is are we going to now experience a similar phenomenon as we've experienced in the quality dimension, which is we keep adding more and more measures,

and the same could apply to inappropriate use. And what I would be curious to understand is whether or not instead of thinking of these things vertically, we could think about them horizontally. How do we measure whether organizations are using decision support or technological criteria to determine appropriate or inappropriate use?

In the private sector, in essence, we use administrative approvals or review of clinical decision-making, and I think what we want to know is what percentage of providers are overruling sort of the guidelines in making these decisions about appropriate or inappropriate use, and the measurement is really -- cuts across just about any testing or any diagnosis you want.

I think that it's a strategy that raises all boats, which speaks to the strengths and weaknesses of this. The strengths of having this discussion is that there's clearly unexplained variation that there is a possibility to capture here. The weakness is it becomes very administratively complex if we think test by test or diagnosis by diagnosis. So there's got to be a different way to think about this.

In terms of overuse and underuse by payment

sector, what's interesting is I think you'd want to measure overuse on the fee-for-service side, and you'd want to measure underuse on the MA side, and you probably want to measure both for ACOs. So I think that that requires additional thought, and I'm not sure I have more guidance on that, but I don't know how we would come up with a common set of metrics or whether that's appropriate across all the sectors, because we're worried about different things.

And then in terms of how to measure a population level or provider, I would pick provider, because I think you want to measure it at the level of those you can hold accountable, and that's the provider sector from my point of view. So those would be my thoughts.

The question that I have that I'd love more information on is Slide 14, and it falls to a lot of the discussions we have about benchmarking. For these first quartile sectors, I'm curious to know who those people are and what do they have in common. I don't know if we can get at that additional research, but I would sort of want to know who those gold standard providers are, if we envision that they are gold standards. They may be underutilizing, but their quality outcomes may not be good. So I think we'd

want to study it, but I would wager that what we may find is that first quartile is both efficient and high quality, and I think we should understand what they have in common.

MR. WINTER: Craig, could I ask a question about that, clarifying question? Well, when you talk about gold standard providers, we're looking here at CBS at areas, but you're saying we should drill down to the provider level and identify the specific providers in those areas or just do a different distribution at the provider level.

DR. SAMITT: Yeah. Those areas, are they -- what do they have in common in terms of payment models or provider structures or integrated delivery systems or at certain geographies? I'd just be curious to know more information about the demographics of that quartile.

MR. HACKBARTH: Craig, could you go back to your first point for a second, the horizontal versus vertical? Just say that again. I'm not sure I got that one.

DR. SAMITT: So for example, in my current and prior organizations, we use decision support, technological decision support to study high-end radiology. So in essence, the methodology is very much that at the point of care, as a provider is selecting a particular test, in

essence they're notified that 99 percent of your peers would not choose this test for this diagnosis. It's not guideline-supported. There's the opportunity to overrule, but -- and you can measure the degree of overruling that, but that applies to more diagnoses than just these three. It could be a whole portfolio.

So the question is, Do we want to measure each of these in isolation? Is that the most efficient way to do this, or should we use an approach that crosscuts whether providers are following guidelines in essence or not for any test?

MR. HACKBARTH: So in the pending SGR legislation, if I understand it correctly, there is a provision on imaging specifically that is similar to what Craig is talking about, and help me out, if you know what I'm talking about. My recollection was you'd have to say I consulted a particular decision support system and in order to quality for payment.

MR. WINTER: Right. The rendering provider, the one who actually performs the imaging study, has to indicate whether guidelines were consulted, certain type of guidelines were consulted when the study was ordered. So

there's these questions about coordination between the rendering -- performing provider and the ordering provider. If they don't indicate that guidelines were consulted, then there is some payment reduction, I believe. And then for providers who are outliers in terms of not consulting guidelines, then there is a provision for some type of prior authorization for extreme outliers.

MR. HACKBARTH: So in order to make your horizontal system work, you have to specify the sort of decision support that must be consulted and then measure adherence to those?

DR. SAMITT: Yeah.

MR. HACKBARTH: I'm just trying to think mechanically what it would be like.

DR. SAMITT: Well, I mean, another way to put it is, is that at the very beginning of the presentation, you talked about quality measures. I'll be the first to step in line to say yes, we want outcomes measures, but in certain instances, we want process measures. For me, use of decision support and a demonstrable evidence of adherence to guidelines is a process measure that should be a quality measure.

The other one, by the way, I'd put in this budget is demonstrable use of decision support for beneficiaries. That is another process measure that if we can find a way to measure that, you would expect that that would raise multiple quality outcomes.

DR. CHERNEW: So this whole topic is I think amongst the most important one that we'll address, because as the system changes, we're constantly hamstrung with this notion of how to measure quality. And I wish -- I really appreciate the work, and I wish I knew more what -- how to go forward.

My general sense in response to the questions are a few things. First of all is I like the idea of a common measurement for -- I'll do the bottom three. I like the idea of a common measurement frame, because you want to compare between, and so the fact that we're concerned about different things is true, but it doesn't mean we shouldn't measure different things. We would just expect to see that they're going to behave differently to sort of confirm that hypothesis.

The bigger issue I have, just generally, of course, is the administrative burden of all of these

different things and all of these different ways, and I think that's problematic. So I find myself saying things that I now worry about. For example, I believe that the provider level is the right level to measure, because that's the people who can act, but I worry about the administrative burden placed on all the providers, and that's a problem.

I think in general, what we have to do is we have to begin to refine the set of measures and think about the administrative costs of them when we put them in place.

I know we've had a discussion of having fewer measures, and that's certainly appealing, given my concern about administrative burden. Some of them might be even measurable through claims data and not put a lot of burden on the providers that we care about, which I view as great.

I worry a lot that if you go down that path, people are going to say, "Your measures are too coarse to pick up the nuances of quality that we care about," and when we were having our IRF-SNF discussion, for example, we got into exactly that problem, which is, well, exactly, but for this diagnosis and in this way, what you're missing is 3 months down the road, there's something that -- or 6 months down the road, there's some aspect of quality we can't

measure. So we're just torn, and because I feel like I'm being so unconstructive, I'm going to move on, because it's just hard. I wish I had an answer, and getting that balance right is a challenge.

The one thing I do want to say that I do think is important is about the overuse and underuse measures. I think they absolutely are both important, but I do want to make one important point that I consider important, which is waste is different than poor quality. So I don't like waste. I don't want to be in favor of advocating waste, but it's not the same issue as poor quality.

In certain payment models, for example, we might not care about waste because someone else is paying for it, and so it's not as big a concern, but we certainly care about bad quality. I think the measures that you have picked here are mostly problematic because they are bad quality because of exposure, et cetera. We will have a different concern and a different way of dealing with things that I think are just waste, and so that -- and I think that matters.

That said, to the extent that a lot of overuse is in fact bad quality, I think it's important that we

incorporate them at least conceptually into our quality measures, and I wouldn't have -- I actually wouldn't even make distinctions about whether it's an overuse or underuse measure. Do we need some sort of quota of a certain number? We want to find the things that are either going on or not going on that are leading to the largest decrements and outcomes and measure those things, provided we can do so in an even loosely feasible or administratively acceptable way, so that's my --

MR. ARMSTRONG: So let me just start by affirming, too, I think this is a very important topic for us to be looking at, and the work you guys are doing reflects conversations we've had in the past and I think is heading us in the right direction.

Following Craig's pattern here, the last three questions, let me just go in reverse order and affirm that I do think that the way you've described this work to date is supporting the direction that we've been talking about taking our quality monitoring and advancing quality kind of agenda.

I won't really comment on this balance between complexity and more metrics. I frankly think the issues of

complexity are overstated, and that the improvements to quality -- and frankly to affordability that are still possible for us overwhelm this additional complexity burden, but I'm sure we'll talk much more about that.

Just to amplify a point I just made, this is not only advancing a quality strategy. This is the path to a lot of the affordability work that we've been talking about too. When we look at some of the potentially preventable visits in emergency rooms and hospitals and across the board, the billions of dollars we spend that could be avoided by measuring these kinds of things are pretty remarkable. And so I would just say it's not limited to advancing our quality strategy. It's also about affordability.

I think overuse and underuse measures should be applied at both the provider and the population level, and I agree that -- and I would take the position that both should be applied to all three payment systems. And the reason why I would say that, I understand intuitively this notion that fee-for-service, you worry about overuse and MA maybe underuse. My own personal experience is working for an organization that is well known for really excellent

population health outcomes and quality and so forth.

We've been stunned to discover -- and by the way, we also have providers who have the same clinical guidelines and go through the same hurdles before ordering and transparently, comparatively report by provider, their practice patterns and so forth. And still, with all those incentives and tools and so forth, we've seen very comparable to the community around us an increase in radiology testing, and we've seen spectacular variation from Tacoma to Bellevue to Spokane in our own medical practices.

And so we need to be monitoring overuse, even in a system with the kind of incentives, because there's a lot to learn, and these are really actionable kinds of measures, even in a system like that. That's it.

MR. KUHN: So one thing on Slide 13, I just want to kind of come to that for a second before I talk about the specific questions. This is very similar when the same Table 2 that was on page 18 in the rated material, except there was an additional line on the top with the percentages. But what was interesting to me about this table and when I read the material and then when you showed it here is if there's also a way we can collect that data by

fee-for-service, ACO, and MA, if that's doable. It would be interesting to see how those array that way, so just to request there.

So having said that, when I look at these questions here, I'll start with the last one first, like others have done, and when I look at that and when I think about it, I think about the National Quality Forum-Measure Applications Partnership, or the MAP that they have, where they are putting together what they call "families of measures." And when I try to think about the families of measures -- and I don't know their total definition. I'm not that familiar with the work. I know what they're doing. I think that these kind of issues in terms of underuse and overuse fit in those families of measures.

And what takes me back to that is a piece Rita had in the New York Times about a month ago where she talked about harm as a result of radiation and too much imaging as part of the process, and so I think it does fit very well into the quality space. It's absolutely there. So when I think about these families, yes, that works for me.

In terms of the issue of the underuse, overuse, whether population at provider level, I agree with Scott,

both. I think it makes sense as part of that process.

And then finally, when you talk about targeting each system, I think about it this way, that it needs to fit the purpose, and I think Scott's conversation here at the end about where they are as a very sophisticated system, it still fits the purpose to kind of move in that direction, so I think it goes across all. I think it makes sense to me.

And then kind of a final appeal that's not part of our conversation today, but I'll put it out there anyway, is I think what we continue to see in this whole area of measure development is continue kind of where we are in the development process, and I wish -- I think all of us wish we were much further along in terms of measure development, risk adjustment, benchmarking, attribution methodologies, all those kinds of things. And I don't know if it fits into this chapter as a conversation, but an appeal for more funding and more resources developed to the development process to keep us moving forward I think makes sense too.

DR. COOMBS: So I'll go backwards, too, from the fourth bullet. I'm pretty much in support of that. And then starting with number one, I was thinking of other things that could result in variations within the next --

the second bullet. And one of the things I thought about -- and Craig actually alluded to decisionmaking. I think it's really huge for all -- for quality, for utilization, for inappropriate, for errors. And I think the decisionmakers, if you're going to decide to actually use this at the provider level, then decisionmaking tools dovetail with that.

If you said you were going to look at it population level, I think decision tools are very important there, too. But when you get to the granularity of a provider, I think it's really a big deal.

And so we actually looked at reliability studies with RAND, looking at variation in quality a few years ago, and it's in the New England Journal of Medicine, and what we found was the variability in reliability was so vast that we couldn't take away points in terms of being able to be tiered according to the quality you delivered. And that was at the individual level.

So in terms of providers, if you have large groups, then I think it makes it a lot easier. But because of the heterogeneity of provider groups, even when you talk about physician providers groups versus, you know, hospital

provider groups, I think it makes a big difference. So that's huge.

In terms of the second bullet, I agree with Scott. The overuse and underuse measures in all three payment systems will be necessary in that there are subgroups in all three that may vary in terms of their results. And George alluded to something about, you know, minority patients within fee-for-service versus managed -- Medicare Advantage, and even in Medicare Advantage, there's studies that come out that show that there's inadequate screening and prevention tools even in a robust system such as an MA plan.

I do think it makes a difference whether you're at a high-performing health care delivery system, as you have, versus a system that actually has great challenges when it comes to the things that you can't tease out. And if you look at both systems in terms of -- all three systems in terms of overuse and underuse, you may be able to discover trends where there's a large group that is disadvantaged in some respect, and it doesn't necessarily have to be -- it could be a regional geographic area that actually has, you know, a group of patients, for whatever reason, that have access issues that relate to a number of things.

But I wanted to bring up the whole notion of defensive medicine and geographic variations. I think there are some situations, when I look at the preoperative stress test, which, you know, anesthesiologists are constantly saying send them to the cardiologist, to the medical doc, and get them cleared. And so a clearance mechanism might be for a cardiologist over the phone, prior to seeing the patient, to get a stress test and say, okay, the stress test, have the patient come to my office. And it is done kind of backwards. But in reality, that's what happens in the community many times because of the convenience of having that patient on the OR schedule.

So I think the number of lower surgeries, how the screening process, whether you have decisionmaking tools in terms of working up patients who really don't have necessarily cardiac problems but that stress test is done as a screening maneuver to enhance the physician's ability to say this patient is cleared for this low-risk surgery, and not knowing the AHA ACC guidelines, which are clear about low-risk surgery in terms of risk stratification.

MR. HACKBARTH: Cori, let me just interject a couple points and give people an opportunity to react to

them as we go around.

The first has to do with what MedPAC's role is in measuring quality or talking about measuring quality. We don't have the expertise around this table nor the appropriate processes to be a direct participant and here's what the measures should be. That needs to be worked on by other entities, whether it's NQF or specialty societies, somebody that is much better suited to that task. So I've thought that to the extent that we have a role and as it's much more high-level sort of strategic, you know, what direction should Medicare be headed?

Which brings me to my second point. We have said, based on discussions around this table, that we think that the measurement effort is getting too cluttered with too many measures, many of which have low value and impose a significant and growing burden on providers. And so we've said in various contexts we think that Medicare needs to be cognizant of that, pull back, fewer measures, less burden, more focused on things that patients care about, including, you know, ultimate outcomes of care or at least intermediate outcomes of care.

Yet, you know, whenever we start talking about it,

we very quickly, you know, get into, well, more measures as opposed to fewer. I think we're all feeling torn like Mike said he is about this. And I know I'm feeling torn that way. I participate in this as much as anybody.

So if you could, you know, react to that. You know, if, in fact, we think strategically fewer is better, how can we advance beyond that rather bland, not very useful statement to make it more concrete to the people who are actually doing the measurement process.

So Cori has the answer.

MS. UCCELLO: I don't know.

[Laughter.]

MS. UCCELLO: So I'll start with the fourth question and try to weave in some of that. But do overuse/underuse measures fit into potential quality strategy? Yes. I mean, they are -- these measures do seem to be tied with outcomes. Rita can talk more about that. And it just seems like a really big deal, and I don't know -- I think about, well, how can we add these, thinking about how we go to some of the physician payment stuff, and we say, well, we want to re-evaluate some of these codes and maybe there's some way to think about that to re-evaluate

the measures that are used and take them off when they don't seem to be really meaningful. And that's not really helpful, but it's just in general the way I would think about it.

In terms of applying overuse and underuse across the systems, I had been someone in the past who said, well, it makes more sense for fee-for-service to focus on overuse and MA on underuse. But I've, you know, been persuaded that it does make sense to apply these across all systems.

The mailing material had a statement -- and Scott has said it, too -- that even in MA plans there's evidence of overuse. I would wonder -- Dave has mentioned this in the past. Just because it's an MA plan doesn't mean that providers aren't paid within that plan on a fee-for-service basis. So it might be interesting -- I don't think we even have the data to do this, but to look at the different types of MA plans and how they pay the providers and whether the overuse and underuse varied across that. But we may need some data for that.

Population measures versus provider level, I really like population-level measures, in part because they can highlight these geographic differences better and kind

of shine a light on, you know, how use and practice patterns may differ and help to kind of get at some of that. And I think it also -- they also acknowledge that it's not necessarily one type of provider that's responsible for this. It can be not just the ordering physician but the hospital or the imaging center that also bears some responsibility. And so look at it overall can kind of see where we need to target and then delve deeper within that area to see all exactly what's going on.

So I think provider-level information is, of course, useful when it's feasible to get it, but I also do like the population measures as well.

DR. HOADLEY: So before I get into these bullets and -- I mean, I really did like the analysis, and I think, you know, we're not talking much about the specifics of the imaging numbers that we put out. But, I mean, I really am struck by the idea that, on the one measure in particular, where we're saying 36 percent is a level of something we initially labeled as inappropriate is worthy of real note here. I mean, that does suggest some things, and not that the others are so small as to be negligible. So I just would -- you know, we don't want to lose those results in

the discussion of the broader principles.

But to the broader principles, again, starting at the bottom bullet, my answer is yes, as I think most of us have been so far. And to the point of the number of measures, I actually think there's some interesting ways to try to think of it, because our concern with trying to get to fewer measures is burden on providers and are they valuable to consumers as users. One of the questions is: Are all the measures -- here we're not necessarily talking about something where we would require a provider to report something, but something potentially the program can calculate out of existing claims data. And I think that's something to keep in mind. Are there measure that we can use in the program that don't require a provider, you know, writing something down and submitting something or a plan, or whoever, but where they can be calculated, then we don't have the same burden issue as we do on other measures that really do require a specific report?

And it's the same thing, I think, on use, and particularly when we think about consumer use. We're not always developing all these measures -- we shouldn't be developing all these measures as things that we're

necessarily going to put out there. I mean, yes, maybe you could put them and make them available. I'm not saying keep them secret. But when you're getting to some kind of a decision tool, you really want to focus in on a much smaller, whether it's summary measures or very specific things that look like they're valuable, but a lot of other measures are useful either just to have them available for researchers to look at, but also for the program to look at. And so even if the sense is that the use of imaging is not a level at which you're going to pick your hospital or your health plan or something like that because it's too specific and too narrow, it doesn't mean the program shouldn't be looking at it or researchers shouldn't have access to the information to sort of say do we have a problem overall. So I that's one of the ways to try to reconcile this desire for fewer measures with, you know, the fact that we keep trying to add more things. It's to consider where they're used and how they're used and where they're collected and how they're collected.

To the point of population versus provider level, my initial instinct, much like Cori's was, I kind of want to know what's going on at the population level and, yes, maybe

it's a little bit of the researcher in me trying to understand the geographic variation that we're all confronting when we look at data. But I'm also very -- find very compelling the notion that we can use the information at the provider level to get at, you know, providers, whether it's organizational providers or individual providers, that may be the outliers. So I guess my instinct is sort of look at population first and then drill down, which was similar to the way Cori put it.

And then I very much think that the application of both kinds of measures in all systems makes sense. Scott has already talked about, you know, inside the MA plan kind of world, and I think inside fee-for-service. I mean, we have a lot of bundled pieces and prospective payment systems that can reverse the incentives at times. And so, you know, whether it applies to any particular measure, maybe not. But over the course of measures, some cases we're going to look at is there under-provision of care underneath a prospective payment system in the fee-for-service system? And so I think it's all those kinds of sort of countervailing pressures, and if we find that the pattern is overuse in fee-for-service and underuse in MA and a lot of

things, okay, that met some previous expectations, there's no problem with that.

So those are my thoughts.

DR. NAYLOR: So a number of years ago, I was driving, and one of my daughters is in the back seat, and she is telling her friend what her mom does for a living, and she said, "She sits on boards." So you had this image of two-by-fours and I was sitting on them. So I want to acknowledge one of them is NQF, and to try to place some of my comments in context. And I don't know where to start, but I would say that I wrote, Glenn, before you said it, "Why is MedPAC focusing on this agenda?" And I do think this is an exceptional report and made me really question that myself.

So one thing I'd start with is at the end as well, but wonder whether or not if MedPAC's efforts to think about promoting synchronization across the way that we look at multiple payment models isn't better achieved by focusing on the earlier measures that you outlined. So I think Healthy Days at Home or preventing avoidable index hospitalizations, emergency room visits, really focusing on the value, one measure that we didn't have here in your initial list,

patient experience, so that equation of the patient experience and a grand measure of quality, patient days at home, over total cost of care, which to me seems like an important parameter.

That doesn't mean that inappropriate use is not exceedingly important, but it's not necessarily, I think, something that our program will need to pay attention to. Everybody else will. I mean, health system leaders, if they are held accountable in the payment programs to this parsimonious set, I think will need to pay close attention to inappropriate use.

I think there's a big challenge with inappropriate use in the sense of people thinking about it as over- and underuse when the same population of people can have overuse, multiple repeated tests, as you've described, and underuse. So even people with back pain who don't get the physical therapy referrals but get multiple imaging tests, I mean, are an example of a group that may not be getting the right care.

So I think it's a world that needs a lot of work in terms of its development conceptually, but I think our goal is to really think about those broad set of measures

across programs that encourage others in positions on the ground level and in C-suites to really look at what is going on here in order to hold them accountable.

The last thing, I think you pointed out very beautifully how much we are -- and maybe this is something we can think about -- encouraging reporting of stuff, but not action on it. And I'm wondering if part of our goal is not to think about how we encourage CMS to begin to say it's not just about reporting, it's getting those rates lower that will be important.

So, anyway, some thoughts from the -- [off microphone] front seat of the car.

MR. BUTLER: So I will do my best because this is a difficult and important topic for sure.

I think the problem I'm having with the questions is that it's almost zeroing in on this over-/underutilization, which is just a small part of the bigger question we started with. And I'll address the questions, but even the chapter is currently called "Next Steps in Measuring Quality across Medicare's Delivery Systems." That doesn't -- you know, I don't see an MA plan as a delivery -- I don't know that it would be thought of as a -- so it

almost is looking like we're addressing provider-level kinds of things and not looking at -- the title itself, you know, isn't probably exactly what we're talking about.

But I don't know if we've framed or been as explicit, at least in this presentation, that we're trying to address -- I think as you started many months ago, are we favoring outcomes versus process, for example? Are we favoring focusing on fee-for-service versus MA? And I agree with David, ACO is more of on the fee-for-service. Are we looking for fewer or more? Are we looking for provider-based or population-based? Are we looking for applying it directly through economics, or are we also looking at reporting in some fashion?

And then even within economics, are we looking for penalties, incentives on the provider side, or how about the beneficiary side?

So I'm trying to frame it a little bit more of those kinds of tradeoffs and coming out with principles that would help then -- you know, we could probably decide on those tradeoffs because I think we've have opinions around that, and it would guide my thinking better.

So now I get into the specific questions here,

overuse and underuse in all three systems. I actually am more in favor of the yield being on the overuse. we're all concerned about underuse, but I don't think that we're going to make as much contribution there. And I would focus more on the fee-for-service system, on narrowing, rather than -- not the MA side.

With respect to the population or provider level, I like the population level, but I'm fearful there are so many, you know, preventable ER visits and preventable -- can be quickly tied up into socioeconomic status and adjusting for that, so I'm a little worried about how that is going to get applied in a payment system, even though that's the right focus.

In fact, I'm not sure exactly what we mean when we say people level versus provider level. I understand the differences in the measures, but I'm not sure exactly how some of this gets applied, and I think some of us obviously have expressed some confusion over how this might be done.

But I would now get to the economics and go back to Mike's comment. I think if it's harmful, you penalize directly the provider side that should know better and can know better. If it's just excessive utilization like, "I

want an MRI because I've got a back pain," I would penalize or make the beneficiary pay if they really want it. So I think where you apply the economics and trying to get the reduction matters.

So those are my recommendations on the questions.

DR. HALL: So I have been puzzling over Mike's comment about waste isn't the same thing as poor quality, and I guess I should have known that already, but I've been thinking about it a lot.

A lot of the things that we're talking about here actually can do quite a bit of harm. We talked about double imaging. There's now triple imaging, which will give you more radiation than you can even imagine in one setting. So there is some harm being done. It's not just waste. It's true harm. And this is a problem that has been in medical care probably since day one. Hippocrates probably said something about it. I don't know what he said, actually.

[Laughter.]

DR. HALL: It's been a long time since he and I talked.

So just one quick story. When I was an intern at a pretty good place, a chief of service said, "One thing you

will do all year long on my service is that you will" -- "if you order a test" -- this is before there were any computers, by the way -- "you must take a red pen and write it in red that you ordered the test, and you must fill in the results of that test with a fountain pen that had black indelible ink," he said, "because I want you to know that you ordered that test, and I want you to verify in an unequivocal way that you ordered the test." So for an entire year, I carried these things around and did this.

Now, that was almost four decades ago, and any given day you see me, you will see Hall has a red pen and a black fountain pen with indelible ink on it. And I think I learned from that experience that overutilization of tests is a very bad thing.

So we've come a long way since then, and I think MedPAC's role in this should -- I think we have a role to play here, but I think at least initially it should be more populational and maybe regional in our scope.

The reason for that is that if you try to get at individual providers who ordered that test, this is going to be very, very difficult. There are so many scenarios. And, by the way, lots of tests that are ordered in the name of a

physician are not really ordered by the physician, particularly in academic medical centers -- in fact, probably the majority of these are not directly ordered by the physician. But I think that's how we can start in this whole thing, and we'll probably find that there are some regional variations, as there seem to be with everything.

And then I think the onus of responsibility falls at more manageable levels, whether it's a portion of the country that has a great deal of managed care or doesn't, and I think from that point we will have sort of set the standard. I think we can do that feasibly. Or we can give everybody red and black pens.

[Laughter.]

DR. HALL: I have a whole lot of them, if you need them.

MR. GRADISON: With regard to the final question, the way I think about this is that the population-based data tell us whether there's a problem, but to deal with it, we have to do it at the provider level. And I think it's extremely difficult. Others have mentioned this. The administrative -- it isn't just a matter of administrative complexity. It's whether it's administratively feasible to

do this at that level.

I'm going to go a little bit more deeply. I'm not especially concerned about this issue as it applies to MA plans or two-sided ACOs, because I think they already have an incentive to do the right thing with regard to both costs and quality. Certainly in the long run they do. So the focus of my thinking -- and it's pretty tentative, I acknowledge -- is what to do with regard to one-sided ACOs and fee-for-service.

There, with regard to overuse, I think that -- and this is certainly rough justice, but I think if we really believe that the double scans and MRIs for lower back pain without doing conservative therapy first and having tests done more often than they should be can be dealt with, to be frank, very directly. Just pay 50 percent for the one that doesn't fall within the -- or something like that, within the parameters. I think that would get everybody's attention. It doesn't say -- it cuts into an issue which we haven't -- I haven't heard the word mentioned here, unless I missed it, and that's the accusation that we're talking about rationing. We wouldn't be rationing. It's available. you just don't make as much money out of it as you did

before, which, again, it may sound simplistic, and my thinking on this is very tentative and simplistic in trying to think about what to do about it.

What I have no idea how to do anything about is in the context of the one-sided ACO and the traditional fee-for-service is underuse. I haven't the foggiest idea how effectively to do that at the level that really counts, which is the provider level.

DR. CHRISTIANSON: So I'll just say a little bit more about Bill's first couple sentences. I've been thinking about population-based measurements and people have been talking here, and to Glenn's point of sort of at a general policy level, I could see where we would implement this by saying, okay, we've drawn our circle around a geographic area that includes ACOs, it includes MA plans, and, of course, traditional fee-for-service; and we will do population-based measurement for each. So we would define the three populations: those folks who have been attributed to an ACO, those folks who have been attributed to an MA plan, and the rest. And then in that geographic area, we would say, oh, you're doing 5 percent better on this quality measure, population-based quality measure if you're in the

MA plan. And then you do that for 160 other areas you've drawn a circle around, and then you'd end up in the MedPAC report saying in 67 percent of the geographic areas we've identified, MA plans are better on this quality measure, and in 43 percent they're worse on another quality measure and so forth.

So you wouldn't need to -- for that kind of analysis you wouldn't need to identify or measure quality at a specific organizational level.

You also really probably wouldn't need to do this -- you know, identifying the areas, and so you probably conceptually could at least do a statistical modeling using the patient as the unit of observation. And I'm not sure all the data would be available for that, but you wouldn't need to go to this sort of geographic area in quite the same way.

If you wanted to do it to be informative to consumers, you would want to measure the populations identifiable for each ACO and each MA, and then the rest would be fee-for-service. And so consumers could see, gee, I've been attributed to ACO A and that's not so good relative to had I been attributed to ACO B or whether I'd

been in MA Plan 1. But it has real limitations because, as a consumer, you're looking at -- if you're in fee-for-service, the average for fee-for-service -- and we know there's a lot of variation, and your particular fee-for-service experience may be better than any of the data that exists for the ACO population-based measures or any of the MA measures.

So it's limited, but it provides you with some information if you're a consumer and you're looking at our report.

If you're going to use it for payment purposes, I think you kind of go back to the arguments that the IOM report made recently, which is there's so much variation within geographic areas, for instance, in the fee-for-service delivery system that you would unfairly penalize some number of providers by giving them low payments simply because the average for fee-for-service was poor quality in their area. So I think we would probably have to be really, really careful if we thought we were going to use the population-based payment measures for payment.

So I'm trying to sort of how this population-based approach gets used, and probably I'm right with Bill in his

first couple sentences, which is maybe to identify geographic areas where there are potential problems, but then you would get right down to the provider level as much as you could, as much as possible to measure performance at that level.

DR. BAICKER: Yeah, I'm as fond of geographic variation as the next gal, and I think it's great to have that, but I do think that the subarea level is really where the action is in terms of payment and also in terms of people choosing providers or choosing systems based on the quality that we're able to give them information about.

So I know there are limitations in terms of small numbers. You're never going to get to individual providers and have reliable measures.

That also then gets to the bigger-picture question. In an ideal system, we wouldn't have to use these measures to signal these things. People would be choosing systems and providers. There would be appropriate incentives for providers to deliver high-quality care and not low-quality care.

And the fact that we have to pick and choose these little measures is symptomatic of the bigger problem. So

the solutions we want to come up with want to move us towards a better system, and that's the framework we're always evaluating these questions in.

And, as such, I think measuring for all the systems, or whatever words you want to use to capture fee-for-service and MA and nascent ACOs, the same measures seem key so that we have comparable information for people and also can adjust payment policy appropriately.

And we suspect there are going to be bigger problems in overuse in some systems and underuse in others, but that doesn't mean we shouldn't measure them all there.

Then figuring out which particular measures is a challenge.

These examples, I thought, were really great in that they focus on something where there are clinical guidelines, where it's not only low value to the patient, or potentially wasteful but also harmful. And there, it's an easy case to make that we definitely want to minimize those things because we're spending money on stuff that hurts people -- that's clearly a loss -- as opposed to the many, many cases where we spend money and it's not clear how much we're helping people; that's tougher.

But, here, we've got these great examples of spending money to harm people that we should clearly stop doing.

And are they then good enough measures to capture low-quality use?

Or, is it a picking-and-choosing problem where some areas are going to be doing really well on some measures and really badly on others?

Is there a teaching-to-the-test problem, where you choose a small basket of measures and people then really work on dampening out overuse of those while then taking the MRI that they were using on the low back pain and using it for something else?

These are all practical questions, and maybe the answer is if you measure enough different things and aggregate them together you can have a reasonably good summary measure, where people can quibble with this one or that one.

You know, there's an analogy to hospital readmissions where with any individual patient, you can say, no, no, this guy really had to go back to the hospital. And that may be completely true. It may have nothing to do with

the quality of care that patient got.

But you put it all together, and if you have a systematically higher rate of those "this guy really had to go back," something is going wrong.

And so maybe the answer is in aggregating enough measures together that for any individual patient, for any individual case, you can say, well, this isn't low quality care. But provider groups or providers or even areas that are systematically high on those things, we know, are doing something that we want to try to discourage.

So those are some ill-organized thoughts.

MR. GEORGE MILLER: Yeah, in line with other stories that we've heard, I recall that I was called to the emergency room because a patient insisted that he needed an MRI because he had seen that done on ER the night before.

[Laughter.]

MR. GEORGE MILLER: So, overall, I think as we examine our role as MedPAC commissioners and look at this issue, I think our role is very, very clear.

I'm not sure I agree with that waste and poor quality are different. I think waste would be in the category of bad. Bad would be bad, and that would be poor

quality, in my view.

So anything that's wasteful or poor quality, we shouldn't pay at any rate, I would believe, once we determine that the evidence is very, very clear that it has no benefit to the patient. And then, of course, overuse exposes the patient to more problems than it should.

To the question, do you overuse or underuse measures that fit into potential quality strategy, I would say yes, we should do that.

Second question about applying overuse-underuse measures at population levels, provider levels, or both -- I would think, for the most part, it would be at the population level, but where the patient insists something be done or -- I think Peter used the example of someone insisted something be done and that a patient may pay for it, but that's not the measure.

But I would go with the population, particularly as it deals with geographic variation.

And then the third question, quite frankly, I would agree that we should apply them to both overuse and underuse measures on all three payment systems although there is some difference in those payment systems, I

certainly understand.

I think the other issue very, very clearly -- as I mentioned earlier, there is still a great deal of health care disparities in America. A great deal. In fact, in the last five years, disparities have not gone down although quality has improved. But disparities have not gone down.

So I would like us to stay on this track because we recommend to Congress about payment levels, and so I think tying those two together makes sense -- to tie appropriate use for a service. We have the hammer, or to use positive terms, we have the carrot for the right incentive for payments, and they should be tied to quality.

DR. REDBERG: Thanks.

I think this was a great chapter and a really important topic. I certainly think we should be looking at potentially inappropriate use.

As Mary is a very busy woman and because, besides boards, she sits on committees -- and Mary and I both sat on the IOM Committee on Best Care at Lower Cost, which concluded that 30 percent of all of our health care -- and I think that's a conservative estimate -- is waste.

And I agree with George. I think waste is bad.

I'm not an economist, but I think there are opportunity costs. You could be doing something else with that time and that money, and so I just cannot justify waste.

And I actually think --

DR. CHERNEW: Can I just say that I wasn't trying to justify waste? I just want to go on record again.

DR. REDBERG: No, you can't talk now. It's not your turn.

DR. CHERNEW: I'm not in favor of waste.

[Laughter.]

DR. CHERNEW: And, fraud. I do not like fraud.

DR. CHRISTIANSON: Make sure the transcription got that.

DR. CHERNEW: Chernew does not like waste.

DR. REDBERG: Can I resume my comments now, Mr. Vice Chair? Thank you. Where was I?

And I wanted to pick up on what Kate said because I think the really important thing besides the waste issue is that these are harmful things. I mean even if they didn't waste time and money.

I, unfortunately, now see as many patients or more

that are coming in because of inappropriate care, which they're suffering from. You know, the radiation risk, because we looked at imaging, is just one of them, but all of these tests also lead to additional procedures. They lead to surgeries. And, as you've documented very nicely in the chapter, there are no benefits to patients for these.

Like Mary gave the example, maybe we're underusing PT and we're overusing MRI. Right, the PT would help a patient.

With MRI, you're talking about, well, if they didn't get therapy before they got the MRI, as if MRI was a therapy. This is a diagnostic test. It's not helping anyone feel better.

I mean, the only point of it would be to do something to help someone feel better, and you don't need an MRI for low back pain to help someone feel better. And that's a whole other story of why we're doing so much, and paying for so much, spinal surgeries that haven't been shown to help people.

So I think that there's a lot of opportunity. It's a win-win because we would avoid a lot of harms.

I mean, any procedure that has no benefit, the

only thing that can happen is harms. Even if you are not personally harmed, you wasted time and money. And a lot of these things lead to other things besides test -- anxiety over things you probably didn't need to worry about.

And I agree that overuse and underuse measures, I think Scott said, should be the same in all three systems. I think that -- you know, I practice at a university setting. I see patients in all different kinds of insurance plans. I would like to treat them all the same and make the decision that's best for that patient and not think about which insurance system they happen to be in.

And I think the other issue that we didn't get to mention, but we've talked about in other contexts, is the role of the patient in shared decision-making because I wager that none of those patients who got any of those inappropriate tests knew that they were getting a test that was not going to help them at all. If we were better at explaining to patients why we were ordering the test, as Bill was referring to, just on its own, a lot of those tests would go away.

In terms of population level or provider level, I would agree with -- I think, again, Kate said, with the IOM

report, or maybe it was Jon, it showed that most of the variation is at the provider level.

So, while I wouldn't argue with having population level and it would be interesting, I think it's really important to look at the provider level because in the same small area you're going to have marked differences and providers tend to be pretty consistent in their ordering patterns.

And then, certainly, I think this fits into our overall quality strategy. You know, I certainly agree that we have way too many measures right now, of quality. But the problem is, as was outlined in the chapter, they're really focused on process. That's a lot of the problem.

So they don't have any correlations to income. They do take a lot of time, and they take a lot of effort. And I would be happy to see a lot of them disappear, but I think these are really important ones.

The idea of tying to guidelines and decision support, I think, is a good one although I do have some concerns because I've seen a bunch of abstracts recently at professional meetings where people embedded decision support for appropriate use into the electronic health record, and

miraculously, all the tests became appropriate, but the volume of tests didn't change at all. You know, it suggests that you get good at knowing what boxes to check.

And I'll say I was talking to a colleague recently in New York State because New York State is considering incorporating making public reporting of appropriate use measures for PCIs for stenting. He told me at his hospital the cath lab director has instructed all the fellows to report all of the patients had chest pain at rest, which of course, makes them all to have acute coronary syndrome, and anything you would do would then be graded as appropriate, which is, I'm sure, not representative of all hospitals but is disturbing to even think of.

And so, in terms of the potential strategy, I think using measures like these and tying our payment, as Bill suggested, to guidelines is certainly a good start because right now we pay for a lot of care even though it's clearly outside of the guidelines. The professional guidelines give direction, but Medicare still pays for care that is considered inappropriate or outside of the guidelines.

But, that we would want to head towards a system

where we're really paying for outcomes because if you are paying for outcomes then you don't have to think.

You know, if you had a pot of money and you were going to get paid for the best outcomes, then you would, of course, choose the things that are most geared to getting better outcomes. So you could get the PT and not the MRI.

And so I would like to see us head -- which will take a little time -- to a system where we're paying for outcomes, and we're not then so focused on the providers can decide what to do and to have patient involvement in that.

DR. NERENZ: Okay. I think at this point in the circle about all I can do is repeat good things that other people have said. So I'll try to do that quickly.

In terms of the first point above, I would certainly would support additional attention to inappropriate use measures, particularly the overuse measures.

I think it was Peter that pointed out that the underuse measures already have a steward and a history and what not. So it may be that CMS and MedPAC could make a stronger contribution in thinking, again, in general, not about specific technical measure definitions in the domain

of overuse.

And, clearly, there's also perhaps a more direct financial benefit that ties into our payment rules.

So, yes, to that one.

I would generally favor applying the same set of measures in all three of these payment systems for reasons others have stated.

I just would observe that the argument for doing it differently would basically assume that financial incentives are the main drivers of practice variation or poor quality, and I'm not sure that's really the case. It matters, but I'm not sure it matters most or matters only. There are other things that matter.

So I think I would strongly favor, if it's a good quality measure, use it everywhere.

In terms of the third point, the word, population, in that bullet I think can have two distinct meanings, and I like one, and I don't like the other for purpose of quality measurement.

A population can be a group of people who have a defined relationship with an entity whose performance is being measured -- members of a plan, patients attributed to

an ACO, patients of a practice, patients from a hospital. And I think that works because you have an entity whose behavior can change and it has actors who can feel guilty and who can feel motivated to change.

On the other hand, a population can mean a group of people who have the same zip code or who live in the same city, and I don't think that works, frankly. I'll just say it bluntly.

There is no acting entity. There is no one to feel guilty. There is no one to change. There is nothing to do.

That works for policy analysts. It works for academics. And I love the Dartmouth Atlas work. But nothing changes. There's nobody to move.

There was, I think, an interesting little article 10-15 years ago under the title of "Who Has Responsibility for the Population's Heath?" And it observed that in Canada and Britain, other countries, there are defined entities who are responsible for the health and the expenditures and care of people in defined geographic areas, and that's part of the social contract in those places. The people have agreed to it. They abide by the decisions.

But the point there is that does not exist in the United States. We just don't have it.

So I just don't know what you do with quality measures at the geographic area. I don't know who acts.

And it occurred as it goes around the table that I don't think CMS is a public health agency. Maybe I'm wrong, but I don't think it is.

So, finally, it's probably not surprising that on the last point I'm certainly in favor of measuring outcomes but not population-based outcomes I think in the spirit that the terms is being used here, certainly not at the geographic level.

And I guess the last thing I would observe is if we have a disconnect often between process and outcome measures the problem may not be with the process measures; the problem may be that the outcome is too distal, perhaps too affected by things outside of the provider's control.

The sweet spot may be to focus on those outcome measures that are more proximal, more directly related to what the behaving entity does, and then select only those process measures that have the tightest causal relationship with those outcomes.

We may be wrong both ways. We may be measuring outcomes that are too distal, and we may be measuring processes that don't have all that much to do even with the proximal outcomes.

MR. HACKBARTH: Okay. I don't need to read the transcript on this to know exactly what I think and where we go from here. I think we agree it's important and it's complicated, and beyond that, I'm not sure I can sum up the conversation.

So, since we're a little bit behind schedule, I won't try to do more than that right now, and we'll move to the public comment period before lunch.

[No response.]

MR. HACKBARTH: And seeing nobody rush to the microphone, we will adjourn for lunch and reconvene at 2:15.

[Whereupon, at 1:21 p.m., the meeting was recessed, to reconvene at 2:15 p.m., this same day.]

AFTERNOON SESSION [2:18 p.m.]

MR. HACKBARTH: Okay. We have two sessions this afternoon, first being using payment policy to promote use of services based on clinical effectiveness and then a session on payment for primary care.

MR. RICHARDSON: Good afternoon, as if I never left.

[Laughter.]

MR. RICHARDSON: In the morning session, you discussed how Medicare might focus its quality strategy by measuring rates of potentially inappropriate use of clinical services in fee-for-service Medicare, Medicare Advantage, and Accountable Care Organizations.

One possible use of this strategy would be to change payment incentives that encourage the overuse, particularly in traditional fee-for-service Medicare, of services that have limited or no evidence of clinical effectiveness.

In this session, we, by which I mean Lauren and Nancy, will present for your discussion three different but related policy ideas. Instead of measuring and comparing rates of potentially inappropriate service use, these ideas,

we'll ask you to consider whether Medicare could use the results of comparative clinical effectiveness research directly in the design of payment policy.

I'll turn it over to Nancy.

MS. RAY: Thank you, John. I would also like to thank Joan Sokolovsky for her contribution to the paper.

As we have discussed changes to the delivery system and benefit design, the Commission has repeatedly raised concerns about the value of Medicare spending and the development of policy driven by the value of services. The goal of this session is to advance this conversation by discussing three ideas that base fee-for-service payment on comparative clinical effectiveness evidence.

First, we describe Medicare's policy applied before 2010 that set the payment rate for some Part B drugs based on clinical evidence.

Next, we discuss the idea of linking payment of new services to comparative clinical effectiveness evidence.

Lastly, we present two case studies on differences between Medicare's payment policies and other groups' evidence-based decisions.

Referred to as the least costly alternative

policy, Medicare between 1995 and 2010 set the payment rate for a group of drugs with evidence showing their comparative clinical effectiveness based on the least costly drug. According to other federal agencies, this policy improved payment accuracy and resulted in savings for beneficiaries and tax payers.

Least costly alternative policies affected a drug's payment rate. The policies were usually implemented by the medical directors of Medicare's contractors and local coverage decisions regionally.

In one instance, Medicare implemented a least costly alternative nationally under the hospital outpatient department prospective payments system for two biologics, erythropoietin-stimulating agents. The contractor's medical directors implemented the least costly alternative policy based on the statutory provision that requires Medicare to pay only for services that are reasonable and necessary for the treatment of an illness. A beneficiary challenged the policy in federal court arguing that the drugs should be paid based on its own statutorily determined payment rate, average sales price plus 6 percent. Two federal courts agreed with the beneficiary, and in April 2010, the least

costly alternative policies were rescinded. At that time, the policy was being applied to two groups of drugs.

The OIGI in a 2012 report recommended that the Secretary seek legislative authority to use least costly alternative policies for Part B drugs. We estimated that for one group of Part B drugs, beneficiaries and taxpayers would have saved up to $122 million if the policy had been continued between April 2010 and December 2012.

We are looking for Commissioner input about next steps concerning this idea. Commissioners could discuss the idea of the statute, restoring the Secretary's authority to apply least costly alternative policies to Part B drug payment. Commissioners could also discuss some of the implementation issues we raised in the paper that include development of a transparent process, a process that permits input and comment from beneficiaries and a wide range of stakeholders, and a process for revisiting the police as evidence changes.

The second idea on today's agenda is about setting the payment rate for new services based on comparative clinical effectiveness evidence. This idea is intended to address instances in which the payment rate for a new

service is higher than its alternatives, even when there is insufficient evidence on whether the new service results in better outcomes.

Two researchers, Pearson and Bach, in a 2010 Health Affairs article proposed what they called the "dynamic pricing policy." It classifies a new service for the purposes of setting its payment into one of three groups based on the availability of comparative clinical effectiveness evidence.

For the first group, there is adequate evidence that shows that the new service improves outcomes compared with its most relevant alternative. The payment rate of the new service would be set according to usual statutory methods.

For the second group, there is adequate evidence that shows that the new service produces outcomes that are similar to its relevant alternative. The payment rate of the new services would be set equal to the treatment alternative, essentially a least costly alternative policy.

For the third group, there is insufficient evidence on the new service's comparative clinical effectiveness. The researchers proposed that the new

service would be paid at a rate based on usual statutory methods for the first 3 years. At the end of the 3 years, Medicare would assess the additional clinical evidence concerning whether the new service improves outcomes compared with its alternatives. Based on this assessment, the new service's payment rate would then be adjusted accordingly.

We are looking for Commissioner input about next steps. Medicare would need legislative authority to link the payment of a new service to comparative clinical effectiveness evidence. Commissioners could also discuss the implementation issues, some of which are similar to those for implementing least costly alternative policies, including establishing a transparent process with opportunities for a wide range of beneficiary, clinician, and stakeholder input and comment.

Here are some other implementation issues Commissioners might want to discuss. The first is the notion of applying this concept to existing services. While the researchers applied this concept to the payment of new services, they acknowledge that it could also be applied to existing services.

Next is determining the time period for generating comparative clinical effectiveness evidence. The researchers proposed a 3-year period. Some might argue that a longer time period is needed. Some might argue that a time period specific to the service is needed.

Another issue concerns the entities sponsoring the research. Should that be the manufacturer, a non-profit, PCORI, and will the research generated be objective? Regarding the research design are issues concerning which alternatives should be included; for example, should watch for waiting as an alternative be included.

Another implementation issue concerns the criteria for evaluating treatment outcomes, for evaluating that one treatment improves outcomes compared with its alternatives.

Lauren will not present a third idea for your consideration.

MS. METAYER: Next, we will examine how Medicare's payment policies do not always align with other groups that rely on comparative clinical effectiveness research. To evaluate this, we looked at the following two case studies, which describe differences between Medicare's payment policies and Washington State's payment policies for medical

procedures, tests in labs, as well as the United States Preventive Services Task Force's recommendations for clinical preventive services.

Our first case study is the Washington State Health Technology Assessment Program. This program determines if the services paid for by Washington State's government are safe, effective, and provide value. Created through legislation in 2006, the program has the ability to make binding coverage determinations for the state's fee-for-service Medicaid enrollees, workers' compensation claimants, and the state's departments of corrections and Veterans Affairs. In total, this accounts for a little over 10 percent of the state's population.

While this program in Washington State uses clinical effectiveness research to make coverage policy, we believe the program has implications for how Medicare could take this type of research into account in its payment policies.

I will now briefly go over the process Washington State uses to evaluate health technologies, but I'm happy to answer any additional questions you have.

First, topics are selected by Washington's health

care administrator for review. Each year, about 10 health technologies are selected. Health technologies include medical devices, procedures, and diagnostic tests.

After a technology is selected, the program contracts for scientific evidence-based reports produced by an outside research group,

In a public meeting, an independent clinical committee of 11 practicing health care professionals use these reports to determine which services the state will pay for. Normally, the panel decides to cover a service, cover a service under certain circumstances, or not cover the service at all.

When making decisions, the panel can take the safety, effectiveness, and cost of the health technology into consideration.

We then evaluated how the decisions reached by the Washington State program differed from Medicare's policies. In some instances, Medicare and Washington State had similar payment policies; for example, both have decided to allow the use of the robotic-assisted surgery when recommended by the attending surgeon but provide no additional payment when the technique is used.

There are also instances in which Medicare may not pay for a service that Washington State does; for example, Washington State pays for vitamin D screening for individuals under certain limitations, and Medicare does not pay for this service.

We then evaluated the instances in which Washington State did not pay for a service that Medicare did. We identified 15 different health technologies Washington State does not pay for, or pays for under certain circumstances, that are paid for by Medicare.

One example of such as a service is vertebroplasty.

We estimate that for outpatient, physician, and DME payments, Medicare paid a range from about $683 million to $2 billion on services that Washington State did not in 2012. Several of the services identified by Washington State and paid for by Medicare have also been identified in the literature to be of questionable value.

The Medicare spending figures are presented as a range, depending on how sensitive a measure is used. The lower end of the spending range, $683 million, includes spending amounts for health technologies that Washington

State does not pay for at all, and it does not include Medicare spending for technologies that Washington State pays for only when certain requirements are met.

The upper end of the spending range, $2 billion, includes both the health technologies Washington State does not pay for, as well as the health technologies that Washington State paid for under certain requirements. In this measure, we collected all Medicare spending for these health technologies, whether Washington State's requirements were met or not. This means we likely collected Medicare spending, which would have also been paid for in Washington State, in our upper spending range.

We are happy to discuss these limitations further if Commissioners have questions.

Our next case study is the United States Preventative Services Task Force, or USPSTF. The task force is an independent advisory panel reporting to the Secretary of HHS about preventive services such as screenings, counseling services, and medications.

The task force assigns each service it reviews a letter grade based on the strength of the evidence and the balance of benefits and harms of a preventive service.

Grades range from an A, B, C, D, or I.

Services that receive a D grade from the task force are those which are not recommended and there is moderate or high certainty that it has no net benefit or the harms outweigh the benefits. Some of these services receiving a D grade are paid for by Medicare. One example of such a service is screening for colorectal cancer in those age 85 and older. According to a 2009 study, the task force had assigned a D grade to 16 services and Medicare-reimbursed clinicians for 7 of these services.

These instances in which Medicare's payment policies do not always align with comparative clinical effectiveness occur for a variety of reasons.

Firstly, Medicare has limited comparative clinical effectiveness information on which to base its payment policies. To help with this issue, the PCORI was established in PPACA in 2010 to sponsor comparative clinical effectiveness research.

Secondly, many new services and technologies fall into existing payment methods or buckets. Overall, the majority of services fall into existing payment methods and as a result do not go through a coverage process which would

consider its clinical evidence.

Lastly, Medicare's payment systems generally do not consider the comparative clinical effectiveness of a service compared with its alternatives when considering payment amounts. While Medicare may take these factors into account when making coverage policies, they rarely factor into Medicare's payment polices.

To address these concerns, Commissioners could explore beneficiary cost sharing for low-value services. As part of its benefit design recommendations in 2012, the Commission recommended that the Congress provide the Secretary with the authority to alter or eliminate cost sharing based on the evidence of the value of services. Adjustments and refinements in cost-sharing amounts could be made as evidence of the value of services accumulates and evolves.

However, there are several issues to developing a process for beneficiary cost sharing for low-value services. Firstly, there could be a process in place to consider the evidence of low-value services that has been generated by outside research groups, such as PCORI, as well as a process for stakeholder and public input. Exceptions would also be

needed when clinicians submit evidence that a service is medically necessary.

Lastly, low-income beneficiary protections as well as supplemental insurance coverage are issues that would need to be addressed.

This concludes the presentation. Commissioners may wish to discuss the ideas and issues addressed in this presentation regarding restoring the Secretary's authority to apply LCA policies to Part B drugs, Pearson and Bach's dynamic pricing policy, as well as ways to align Medicare payment policy with evidence-based decisions.

Thanks.

MR. HACKBARTH: Okay. Thank you.

Before we go to round one, could I just digress for a little bit? I want to make sure everybody understands the method by which the payment is calculated for these Part B drugs that were talked about. It's in the paper, but I just want to explore that for a second.

So do you want to, Nancy, describe how the payment for Part B drugs is calculated? Then I have some questions.

MS. RAY: The payment for Part B drugs is established on average sales price plus 6 percent.

MR. HACKBARTH: Yeah. So you have a drug manufacturer selling the drug to who? And come on up, Joan, if you want to participate.

[Laughter.]

MR. HACKBARTH: So in this process, who are the purchasers in this sale?

DR. SOKOLOVSKY: So I didn't hear the -- what's the question?

[Laughter.]

MR. HACKBARTH: The basic method for paying for Part B drugs is 106 percent of the average sales price. That suggests there's a transaction between the manufacturer and a purchaser or the sale. Who are the purchasers of these drugs for which these sales price are calculated?

DR. SOKOLOVSKY: Physicians, hospitals. The average sales price is based not specifically on what a provider pays but on the revenue that the drug company makes from the drug, including all rebates that it may give.

So at the end of a quarter, the manufacturer looks at all the revenue it made from a particular product and submits that product, that information to CMS. CMS takes that information, and by the end of the next quarter, that

would be -- it posts that as the payment rate for that quarter plus 6 percent.

MR. HACKBARTH: Okay. So for the sake of simplicity, let's say we're talking about a Part B drug that is sold to physicians or medical groups. Now what I'm interested in is, Do those purchasers, the physicians or medical groups, have an incentive to try to hold down the price that they're paying for that drug?

DR. SOKOLOVSKY: They very much do have that incentive, and in fact, if they can't purchase the drug at the payment rate, they are likely either not to order that drug, look for a cheaper drug. They may send the person to the outpatient department of a hospital to get it.

There are certain cases, certain specialties will tell the patient to purchase it at a pharmacy and have the pharmacy deliver it to the physician's office, and if it's purchased at the pharmacy, it becomes a Part D drug.

MR. HACKBARTH: Yeah. So the 106 percent of the average sales price, that money, that Medicare payment goes to whom when Medicare --

DR. SOKOLOVSKY: That's what CMS or Medicare gives -- pays to the physician.

MR. HACKBARTH: And so -- and pardon me for being a little bit pedantic about this, but I just want to make sure that everybody understands all the steps here. And so the incentive of the physician to bargain, if you will, with the manufacturer is that if they pay more than 106 percent, they don't get paid or they end up losing money.

DR. SOKOLOVSKY: That's right. You lose. Yes.

MR. HACKBARTH: And so the competition, if you will, is to get it less than the average, and to the extent that they can get the drug for less, the physician gets to keep that at an increment.

DR. SOKOLOVSKY: Yes. And there's -- I think a lot of people have the misconception that you go to the store and buy the drug at the average sales price, and that's not how it works.

MR. HACKBARTH: Yeah. In fact, that's why I just wanted to make sure that people sort of understood the transaction, underlying transaction that we're talking about.

Thanks, Joan.

MR. GRADISON: It seems to me that there used to be an average wholesale prices, and there was all kinds of

problems with that, and that this was put in to try to clean up the program actually and avoid some of the misrepresentation, actually, of prices under the average wholesale price system.

MR. HACKBARTH: Jack?

DR. HOADLEY: Yeah. I should know the answer to this, but the new -- when a drug is new before there have been a couple quarters of data, what's the marker for the price at that point?

[Laughter.]

DR. HOADLEY: Sorry, Joan.

DR. SOKOLOVSKY: At the beginning, before there is any data, the assumption is that it's not AWP, but it's WAC. And that could vary a lot from the transaction price, and it will take 6 months before the price actually falls to what they're actually getting for the drug.

DR. HOADLEY: Effectively, the manufacturer is setting the initial price for --

DR. SOKOLOVSKY: Yes.

DR. HOADLEY: -- the first couple of -- first 6 months at least. Yeah.

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: Thank you.

So round one clarifying questions? Peter.

MR. BUTLER: I have two. There's some $12 billion or something spent on the Part B. Is there a gray -- and some are -- they're often associated with they have to be physician-directed or they are, you know, injected or whatever, but some are like oral drugs that don't require assistance, just oversight. Is there a gray definition of when something could be a Part B versus a Part D drug?

[Laughter.]

MR. BUTLER: I guess so.

MR. RICHARDSON: This is obviously your meeting.

[Laughter.]

DR. SOKOLOVSKY: It's largely determined by statute. For example, for cancer, for chemotherapy, chemotherapy is covered by Part B, but then they started to make generic oral substitutes, exact substitutes, but what they had to infuse before. So Congress didn't want to create an incentive to keep infusing when you could take a pill, so they decided to cover the exact oral equivalents of the infused drugs under Part B too. And then there are things like vaccines that are also in statute.

And then the general term is if a drug has to be administered by a physician in general, it's a Part B drug. If it's self-injectable, it's a Part D drug.

MS. RAY: And then there is the --

DR. MARK MILLER: The natural -- and see if this is what you were asking, because I thought I heard you saying is there any natural rotating off of B to D.

DR. SOKOLOVSKY: No.

MS. RAY: No.

DR. MARK MILLER: That's what I thought, too, but I'm trying to figure out whether that's what you were asking.

MR. BUTLER: Well, not that narrow of a question, but I was trying to think as we addressed it for policy issue, is there an opportunity to reclassify some of these into or out of B as part of the solution of what we're trying to aim for?

MR. KUHN: That's an interesting question, Peter. I don't know the back-and-forth, classifying one or the other, but another example is people with COPD. So they have a nebulizer. They're at home. They use albuterol four times a day. They're basically locked in their home. But

under the Part D benefit, you can get an inhaler that then you can take, and then you can get out in the community, go to church, whatever the case may be. So depending on whether it's a B- or a D-covered service, it does kind of free the folks from being homebound at least in that case, and there might be other instances as well.

MR. BUTLER: And I guess the other somewhat related part, because there's often payment separate from but connected to the delivery of the drug for the physician that's doing the -- so if it's an oral drug, I don't -- the physician doesn't get any separate payment for that, right? Because they're not doing anything other than ordering the drug, right? Whereas, in infusion therapy or something like that, again, I'm just trying to relate whether there is economic incentives that favor the Part B versus the Part D, the way the thing is set up.

DR. HOADLEY: There are also, of course, differences in cost sharing. I mean, the cost-sharing structure is very different in B and D, so there's a difference on that side as well.

DR. MARK MILLER: You started off to say two things. Was that two, or was that one?

MR. BUTLER: Probably three. I don't know.

[Laughter.]

MR. BUTLER: No, there were two, two different things. One was Part D, what's in Part D versus B, and then the second was really the physician charge part of this, if it's Part B versus the drug charge part of the service.

MR. HACKBARTH: Clarifying questions?

DR. SAMITT: Yeah. On Slide 6, I'm trying to understand how the lawsuit that was described interrelates with the concept of medical necessity. So I'm not sure I fully understand. Did the provider prescribe this drug as deemed medically necessary, but the LCA policy applied? How would this be different than the development of a transparent process you've described that would provide exceptions based on medical necessity. So I'm not sure I understand the distinction.

MS. RAY: Okay. So the lawsuit -- so when Medicare implemented the least costly alternative policy, the Secretary based it on her broad authority to cover only those expenses that are reasonable and necessary for the treatment of an illness or injury. What the courts found is that they said, you know, but Congress has this very

specific rule saying this is how you should pay for Part B drugs, and they -- basically, the court said that the ASP provision trumps the broader authority that the Secretary has.

DR. SAMITT: Okay.

MR. HACKBARTH: And that's a basic rule of statutory construction when there's a provision that deals specifically with it. It is given more weight by the court than a general provision.

Mike.

DR. CHERNEW: I have a question about slide 18, also actually mentioned in the chapter. You say in the second bullet point, which is, many new services fall into existing payment methods so they don't have to go through this process, but I believe they then would update those bundles if there was some -- is there a lag by which that happens, so it's essentially an empirically-derived updating, or do they do anything else that changes the cost of the bundle that this new service is fitting into?

MS. RAY: Okay. So I think it probably depends upon the payment system you're talking about.

I mean, if it's a Part B service, let's say --

let's pretend it's a new -- I don't know -- a new imaging service. The Secretary would value -- would determine the work RVUs, practice expense and malpractice to determine the payment for that new service.

DR. CHERNEW: I was thinking more of like a DRG, where there's a new technology or service or other thing that's happening in that admission. The DRG rate gets revalued, I think, at some point to reflect the new cost within that DRG, and I'm interested --

DR. MARK MILLER: That's right.

DR. CHERNEW: And I'm interested in the timing and the process by which that happens because that seems analogous.

DR. MARK MILLER: Okay. So there is -- and I'm going to look at Julian while I'm doing this.

There's a lag.

Well, hey, man, we pull consultants in when we need them. You know.

So there is a lag.

So, if something shows up, a new device or something like that, that cost starts getting reported through the cost reports and starts getting pulled into the

process of recalibrating DRGs. It may take some iterations, a year or two.

And let me just say one other thing. There is a process within both outpatient prospective payment and inpatient prospect payment, where you can designate certain technologies as cost-increasing but quality-improving, meeting some particular set of tests, and say, for these, there is going to be an accommodation for the fact that they're entering now.

MR. HACKBARTH: So CMS is rendering a judgment sort of analogous to what we would be talking about here -- that the gain is sufficiently large that it warrants a special payment adjustment, a clinical gain.

DR. CHERNEW: Right. I was trying to figure out if there's sort of some precedent for how this works in that process.

The other question I loosely had is I believe what happens in that process is if there is a DRG that gets a new service sort of underneath it and it is more expensive and that DRG gets a higher weight, it's done in a budget-neutral way. So other DRGs or other services that were totally innocent end up getting lower payments because of the

budget-neutral way in which these revaluings are doing.

I think that's right, but --

MR. HACKBARTH: Why don't you come to the mic, Julian?

MR. PETTENGILL: For the first two years -- first of all, if you come up with a new procedure or a new product, you have to apply to get it classified, get it coded -- a code for it so that it can be classified. You do that through the -- there's a Clinical Coordination Committee, ICD-9 coordination committee. You that first.

Then you can apply to get additional payments during the first two years for that technology, but you have to meet five criteria, one of which is that it has to be new, truly new. A second one is that it has to be at least as good as what's already available out there. And then there are some others.

Then during that -- if you succeed with that application, then you will get providers who will get extra payments for that new procedure or new product for a two-year period.

Following the two-year period, the bills -- claims -- will show up with that new code on them, and then CMS

will have to decide where it goes in the DRGs. Okay.

And then once they decide that, it will be factored into the calculation of weights.

MR. HACKBARTH: So how frequently are these provisions of the inpatient hospital payment system and the outpatient system triggered to allow increased payments for new technologies? It's been relatively few cases, right?

MR. PETTENGILL: It's relatively rare, yes.

MR. HACKBARTH: Clarifying questions, Bill?

MR. GRADISON: First of all, I'd just like to observe that the subject we're focusing on here has to do with the use of services; the examples pretty much have to do with the use of a product. That may be an unimportant semantic difference, but I'm not at all sure that that's the case.

What runs through my mind is just kind of a question as to whether evidence-based research comes up with clearer answers in the case of products -- drugs being an example, medical devices being another example of a product -- versus services, which might be a new way to do bypass surgery or something of the kind.

The reason I say that is not to question the

general objective here or to downplay the importance of rationality, but my sense as a layman is that more often than not, when you read the end of the reports, they say, but, you know, we wish we had a little bit more information about this subset of patients or about this comorbidity.

They are not always just 100 percent, and yet, this would, in application, sort of be based on the assumption that they are 100 percent because we're going to change the policy with regard to the reimbursement based upon the study.

Also, I'm not unmindful of the political hurdles of this. I remember when AHRQ, which I thought was one of the better things we did when I was there, almost went under because of its initial recommendations with regard to back surgery. I mean, it almost led to its demise.

I don't mean we shouldn't act. That is not my point at all.

DR. REDBERG: That was actually the Agency for Health Care Policy and Research.

MR. GRADISON: But this is really treacherous ground, which leads me to a question.

I normally don't ask about what's going on outside

of our borders because we have to deal with our own problems, but I just wonder if you can shed any light on how other countries deal with the same question and any way that might help us gain a useful perspective.

MS. RAY: Other countries?

[Laughter.]

MR. HACKBARTH: What I'd suggest is let's not try to answer that off the top of our heads now. We can come back, Bill, with some information on that.

Other clarifying questions?

[No response.]

MR. HACKBARTH: None.

So to kick off round 2, let me ask sort of a broader clarifying question about PCORI. And we're talking about basing payment -- linking payment to assessment of clinical effectiveness. Obviously, one potential source of that information is PCORI-funded research.

I'd like for you to just explain a little bit about how PCORI information can be used by the Secretary, and not used. The statute creating PCORI has some language on that. So would you just sort of outline that?

MS. RAY: Sure. So PPACA has several provisions

regarding how Medicare can use information generated from PCORI.

And so it does say that the Secretary can use the evidence from PCORI to make coverage decisions if the Secretary uses an iterative process and if it is a transparent process, which includes public comment and considers the effect on subpopulations.

PCORI also includes specific limitations on how the Secretary can use the information. For example, the Secretary cannot use the evidence in determining coverage reimbursement or incentives if it treats extending the life of an elderly, disabled or terminally ill individual as of lower value than extending the life of an individual who is younger, not disabled or not terminally ill.

So there's a couple of provisions like that. I think it remains to be seen how the Secretary is going to interpret these provisions in PPACA, you know, once PCORI does generate information.

MR. HACKBARTH: And the reason I just wanted to spend a minute on this is that in various places I've been you hear people talk about this language that was included in PCORI and some people seem to interpret it as, well,

basically, the Secretary can't do anything meaningful with the information; the restrictions are so stringent that there really is no use for this information within Medicare.

Mark gave me the language, and I read through it quickly. It actually didn't read that way to me. It seems like, in fact, the Secretary does have considerable latitude, legal latitude. But having said that, as Bill points out, politically, this is extraordinary sensitive work.

So I just wanted to make that observation at the outset.

So, round 2, Dave.

DR. MARK MILLER: Can I just say one thing as we go around on round 2? And I'm sorry I didn't clear this with the boss, so this might be my last meeting.

When you comment, I think there's often a real general sense of like this is, you know, you get the evidence; you make a decision. But there are many complications and many process issues.

So, if you lean into, okay, this is a direction to move in, I also think try and comment on trying to clear those difficult hurdles.

So I think I took Bill's comment this way. I did a study. The study shows that it's a little bit better, but there are some caveats. Now what?

And I think -- and there's a number of examples of that.

So, as you comment, if you could also comment about the practicality of getting down the road, I think that would help us figure out what do to with this session.

DR. NERENZ: That's okay. I think I may have three questions rather than comments, but I think they'll go quickly.

What we're talking about here seems to be very much in the spirit of what Oregon Medicaid did a few years ago. Could you talk just a little bit about where that stands and how that does, or does not, relate to our current topic?

DR. MARK MILLER: Joan did this, too?

MS. RAY: I told you she was a member of the team.

DR. MARK MILLER: Well, did you guys make her do all of it?

[Laughter.]

DR. MARK MILLER: I didn't know this.

DR. SOKOLOVSKY: At least, if I knew in advance I was going to be asked these questions, I could be prepared.

DR. MARK MILLER: Just sit there [inaudible.]

[Laughter.]

DR. SOKOLOVSKY: So Oregon has a wide-ranging process now that's been going on for quite a few years, where they use stakeholder meetings, public forums, evidence-gathering all over the state, to find services that are more and less important. They rank those services then, using, again, a very transparent, open process. And the idea is to pay for only things that they can afford, going up the ladder of the most important things.

In the past few years, they've been changing the process somewhat, trying to get at things that are less one procedure versus another procedure and more does this really help people.

Again, it was a very controversial thing, but again, they seemed to get a lot of consensus, going from town to town and having these open forums.

I don't know -- it's been two years since I looked at it. I don't know exactly where it stands.

But the other thing is this is also going on in

the private sector in Oregon, and insurers have actually gotten together as a group within Oregon to come up with benefits for the public at large and for public employees and so on, where they've identified both high-value and low-value services. And if you want the low-value, services you can have them, but there's a surcharge that's applied beyond the regular co-payment.

And there's been what seems to me as amazing cooperation, creating these kinds of processes.

DR. NERENZ: I guess then the second question would be about politics at the federal level versus what we see in Oregon.

Given that there was a legal decision against the LCA policy, combined with the observation about the language that does at least put some restrictions on PCORI, in fact, observing that PCORI wasn't allowed to call itself by its proper name, comparative effectiveness -- it had to be called something else -- it seems like movement in the direction we're talking about here is running against the stream or against the current in terms of political forces on the Hill.

So the question is, do you see any change in that?

Do you see signs that Congress would be more receptive to this than was the case, for example, three or four years ago with the Affordable Care Act?

MR. HACKBARTH: I wouldn't want to get into trying to characterize the political environment beyond what Bill said, the voice of experience here, that the politics of this are very sensitive and very difficult. And that's an important consideration.

But I think our first responsibility is to evaluate the issue on the merits and be sensitive to not so much the politics but the values that underlie the politics and not have that drive our --

DR. NERENZ: That's okay.

I, perhaps, could have framed it a little better. I was curious if there is any change in thinking, what is the substance of that change, and can we tie into that, but that's just a third question.

The comparative effectiveness basic paradigm is about average benefits or risks -- Drug A, Drug B, Device A, Device B. There's always variation around the averages.

And, as we get perhaps some additional traction in domains of pharmacogenomics and personalized medicine, what

do you think about how that will play into this discussion?

Is it going to make it harder to push these sort of ideas forward, or can you weave that in somehow and still have it work?

MS. RAY: I think there is an issue that we try to raise about what to do about, well, if in one subpopulation you do see that Widget A is better than Widget B, but in every other subpopulation you don't see that. And I think that is a challenge that needs to be thought out with these ideas.

MR. HACKBARTH: I think it's a really big challenge from a technical standpoint. Conceptually, though, it's really quite similar to what we talk about in value-based insurance design, where you say, well, you may want to lower the co-payments for certain drugs for diabetics because we really want them to take the drugs.

Actually, that's not a great example because nondiabetics aren't taking those same drugs, but you get my point -- that for people, where there are high-value services, you want them to not have many barriers. If it's not a high-value service for that population, you may want a higher cost-sharing barrier.

So it's the same conceptual issue, but technically, it can be a real challenge.

MS. RAY: Right. And I just want to add that one idea to think about is we discuss, as one of the implementation issues, including an exception process so that if a clinician thought that something was medically necessary that that could be addressed.

MR. HACKBARTH: Okay, Rita.

DR. REDBERG: Thank you. This was a really fabulous chapter and a lot of information to put together.

I guess to address restoring the Secretary's authority to apply LCA policies to Part B drugs -- I mean, I kind of look at everything we discuss from my perspective as a clinician, who takes care of patients, and an evidence-based sort of researcher. In those terms, it makes a lot of sense to apply least costly alternative. If you have two equivalent treatments, why would you want to pay a lot more for one?

Now that's not saying if people want to pay more, they can. But as stewards of Medicare's pricing policies, it doesn't make sense for that to be set as policy -- to pay a lot more money for equally effective treatments.

And I think sort of our current policy helps to explain why we spend more than twice as any other country in the world on healthcare but our health outcomes are ranked 37th in the world by WHO standards.

Someone -- I think Bill -- asked about Europe, but when I compare us to Europe, I think you can't even compare because the prices of these drugs that we're talking about are 1/5th to 1/10th in Europe for the same drugs. So they don't have these kinds of issues of these very, very high costs, and their use is much lower.

I mean, I think it's different in all the countries because, obviously, Britain has NICE. But, in general, there is a lot lower volume of services and better outcomes. So I think perhaps we could learn something.

Also, that example you gave was actually -- that wasn't AHRQ. That was the Agency for Health Care Policy and Research, and they got nixed in AHRQ because the data showed that surgery for back pain was harmful compared to medical treatment, and there was a lot of political reaction to that.

So I think focusing our policies on what is best for Medicare beneficiaries, obviously, we want to give the

best treatment and the best value. And so it is different now, I think, for it, depending on whether you're looking at drugs or you're looking at procedures or you're looking at surgery.

And you gave a few examples that I thought were helpful in the mailing materials, like IMRT and proton beam therapy, because -- well, I mean, first of all, the U.S. Preventive Services Task Force, which you also started with -- I mean, it doesn't make a lot of sense to me why Medicare pays for Part D recommendations because not only are they not helpful, but they're harmful.

So, for example, PSA screening, which the U.S. Preventive Services Task Force says, I think, is Part D and we shouldn't be doing. Yet, Medicare does pay for it.

But it's not just the cost of the screening. It's the cost of all of the treatment that has not been shown to extend life for men from the PSA screening. And so you have men getting unnecessary surgeries that lead to impotence and urinary incontinence, and men getting chemotherapy, and then men getting proton beam and IMRT, and at incredibly high rates.

I mean, you look at -- Medicare's payment for IMRT

was $20,000 and for proton beam was $48,000 back in 2007. Well, as you know -- and it's happening here in Washington and across the country -- people are now investing in buying proton beam therapy units for their hospitals because Medicare is paying very generously for this even though it hasn't been shown to be more effective than even watchful waiting -- essentially, not doing anything.

And once you make that kind of investment, the chances are you're going to use it, and you're going to use it probably for people that are not going to benefit from it, and probably for more than even -- well, most commonly for prostate cancer.

So I think it's a really important issue that we absolutely should be talking about and dealing with because it's our responsibility to try to spend money wisely to help beneficiaries. And there are very good data that we're spending a lot of money on things that are hurting beneficiaries under these current policies and current pricing, and certainly, this very generous reimbursement encourages that.

You also gave the example of vertebroplasty and how Washington State doesn't pay for vertebroplasty. Well,

surgery is a whole different policy because there isn't kind of FDA for surgery. And so you can just start doing a surgery, and you don't have to have any evidence that it's of benefit.

That, obviously, happened with vertebroplasty. A few years later, there were two randomized studies published in the New England Journal, neither done in the U.S., but very high quality studies, against a sham procedure and showed no benefit for the surgical procedure, vertebroplasty.

My understanding is they kind of put a needle and some --

MR. GEORGE MILLER: Cement.

DR. REDBERG: Cement inside the spine to stabilize.

MR. GEORGE MILLER: Right.

DR. REDBERG: But no benefit, compared to a sham, but Medicare continues to pay for this.

So, again, a procedure where no known benefit, definite harms people suffer -- you know, there were complications, not to mention having a surgery that didn't do any better than not having a surgery in the randomized

control trials and at a big expense.

So I do think we should try to better align Medicare payment policy with cost-sharing.

Now that's not to say if somebody wants to have those procedures, as someone said, they should be able to have those procedures. But that doesn't mean Medicare should pay for them. You know.

I think our responsibility is to align payment policy with the best evidence. If people choose to have low-value procedures, I think that should be their choice, but it should not be Medicare's responsibility to pay or pay more for things that are not of higher value.

Oh, and the last thing I was going to say to address -- because I think it is an issue of how do you -- you know, everyone is different. I'm not that optimistic that genetics is actually going to be the answer to telling us what is and isn't going to do, but I do think we could do a lot more with registries, and Medicare has been experimenting with a coverage with an evidence development process.

But, basically, we could collect data. I mean, we have billions of beneficiaries. If we tracked them and

tracked what procedures they got and tracked their outcomes, I think we could then learn what is working and what isn't working and then use that iteratively to adjust our coverage and reimbursement policy based on what is and isn't working for our beneficiaries.

So I think we could combine these payment policies and coverage policies with collection of more data so that we could be smarter about what we're doing and use the money to best help beneficiaries.

MR. HACKBARTH: So Rita's comment reminded me that I neglected to ask one other thing about the Part B drug payment system.

So, in our earlier discussion, we established that when the physician is buying Drug X he or she has an incentive to try to get it at the lowest cost possible. To the extent that they can get it for less than 106 percent of ASP, they benefit financially from that.

Now let's take it one step further. Let's say there are two drugs, X and Y, for treating the same clinical problem. X is the new, very expensive one. Y costs a lot less.

What I'm interested in is, what are the

physician's incentives to choose the lower cost drug when there is no evidence of clinical gain from the higher cost drug?

DR. SOKOLOVSKY: Well, let me give you an example right from Nancy's case study. When they took away the LCA policy, then the drug that had been the most expensive, and still was the most expensive, saw a huge rise in its market share because there was a bigger gap.

MR. HACKBARTH: Yeah, and that gap is income to the physician.

So I just wanted to touch that last base, which I neglected to.

DR. HOADLEY: Part of it is that, as we're just talking here, 106 percent of a bigger number is a bigger -- is more. So you're getting your 6 percent add-on, on top of bigger.

And there actually have been proposals out there to make it flat add-on instead of a percentage add-on, which would partially, but only partially, address that point.

MR. HACKBARTH: George.

MR. GEORGE MILLER: No, Rita covered a lot of things I was going to say.

DR. BAICKER: So one point I wanted to make just in response to the discussion about a priority list and how that has worked in Oregon and elsewhere is my reading of how well it worked was a little less optimistic in the sense that there was an agreed upon priority list, but there was a lot of pressure to move that line of coverage down and down the priority list, so that in the end I thought the evidence suggested that very few things were excluded, in the end, from publically covered programs.

So you need to not only be able to agree on what the ordering is, but then if you're going to try to draw a line, there's going to be a lot of battling over where that line is. And then, of course, there's even more battling over the order right around the line, which is the stuff that's of questionable value by definition.

So, in some sense, the LCA-type policies that avoid drawing a bright line and saying covered-not covered can do a better job of saying: You can still get all this stuff. It just costs more to somebody in the system -- and the question is who -- to get the stuff that is of higher price but not demonstrably higher value.

That seems like a more promising way to go and

also less restrictive for beneficiaries. Then one wants to have an exception process for, I would think, especially low-income beneficiaries but anyone for whom -- there are very few things that are better for every single patient. There's always a patient who the other one might be better for.

And, there, I think you get back into that slippery slope challenge, that not having an exception process seems unreasonable given the heterogeneity of medical care. But then as soon as you have an exception process, how do you keep it from being a rubber stamp to get this idea at full reimbursement? All you need to do is fill out an extra piece of paper.

And that -- you know, I don't have an answer to that, but it seems like having some sort of safety valve is necessary. But having it be a valve rather than an open spigot is a challenge, to use all plumbing metaphors.

[Laughter.]

DR. BAICKER: And, therefore, I'm done. I don't have any other plumbing knowledge.

MR. HACKBARTH: Remarkably consistent in your plumbing.

DR. CHRISTIANSON: I can't think of any plumbing metaphors.

DR. BAICKER: Then you're done.

DR. CHRISTIANSON: Then I'm done.

[Laughter.]

DR. CHRISTIANSON: I agree with the first point. I think we should follow the OIG's lead and pursue that.

I don't know what to think of the second bullet, the dynamic pricing policy. I think I'd have to think a little bit more about that. It seems reasonable. I'm not sure whether there have been alternative policies that have been developed to do the same thing. Probably not. I'm not sure that that has the same level of attention needed by the Commission as the first bullet.

And the last bullet, I'm totally in agreement with Kate, I think it's an easier call than trying to draw this line and say something's covered or not covered. And I think we need to do it if we're going to be stewards of Medicare's dollars, which I think is one of the things we're supposed to be doing. So I think we need to advocate for that.

MR. GRADISON: In addition to the idea that maybe

somebody wants a more expensive procedure they've got to pay for it or pay some larger proportion of it, I think we might want to give some thought to the flip side, too, which is that if somebody chooses a less expensive, they get a monetary benefit. I mean, so often we talk about these financial incentives just between the drug company and the provider and the hospital. But money might have a bearing on the choices that the actual beneficiary makes. That's a kind of -- I don't know of an example of where we do that, and I can see where it might be considered inappropriate, we're mixing dollar incentives with lives and all that. But it might influence behavior in the direction we'd like it to go.

Not to raise any questions that Rita might not want raised at this point, but as I thought about what I was saying a few minutes ago might have come across as anti-science, let me just point out that there can be some pretty high-level groups that come up with some recommendations on things that aren't exactly universally accepted, and I think, of course, of statins as the most recent examples of the point where people can examine the data -- I mean experts -- and come up with very different conclusions. And

so in a sense, the assumption here is, well, we're going to get a study and it's going to be so good, nobody can question it. Therefore, we should implement it. And if it is that good, we ought to implement it. This was a high-volume issue, the statin issue. It isn't that simple.

DR. HALL: I think this is a very important issue and extremely complex issue. Just a couple of points.

One, when the LCA policy was in place, the courts of appeal were usually the managers of the regional Medicare administrations around the country.

MS. RAY: [Off microphone.]

DR. HALL: Right, yeah. And I can tell you the number of hours that were spent and amount of anger and frustration that developed over that process was monumental, so that at least the physician community very strongly supported trying to get rid of this. And a lot of it was not so much the argument over who was right but that the mechanism of having to tie up your office for a half-hour or maybe five or six phone calls just wasn't worth the effort. So as a country, we should probably be able to do better.

On the other hand, in the non-Medicare world, most prescribers are quite used to the idea of restricted

formularies. In fact, most offices in any large city may be dealing with 20 or 30 different formularies for drugs that are -- where certain drugs are restricted, probably along the lines of LCA policy. So we're not reinventing the wheel here when we say that the standard of medical practice now is to understand that there is some restriction based on price and efficacy.

I worry that the clinical evidence on PCORI, which I strongly support, isn't really in yet as to whether PCORI is going to be a solution to some of these problems. PCORI has a lot of studies out and a lot of money out there, but very, very precious little evidence. That's not a criticism of them. It's just a matter of timing.

The other thing about if we say, well, you can pay for it if you want it, that really kind of restricts the poor and minorities who really don't have the option of just paying for it. You take one suitcase instead of four, and they say, well, if you want four, you can pay for it. So I worry a little bit about social justice when we deal with this.

I think we need to look much more carefully at what kind of standards we might assume for Medicare, and one

would be to take a really deeper dive on PCORI and where we think things are right now on the amount of evidence that's out there that we could use and translate, say, in a year or two from now.

MR. HACKBARTH: So Bill raises the notion that there are decisions being made like this -- and he gave the example of drug formularies of private plans -- that have some of the same quality, where judgments are being made about cost versus effectiveness, and we're going to use this drug and not that drug. And I just wanted to note that that's also a mechanism for decentralizing decisions about this.

So one of the desirable characteristics of saying, well, you can -- Medicare will pay this, you can have the drug if you really want it by paying more, is it means it's not a black/white decision. There's some choice involved, and so it takes some of the heat off.

Well, another potential mechanism for taking some of the heat off, creating an environment where people are making these judgments on a decentralized basis is through, you know, Part D plans, Medicare Advantage plans, or through bundled payment systems in traditional Medicare. And so,

you know, there are different paths by which this problem can be approached, and I think one of the things that we need to think about is taking all factors into account, which of these paths is not only the most logical for Medicare but the most likely to be durable, politically acceptable, legally strong, et cetera.

MR. BUTLER: So I'm not an expert on the politics of getting the reinstallment of the Secretary's authority, the likelihood of that occurring, but I had mentioned the $12 billion in Part B because you sit there and you say the amount of time we spend on LTCH and IRF payments, which together equal Part B spending on drugs, think about the time we spend on those two issues, and this is as large as those two combined. And home health is only $18 billion. So just the Part B side of drugs is $12 billion, and it looks like there's a solution here that will not impact the fundamental care of the people we're delivering services to.

So we ought to spend some time on being bold about saying -- whether it's an offset to SGR or whatever it is, this should be an easier place to address things that make a difference than some other areas. So I don't know if that's practical, Glenn, or -- but in terms of prioritization, it

seems to make a lot of sense.

The one that drives me -- just I have to vent on this one, the proton beam thing, where it's often maybe $100 million and every day I hear this marketed in Chicago on the radio about how it's -- I'm not saying it's false advertising, but it certainly is encouraging, you know, treatments to fill a largely vacant site with services that, you know, don't make a difference. It's frustrating.

DR. NAYLOR: So we don't hear those commercials in Philadelphia. I really also support --

DR. REDBERG: They're building a center. You will [off microphone].

[Laughter.]

DR. NAYLOR: I support the principles associated with returning to least cost alternative policy. And just a couple of things.

I do appreciate the attention that you paid in this work to the process and the transparency of the process that I think will be central in success. And I do think it represents kind of an opportunity to really get beneficiaries engaged. So in a recent study committee on delivering high-quality care to cancer patients, number one

priority was trying to make sure that the beneficiaries had information about what the benefits were, what the risks were, what the costs associated with, what the evidence was and its limitations. And so I wonder whether or not some of our direction can't be to make sure as we're trying to push policy change, we also push for really making the kind of information that engages beneficiaries in decisionmaking, and some have talked about other incentives that might be associated with that. But I think just basically making sure that people have the knowledge upon which they're making decisions is central, fundamental, and so on.

The second part that I really liked is that I think we can really promote understanding of best practices here, best practices or at least lessons learned from states such as Washington and others, and kind of enabling a real conversation then about what MedPAC might do from knowledge of multiple local initiatives, state initiatives.

S those are my comments.

DR. HOADLEY: So on the least costly alternative, I definitely support, you know, our getting involved and making suggestions on changing that policy. And, you know, there's even more potential dollars on the table than some

of the examples in the chapter with the IG's memo of a couple years ago on the macular degeneration drugs that can raise the dollar stakes even higher. So there's definitely real money on the table with that one.

I think beyond that, you know, I wanted to talk for a minute about sort of the whole notion of how the beneficiary gets involved and this notion of cost sharing. I think the problem is there's a lot of different situations, so it's one thing when you talk about -- I mean, we have this in Part D, differently designed, differently run program in a lot of ways, but we've got tiered cost sharing formularies and those sorts of things. So this isn't unique.

But I think one of the things that differs as we think about the different kinds of examples that have been used here is do we treat the idea that the beneficiary might pay the difference the same way in cases where clinical evidence is quite clear that something is an undesirable service versus ones where the case is much closer, do we treat the beneficiary's responsibility differently in situations where they can clearly understand the choice of two different competing drugs versus some surgery that their

doctor has said is good for them even though Medicare is maybe saying no, you have to pay extra for that? Obviously getting into better beneficiary education and the shared decisionmaking and some of that could be a part of this story.

Do we treat beneficiary responsibility differently when the size of the cost difference is different? So it's one thing to say, okay, two drugs, one is $100, one is $50, you pay the extra $50. It's another thing to use some of these thousands and thousands of dollars for these procedures.

Now, the examples we've talked about are mostly ones where we think -- a lot of people think pretty clearly they're not desirable procedures, but if you get to one that's more on the border and then the difference in cost is $20,000, we're not just talking about the effect on a low-income person now. We're talking about the effect on a lot of other people.

And then all of that comes back then to this question of how do you do an exceptions process, and on the one hand, we don't want -- to go back to the plumbing analogy, you know, we don't want it so open that the spigot

is just open; but we also don't want it so closed that it's barely a drip coming through, if I can work in that metaphor. And like so often we talked about on the Part D side, exceptions processes that we don't understand very well and the sense of frustration, when people do want to go through an exceptions process it's so hard to do and it requires so much work both by the doctor and the patient that people give up and don't do it, even when maybe there's a legitimate case.

And so I think it's the right concept, but figuring out how to do those well is something I'm not sure we've figured out yet. So there's a lot of things in there that the last thing I had written down in my notes, but we've sort of gone to politically what's possible, because, again, as we've said before, there's a lot of politics around these issues, and even to do some of these things is going to get a lot of pushback. But I do think there's a lot of tough things to think through on the beneficiary role and how we could get that right and be fair in lots of situations.

MS. UCCELLO: All of this plumbing talk is just reminding me that I really need to remodel my bathroom.

[Laughter.]

DR. HOADLEY: But Medicare won't pay for that.

MS. UCCELLO: It's all me.

So I think this chapter is a really great complement to the chapter we just had, and Bill G. brought up something that I think is worth repeating: that we can think of overtreatment in terms of quality or we can address it through payment. And in this chapter, we're just thinking more, you know, explicitly about payment changes to address some of these issues. So I just thought that was an interesting way to kind of think about these things.

And also, as Glenn talked about, does moving to broader bundles kind of address both of these better? Probably yes.

So in terms of the three questions here, you know, yes, I think it makes sense to restore LCA policies.

In terms of dynamic pricing, I think that makes sense. I was really intrigued by the suggestion about using an escrow account for the way to do this, because I think if we start -- I mean, there are now three options. One would be to just pay them a higher price from the beginning and then have to lower it, and that's not great. And the other

one was you start out low and then just later maybe pay them more. And so this seems like a really good compromise.

And the third -- oh, and one more thing I wanted to say on this. I am not an expert on this at all, but in terms of the comparative effectiveness analysis, it's my understanding that it's better to have as inclusive a set of options in the head-to-head trial directly because you don't really have the transitive properties of looking -- getting results from different studies that have maybe different methods and different populations. When you compare them, it doesn't actually work. So having them all in the same study under the same rules is the best way to really get at what's going on.

And the third one, yes, you know, bringing cost sharing into this makes sense.

DR. COOMBS: So I enjoyed reading this chapter as well. Thank you very much.

One of the things I thought about was I recently was in San Francisco for a critical care meeting, and I went to an update on post-cardiac arrest management in the ICU. And, you know, the article appeared in the New England Journal that said 34 is no good anymore, 36 is just as good

as 34. So in the ICU, we chill people after cardiac arrest, hoping that they have great neurologic recovery and can kind of avert some of the changes that people see if they don't have the hypothermic protocol.

As it turns out, this study actually showed that there's no difference between 36 degrees and 34 degrees, which says that basically a lot of what we've been doing in this one study -- just this one study -- maybe we've been going overboard with hypothermic protocol. Yet it has been implemented in every single center as a standard of care.

Much of the discussion centered around we need more evidence before we stop doing it, which is always interesting. And it's like the dying of the Swan-Ganz catheter, which has already passed away, in the sense that physicians will have major interventions for some period of time, and it's a very hard period -- very difficult period before we get to the place where we say that's no longer good, let's change and about-face on that.

I think about that when I think about comparative effectiveness in all venues, and so the slide that's on, let's see, page 11, I was thinking, well, how better to deal with this, because I'm not a lumper, and I wouldn't say that

we could satisfy any of these three categories with just one solution from our summary slide. And I was wondering, in the first category where it says evidence of improved outcomes compared with alternatives, you might see that there's this category one group of entities that has so much persuasive data that's out there, and you might have a different approach. You might do an LCA approach to that.

Michael said something, I think it was three months ago, about -- yeah, and I extracted it.

DR. CHERNEW: [off microphone].

DR. COOMBS: Okay. Which was to have the Secretary be responsible for giving the directive for determining certain -- making certain decisions around this.

I do have a problem with that because you're building an infrastructure of decisionmaking on one entity, you know, and that in and of itself seems like it might be binding on this set of circumstances.

If you go to the second category, you might do what's proposed in the paper by Pearson and Bach in terms of the dynamic pricing approach.

And then the last category, I would have a problem with doing a dynamic pricing approach to that one because if

you come up with a very expensive alternative, you're going to have that implemented for three years, which is going to be very costly, for some low likelihood of effectiveness.

And so I'm thinking that maybe there's a way to divide and conquer and approach each one of them in a tailored fashion. And so I think that protocolized care is very good, but I think there's several areas now where if prostate cancer would just disappear, we'd be all set. But people are going to be taking PSAs for countless ages of time, and there's always going to be alternative therapy and shared decisionmaking, which is a part of the choice part that you told us to look at today, which is really important, and given that there's this window of data that's constantly changing based on information, you know, it would be not good for us to lead the way and having draconian measures around some of these things. Some of them, like the virtual colonoscopies and things like that, I think you can move ahead with, but you really have to decide what kind of interventions are going to be -- whether it's biologics or whatever, are the things that you want to say let's hang our hat on. And I don't think you can do an all or none. This is not like an action potential. You have to begin to

look -- I think tailoring for me makes more sense, a tailored approach.

MR. KUHN: I think folks can tell that we're struggling with this one. We know that there's a fairness issue that we're trying to get to value in the Medicare program. At the same time, I think we're also sensitive to the developers that develop the devices and the new drugs and others and want to make sure that they use their capital wisely and they're rewarded for putting their capital at risk as well.

So I want folks to at least come away that I think generally the Commission is very sensitive to both sides here, but we also want to be respectful to the taxpayers who are funding all this, as we know.

So, Glenn, if I might, I'd just say that when we get to the end of this session today, if there's folks in the audience, help us out here. You know, stand up at the microphone and make some comments, both if there's providers, consumers, or even developers out there, and also follow up with the Commission, because I think this is one that we're -- there's an issue here, we're struggling, and so I think we need some help her.

But having said that, we're focusing a lot on the LCA process here that's been invalidated by the courts. But the Secretary right now has a pretty good suite of tools to use. Not all of them are perfect. Some of them are pretty inexact, but let me just kind of catalogue those here, because one of the other things we might want to think about is are there ways we can refine or make some recommendations to refine some of the existing processes out there to make those more functional as we go forward?

So, one, I believe they still have the authority, the local coverage determinations, which provide both coding and payment guidelines authority that are out there. And as Glenn talked about earlier, it is a decentralized process. It gets it out in the communities, out in the fields, real engagement with the providers out there that seems to -- everybody understands that process, seems to work pretty well.

There's the inherent reasonableness process. IR was also invalidated by the courts years ago. CMS had to go through a new rulemaking. They've rarely tested it since they've gone through the new rulemaking, have tested it at all, but nevertheless it is a tool that's on the books that

they can use now.

MR. HACKBARTH: Herb, describe a little bit more for people what inherent reasonableness is and where it's applied.

MR. KUHN: So mostly the application -- and Mark and maybe others here can help me -- is mostly, I think, for in the durable medical equipment area, but I think it could be used in the drug space. But it goes in terms of increments. So you can't go in and say, like LCA, and bring two together in terms of same prices. You can only reduce, say, a price by about 15 percent as part of the process. Do I have that right, Mark? Okay.

DR. MARK MILLER: It's mostly -- and anybody can help me out. Should we get Joan to walk off and come back?

[Laughter.]

DR. MARK MILLER: I don't know how you guys want to do this. But my sense of the IR process -- and I haven't looked at this lately -- is it's really a price process

MR. KUHN: Right.

DR. MARK MILLER: It's just sort of these two prices are different, this thing is about the same, and, therefore, the Secretary is going to walk it from one price

to another.

MR. KUHN: Yeah, it's kind of -- it tries to kind of create a leveling process there.

DR. MARK MILLER: Yeah, whereas this is more infused, if you will -- how do you like that?

[Laughter.]

DR. MARK MILLER: The Chairman doesn't like it, so we won't be doing that.

This has more of what's the evidence and, you know, then setting the price in that instance.

MR. KUHN: Right.

DR. MARK MILLER: Shouldn't have used up all of the plumbing -- [off microphone]

[Laughter.]

MR. KUHN: Yes. So you've got the IR process. There's administrative rulings, which are rarely used, but there are opportunities, particularly when you have the beneficiary opportunity to pay for more that's out there. I know the most recent one I'm aware of is with intraocular lenses and the dual aspect nature of those IOLs. So Medicare would pay so much, and then if the beneficiary wanted the other benefits of the enhanced features of the

IOL, they would have to pay separate out-of-pocket.

There are registries, as Rita had mentioned. We know there's one for cardiac implantable devices. That's been up and going for six or seven years. Wonderful data in that registry, perhaps others to mine to influence national coverage determinations could be part of their toolkit. There's coverage with evidence development where they begin covering now, collect the evidence that's out there.

In the DME space, of course, we have competitive bidding is another tool that Medicare has right now.

And then, finally, the new tech add-on that we talked about with new technologies that come out and the ability to enhance the payments immediately.

So there is a big suite that's out there, but all of them are clunky, cumbersome, difficult to implement. I don't know if LCA is any easier for them to kind of move through the process, but, you know, as we go through that, it would be interesting if folks could give us thoughts on any of those. But are there ways to even refine those to help the process move forward as we think about this?

MR. HACKBARTH: Herb's comment also sort of highlights that, you know, it's one thing to say for MedPAC

to recommend and Congress even to enact new authority for the Secretary. It doesn't mean that the Secretary will use that because often these things are complicated and are controversial, and so it's not just a matter of having the tools. It's also a willingness, a determination to use them.

MR. ARMSTRONG: So I want to acknowledge, like other Commissioners, this is, I think, a really important topic, and it's very complicated, and I wish I could offer more specific advice for how we go forward with this. But I will just make a few points, I think many of which have been made already.

First, I don't think I could make the case any more strongly than Rita did that the evidence should influence our payment policy and that this -- it's an important agenda for us to move forward with. It's complicated, but it's already being done. And so this is what my organization does all the time, and so let's look at what's working and what's not working. Let's also recognize this isn't just about affordability and expense trends. This is about saving people's lives as well. There are a lot of procedures and drugs that we never covered, never

allowed on our formulary that were withdrawn that killed people. And that alone calls on us to do a better job of really applying the evidence to these coverage decisions.

We do worry about the pushback. I know many of us have commented on that. I welcome it. I think that this is what our particular responsibility of MedPAC is, is to do what we think is the right thing, not the feasible or expeditious thing. And so if we're really getting a lot of people's attention, then I think we're doing our jobs.

The point has been made -- I live this -- we will really need to look at an exception policy. The evidence is constantly changing, is one issue, so we need to be flexible, and yet we also need a process by which we're using judgment on a case-by-case basis. So I don't -- there are organizations that have figured out how to strike that balance. I think we can figure that out.

Some of it will -- I thought Glenn was referring to one really excellent idea, and that is, at a federal level, being clear about the features of a process that are meeting our expectations that we can judge as opposed to having the right answer for coverage on all cases or something like that.

And then, finally, I agree with this point that several people have made that, you know, if beneficiaries choose to do something that is of low value or potentially even harmful to them, and they want to pay more money for that, I think there's discretion that we should tolerate. But I would push even more strongly -- a point several people have made -- that when beneficiaries truly understand the implications of their choices, as driven by the evidence, I trust that fairly frequently they're going to make the right choice.

And so in our own case, we know just consistently applying evidence-driven alternatives to hip and knee surgery has driven a 25 to 40 percent drop in patients choosing to have the surgery as opposed to the alternatives, which are, in their cases, better alternatives, they're happier, and the cost is significantly lower. We ought to ask how do we hold ourselves as accountable to engaging patients in those conversation at the same time we're talking about different payment structures.

DR. CHERNEW: So again, it's another really good topic and a very good chapter. I just want to start by picking up something Herb said, which is there's a broad

issue just generally about balancing innovation and stewardship. A lot of that doesn't play in -- come into play here, because we're typically at least -- and this is talking about things that are really very similar. So the innovation is really not that much, and I think the stewardship is much more important, by and large.

So going down the list, I find the court case, it may be legally reasonable, but I find it frustrating in general when you go through some of the particular examples. So I'm loosely supportive of the LCA-type policy.

I'm not horribly optimistic about it for a whole bunch of reasons that that would solve the problem. In fact, when we tried to do this before, we were trying to pick areas. We got into sort of Jon's problem. We got narrower and narrower and narrower, and there's a few sets of things, and they were clear examples. And I think that's better than not being able to do that, but I wouldn't view that as a broad solution to this problem as a general rule, so that's my basic take on that.

I think that I am going to jump to the third one, because I think it relates, because again, the way the LCA policy works is you're just charging someone more for the

amount that's over. That's very much like charging them more for low-value services, which you might imagine, as a value-based insurance design advocate, I'm a big supporter of charging people more for low-value services. I think it's important to align them. I think charging them more helps motivate people to look for the evidence. It helps align the patients and the physicians' incentives. I think it's a reasonable thing to do. There's a question about how to do that and how to put it into place. There's a lot of operational issues about how one might do that; for example, how it interacts with supplemental coverage matters and things of that nature.

But I like for some of these things that we talk about where there's sort of patient demand for X, Y, or Z, and there's marketing campaigns going on to get patients to do X, Y, or Z, I think having some patient counterweight is valuable. It allows you to have a little more flexibility in the system as opposed to this is not covered at all or it is covered.

So by setting the right amount of cost sharing, I don't worry so much if you get it wrong in some instances, although again you have to worry about equity and a variety

of things. I'm supportive of that, of the cost-sharing approach.

With regards to the dynamic pricing policy or more generally the role of -- I'll go with comparative outcomes research and all this or PCORI, I'm obviously a supporter of research in general. I am weary of going too far down the road towards a research-driven pricing-type model or system just in general for a variety of reasons.

I think very much on what Bill was saying -- I'm skeptical of how the research actually plays out. It's often not so cut and dry. I think there's a lot of issues about how it changes, what comparator you pick, over what time you look, and so it's not that I have a problem with it sort of in concept as much as in practice. I think it's going to be much harder to do.

In fact, I think in Oregon -- and again, Glenn could say -- they had a process that started the very first time. It was a very research, pro research -- you know, they were going to have a list. They were going to do researchers. They were going to turn the keys over to the academics -- no one ever does that -- and it was going to be wonderful. And now they have a process that is town

meetings and consensus building and discussion of values and the sort of research notion that we're going to tie this, and then we're going to get to list. Really, it's a lot weaker than one would think in a world where you think someone is going to do five studies, and then they know exactly what you should price and what you should charge. I think that turns out to be very complicated for a whole bunch of reasons about knowing how to value quality of life, knowing what the right comparators are, and just an enormous number of subgroup heterogeneity issues.

So I am -- I don't have a problem with the basic idea behind some of the Pearson and Bach things. You start at one price. You move to another price as evidence comes in, but in there -- and I think the real tension is there needs to be discretion in how this plays out, and it's never going to be tremendously cut and dried.

And I'm weary of very strong connection of sort of price setting to sort of outcomes research or some other version of that, but I do think giving the Secretary some discretion -- and I very much appreciated Herb's comment -- maybe enough discretion exists there now. I wouldn't know, but you're going to need some discretion, an I'm

particularly interested in how that plays out if we move to broader bundled payment models.

You know, I tend to think that changing the payment system and bundling around this helps you, because other organizations can manage this, but in many of these settings, I think there's other ways in which the innovation just gets put in, and the prices get driven up. There was a particular service that got a particular fee, but it fit through a given DRG or fit through a given APC.

So thinking about how we manage innovation and how that affects the prices for a whole set of things and how that works in more broadly bundled settings is a general agenda item that I think is going to be really important, because if in fact technology both improves -- broadly speaking, improves people's health if used wisely and increases spending if used wisely, we need to think about a system that allows us to manage that efficiently, because any waste in that process just drives out good things and causes us to do stuff that's really inefficient.

DR. SAMITT: I think mostly everything has been said. I have one overarching comment and one specific.

I look at these things, and they just all

naturally make sense, but I think we're asking the wrong questions. I mean, I think that these policies certainly align with what we're trying to accomplish, but I think we then all step back and have reservations, because it really then warrants out ability to decide what's high value and what's not high value, and that's where the complexity is.

But I'd say that it's a heavy-lifting but very worthy discussion. How do we improve the value of health care if we're not willing to invest in understanding what works and then making the tough decisions to align incentives to pay more for those things that demonstrably work versus things that don't? So if we have any major task, it's to do exactly that, and that's the piece that I feel is missing. We need to invest more in comparative research and then be willing to make decisions to pay more for the things that work better.

The one specific thing that I would suggest, which may be provocative, was I was surprised to see that we're still paying for these Grade D USPSTF services, and it feels to me -- and this falls into the shared decision-making realm -- that at a minimum, if anyone is going to prescribe these services, there needs to be a precaution label for

patients that essentially says if you're going to do these things or you're going to prescribe these things, you must communicate in a very frank manner of the potential risks of these services to your beneficiaries should you prescribe these things. I don't know if that is required today, but it seems as if that would be essential as one necessary step in the shared decision-making realm.

MR. HACKBARTH: Okay. Just one last question, and maybe this will be a rhetorical question, given where we are.

There's been relatively little talk about the effect of changes of this sort on innovation, which is actually one of the arguments that you often hear the manufacturers of new drugs and new devices, et cetera, raise, and if you adopt a tough policy on this, on pricing of these new items, that they won't be able to fund sufficient research and the like.

And I was wondering whether in fact there are any roughly analogous examples in other industries that have been studied by economists. My instinct as a non-economist has always been, oh, you'll still get innovation. It's just that the innovation will be redirected and as opposed to

spending a lot of money on sort of "me too" marginal improvement products and then marketing them heavily, they may invest their research on things that are really substantial clinical gains, but that's just my hunch.

Presumably, the more advance gains are also more difficult and more risky, et cetera, and I'm just wondering whether there are any sort of examples that we can draw from another industry where the environment has changed and the R&D process has adjusted to reflect a new, more cost-conscious environment.

So as I said, that can be a --

DR. CHERNEW: I'm looking -- I don't know a particular example like that, but I would say that outside of health care and just in general, the premise that the potential to make profit drives innovation is probably supportable. The notion that you need to make a lot of money on something that is not very good to fund innovation and something that is good, I don't think that's exactly the important thing.

I think the key thing is if you do come up with something good, you have to be able to profit from it.

MR. HACKBARTH: Yeah. And so my layman's notion

has been that if you can make a big profit from doing something that really isn't a gain, that actually that distracts from the sort of innovation we want. It creates sort of a perverse incentive, "Oh, I can get a lot of -- I can get rich doing little. Why should I take big chances and invest in things that are really hard?" And so I think it may be even counter-productive to the sort of innovation we want to pay high prices for things that are marginally beneficial. Just my --

DR. SAMITT: I mean, I don't think it's rhetorical. I think we're probably already seeing that in the pharmaceutical companies today in that they're -- you know, they've clearly gotten the message that they can no longer make "me too" agents, because the industry isn't going to compensate drugs that have no supplemental efficacy.

So the sense is they're redirecting their research toward the things that are more likely to be superior in efficacy or approaching treatment in a somewhat different way. So I think we're already seeing not a diminution of innovation but a redirection of innovation, if that makes sense.

MR. HACKBARTH: But if that were in fact the case, then the argument for doing difficult things -- and these are difficult things that we're talking about. It's not just that, oh, it saves taxpayers money, and it's consistent with stewardship. It's also about shaping the future of innovation in our industry and getting it focused on doing the things that are really valuable for patients as opposed to squandering a lot of money on marginal advancements.

Kate and then we will --

DR. BAICKER: So I think Mike's general point that you want people to reap the -- reap profits when they develop things that are really valuable to people and not when they don't is clearly fundamentally true and important, and the problem with the health care sector is that we don't have any real price signal for a lot of stuff. So normally, that works because you invent something really valuable, and people want to pay you extra money for it, and so there's your incentive.

Because we're interfering with that in so many ways in the purchase of health care and with it -- I can't think of great examples of really innovative sectors that have the same kind of strange pricing mechanisms or lack

thereof that we have in health care, so it's hard to come up with another example, but then I get uncomfortable -- so I'm very much in favor of having financial reward for new life-saving stuff, whether it's innovative treatment, devices, drugs, whatever it is, but I get a little nervous when we start saying we want to direct innovation by further rejiggering payments. Rather, I think we want to get out of the way of subsidizing stuff that's not a particularly high value and not getting people reap rewards from stuff that is high value. To me, that's sort of getting out of the business of picking winners and losers and letting the value of the thing that's produced drive its remuneration more than -- so I think that's what you were getting it.

MR. HACKBARTH: It is.

DR. BAICKER: But towards the end of what you were saying, it started to sound more like we want you doing this. We don't want you doing that.

MR. HACKBARTH: Yeah. No. And we do need to move on.

So my notion is basically we don't have a price signal in this market, and really, this is about establishing a price signal about what sort of innovation we

value. And to the extent that we're just paying basically whatever is asked, we don't have a functioning market, and so in addition to protecting taxpayer funds, in part this is about creating a functioning market for innovation in health care, and I think that's an aspect of this that really isn't given sufficient attention, so we can talk more later. We need to move ahead to get done. Okay.

So thank you very much, all of you, including Joan. Appreciate the good work on this, and so now we'll move to our last item for today on payment for primary care.

DR. MARK MILLER: Before you get going, are you going to need an extra chair for Joan or what? How is this going to go?

[Laughter.]

DR. HAYES: [Off microphone.]

DR. MARK MILLER: Got it.

[Pause.]

DR. SOMERS: Good afternoon. In this session, Kevin, Katelyn, and I would like to explore with you the idea of creating a per-beneficiary payment for primary care practitioners in the fee-for-service Medicare program.

Recall at the November meeting, the Commission

discussed establishing a per-beneficiary payment for primary care as a way to support primary care and explicitly pay for non-face-to-face care coordination. We reviewed the reasons why the Commission has been concerned about the current state of support for primary care; namely, that primary care is essential to delivery system reform, but the current fee schedule undervalues it relative to specialty care and does not explicitly pay for non-face-to-face care coordination.

Those shortcomings of the fee schedule have contributed to compensation disparities between primary care practitioners and specialists, such that average compensation for some specialties can be more than double that of primary care practitioners.

For example, based on 2010 data, the average compensation for radiologists was $460,000, while the average for primary care was $207,000. Faced with such compensation disparities, practitioners may increasingly opt for specialty practice over primary care practice, exposing beneficiaries to an increasing risk in the long run of impaired access to primary care.

In response to those concerns, the Commission has made several recommendations to address the inadequacies of

the fee schedule. To rebalance the fee schedule, the Commission has proposed identifying overpriced services and pricing them appropriately, replacing the SGR with payment updates that are higher for primary care than specialty care, and establishing a primary care bonus funded from non-primary care services. To advance support for coordinated care, the Commission recommended establishing a medical home pilot. Variants of the recommendations for a primary care bonus and a medical home pilot were established under PPACA.

So now we come to today's agenda. In response to questions at the November meeting, we'd like to provide some information about the experience with the primary care bonus program established by PPACA. The program expires at the end of 2015, so we'd also like to hear the Commission's views about extending the current program or replacing it with a per-beneficiary payment for primary care. If the Commission is interested in a per-beneficiary payment, then there are design and funding issues that must be explored.

The primary care bonus program provides a 10 percent bonus on primary care services furnished by primary care practitioners. In 2012, bonus payments totaled about 1 percent of fee schedule spending or $664 million. About

200,000 practitioners were eligible for the bonus, accounting for about 20 percent of practitioners who billed Medicare in that year. Bonus payments per practitioner averaged about $3,400; however, practitioners who provided more primary care services to a greater number of fee-for-service Medicare beneficiaries received much more than the average; for example, the average bonus for those in the top quartile of the bonus distribution was about $9,300.

To continue to support primary care after the bonus expires, the primary care bonus program could be extended. It is administratively simple. Practitioners do not apply for the bonus. It is made automatically based on the provider's specialty and claims history, and practitioners and administrators already have experience with it. However, it is still based on the fee schedule, and so it still rewards volume and is not an explicit payment for non-face-to-face care coordination.

Alternatively, to explicitly support non-face-to-face care coordination and to move away from the volume-oriented fee schedule, the primary care bonus could be replaced after it expires with a per-beneficiary payment to support primary care. Other payers are experimenting with

per-beneficiary payments. After briefly describing those efforts, I'll provide a cursory look at design issues, and then Kevin will explore different ways a per-beneficiary payment could be funded.

The private sector, Medicaid, and the demonstration programs of Medicare are making per-beneficiary payments for primary care throughout the country. Per-beneficiary payments typically are between $3 and $7 per month, although payments can be much higher, depending on the complexity of the patient and practice standards achieved. Common practice requirements include maintaining 24/7 access to health care providers, hiring a care manager, implementing care coordination processes, and achieving medical home certification.

Katelyn has researched these efforts and would be happy to discuss them in more detail on question.

Now we'll move on to discuss some design issues and funding options -- oh, wait. Did I skip one? I'm good. Okay. Sorry.

Now we'll move on to discuss some design issues and funding options for a per-beneficiary payment. Design issues include how much to pay, how to attribute a

beneficiary to a practitioner, and should there be any practice requirements to be eligible for the payment. All of those considerations largely depend on the goals of and available funding for the per-beneficiary payment. For example, goals could include simply directing more resources to primary care services or redesigning the delivery of primary care.

Our first design issue to consider is how much to pay. Obviously, this would in large part depend on available funding, but to motivate discussion, consider using the same funding level as the primary care bonus program.

Bonus payments in 2012 totaled about 1 percent of the fee schedule or $664 million. Primary care practitioners who received bonus payments provided primary care services to about 21 million fee-for-service beneficiaries. Dividing $664 million by 21 million beneficiaries results in about $31 per beneficiary, dividing by 12 produces a monthly per-beneficiary payment of about $2.60. So given the typical per-beneficiary payment range of $3 to $7 per month, $2.60 is at the low end but still an amount that's seen in practice. Also note in the example

considered here, beneficiaries would not pay cost sharing.

Moving on to our second design issue, beneficiary attribution. Unlike the service-based primary care bonus, a per-beneficiary payment necessitates attributing a beneficiary to a practitioner to ensure that the right practitioner gets paid and that Medicare does not make payments to multiple practitioners on behalf of the same beneficiary. One option is for beneficiaries to provide written consent as to whom they consider their primary care practitioner to be. A second option is to attribute beneficiaries to practitioners who furnished the majority of their primary care in a year.

Requiring written consent of the beneficiary could encourage a dialogue between beneficiaries and their practitioners about responsibilities for providing coordinated patient-centered primary care. However, having practitioners ask beneficiaries to sign consent forms may also inadvertently place beneficiaries in awkward situations in which they feel under pressure to sign.

The second option, attributing beneficiaries to practitioners based on who furnished the majority of their primary care services in a year, would be simple to

administer. Like the primary care bonus, the practitioner would receive payment automatically, without extra paperwork requirements, on behalf of practitioners and beneficiaries. However, in this case, the per-beneficiary payment would likely have to be paid at year's end, so that the practitioner who furnished the majority of visits in the year could be determined.

Moving on to our third and last design issue, should any additional criteria be required of primary care practitioners to be eligible for per-beneficiary payments? For example, in return for payment, practices could be required to improve access by, for example, increasing office hours or maintaining 24-hour phone coverage. A team-based approach to primary care could also be encouraged by requiring a care manager to be on staff or processes that facilitate care coordination to be in place. Having practice requirements provides a specific return for the additional funds directed towards primary care; however, depending on the size of the payment, additional requirements could limit practitioner participation. Finally, requirements would also necessitate some sort of process to ensure that practices are in compliance. For

example, practices could attest to fulfilling requirements or an independent third party could verify that requirements are being met.

Now I'll turn it over to Kevin to discuss ways in which a per-beneficiary payment could be funded.

DR. HAYES: Given the concerns about support for primary care and given the Commission's recommendation to rebalance the fee schedule, funding the per-beneficiary payment for primary care would require working within the fee schedule. Where in the fee schedule should the funding come from? In considering this question, you might use the eligibility requirements for the primary care bonus as a framework.

Recall that the requirements for receipt of the bonus include, first, that it's applied to the payments for a subset of evaluation and management services, such as office visits. The bonus is available to practitioners in certain specialties, such as internal medicine family medicine, and nurse practitioners, and it's available to those for whom primary care services account for at least 60 percent of total allowed charges.

Julie showed that the bonus is equivalent to a

monthly per-beneficiary payment of $2.60. With that level of funding as an example, one option for funding the primary care payment is to reduce payments for everything in the fee schedule, services and practitioners not eligible for the bonus. This is the option shown on the left side of this graphic.

Funding for the primary care payment would come from about 90 percent of the fee schedule. It would require a reduction in payment for those services of 1.1 percent.

Another option is to hold all evaluation and management services harmless, not just those eligible for the bonus, regardless of specialty and regardless of whether primary care services account for at least 60 percent of a practitioner's allowed charges.

Going from left to right then on the graphic, this is the option shown on the right side. In this case, funding would come from about 75 percent of the fee schedule. Because the funding would be coming from a smaller portion than the earlier option, the reduction would be a bit larger, 1.4 percent.

The third option you might wish to consider for funding the per-beneficiary payment is to fund it through

reducing payments for overpriced services. Doing so would be consistent with a series of recommendations the Commission has made on identifying and reducing payments for overpriced services.

Most recently, in our October 2011 letter on repeal of the SGR, the Commission recommended that payment reductions should achieve an annual numeric goal for each of 5 consecutive years of at least 1 percent of the fee schedule. If that 1 percent savings were redistributed to fund a per-beneficiary payment for primary care, the monthly payment would rise over 5 years from $2.60 to $13.

Note that this idea of redistributing payments from primary care services to the primary care -- from overpriced services to the primary care payment is different from the proposal in the SGR repeal legislation now being considered by the Congress. There, the proposal is to have an annual goal for savings from overpriced services but equal to at least 0.5 percent of fee schedule spending and to redistribute those savings in a way that is budget-neutral.

As we will see in a moment, current policy is to redistribute such savings broadly through, say, a budget

neutrality adjustment to the fee schedules conversion factor.

There are reasons to believe that it's feasible to reduce payments for overpriced services and achieve a level of funding equal to 1 percent of fee schedule spending. PPACA requires that the Secretary validate the fee schedules' relative value units, or RVUs, and make appropriate adjustments. For example, validation must address inaccuracies in what are known as the "fee schedules time estimates." The statute defines the work of physicians and other health professionals as consisting of time and intensity. That is the amount of time it takes to furnish a service and the intensity of work effort per unit of time. There is a time estimate for each service with a work RVU.

Studies have shown that the time estimates are highly inaccurate. Contractors working for CMS and the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services have found that the time estimates are too high. GAO has found that the fee schedule does not adequately account for efficiencies that arise when a physician furnishes multiple services for the same patient on the same day.

The other factor in the statute's definition of work, intensity, is another potential source of savings. CMS has been reviewing potentially mis-valued services and consulting with the AMA Specialty Society Relative Value Scale Update Committee, also known as the RUC. While over the course of this initiative, time estimates have gone down for a number of services, their work RVUs have not gone down as much. The time estimates decrease by an average of 18 percent, but the work RVUs decrease by an average of 7 percent. The only reason we can think of for why this might be happening is that the RUC is offsetting some of the decreases in time by increasing the other work RVU factor, intensity.

Funding the per-beneficiary payment for primary care would require targeting savings from overpriced services to the per-beneficiary payment. The statutory requirement is that changes in the fee schedule's relative value units must be budget-neutral. Absent a change in current policy, savings from overpriced services are redistributed equally across the fee schedule. Underpriced, accurately priced, and overpriced services all receive the same budget neutrality adjustment.

Under the funding mechanism discussed here, the budget neutrality policy would be revised, and savings from overpriced services would be redistributed instead to the payment for primary care. In addition to providing a funding source, doing so would help rebalance the fee schedule.

To summarize our presentation, we made two major points. One, the current 10 percent bonus for primary care expires at the end of 2015. Two, if such a payment for primary care is to continue, options we discuss today are to extend the bonus as it is currently constructed or replace it with a per-beneficiary payment. If your preference is the second option, the per-beneficiary payment, we would appreciate your discussion of two issues, design of the payment and funding.

Thank you.

MR. HACKBARTH: Okay. So even more than usual, I am the one to blame if you don't like this topic. I'm the instigator behind this, and I wanted just to say why that is.

Why take this up now when there is ongoing -- a number of medical home demonstration projects underway, some

of which include Medicare? And incidentally, many years ago now, like 2008 or something like that, we were one of those who recommended that these demonstrations be created.

So why now? Why not just wait for the end of the medical home demonstrations? There are two reasons for that. First has been alluded to in this presentation, which is the existing primary care bonus expires at the end of 2015. So it seems that that does create an opportunity or even a necessity for us to address, well, what after the end of 2015? Do we want to continue the existing bonus, or do we want to reconfigure it and do something like this? So that's one reason.

The second reason for me personally -- and people should feel free to disagree with this -- is that I've become increasingly concerned about the medical home demonstrations on a number of different grounds.

First of all, I am a little bit worried that the medical home model has been -- become gold-plated, and that in order to meet all of the NCQA requirements, et cetera, there are a lot of bells and whistles that have been added to it, and I'm hardly expert in this. So again, feel free to disagree, but my impression is that not all of them have

really been validated as adding value, but they add cost, and so I'm worried that maybe the medical home model has a real cost disadvantage that it's going to be carrying with it.

Second is that my hunch has long been that what these demos will ultimately show is that, hey, it works in some places, and it doesn't work in others. A lot of this is context-dependent. So you plop a medical home down in the middle of Group Health Cooperative at Puget Sound, you get one set of results, or in Geisinger Clinic, you get one set of results. You plop a medical home down in the midst of Miami, you may get a different set of results. And so what we will find from the demonstrations is not a clear answer, does this work or not to reduce cost and improve quality, but rather results that are really a function of the different locations that happened to be put into place. And I think, ultimately, the results may be equivocal, and we will still have a core problem, even after the demos finish.

We have too little primary care for the population that needs to be served, an aging population in Medicare, a population with more people with insurance covered in

general, and so what I've been searching for is ways that we might be able to address that mismatch between supply and demand more quickly than counting, putting all of our eggs into the medical home basket.

So how do I think this may fit into that? It's about changing what qualifies as productivity for payment? If you're in a fee-for-service payment system, purely fee-for-service, your productivity is see more patients, more visits. That's what you get paid for, but in fact, what I think we need to do is expand the capacity of our existing primary care practices to care for bigger populations, not generate more visits with the patients they have, but assume clinical responsibility for a larger population, and then bring to bear other resources, like nurse practitioners and PAs, health educators that expand the capacity of the practice to be responsible for a bigger population. Substitute e-mail and telephone visits for face-to-face visits, which the fee schedule doesn't pay for. So it's create a payment flow that encourages the redesign of the primary care model, so that it can care -- we can care for more patients with the existing resources or small increases in resources.

I'm all in favor, as the President has proposed, of training more primary care clinicians. That's got a long tail on it. Even if it were enacted tomorrow, the clinicians come out of the pipeline way down the road. So I'm trying to think of things that we can do in the meantime, or if that doesn't happen at all, that will again expand the capacity of our existing primary care practices to care for a broader population, not just pay them more for generating more face-to-face visits with existing patients.

So that's my thinking, and people again should feel free to challenge that way of thinking about it, but that's why I bring this issue back.

So let's have clarifying questions. Alice, then Peter, Mary.

DR. COOMBS: So I was wondering what the 10 percent reimbursement equalization between Medicare and Medicaid comes out to be in terms of the total price of that compared to what's happening here with the bonus.

DR. MARK MILLER: Why don't we come back and answer that, unless somebody has got it right on them, because I don't think we've talked about this in detail in getting ready for this. Sorry. We'll have to come back.

DR. NAYLOR: I was just wondering, Has there been any evaluation beyond what you reported of the impact of the bonus on access, quality, prime outcomes?

DR. HAYES: That one, we did talk about internally, and --

DR. NAYLOR: Joan.

DR. HAYES: Well, I see she left. So we're adrift now, and we'll just have to make something up -- no.

[Laughter.]

DR. HAYES: Well, of course, at some level, Julie has described some of the impacts, just in terms of funding and this is the amount of dollars and the number of practitioners and the number of beneficiaries using, receiving service from those practitioners.

We would -- consistent with the points Glenn was making, we would like to know more in terms of the impact, say, on supply as this led to any changes in specialty choices among new practitioners, but, one, it's early. I mean, we've got data, as you can see, for the first 2 years of what would be a 5-year program. So that's one thing.

The other is that what we're looking -- you know, a reason to wonder about the impact of that, of this

program, just on supply, it has to do with it was temporary. I mean, it was known. So we would like to be cautious about anything like that.

The other thing that comes to mind is just the subtleties that go into the matter of specialty choice. Those of you who were on the Commission when Karen Borman was a Commissioner will recall a point she made about maybe it's a lot of things having to do with specialty choice, but the ability to develop, say -- one of her favorites was an ability to develop a skill set, an area of expertise you could call your own, that that was something in surveys of new physicians that was identified as a big factor.

But putting all that aside, when we turn to what's happened with the bonus and we connect it to what the Commission was talking about in June of '08 when recommending the bonus to begin with, the objective was fairly specific. It was we have an under-evaluation of primary care, and so now we've got $664 million that's going in to help kind of counterbalance and offset that kind of a problem, so that's one thing.

The other thing that was an objective of the Commission was to just make an investment in primary care

practices to help them prepare for whatever the future is going to be, whether it's going to be medical homes or just transformation, however you label it, and so here again, there has been clearly an investment.

So it's kind of there's a lot of nuances to answering a question like that, and it just kind of depends upon your frame of reference and what your expectations are about the thing.

MR. BUTLER: So page -- Slide 5.

And while you're doing that, just to clarify Alice's question, I think you're talking about we have the 10 percent bonus on the Medicare patients, and then there's also paying Medicaid at Medicare rates. That's what you're asking for.

DR. MARK MILLER: Yes. I understood that -- [off microphone].

MR. BUTLER: Which is obviously largely dependent on how many Medicaid you got, too, in your practice, but okay.

So I'm trying to get a sense of the size of the dollars that we're kind of giving all in exchange for these we get, all this flexibility and redesign, and it doesn't

look like much, but that will be my round two.

[Laughter.]

MR. BUTLER: But let me understand it, because the $3,400 average here is what the average primary care physician is getting now, right?

DR. SOMERS: [Shakes head yes.]

MR. BUTLER: With the 10 percent bonus, right?

Okay . So then in the Slide 9, you say this is an example. So you've got 31 bucks per beneficiary here. Can I cross-walk that and say that means maybe 110 or 120 charts, Medicare charts? Because if you take that times the 31, you get to the 3,400 bucks, or is this just an example?

DR. SOMERS: Well, this is kind of equivalent dollars. So --

MR. BUTLER: That's what I'm trying to say. Is it the equivalent?

DR. SOMERS: Well, one is just that -- yeah, one is just the number of practitioners, around 200,000 who received the $664 million --

MR. BUTLER: Right.

DR. SOMERS: -- in bonuses. Is that what you're asking? And so that comes up to about $3,500.

MR. BUTLER: Right. But can I take it a step further --

DR. SOMERS: Okay.

MR. BUTLER: -- and say that that $3,400, those practitioners, are they now getting on average about 31 bucks per beneficiary?

DR. SOMERS: Yeah.

MR. BUTLER: Does the math work?

DR. SOMERS: That's right.

MR. BUTLER: So that's kind of the pool we're talking about that would be --

DR. SOMERS: Except this is a per-beneficiary, and the other -- if a physician -- in the primary care bonus, if the physician has a smaller panel of fee-for-service Medicare beneficiaries, but has them coming in the door a lot, then --

MR. BUTLER: The numbers are different.

DR. SOMERS: -- then they're going to generate --

MR. BUTLER: Okay.

DR. SOMERS: -- more bonus, and in this system, they would generate a smaller bonus for themselves.

MR. BUTLER: Oh, so then -- okay. So then quickly

back to 5. I'm almost done. So the 3,400 bucks means that the average practitioner is getting $34,000 from Medicare because 3,400 is 10 percent, right? So the 10 percent --

DR. MARK MILLER: [off microphone.] I think you have to be a little careful [inaudible] instance.

MR. BUTLER: It's the 200 that are eligible, 200,000 that are eligible, right?

DR. SOMERS: And the 200,000 that are eligible are getting the $664 million. So just on average, a physician is getting $3,400 and a bonus.

MR. HACKBARTH: And Peter's point is that since they're getting a 20 percent add-on for their primary care fees, then the total amount of primary care fees on average per practitioner is $34,000.

MR. BUTLER: Right.

DR. MARK MILLER: Oh, I thought you were saying $34,000 for all of their services.

MR. BUTLER: No, just the Medicare, and that --

DR. MARK MILLER: No. No. That's --

MR. HACKBARTH: Primary care or Medicare.

DR. MARK MILLER: -- the primary care.

MR. BUTLER: My last question is that's just the

E&M codes associated with primary care. So if they're doing x-rays and other things like that, that would be additional income in their practice for -- that's related to primary care but not the E&M codes themselves.

DR. HAYES: Yeah.

MR. BUTLER: Okay.

DR. HALL: Just a couple of quick clarifications. The offsets to pay for the added beneficiaries we're going to talk about, that comes out of the overpriced services by primary care specialists, so are we just taking out of one pocket and putting in another? Where is that money coming from?

DR. HAYES: Well, recall that we talked about three ways to fund this.

DR. HALL: Right.

DR. HAYES: One way would be to adjust payments for -- and this would be our chart -- would be on the left side of this graphic, which would be to take the funds from 90 percent of the fee schedule, okay? So that would be the services -- right? So that's one -- that's one option. Another would be to say take it from 75 percent of services.

But I think what you're asking about is the other

option, which is to take it from overpriced services.

DR. HALL: Right, exactly.

DR. HAYES: And for that, you know, it's a question of what is found to be an overpriced service. If through validation of RVUs or however this is accomplished it's found that, say, some of the services that are furnished by primary care practitioners are overpriced, then that indeed would be some of the source of --

DR. HALL: But is it across all physicians who are participating in Medicare or just the --

DR. HAYES: Yes

DR. HALL: -- primary care doctors?

DR. HAYES: No, no. The overpriced services would be --

DR. HALL: Surgeons, psychiatrists, et cetera.

DR. HAYES: Yeah.

DR. HALL: Nurse practitioners.

DR. MARK MILLER: If Bob Berenson --

DR. NAYLOR: [off microphone].

DR. MARK MILLER: Well, you know, if Bob Berenson were here, he would argue that -- it is from across all the fee schedule, like you said. But he would argue that what

happens in the fee schedule a lot is that on the procedural side there's much more opportunity to create new services and bring new services in, which generally are higher priced and then don't fall.

DR. HALL: Right.

DR. MARK MILLER: And so his, you know, contention and some evidence, although it's being sought out, was when you identify these things, they will tend to come from that side of the fee schedule. I think that's what he would say if he were here.

DR. HALL: Okay. And just one other quick clarification. The model seems to be one practitioner, one patient. So how do you deal with a group practice of five physicians, maybe six nurse practitioners, assorted other people? Which of the five physicians in the practice gets the credit?

MS. SOMERS: I could see it being implemented on a practice level or billing one --

DR. HALL: Okay. So they all have a billing number, and they would be -- okay. Thank you.

MR. HACKBARTH: Other clarifying questions?

MR. GEORGE MILLER: Yes. Could you just help me

with the patient-centered medical home model, what the requirements are? The Chairman mentioned the gold plated of this, and how does it relate to this issue, or is that a separate issue, the PCMH model?

MR. HACKBARTH: NCQA -- and there may be others as well -- have developed standards for who qualifies as a medical home.

MR. GEORGE MILLER: Right

MR. HACKBARTH: And some payers and some demonstration projects say that in order to get additional payment, you have to meet standards.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: And some of them use NCQA standards, and as I recall, NCQA has various levels of medical home-ness, and the more the characteristics you have, the higher payment you qualify for in some of these demonstration projects or through some private payers.

So as was mentioned in the presentation here, even if you go this route, you would still have to have some standards on who qualifies for this additional payment.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: And the only thing I'm suggesting

is that you can make those standards really rich, you know, require electronic medical records and, you know, 24-hour coverage, and a long list of requirements, or you can make them leaner, as I understand some of the state Medicaid programs do for their primary care capitation payments.

And so I just mean to say that there's a continuum, and in thinking about this, I am just urging that we not just load requirements onto it, all of which generate costs and may not generate commensurate value, because if you do that, then you sink the idea economically. It just becomes too expensive, and the amount of capitation payment required to make it viable gets huge.

MR. GEORGE MILLER: Okay. So my clarifying question is you're not prescribing a specific set of parameters for a patient-centered medical home, but the primary care physicians, you still want to drive them to patient-centered -- beneficiaries, I mean.

MR. HACKBARTH: The paper alludes to potential requirements that you may have.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: And so if we decide to go down this path -- if -- then you would have to say, well, which

standards do we wish to adopt.

MR. GEORGE MILLER: That's my clarifying question.

MR. HACKBARTH: Okay. And I'm just saying let's be as lean as possible while still getting the job done.

MR. GEORGE MILLER: But they still would qualify for the payments if we do that lean method versus someone else who may have higher standards, that would -- they would be separated from that, right?

DR. MARK MILLER: And, again, I would just focus you on the last thing he said and what we tried to say in the paper. It's a threshold question. You could also do this without asking for requirements, but that's the threshold question.

MR. HACKBARTH: And just for the record and people in the audience, I really don't mean to pick on NCQA -- that's not my point -- but rather just to say that conceptually, you know, there is a continuum here. You can have lots of requirements, or you can have fewer requirements. The more you add on, the more expensive the model becomes.

DR. HAYES: Just one point, Glenn. On the Medicaid bump that Alice was asking about, just as one way

to compare this bonus with that, Kate Bloniarz tells us that the Medicaid bump was scored at $11 billion over two years, or somewhere in the area of $5 billion for one year. So that gives you some idea of what the spending impact of that would be relative to this.

MR. HACKBARTH: So shall we go to Round 2. Bill Hall, do you want to lead off?

DR. HALL: I don't have too much to say. I'd just speak very much in favor of this idea to further develop it. As we all know, we're going to have a huge crisis in primary care for Medicare patients over the next 20 years, and this is, I think, a creative solution and one that I think would be well accepted. And we'll work out the details as we go along.

MR. HACKBARTH: I don't remember which way I went last time. If you're ready, Bill Gradison, go ahead.

MR. GRADISON: To me this is sort of a Sophie's Choice between continuing something like the current 10 percent add-on and having the requirements which were discussed, the 24 hours and e-mail and this and that.

I'm struck by the signal that might be sent, however, if the 10 percent is allowed to expire. It may

expire. It may be hard to come up with the financing. To me, this is the next step after SGR in a sense because it's not financed into the future, but folks come to expect it.

To put it another way, the current legislation which has been proposed with regard to the SGR doesn't do anything that I understand to shift funds from specialties into primary care, which was our recommendation. Everybody gets the 0.5, if I understand it correctly, in each of the years that it contemplates. So that isn't a really encouraging signal either in terms of the latest evidence of the way that people who make those decisions are thinking.

I think it's been very instructive -- I think it is instructive to look at what's happened at the state level where during the economic downturn, with the large increase in Medicaid enrollment, and very necessary increase as well, a lot of states cut back their reimbursement for primary care by 10 percent. Actually, that's the actual number in a number of states. And there is great pressure to restore that amount, and properly so. But I just cite that as possible evidence of what the expiration of the current temporary 10 percent might look like.

One final note. Adding too many requirements,

desirable as they are in the improvement of the structure of primary care, is just another unintended but, I think, very effective way to push the doctors into the arms of the hospitals, because that's how you get your 24-hour coverage, and that's how you get your online capability, and I just think we ought to -- I'm not using it as an argument for or against, but I think it is something to consider as these potential options of expanding the requirements are considered.

DR. CHRISTIANSON: Okay. Four kind of random thoughts.

One is of the two options, I would not prefer the bonus option on top of the fee-for-service payment system. And I think there's also very little we can -- just anecdotally, probably very little we can learn from the experience with the bonus option. The physicians I talked to basically said, you know: We knew it was only going to be there for a limited number of years; given the financial pressures on Medicare, we can't believe they're going to extend it; it has been nice. So in terms of looking for behavioral changes in that particular experiment, that's just anecdotally -- I wouldn't be optimistic.

I also was happy to see that the goals, as it was originally listed, do not include attracting more physicians into primary care. I don't think the dollars here are going to reduce that payment differential between the high-paid specialists and primary care, so that alone is going to be a big motivating factor for physicians moving to primary care. Maybe on top of some other changes it will have an incremental effect.

In terms of practice requirements, I think a lot of practices now are going to meet those requirements. A lot of private insurers have these kinds of programs now. Whether it's payments to the practice, Medicaid in many states has this. So there's lots of requirements out there that the practices are meeting to get these bonus payments in other programs. So whatever Medicare puts out there, for a lot of practices I would think they will have already met -- especially if they're lean requirements, will have already met those requirements.

And then, any, I think thinking about how this interacts with ACOs and ACO payments and what the benchmarks will be from year to year for ACO payments, is this layered onto ACO payments on top of it for the practices within an

ACO? What does this mean for the way ACOs will organize internally?

MR. HACKBARTH: Well, as with other payments, ACOs are just a conduit for Medicare fee-for-service payments. So to the extent that this was added, ACOs would benefit from the added payment in proportion to the number of qualifying primary care clinicians they've got.

DR. CHRISTIANSON: Right. So that gets back to the comment that Bill made, I think.

DR. BAICKER: So it seems like we're all on board with the idea of wanting to make sure that primary care is adequately paid for, and the choice is a fixed versus a variable add-on, and all the discussion we've had about, you know, too much churning people through and it's about these other kinds of services that aren't currently on the fee schedule we want to promote, all suggests moving towards this fixed lump instead of a variable add-on.

The only caution is do we think that what we're short of in primary care is visits, and if we're worried that there aren't enough visit slots -- and that's a big if -- then going to the fixed does nothing to add more appointments for people under the existing system. But if

we think that's not the problem, the problem isn't that there aren't enough appointment slots for beneficiaries with primary care, the problem is they need stuff that doesn't currently fit into a billable appointment slot, then this seems like the right way to go there. But, clearly, it shifts the incentive away from more appointment slots and towards having a bigger patient panel. It's a small incentive relative to everything else. So I don't think we need to worry so much about, you know, suddenly they're going to have these enormous panels and people will be flooding into primary care to sign up people and then never see them. It seems -- this is small. So it seems like a move in the right direction, but I think those are the terms that I'd evaluate the options based on.

MR. GEORGE MILLER: I think Kate nicely laid out a landscape, but personally I would extend it. I've talked to physicians who are thrilled with the additional payment, and no one said we wish it would go away or that if it goes away, it would be okay. I haven't talked to those physicians.

And I think we do need to wrestle with what's the best way to drive both access -- I think what we're dealing

with is access of patients, and depending on what community you are, whether that's more or less and how to design it in a way that that physician, she can expand her ability to see more patients by hiring nurse practitioners or being able to communicate with patients through a different mechanism other than face-to-face visits. So I think the add-on will accomplish that goal. So I support that part of it.

MR. HACKBARTH: Before I forget, let me just mention one thing I saw, and I believe this was in Health Affairs and was written by a fellow who's the head of Permanente in Northern California, I believe. He had a piece on Kaiser Permanente's efforts to use new tools like e-mail and phone consultations and the like, substitutes for face-to-face visits. And it was striking that, you know, he had a graph in there and showed a very significant increase in non-face-to-face encounters with patients -- e-mail, telephone, et cetera -- but not a lot of change in the number of face-to-face, suggesting that at least at this point in their efforts there wasn't a lot of substitution going on.

And so it was a little bit perplexing to me but -- and not what I would have expected. I don't know if you

have experience on that, Scott, that you can share. But while that was in my head, I just wanted to mention it.

Do you have something on that point, Scott?

MR. ARMSTRONG: Yeah. We've seen a huge increase in the volume of these virtual visits, the e-mail visits, and have not seen the return that we expected on that in a number of ways. The lower per beneficiary number of in-person visits would be one of them. And, in fact, what we're finding is when you really look inside those e-mail encounters, those strings or whatever they're called, a lot of it is useless.

And so we're trying to look at ways of actually putting some financial incentive in there to make sure our patients use e-mail wisely. And we don't know what the answer is right now, but it goes to your point earlier. We built, you know, a gold-trimmed medical home, and we get more than our return on lower costs elsewhere. But we think we can get a much better return if we kind of brought the cost structure of our medical home down a little bit, and I think we can do that without losing the benefit of lower costs or better outcomes elsewhere.

DR. REDBERG: So just to pick up on a few of those

points, and then I'll address the questions.

I'm not that surprised that visits didn't go down because, I mean, in my specialty cardiology practice, I think the e-mail is mostly replacing phone calls, because people ask little things in e-mail but not things that we would have come in for, or they're things they wouldn't because they can't get through on the phone but the e-mail is a lot easier. And whether it's -- how useful it is I think would be something that we should all be keeping an eye on. But it certainly seems like a way to increase access.

And then in terms of the patient-centered medical home, I would just echo what you said earlier. In my experience at Journal, JAMA Internal Medicine, we're seeing a lot of manuscripts evaluating patient-centered medical homes, suggesting that it's not giving the benefits that one had hoped from them and certainly deserves -- and they're not an inexpensive way to try to increase primary care access. So that leads into I would favor replacing with a per beneficiary payment, because I think it does offer a better model of designing improved access and making primary care more attractive.

I guess I don't agree that it would go over that well, because whenever there are cuts from other -- like the high overvalued procedures, I still expect we'll hear about it from the people that use the overvalued procedures. They rarely say, "Oh, yes, we thought they were overvalued, and we would like to donate it to primary care."

[Laughter.]

DR. REDBERG: But it seems like a reasonable model. It does concern me in the mailing materials that 28 percent of Medicare beneficiaries said they had a small or a big problem seeking a primary care physician. And so I think a significant kind of rebalancing and things we can do to encourage more primary care is going to be very important. Especially for a lot of the things we're talking about, you really have to have a strong primary care of someone who can talk to the patient, explain risks and benefits of procedures, you know, address outcomes.

So for all of those reasons, I favor the per beneficiary payment model.

MR. HACKBARTH: Let me just say a word about the financing question. You know, if we recommend a higher payment for primary care, I think it is incumbent on us to

say where the money would come from. But even if we didn't recommend an increase in payment for primary care, I think we would still recommend changing payment for overpriced procedures. So it's not like, oh, we wouldn't do that but for primary care.

Now, what happens to the money would be different, you know, whether it just flows back through the overall fee schedule as opposed to targeted to primary care would be different. And there has been some legislation that has said we'll take it as savings, budget savings, you know, overpriced procedures. But just to be clear to the people in the audience --

DR. REDBERG: Good point.

MR. HACKBARTH: -- we'll propose going after over priced procedures, whether or not there's a primary care bonus or not.

DR. REDBERG: Good point. And just one more point. With regard to tying this increase to access and 24-hour, I do think that would be worthwhile. And I'm also wondering, I think in one of our other -- you know, in the quality measures, we had potentially preventable ED visits, but I think that would be a good thing to tie to primary

care practice because a lot of admissions that I see coming into our hospital are people that were unable to reach their primary care doctor, then they're coming in with problems that, if they had been able to talk to their primary care doctor, you know, a pain they had for five years, they would not have been admitted in a lot of those cases.

DR. CHRISTIANSON: Sorry. I forgot one of my points I was going to make. We kind of like -- first of all, we think of the payment as going to physicians, and in large part it may go to physician organizations, organizations that employ physicians. So we kind of have this nice assumption that physicians, however defined, are going to plow this money back into redefining primary care. It goes to organizations that employ physicians. They're going to use the money wherever they think it can generate the most return. And that may very well be investing in specialty services that are overpriced but expand their capacity. So, I mean, just keep that in mind. This is not like the money is locked into primary care that they get.

DR. NERENZ: Like others, I think I would generally favor some form of per beneficiary payment rather than the current bonus. One reason -- and I'm happy to be

corrected by others here. The current bonus as an incentive to make primary care more attractive seems like a homeopathic dose of incentive. If there's a $200,000 gap in salary between primary care and, say, procedural dermatology, now there's a $197,000 gap, and I'm not sure that's going to steer too many people into different --

MR. HACKBARTH: [off microphone].

[Laughter.]

DR. NERENZ: I couldn't think of one.

DR. REDBERG: It's going [off microphone].

DR. BAICKER: Drop in the bucket.

[Laughter.]

DR. MARK MILLER: Nicely done.

DR. NERENZ: Drop in the bucket, thank you. Very good. Small drop.

And, also, you know, the amount, if it's about reconfiguring practice, you can't hire a nurse coordinator with it, you can't buy an EMR system with it, you can't -- okay. So I think I would steer in the other direction.

In terms of design, on Slide 10 you mentioned a couple ways --

DR. MARK MILLER: Wait. What was the other

direction? [off microphone].

DR. NERENZ: Fixed payment, yeah, I'm sorry.

DR. MARK MILLER: If the dollar amount [off microphone] is just working with the same pool of dollars --

DR. NERENZ: I'd go a larger dollar amount. I'm going to get to that.

DR. MARK MILLER: Okay.

DR. NERENZ: I start with observing what is, but then if we talk -- you list two ways of linking patients to doctors. It seemed like there was a third way. I'm a little surprised to see it not listed, and that is, in terms of a code on a claim form. This is how it's done in a couple of the new care coordination codes that CMS has authorized. I think this is how 90-day global payment gets done. Basically a physician asserts, by submitting a claim, that this relationship exists. So that's actually the way I would think to do it most easily, and you wouldn't have to invent a new concept.

DR. MARK MILLER: But the catch is, if I'm following you here, then the first physician who puts a code on and submits it gets the PMPM, and what if that's the physician who provided one visit and this physician provided

seven visits. And so we were trying to say if you do this PMPM, you want to look at what happened and then give the PMPM to the one who did most of the primary care work.

DR. NERENZ: Well, except you can't do it then until after it's all over.

DR. MARK MILLER: That's the downside.

DR NERENZ: No, I under -- there are problems either way.

MS. SOMERS: Could I add, I think the CMS care management code that they're considering, they are also considering to have beneficiaries sign a written consent form for the physician to be able to build to the code.

DR. NERENZ: I guess you could do it. It just seems a clunky thing that we don't typically add to other kinds of payment for other sort of services. But, okay, minor point.

But, anyway, where I was going to take that is that if we really stretch the concept a bit, you could actually think of different intensities of code or level of code that would claim different levels of accountability for certain defined points, meaning if we think this is about the range of things that a physician will or can do for a

patient, presumably a physician could claim then to be responsible for things like reduced admissions, reduced ED visits, whatnot, and then actually enter into a P4P model sort of model in which there is gain sharing to the extent that actually occurs.

Which then takes me to the other point about, back to the last slide, Slide 18, about funding. It would seem to me that the proponents of care coordination as a concept typically talk about it as something that pays for itself, that when it gets done, you have fewer admissions, fewer readmissions, fewer complications, fewer ED visits, fewer this, fewer that. So if we are going to pay for care coordination or structures that promote care coordination, the one way to think about it is it ought to pay for itself. And then if the data we have in front of us from demos say, well, no, it actually doesn't, then it seems like we ought to apply some of the thinking we've had all day long earlier today about why should we pay for a service that has no demonstrable value?

MR. HACKBARTH: So this is an important point, David, and the one that I was trying to address at the outset, and I apologize for not being very articulate.

So one way to evaluate this is: Does it reduce, you know, ED visits or hospital admissions or readmissions? And, you know, I think that it may -- the evidence may be at least ambiguous. It may some places and not in other places. And my concern is that evaluated on that basis, let's stipulate for the sake of discussion it will fail. You know, we won't be able to disprove the hypothesis, it has no effect, the evidence just won't be strong enough.

The problem that I'm focused on is how do we get enough primary care capacity to serve the population, even if it increases cost, because primary care physicians are discovering problems that need more care. I think that's still an important thing to do.

And so I'm trying to focus on the supply problem. How do we expand the capability of primary care practices to see all the patients who need to be seen? My hunch is that that will yield some cost and quality dividends, but even if it doesn't, I think it's good on its own merits, particularly given what I see as an imbalance between supply and demand for primary care.

DR. SAMITT: So I support a replacement with the per-beneficiary payment as well. My feeling is the dollars

are not nearly enough to matter in what we're trying to accomplish here. So I think we need to find a bigger pool, and I'll come back to that.

I do think we need to align the bonus with some of the other things we want to accomplish in the program, which is to achieve higher quality and efficiency of care, and I tie it back to several of the other discussions we've had today. Are there other outcomes or incentives that we would reward linked to this bonus that would instigate reliance on decision support or shared decision-making or ER hospital utilization or readmissions? There are a lot of things that distinguish a value-based primary care unit from a non-value-based, and now is our opportunity, especially if we are going to offer this bonus, to reward those things.

I would say in terms of the design features, the attestation model is the one that I would certainly prefer.

And then in terms of funding, I think that, especially if we need to find a larger pool, we're going to have a harder and harder time taking it out of redistribution. So I think we're going to need to find it out of downstream savings. If we are to invest more -- in several of the primary care models that I've been fortunate

to redesign, we make substantive increases in primary care income linked to what we expect will be the quality improvements in downstream utilization savings. You have to expect that those downstream savings will occur, and that's in essence what funds your ability to upstream investments to primary care, so that's how I would think about it.

DR. CHERNEW: So I'm a little ambivalent, and let me explain why. First, it's not because I'm not a supporter of primary care. I am. It has to do with some of the other details.

But before jumping into the design issues and some of the specifics, I want to say a lot of aspects of where we're going in the system actually are relatively supportive of primary care. So for example, in the ACOs, you get assigned based on your primary care, who is providing the primary care, which gives an incentive for the ACO to make sure they have primary care providers and enough capacity and to have them treated well.

In Medicare Advantage, I think most of the plans I know worry a lot about primary care. This is sort of an issue in those other systems, and I agree very much with your concern that the primary care system outside of that,

maybe even inside, is under a lot of threat. So in that sense, that's sort of the positive about why I sort of share the motivation.

I'll get to my ambivalence in a bit, but if we go forward, because we're concerned about that, which is reasonable, first, let me say the way I would do it design-wise is I support the fixed payment over the bonus approach, because it gives a little more flexibility, which I basically like.

I also think -- so I would like it if someone had to be designated as the primary care provider, although I recognize there's a potential for abuse there. I have two doctors, and now both of them want me to sign, and I feel so stressed. And I worry about that, but what I like about that -- I don't know how Cori's mom -- we could do the Cori's mom test. She should testify.

[Laughter.]

DR. CHERNEW: But what I like about that is we have big attribution problems. I think a world in which people designate a primary care provider would be helpful for a whole slew of things that we want to do, and if I wasn't concerned about the Cori's mom problem, I would

definitely go that route. So that requires some thought to figure out how big that particular problem is.

I very much believe we should do this with relatively few requirements. I think the administrative cost of the requirements and just overall just dampens the effectiveness. For the amount of money we're talking about, it just seems like a much bigger hassle, and if you're going to do this with the way we're going, I would make it as attractive as you can to primary care and as least prescriptive as possible for primary care.

And that gets me to the other part, which several people have said. I'm not sure there's enough money in this to achieve our goal. So my ambivalence is sort of is what we're going to get worth the lift. If we put a little bit of money in, we change to a fixed fee, we do all these other things, have we really accomplished the basic problem we have for doing all of that work?

The problem I have is -- so then the obvious solution is, well, we should put more money into it, and that sort of makes sense to me, but then it runs into the overall funding, pay for SDR, do we have enough money to put in there, and so I end up not knowing. I haven't yet seen -

- the chapter is very good, but I haven't quite seen the sweet spot to make sure that there's enough money to get enough bang to get us where we want and not cause problems other places.

I would say overall, just to finish up with my design comments, to the extent possible, reducing overpriced services is my preferred way of dealing with this as opposed to some of these other general cuts, but that is for a whole bunch of reasons, as was pointed out very eloquently. That's a heavy lift to know what's an overpriced service and how do you set it up, but conceptually, I prefer that, although these cuts to the other parts of the fee schedule aren't so big that I don't feel horribly opposed to them if that's the way that we went. My bigger concern would be if the alternative was to use those to fix the SGR, I guess I'd probably take the SGR fix, if that was what was on the table.

DR. MARK MILLER: I know we're running out of time, but because this has just happened twice, there's not enough money here, and we don't have to discuss it. I just want to put it in your head, and we can come back and talk about this, because this isn't the last time we'll talk

about it.

But could you put up 15 for just a second?

If you followed this path and you extracted this from the overpriced procedure, note that by year five, you're talking about $13. That's a 5X increase in the amount of money here that's available to this, $3 billion type of discussion. Now, that may still not be big enough for you guys, like still not enough to move stuff, but this starts to get into 15-, $16,000 per physician, depending on what your denominator is.

Sorry, Kate. Got over there in your turf. Apologize for that.

But there might be some money by year five if you took that route. Just a thought.

The issue with your idea is CBO is going to say I will not score, because I don't have the evidence, and you're saying, "But I want to see some more money."

DR. CHERNEW: Well, frankly, I would say CBO doesn't have the evidence, and a lot of the evidence that's come out lately isn't particularly encouraging on the basic notion that if we just give you a bonus that we will get a payback.

I think if you lump that with a bunch of other things, you might, but I think it's quite optimistic to say we're going to do this, because we're going to get a cost savings.

The part that I found more discouraging from recent evidence is I would have -- if you just would have asked me a month ago, I would have said, "Well, I suspect quality is going to be a lot better, but you're not going to save a lot of money on the back end." That would have been my bias.

Some things I've seen lately suggest that, you know, quality is not all that much better either. So I don't really know how to digest all of that stuff. So I guess that adds to maybe that's enough money to get something. I'm skeptical that the solution to not getting enough quality is, well, we need to put more requirements to make sure we get it. I see that as a dangerous path.

So it leaves me, as I started, somewhere ambivalent around believing in the Hackbarth premise that we have to work on primary care and more money and there's a danger, and worry that some of the things that we're talking about don't quite get me there, and they have a cost that

might distract from other things.

MR. HACKBARTH: Just one point on the financing. So you kind of mixed financing. So if you're not doing things like overpriced procedures, the test is do you save enough on hospital admissions or EE visits to offset the fundamental cost of any added payment. If in fact you do overpriced procedures, then you don't have to finance all of it out of reduced hospital days, but only a piece of it. It may meet that test. It may not be fully self-financing, but it could be partially self-financing, and so you could have a combined financing package to help support a larger number.

DR. CHERNOW: Right, absolutely.

DR. SAMITT: You know, the other thing I would say is while the numbers start to become more substantive by year five, I think we also have to remember that the availability and the interest in primary care has a tail that follows the change of the economics, and so we're not going to begin to see -- if we want to see a shift from specialty to primary care and we start to see that in year five, we're not going to really see more primary care physicians available until year eight or year nine, and so

that's why it needs to be a bit more substantive a bit earlier.

MR. ARMSTRONG: So I'm not sure I have a lot more to add to this, but I do think part of what we're debating here is how much do we really want to accomplish with this particular policy issue.

Glenn, your argument that, well, really all we want to do is expand the capacity of primary care is I think one goal, and I think what you're hearing is, well, we want to do more.

My own experience, I know Craig's as well, is that we justify incremental investments in primary care based on an expectation we're going to lower cost somewhere else in our system and get a return on that investment.

And as Commissioners, we can't necessarily apply the logic exactly the same way, and so I think that's part of what's playing out here.

I not surprisingly would replace with some kind of per-beneficiary payment. I wish for my previous point, it could be somehow connected to a population outcome or whatever to just avoid the disincentive of piling on a lot of beneficiaries without providing them what they need, but

then again, you get to the whole point that this isn't that influential a dollar amount, and so are you really worried about that.

To that point, I wish I could put primary care on the table and just imagine in the next 3 to 5 years what are all the different payment policies that are going to affect primary care, this just being one of them. We mentioned the ACOs, and there may be others, so kind of net of it all, it might look very different than just kind of what we're talking about here, and we may feel better about that.

With respect to design issues, I do believe that there should be an attribution methodology prospectively, and I know we run into issues with that, but one day, that should be the case for everybody.

And my final point would be with respect to practice requirements, I am not really that worried about that. I mean, primary care is expected to comply with all sorts of requirements, by all sorts of other payers already, and we ought to just look and see if this is anything more than what they are already doing and I think be sensitive to that.

The other point I would make is that to the degree

we create requirements, we should really be aggressive about pushing a team-based approach to practice of primary care and the use of non-physician providers, because there's no way primary care issues get solved without employing nurse practitioners and other non-physician providers, and I think that's in here, but I think it's just worth amplifying.

MR. HACKBARTH: On the economics of this, I really agree completely with the perspective that Craig and Scott have offered, although if you're in your position, you also have revenue gains. So if you expand your primary care capacity and increase the population served, you get more money coming in on the revenue side, and it doesn't have to be fully justified through cost savings. It's a combination of revenue and cost.

Medicare, we don't get increased revenue, so we've got sort of a truncated financial analysis. It's only a cost saving analysis. So our financial calculation has to be different than yours.

Herb.

MR. KUHN: With what Glenn said, it might be hard for me to make my points, but let me try.

[Laughter.]

MR. KUHN: But I like that.

I look at this as two things. One is, as we set out in the beginning of the conversation here, a rebalancing of how we pay for primary care, and the second, of course, is a payment system that helps redesign the delivery system.

So on the rebalancing issue, I think we're all frustrated that it takes so long to get RVUs revalued as part of the process. MedPAC has been opining on this for well over a decade, and we've got a long way to go. If you fast-forward to a decade from now, I think you could easily see that MedPAC could be sitting around this table, future Commissioners having the very same conversation where we are on that.

So having said that, I understand the notion of a bonus in order to help that rebalancing process to help send a signal to primary care physicians, that we find them valuable in the system, and that's what we want to do.

The way we've looked at things before, it is targeted. We know kind of where the money is going, to who it is going to. I don't know what we're expecting from it. I think you'd have to almost look at a longitudinal study to see if it really made a difference, and I think that would

be very hard to do as part of the process, but nevertheless, I think it is what it is, and I think we just -- that's part of the process.

The second thing is that if we really are looking at redesign of the care system, then we have to think differently in terms of the medical home and everything that everybody said before, so I don't need to repeat all that. But I'm kind of like Craig and Scott and picking up what Kate's term, a "drop in a bucket here." $2.60 a month, you're not going to get a lot of behavior change. You're not going to get some activity here.

I went and looked before I came to this meeting, kind of some of the requirements or some of the things that medical homes have to do. So you've got a nurse care manager. You have the time of the physician. You got the director for the medical home. You probably have administrative report, and depending on your population, you might even have a behavioral health consultant that you have to engage with. That's a lot of activity to fund out of $2.60.

So that's just going to be part of the process. So again, if all we're talking about is rebalancing, I'm

fine. I don't have a preference whether you give to the physician or per patient. It's just a signal to primary care. We're are as frustrated as you are with the process to change the RVUs. We believe in you, but if it's going to get into redesigning the system, I think we really kind of need to dissect what those different payments -- who they have to bring into this system, and kind of the expectation is a part of that.

DR. COOMBS: I'm going to ditto you, and I think this is a great idea. I'd like to "biggie size" it, but --

[Laughter.]

DR. COOMBS: I know that we are dealing with restricted revenue.

One of the things that I thought about is that you get this aliquot of funds. What could you do that's innovative with it? Well, if you have a large pool like Craig's group or Scott and you have a large pool of providers, you might do things that are targeted at some specific subset in your patient population.

For instance, Boston Medical Center has actually Spanish-speaking navigators to make sure that patients are -- from the time they hit the door, they're -- and contiguous

contact with these navigators to get their performances improved in a certain area. So if you knew already what you needed to do to get to the next level of better outcomes in a certain area, this funding might help you with something like that.

The amount of whatever you need to do to improve your infrastructure, the cost of it, I don't think would ever -- you'd ever reach any kind of significant level, because financially, it would be I think nearly impossible to do some of the creative things that you might like to do.

The reason why I brought up the Medicaid issue is because the Medicaid monies are much greater for a primary care doctor, and so seeing this at the same time -- so there's a couple of things that are happening at the same time. If the SGR fix is one of the issues and we can get that, that's fantastic, but if the SGR, if we get a 2-month patch and we continue down the same road, then I don't think it makes a difference what we do with this right here, because that's going to be small potatoes in the big picture. And so I think those are the important things for the providers.

Whether or not it makes a decision whether or not

someone stays in internal medicine or retires or is attracted to primary care, I don't think it would make that much difference. You have to be mission-minded to be in this field.

MS. UCCELLO: Sop my mother.

[Laughter.]

MS. UCCELLO: She does realize she's gotten famous. When I talked to her the other day, she said, "You've got one of those MedPAC meetings coming up, right? Do you need my help with anything?"

[Laughter.]

MS. UCCELLO: I didn't realize the answer to that question was yes. Maybe next month, I will be sending her in my place.

DR. MARK MILLER: What I remember from the story is that you didn't understand the letter.

[Laughter.]

MS. UCCELLO: I understood the letter.

DR. MARK MILLER: Oh, okay. My mistake.

[Laughter.]

MS. UCCELLO: Okay. To the questions at hand, in theory, I like the per-bene payment based on attributed

members with practice requirements, paid for by reducing payments for overpriced services.

But I want to be more sure that the benefits of this outweigh the burdens. Now, Scott mentioned that, well, these practices are already meeting these requirements. Well, if they are, then why would we pay them more for doing what we want them to do under this? So I'm just -- there seems to be some disconnects here that I just want to think, learn about some more.

Also, in the mailing materials, I think this is where Joan would come in. There was some feedback from the focus groups that the docs were saying that some of the problems here are arising because of communication issues between the primary care docs and the specialists. If that indeed is seen as a problem, I would want some of those requirements to focus on that issue.

I don't know what my mom would say.

DR. HOADLEY: So a lot of this ground has been covered. I was doing some of the same arithmetic that Dave started and that you all continued, including Mark's point about year five on this chart actually starts to get closer to real money, and if you thought year five and you thought

about those physicians that are at the higher end of the use, you could see things if they have a larger panel and if we do per beneficiary.

And I would sort of say the same things Cori did about sort of where I come down in the concept of all those things, but what I keep thinking about is what are the optics of all of this, and it's a lot of what we've been talking about. Are we in doing this trying to send a signal to the profession sort of writ large that, yes -- since a couple people have articulated this -- yes, we value primary care, we want to make sure it doesn't go down again, we don't want to let that bonus go away, and we actually think there's a smarter way to do it in concept, even if -- you know, are we also sending in fact a sort of individual physician-level signal? And that's where the small dollars kind of doesn't seem to pan out very well.

I remember from a focus group many years ago, not so much on -- long before this primary care bonus, but it was on some of the quality bonuses, and when you asked docs, "Well, do you sort of know why you're here?" "Well, I see that I get a bigger check one month or an extra check comes in. I don't really know what it was for," and I wonder if

that's kind of what's -- to what extent that's going on here too. "Oh, yeah, I did notice there was a little more money." Now, does a larger practice sort of figure this out and say, "Okay. We will get more if these things happen," and that's, I guess, what you'd be hoping for is that you're sending a signal, if not both to the profession as a whole but at least to practices. And if you've got a 10-doctor practice and you add up all those bonuses and it's at the higher end, then maybe you actually can hire that navigator or hire another nurse practitioner. You may not be able to afford another doctor, but I think that's part of how we should think of these is where are the optics, and do we understand what -- in the case of this bonus, what physicians know about what they're getting, and do they understand that this bonus, so far for these 5 years has meant these things, or is it just somehow lost, the kind of thing their office manager knows about, and they may be aware of more money?

So I'll stop there.

DR. NAYLOR: I'm going to ask you all to envision 5 years from now a primary care system in which nurse practitioners and physician assistants are working in

partnerships with patients and families in the public health system and referring to physicians when they need really important clinical diagnostic work and very much focused on downstream outcomes to get to higher values.

So I really do think part of the challenge is our own being able to envision -- re-envision a primary care system that is based on evidence about what's critically important.

We know how critically important patients and families are to being viewed as part of the team, forming partnerships, and we know how important it is that we begin to figure out how primary care is seen more in the Barbara Starfield longitudinal, getting to better health, getting to better individual and population health outcomes, figuring out when people need better palliative care and not more acute care, those kinds of decisions. And I think it's really important for us to be open to explore those possibilities.

So I think this is a very important opportunity. I think the bonus system is a temporary fix. I think this represents our opportunity to think about how we could redefine primary care to achieve the goals of the Medicare

program, which his as you describe it here, improving access, getting quality, and yes, absolutely achieving cost savings in the way.

So I think this is a terrific opportunity. I don't know whether per- beneficiary or per-month payments get us there, is the best strategy. I wonder how it gets us to the population health defined by the population this primary care practice setting is responsible for, how it gets to those kinds of outcomes, how it embraces community health workers and peer support and all the things that we know now from evidence are a central part of primary care.

So I think this is an extraordinarily exciting time to think about our role in redefining it and thinking about the incentives that will get us there.

MR. BUTLER: So I have three points. One is, one more time, the Jay Crosson story, a West Coast Commissioner who couldn't go to sleep because of the time change, and we were looking at like a half a percent increase in physician fees. And he was saying, "Okay. If I get a half a percent a year over 10 years and my costs go up 3 percent a year, I counted last night falling asleep, I'd have to do like 50,000 office visits myself to come out whole." So it just

doesn't work in that.

So my second point, though, after I do that icebreaking story, the --

[Laughter.]

MR. BUTLER: -- is that the payment -- it's related, though. The payment is becoming totally -- for primary care is becoming totally detached from what they're actually getting paid, because virtually all of them are getting employed by health systems and multispecialty group practices. And we've already referenced both downstream revenue, which increases their value, as well as downstream expense savings under risk models, which increases their value and their salaries. And then hospitals themselves, we don't hire them to make money off them. They are managing care. So how much we're paying them is becoming not very much related to Medicare payments, frankly.

And now you throw on ACOs, and everybody scrambled and said I got to have more primary care, so I can have attributions to the primary care physician, and suddenly, their salaries are going up, even in the absence of changing the system. And I think that that's going to continue to occur.

Now, having said that, I would say even as a health system, if you put the full primary care cap in there, exclusive of the ancillaries and so forth -- I realize there is some toxic behavior that can occur, but if you had not $30 but $300 per beneficiary, then as a model of primary care within our system, I'd have more flexible dollars to try to say how do I really do Mary's model, because I got the pool of dollars to kind of now -- really kind of do whatever it takes to connect and own those patients, and now I have a real incentive to get them attesting to my system. And $2.60 Is not going to get me to a test.

So I would go for a bigger capitation around this, which I think systems would be interested in having as a flexible pool of dollars, and make it optional, if you want, so you don't have to force everybody into that, and that's the way I'd go.

MR. HACKBARTH: We will obviously be back to this one at a future date. Thank you for all your work on this, and we'll now have our public comment period.

And before you start, Sharon, let me just see if there's anybody else who wants to come to the microphone?

Anybody else planning --

MS. McILRATH: I don't actually want to.

[Laughter.]

MR. HACKBARTH: Okay. It's going to be that kind of a comment, huh?

[Laughter.]

MR. HACKBARTH: When this light comes back on, Sharon, that's the end of your time.

MS. McILRATH: So I'm Sharon McIlrath, AMA.

I feel compelled to get up and make some response to some of the comments that were made about the highly inaccurate time data and about the length of time that it is taking to address misvalued codes. Perhaps I'm overly sensitive. It sounded as though that were partly another slap at the RUC.

I think you should know that, I mean, when you first made this recommendation for the target savings in 2011, there was a lot more money on the table than there is now. The RUC has been working and doing highly controversial things that have made a lot of money for a lot of consultants in this town who have been taking a lot of time from different congressional members and from CMS

people because they didn't want the cuts that had been recommended. So to imply that they haven't been doing anything I think is unfair.

Also, I want to comment on the time data in particular. The times that -- there's some reference to times where the values that were recommended by the RUC did not go down commensurately with the time change, and that is because in most of those cases, the original time data is Harvard time data, which there's not time to have a lesson about how that was all developed. But that time data was not good. It was, you know, the problems with the Harvard data was what started the RUC in the first place.

So the times, initial times, were just wrong. So you can't make a comparison of what happened to the work values and expect that there's going to be some relationship that's perfect between those two.

If you want to have a lot of more, you know, looking at time -- I've said this before -- you will find that there are some other places where the time is iffy in some people's eyes. For instance, for a Level 4 new patient visit, the time for physician is 24 minutes with the patient, 40 minutes overall, and there's 53 minutes of

nursing time. So there are some people who think that not all Level 4 visits would live up to that particular thing.

So the other piece of it is, though, you can't -- if you're trying to get all the money from all of the other services except the E&M codes -- and, granted, you're not looking at the E&M codes for all physicians; it's only for the ones that are called primary care because of the virtue of the 60 percent and being the chosen specialties. You still -- the percentage of all of the spending that is E&M means that you have to make much larger cuts on those other services than you would otherwise anticipate, and those other services, 86 percent of the things have been, you know, cut in some way as through this -- or will have been; some of it isn't completed yet -- through this misvalued code project. So to think that you're going to make big changes and finance a lot of a primary care per member per month service is not realistic.

In terms of what else, you know, has the RUC done to try to revalue the situation and actually deliver the message to primary care that, yes, we think they're important, they have -- they made recommendations at the request of CMS for medical home payment. They actually just

recommended the resources. CMS put the number on it. But we figured it would have been about $80 for a primary care. So it was gold-plated, but one of the issues that the RUC has addressed, along with the CPT, when they're talking about this sort of payment or whether they're talking about the care coordination codes, is do you try to make it so that everybody gets a little payment, whether they do anything or not? Or do you try to target it to the people who are really doing the treatment of the really difficult patients and they really are doing a lot of care coordination and follow-up and using those services that we're asking them to put in place?

The RUC and the CPT, and including all the primary care doctors that have been involved in that, have opted for trying to address the high-level patients. That's why -- and that was part of the argument with the original CMS demo that never happened. But these were the highest complexity patients that people were going to be paid $80 for.

So one of the issues, one of the tradeoffs is whether you want to have everybody get something or whether you want to pay those people who are really treating those -- the most difficult patients more. So, I mean, just -- and

I will issue the invitation again. We would love to have anybody who wants to come and see a RUC meeting and see what does really happen.

MR. HACKBARTH: Okay. Thank you very much, and we reconvene tomorrow morning at 8:30.

[Whereupon, at 5:36 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, March 7, 2014.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 7, 2014
8:31 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:31 a.m.]

MR. HACKBARTH: Okay, good morning. We have two sessions today, the first a continuation of our conversation about synchronizing payment models across, or benchmarks across payment models -- something like that -- and the second on risk adjustment in Medicare.

So on the benchmark issue, who's leading the way?

DR. LEE: Good morning. In recent months, the Commission has been thinking about the relationship between different payment models under Medicare, such as ACOs, Medicare Advantage, and traditional fee-for-service.

In November, we began our discussion on synchronizing Medicare policy across the payment models, initially focusing on laying out the issues and questions for the Commission to consider. In today's presentation, we'll focus on one particular aspect: synchronizing Medicare benchmarks across the payment models.

Before we continue, we thank Katelyn and Scott for their contributions to today's presentation.

So let's begin with a review of our previous presentation from November. Under the current Medicare program, there are three payment models: traditional fee-

for-service, MA, and ACOs. But payment rules are different and inconsistent across those models, and as a result, program payments can be quite different for similar beneficiaries across the three models.

This policy context raised several questions that the Commission considered back in November.

One basic question is: Given that we have different payment models in the current system, how do they and should they relate to one another? Is this an equal relationship? And if not, should it be? Or should it favor some models over others?

In particular, does synchronizing mean financial neutrality across fee-for-service and other models? And how should synchronizing Medicare policy address spending variations within and across areas?

These are very broad and abstract questions, and the Commission discussion in November centered around the second question of financial neutrality across the three payment models and specifically on the key importance of getting the right spending benchmarks.

Today's presentation is in four parts.

First, we'll briefly review current payment rules

for fee-for-service, MA, and ACOs.

Second, we'll explore the principle of financial neutrality, using the spending in traditional fee-for-service as the benchmark for ACOs and MA.

Third, we'll present our analysis of an illustrative example, where the spending benchmark equals 100 percent of local fee-for-service based on data from the Pioneer ACOs, fee-for-service, and MA in 2012.

And, finally, we'll discuss several additional issues for the Commission to consider.

This slide summarizes the current program rules for the three models. We'll just highlight a few key differences here, but there are more detailed descriptions in your mailing materials.

Focusing on the Medicare program's perspective, traditional fee-for-service and ACOs are similar in that the program pays both models based on the set Medicare payment rates by service. The main difference between the two is that ACOs can get bonus payments or penalty based on spending and quality targets.

By contrast, Medicare pays MA plans risk-adjusted capitation payments based on what MA plans bid to provide

the Medicare benefit and how their bids compare to MA benchmarks, which are tied to local fee-for-service spending.

Today's presentation focuses on program payments, so we won't go over beneficiaries' perspective summarized in the second half of the table. But we just want to mention that beneficiaries have an analogous set of questions related to Medicare policy across the payment models.

Previously, the Commission has thought about the principle of financial neutrality in the context of MA payments. The Commission has long supported private plans in Medicare because they can be more flexible and innovative in developing care management techniques than fee-for-service; and if their payment rates are set appropriately, they have incentives to be efficient. Therefore, the Commission has recommended financial neutrality between MA and fee-for-service and setting MA benchmarks at 100 percent of fee-for-service.

Now David will discuss in more detail what these spending benchmarks mean and why they are important.

MR. GLASS: Given that the payment rules for the three models are different, as Julie has just explained,

what does the benchmark mean for the different models?

For MA plans, the benchmark is the upper limit for Medicare payment to the plan. The actual payment is determined by the benchmark and the plan's bid for delivering Part A and Part B services. As the chart shows, in the first row, if the bid is higher than the benchmark, the plan is paid the benchmark. The beneficiary is charged an additional premium above the Part B premium to cover the difference between the bid and the benchmark, and there are no additional benefits.

If the bid equals the benchmark, the payment is the benchmark.

If the bid is lower than the benchmark, the payment is the bid plus a share of the difference between the benchmark and the bid. The share depends on the plan's quality. The higher the quality, the higher the share. There is no additional premium, and the beneficiary gets additional benefits.

The motivation is for MA plans to bid low so that they can offer additional benefits and attract beneficiaries. Of course, if the benchmarks is greater than fee-for-service, then payments generally will also be

greater than fee-for-service.

It is guaranteed that Medicare program payment will be the benchmark or less because the capitated payment is set in advance.

For ACOs the benchmark is the expected payment for beneficiaries in the ACO. If spending for beneficiaries attributed to the ACO is less than the benchmark, the savings are shared, and total program payment will be lower than the benchmark.

If spending is higher than the benchmark, the ACO will share part of the loss if it is in a two-sided risk agreement. If not, the program will bear all the additional spending, so total program payments will be greater than the benchmark.

The motivation for the ACO is to lower service use or alter the service mix so that program spending will be lower and it will share in savings.

There is no guarantee, however, that program spending will be less than or equal to benchmark. Thus, there is an asymmetry built in because the benchmark means different things for MA and ACOs.

Fee-for-service is what it is. There is currently

no benchmark, and the motivation is to offer more services to increase revenue.

DR. MARK MILLER: David, before you go to this one, there are a couple questions from Commissioners. If you could just orient them to the X and Y axis.

MR. GLASS: Sure. So we want to show you what MA benchmarks looked like in 2012 because that was the first performance year for ACOs and the starting point for our simulation.

So what we have done here is we've arrayed the counties by their fee-for-service spending along the X axis, so each county has a yellow dot corresponding to it along -- and the counties are arrayed along the X axis, with the lowest-spending counties on the left there near the Y axis, and the highest-spending counties to the right. That's the yellow line. And spending varies a lot, between about $500 a month in the lowest-spending county all the way over on the left to about $1,300 in the highest-spending county over on the right. So that's $1,300 per beneficiary per month.

Now, if benchmarks were set equal to local fee-for-service, they would look like that yellow line.

As you can see on the left, though, where fee-for-

service spending is around $600 per beneficiary per month, MA benchmarks, which are the green dots here, are all higher than fee-for-service spending. That's why the green dots are above the yellow line, and they're around $700 to $800.

On the right, where county fee-for-service spending is higher, in some counties MA benchmarks are lower than fee-for-service, and those are green dots below the yellow line -- which I actually can't see from here, but I assure you there are some there.

So this is what it looked like in 2012, but the picture is changing, so the next slide illustrates what things will look like in 2017. And here we have simulated what MA benchmarks would look like in 2017 when the benchmarks specified in PPACA are fully phased in.

So here again the yellow is the county fee-for-service spending, where the counties are arrayed lowest to highest spending. And then the green is what the benchmarks would be for MA, and you can see that they're above the line to the left and below the line to the right, and that's because what PPACA does is it separates the counties into quartiles of fee-for-service spending. And on the left, where the fee-for-service spending is low, the benchmarks

for MA are set at 115 percent of that and then 107.5, 100 percent where the lines coincide, and then 95 percent where the green line is actually below the county fee-for-service spending. So that's the setup.

So the relatively higher benchmarks in the lower spending counties are intended to keep plans available in those counties. The 95 percent counties are intended to reflect the idea that savings should be available there for MA plans. Altogether, we project MA benchmarks will be somewhat above 101 percent of fee-for-service when these are in effect. That is before any quality bonuses.

So, remember, these are not population-weighted quartiles. They're just how many counties -- just by counties. And so about 40 percent of beneficiaries actually live in the highest-spending quartile where benchmarks will be 95 percent of local fee-for-service.

Which brings us to this slide. So the yellow line is the same as we've seen in the last couple local fee-for-service spending, and we're just showing where the 32 Pioneer ACOs are along that spectrum, and they tend to be located in the counties at the higher spending end of the spectrum, although not in the ultra high locations. And

there are clusters in Boston, Southern California, and Minneapolis.

So this should be kept in mind as Jeff walks you through the simulation. The simulation looks at each of these ACOs and simulates what happens to spending for their beneficiaries using different benchmarks. So each ACO is going to constitute one case in the simulation.

DR. STENSLAND: All right. As David mentioned, we simulated the relative program spending under three payment models: ACO, fee-for-service, and MA. The unit of analysis is each ACO. The question is: How does Medicare spending differs across the three payment models?

To answer the question, we simulated spending on the three models as is shown on this slide.

We started by reporting the actual ACO spending in 2012 for the beneficiaries in the 31 ACOs, so we have 31 pools of beneficiaries.

We also report simulated fee-for-service spending if the beneficiaries were not aligned with the ACO, and this is slightly more than the ACO spending.

Then, most interestingly, we simulate what program spending would have been if the patients had joined an MA

plan. We simulate the MA costs under two scenarios:

First, we use actual 2012 benchmarks and bids to simulate spending.

Second, we simulate what spending would have been if benchmarks were set to 100 percent of fee-for-service and the bids did not change.

I will not get into the technical details of how the estimates were made. All those details are in the appendix to your mailing materials.

This slide highlights the differences in program spending under the ACO and MA models. Let's start with the first row, and focus on the last two columns. The row shows that in 2012, given 2012 benchmarks, the ACO plans were the low-spending model in 15 markets and MA plans were the low-spending model in 5 markets.

So why were ACOs more likely to cost the program less than MA plans given the 2012 rules? The primary reason is that the average MA benchmark in these markets was set about 10 percent above fee-for-service costs, and some MA plans bid above fee-for-service costs for the basic A-B benefit. And even those who below fee-for-service, they will receive rebate dollars to pay for extra benefits.

These extra benefits increase program spending.

Now, ACOs were most likely to be the low-cost option, and this shouldn't be surprising since ACOs reduced spending slightly below fee-for-service on average and MA was a little above fee-for-service on average.

Next, let's look at the second row, and this is the second simulation where we asked what would happen if the MA benchmarks had been set at 100 percent of fee-for-service. In this simulation we still model a 3 percent quality bonus on average so the net quality-adjusted benchmark would be 103 percent of fee-for-service. This lower benchmark -- down from roughly 110 percent before to about 103 percent now, this lower benchmark lowers the program cost of having people in MA plans. MA becomes the low-cost option in 19 of the 31 cases. ACOs cost less in seven of the markets. There are also five cases where expected fee-for-service cost was lower than MA or ACO expected costs.

The bottom line is that even with the lower benchmarks, one model does not always deliver the lowest program costs. In other words, costs differ across the different models. They also differ across individual MA

plans.

In addition to relative costs differing across markets, there are also differences in the size of networks, which beneficiaries may care about; there's differences in supplemental benefits, differences in care coordination. And so given all those differences, it's not always clear when ACOs and when MA plans would provide the most value for the beneficiary.

However, it's important to note that we do not need to decide which model creates the most value. If the program sets the benchmarks equal, beneficiaries will be given an incentive to choose the model which they believe provides the best value for them. The models can compete with each other for market share of beneficiaries. Over time, we would expect ACOs to become better at reducing costs. They're just in their first year right now. In addition, we may expect lower bids from MA plans once the benchmarks are lowered and put pressure on MA to bid lower to compete relative to fee-for-service.

Now, we just talked about the basic benchmark and setting that equal to fee-for-service, but there are some key details regarding how the benchmark is set.

First, under current MA policy the benchmark can moves up with a high quality score, but it does not move down with a low quality score. In contrast, for ACOs the share of savings cannot move up above 75 percent, but it does move down if they have a lower quality score.

So a question would be how to synchronize the effect of quality scores on benchmarks in the two models. One option would be to have a budget-neutral adjustment where the benchmark goes up 2 percent for high-quality providers and down 2 percent for low-quality providers for both ACOs and MA plans. A key issue is that if the quality adjustments to the benchmarks are not equal, then the benchmarks aren't truly equal.

Second, there's the issue of risk adjustment. Currently ACO benchmarks are based on historical spending, but this raises some long-term issues as we discussed in the paper. One option is to move to a prospective benchmark using HCC scores and historical county average spending per beneficiary in the county over the past five years to set benchmarks in ACOs. This would basically mean we'd be setting the ACO benchmarks similar to the way we set MA benchmarks, and the ACO's objective would shift from having

to beat their historical experience to having to beat the average performance in their county.

Third, there's the issue of financial responsibility over time. With Pioneer ACOs, even if the patient becomes dissatisfied with the ACO physicians and leaves, the Pioneer ACO is still responsible for the costs of care for at least one year after the patient stops seeing ACO physicians. This gives the Pioneer ACO a strong incentive to keep their most expensive patients satisfied with timely appointments, care coordination, and satisfactory referrals to specialists.

In contrast, if an MA enrollee becomes dissatisfied, they can leave at the start of the next year. The MA plan is not responsible for these costs of the patients after they leave the plan, and therefore, it has less of a financial incentive to keep high-cost enrollees satisfied and enrolled in the MA plans. They may do all they can to keep them satisfied just for reasons of professionalism, but they don't have the financial incentive. And as Dan will discuss in the next session, beneficiaries who leave MA plans do tend to have higher costs than their risk score would suggest.

Going forward, therefore, we may want to synchronize the degree of financial responsibility over time between ACOs and MA plans.

So we have talked about synchronizing ACOs and MA plans, but what about fee-for-service? If fee-for-service is the common benchmark and fee-for-service is really high in certain counties, is there a need for a better cost objective than just fee-for-service? Do we really want a $14,000 benchmark for anyone?

A related question is how much will ACOs be able to reduce fee-for-service spending and, thus, fix this benchmark problem in those high-cost areas. There's the question, can ACO solve the high fee-for-service spending problem?

Second, there's the question of how do we reward MA plans for low bids and ACOs for low cost. Currently, MA plans, when they bid below the benchmark, they get a share of the savings, which is the difference between the benchmark and the bid, but they must use those rebate dollars to fund additional benefits for the beneficiary. Right now, ACOs receive an unrestricted share of savings.

So there is a question of whether we should allow

MA plans to also receive an unrestricted share of savings, just as ACOs do. We would need to also think about how this would affect beneficiaries and the additional benefits they currently receive.

So this leads to some potential discussion topics, and the top-line question here is, How should we move toward common benchmarks for ACOs and MA plans. Second, how should we have comparable quality adjustments to those benchmarks? Third, should we move to a common risk adjustment? If so, should we move towards paying ACOs based on HCC scores multiplied by the average spending in the county? Finally, right now Pioneer ACOs have greater longitudinal responsibility for patients in MA plans. Should MA plans be penalized if that particular MA plan has a really high share of high-cost beneficiaries that leave the MA program? And Dan will discuss this issue further in the next session on risk adjustment.

I will open it up for comments and questions.

MR. HACKBARTH: Okay. Thank you very much. Well done.

Let me ask a couple of clarifying questions. Could you put up Slide 9? You said that the 2017 MA

benchmarks work out to 101 percent of fee-for-service. Did I hear that correctly?

MR. GLASS: [Off microphone.]

MR. HACKBARTH: Is that calculated on a county-weighted basis, or is that beneficiary-weighted?

MR. GLASS: I believe it's beneficiary-weighted.

Scott?

Yes. Scott nods. It is.

MR. HACKBARTH: Okay. Well, if it's beneficiary-weighted, I should let David explain it. Scott's question was, What's the difference between beneficiary weighting and county weighting of this average calculation?

MR. GLASS: Well, it is a beneficiary. I mean, we take, I would assume all the benchmarks per the -- where the people are in the MA plan.

MR. HACKBARTH: So that --

DR. MARK MILLER: Relatively straightforward, does every county have an equal weight in deciding what that number is, whether you have 100 bodies in that county or one body, or whether after you do that, you weight by the number of people. And so a county that has 100 people counts much

more than a county that has one person, and so it's basically saying it's beneficiary-weighted, and so it's weighted where most of the people are to drive the 1.1 percent.

MR. GLASS: Yeah. The picture here in the quartiles are county-weighted.

DR. MARK MILLER: Right.

MR. GLASS: Our calculation of how this would turn out is beneficiary-weighted --

MR. HACKBARTH: And that's what --

MR. GLASS: -- because that's what's spending would be.

MR. HACKBARTH: That's what I was trying to verify.

DR. MARK MILLER: Yeah. You implicitly have to do that, because you're rating each county's status on a line versus calculating an average.

MR. HACKBARTH: And then Slide 12. So in the second row here, what assumption was made about bidding behavior in calculating, doing the simulation?

DR. STENSLAND: So we assumed the bids stay the same.

MR. HACKBARTH: Stay the same. Okay. Thanks.

DR. STENSLAND: If they went down -- and they would look even better.

MR. HACKBARTH: Right.

Clarifying questions. Kate and then George and Craig.

DR. BAICKER: My question was on this slide as well. I thought the simulation was really interesting. I wasn't sure how to interpret the note in the appendix on methodology about what you did about risk adjustment. I interpreted that to mean that you kept the risk the same for the MA pools across the count, that you normalize that, but what I was trying to get at, was trying to ask is what share of this difference might be attributable to differences in the type of person who is enrolled in each plan, and is that baked in when you simulate a movement that it might be a different risk person who is moving in, or is it all assuming the same spending profile of the people who are currently enrolled? That was not very well posed. Could you figure out what I was asking from that?

DR. STENSLAND: We track the individual people. So if we come up with a risk score for each individual, and

that will be the risk score then that determines their MA payment, and their fee-for-service spending would be based on that individual's fee-for-service spending or their individual ACO spending.

MR. GLASS: The individuals are people in ACOs, and they each have a risk score attached to them, and that score is used to figure out the MA payment.

DR. MARK MILLER: But I think her question was does it change from the base case to the simulation case, and I think the answer to that is no. You assume that the risk was constant.

DR. STENSLAND: No, not exactly.

[Laughter.]

DR. MARK MILLER: At least we're getting to the question.

DR. STENSLAND: Yeah. Now we're deep in the weeds. There is an adjustment to the risk score that CMS makes, and that they assume that when people join the MA plans that the MA plans make an effort to code them optimally, to code everything, and that that results in a higher risk score.

So we did assume that -- and I think it's

something on the order of 3.1 percent shift in expected risk score because of that. So we did assume in the simulations that when somebody shifted to become in an MA plan, their risk score would go up by 3.1 percent. Is that --

DR. BAICKER: And you brought their risk score with them. So it's --

DR. STENSLAND: Correct.

DR. BAICKER: -- the simulation is not abstracting from the fact that right now, the pools of people look different in the different types of plans. It builds in the type of person who's moving between plans.

DR. STENSLAND: Right. So it would be based on your -- basically, we would say what is Kate's actual experience and what was her diagnoses over the past several years, and then we assume that once you join the MA plan, they will find a couple more things that you have that should be coded, and they will code them, which -- and then the risk --

DR. BAICKER: What are those things?

DR. CHERNEW: You have to join the MA plan. They will tell you.

[Laughter.]

MR. GEORGE MILLER: Yeah. I had a similar question, but let me deal with my first question, and that is, if I remember correctly, the MA plans are subsidized. So is that counted in the calculation comparing the cost of the subsidy for the MA plan? Is that calculated as we move -- especially on Slide 9 -- go back to Slide 9. As we move from -- as we look at 2017, is this subsidy for the MA plan taken into consideration as we compare these across the three entities?

MR. GLASS: Well, in the sense that the subsidy is built into the benchmarks, yes, it would be, if that's what you're asking.

MR. HACKBARTH: That's the mechanism by which the subsidy that you referred to is created, and so this does reflect the changing subsidy as a result of the Affordable Care Act.

MR. GEORGE MILLER: Over time.

MR. HACKBARTH: Over time.

MR. GLASS: Yeah. And if you look at the previous one --

MR. GEORGE MILLER: Yeah.

MR. GLASS: -- the subsidies are much higher

there.

DR. MARK MILLER: But I thought -- and I'm not batting very well today, but I'm going to try again. Go to the simulation slide. I thought he was asking what's happening to the subsidy here. Is that what you were asking, or were you back at the other two?

MR. GEORGE MILLER: Well, that was the second part of my question, what would be happening here, and is the subsidy in play here, but it was both questions.

DR. MARK MILLER: All right. And so what I would say is when you move from the top line to the bottom line, what's happening is that subsidy for MA plans in a big way is being pulled out, if that's what your question is, and that's why the MAs become more competitive.

MR. GEORGE MILLER: Okay. The subsidy would come out. Okay.

DR. MARK MILLER: In this bottom line. I mean, we're taking in a very general term. It varies by plan and all the rest --

MR. GEORGE MILLER: And this is a simulation, so yeah.

MR. HACKBARTH: Yeah. So what I understand George

to be referring to as the subsidy is the level of payment above Medicare fee-for-service cost --

MR. GEORGE MILLER: Right, right.

MR. HACKBARTH: -- which today is a significant number. The Affordable Care Act by 2017 lowers the benchmarks and thereby reduces the subsidy, as George is using the term.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: And then this bottom row here assumes that it goes away altogether with benchmarks set at equal to Medicare fee-for-service cost, more or less, because the quality.

DR. MARK MILLER: Yeah. Right.

MR. GEORGE MILLER: But yet even with that, traditional fee-for-service is not below the 31 options.

MR. HACKBARTH: Well, the fact is --

MR. GEORGE MILLER: Just on the five cases. Yeah.

MR. HACKBARTH: -- as you reduce the subsidy, the payment above fee-for-service, Medicare fee-for-service becomes the lowest cost opinion in fewer places.

MR. GEORGE MILLER: Fewer, right.

MR. HACKBARTH: But still in some places is part

of what this second row is saying.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: Even if there were no subsidy, again, setting aside the quality --

DR. MARK MILLER: I got it.

MR. GEORGE MILLER: Yeah. Setting aside.

MR. HACKBARTH: -- Medicare fee-for-service would be lowest cost in some parts of the country.

DR. MARK MILLER: And the reason that the other one, you know, ACOs and MA come out as a lower cost option, fee-for-service, is because ACOs are lowering their expenditures below their fee-for-service or, alternatively, MA is able to bid below or at -- well, below fee-for-service.

MR. GEORGE MILLER: But does the simulation also show that historically that has not been the case? And I'm trying to compare what we know over time versus what you're simulating here. Would the fee -- excuse me. MA plans hadn't bid below the fee-for-service prices historically.

DR. MARK MILLER: Yes. So historically, what our analysis has shown -- and this is the stuff that mostly Scott has -- Scott and Carlos have done -- is back in the

day, when the benchmarks were well set, well on average, well above fee-for-service --

MR. GEORGE MILLER: Right.

DR. MARK MILLER: -- managed care plans actually as an average bid above fee-for-service.

MR. GEORGE MILLER: Right.

DR. MARK MILLER: And then as the benchmarks have come down, our analysis has shown that managed care plans have begun to bid below fee-for-service as an average, and just one little tiny fact, that tends to be the HMO plans --

MR. GEORGE MILLER: HMO.

DR. MARK MILLER: -- that are driving that, that bidding process. They tend to bid below fee-for-service.

MR. GEORGE MILLER: 95, if I remember correctly.

DR. MARK MILLER: I think that's our latest number.

MR. GEORGE MILLER: Yeah, yeah. Okay.

And then the second part of my question is similar to Kate, and I think it's been answered, and that is the impact of the risk adjustment, but I think I got the answer the last time.

MR. HACKBARTH: Craig, I think is next.

DR. SAMITT: So Mark may have helped a bit with this, but also on this slide, I'm having trouble reconciling when you take into account the 3 percent quality bonus, why is such a large percentage of the counties have MA as the lowest cost option. So is that primarily because the bidding is below the benchmark, and then the quality bonus brings it back up again but not quite high enough to the benchmark? What is the primary -- how does the math work that ultimately results in MA plans being so low in the second row?

DR. STENSLAND: There's two things going on. You have low-bidding MA plans. So let's say they bid 95 percent of fee-for-service, and the benchmark is 103 with the quality bonus. And so they get some extra benefits of maybe 3 percent, and it moves them up to 98 percent of fee-for-service. And so there, you're saving money.

The other ones are if the MA plan was bidding above fee-for-service. We then assume that Medicare is not going to pay that full bid anymore, and beneficiary will have to pay the extra cost or that they'll move their bid down to fee-for-service. So there, they are basically, with the quality bonus, moving down to 103. So with them, you're

still losing a little, or they cost a little bit more. There are some that are bidding lower that save you money, and on average, in most cases, they tend to cost less than the other models, because you have enough savings from those that are bidding below fee-for-service to offset that little extra they're getting with the quality bonus.

MR. HACKBARTH: Clarifying questions. Mike and then Scott.

DR. CHERNEW: So I apologize on this same line of questioning, but you should take it as a compliment, because it's really important.

And so my first question is you assume that the unit of analysis is an existing ACO, so the people in the ACO, but when you get to the point -- I'm just trying to compare ACO and traditional fee-for-service. I'm trying to figure out how you could have an assumption where the traditional fee-for-service would ever be better than the ACO, and so is that a simulation based on actual results? Is it a simulation based on simulated results? Because if you did something simple, because they have the base -- they have a benchmark, which is kind of what you set up. They're in fee-for-service. They're enrollees trended forward. The

only way they could do worse is if you sort of -- some of them by chance are for whatever reason are going to do worse. Did you use their actual performance to get to the fee-for-service?

DR. STENSLAND: It's the expected fee-for-service. So you could almost see that little "5" down there almost as random variation --

DR. CHERNEW: Yeah.

DR. STENSLAND: -- where they were lower than you would have expected, given their historical spending.

DR. CHERNEW: Yeah. So there's some sort of just -- they're in the ACO. There was just some randoms, and that's just -- when you say counter the markets where that was the lowest cost option, that's the kind of markets where the enrollees in the existing ACOs would have been cheaper had they stayed in fee-for-service as opposed to some other simulation. Like the entire market, in that market, if everyone would have become an ACO, it would have been more expensive.

DR. STENSLAND: All right. So let's say you have these people, and they were in fee-for-service, and you have their expected costs. And their expected costs for those

five were lower than the ACO cost, meaning the ACO didn't have lower their cost below their expectation, maybe for random variation or for whatever reason.

DR. CHERNEW: Right.

DR. STENSLAND: And those costs in the fee-for-service were also lower than the MA plan possibly due to favorable selection or possibly due to the 3 percent quality.

DR. CHERNEW: But that doesn't say anything about if another organization in those markets joined and became an ACO. In other words, I guess my question is you're counting up markets, but your unit of analysis is ACOs.

DR. STENSLAND: Right. And we say markets up there, and that's kind of for simplification, but it is -- the unit of analysis is the ACO.

DR. CHERNEW: Right. So it's sort of the number of markets where the unit of -- where the ACOs would have been cheaper or not. I understand.

DR. STENSLAND: Yeah.

DR. CHERNEW: I may have muddled it for everybody else.

DR. STENSLAND: Yes.

DR. CHERNEW: But it's now clear to me.

[Laughter.]

DR. CHERNEW: My next question, just to be clear -- no, I'm happy, though. I'm egocentric enough that that matters.

DR. STENSLAND: You can tell.

DR. CHERNEW: Right.

My second question, though, is -- my second question is when an MA plan bids below the benchmark and a portion of that goes back to Medicare and a portion is captured by the beneficiaries, is that portion that goes back to Medicare counted to make the MA program cheaper, to lower it, or is it not?

DR. STENSLAND: Yes. It makes it cheaper. Think of it as the dollars going out of the Treasury on net.

DR. CHERNEW: On net. That was the key question.

MR. HACKBARTH: Scott and then Herb.

MR. ARMSTRONG: First, I do want to say I'm really happy that Mike is happy.

[Laughter.]

DR. CHERNEW: Thank you. This is such a nice group.

MR. ARMSTRONG: But I'm still trying to get my head around this, and he definitely confused me.

[Laughter.]

MR. ARMSTRONG: I'm on Slide 10 for just a moment, and I think this question is kind of in the neighborhood of where Mike was going. Are you worried that since the way you've done -- which it was brilliant. I mean, I think -- I wish I was smart enough to totally get this, but I think this is really great. Are you worried at all that given that the unit of comparison in the modeling are the ACOs, that so many of the ACO beneficiaries are in the really high fee-for-service spending markets, and that that would somehow distort the relative cost in the comparison, or is that really not something you would be worried about?

DR. STENSLAND: I'm not too worried about it, and I would expect the ACOs to form in markets with high spending, because that's where they really have some opportunities to reduce the spending, and you may say that is probably the markets where we want them the most, because it's kind of where do we have a problem. It's kind of on that side of the graphic. So where do we need the ACOs to try to fix that problem? It's on that side of the graphic.

MR. ARMSTRONG: It's also on that side of the graphic, though, where you would expect the MA bids to be good relative to the fee-for-service.

DR. STENSLAND: Right.

MR. ARMSTRONG: So that's why I was just wondering if because -- well, that's why I -- okay.

DR. MARK MILLER: I can help. Go back to the simulation slide.

MR. GLASS: Let me make one point. Now, it's also where the population is. Remember 40 percent of the population is on that top quartile over there.

DR. MARK MILLER: To the simulation.

The other intuition that you might be having is if ACOs were spread more systematically across the country, would these results look different? And I think the answer to that is yes, they would, because if ACOs were in parts of the -- more likely to be than they are in this analysis in parts of the country where traditional fee-for-service is lower, they, like MA, would have a tougher time beating that. And so I think your intuition is are these results somewhat dependent on where they happen to be located. The answer to that is yes, but then the second part of that is -

- and if you were trying to beat fee-for-service, where would you go? They tend to go to the high thing. So I think that's what was -- you know, you were thinking about.

MR. HACKBARTH: Is that on this particular point?

DR. STENSLAND: I was just going to say that the MA plans look a little bit better in these 31 markets than they do on average across the country, and that is because these 31 markets tend to be in places where MA tends to bid a little bit lower relative to the benchmark.

MR. GRADISON: I realize that we only have data for the Pioneers so far, but when would you expect to have a larger universe of ACOs and be able to update this beyond the Pioneers?

DR. STENSLAND: I don't know. We haven't gotten through that with CMS yet, so I'm not sure when they'll give us that data.

MR. GRADISON: Thank you.

MR. KUHN: Just a quick question on the risk scoring and the coding intensity initiative, and you talked about the 3.1 percent that's in there right now for MA. We're going to move presumably later this year to ICD-10, and the opportunity for even more coding intensity arises

with that. Case-mix indexes will probably start to move. Do we think -- is there any early indication that that would change the simulations going from I-9 to I-10 in any way that would be significant?

DR. MARK MILLER: It's acceptable to say we don't know.

[Laughter.]

DR. STENSLAND: To the extent that we could come up with a new estimate that was a right estimate of what the coding adjustment is, it wouldn't change it at all, if we had the right coding adjustment. If somehow the coding changes and we're not really aware where it's going, then it might change the estimate.

DR. COOMBS: So I hate to muddy the waters even more, but with the ACO fee-for-service, with the simulation especially, did we look at whether or not -- and the areas you named were New York, Minnesota, Boston -- at whether or not the ACOs were hospital, large -- you know, the size of the ACO, whether it was hospital based or provider based in the sense of physician, nurse practitioner? Because I think that really makes a difference, you know, where you have these large, large groups that are merged with multiple

systems versus a large physician-based ACO that has a different kind of relationship with the hospitals. And, you know, so not much literature is out on the difference in terms of cost, but the thought has been that if you have a hospital base, some of the energy goes into reinvestment in infrastructure within the framework of hospital-centric activities.

DR. STENSLAND: We only have a sample of 32 of these Pioneers, and it's not clear that hospital based or the physician based are doing particularly better or have an easier time winning bonuses. The places that do have an easier time winning bonuses tend to be those that had relatively high spending before the ACO time period started relative to the average spending in the county. Those that were kind of the low spenders in their county before they started tended to have a higher -- more difficulty bringing their spending down. You know, if you're already low, it's hard to go lower. If you're high, it's easier to go lower.

MS. UCCELLO: So this discussion has helped answer questions I didn't even know I had. So a quick question on Slide 13. So this common budget-neutral adjustment, do you actually mean budget neutral or do you mean symmetrical?

Would this be forced to be neutral?

DR. STENSLAND: Symmetrical.

DR. HOADLEY: So back on Slide 12, I want to make sure I understand that between row 1 and row 2, the only thing that you changed is the MA benchmark and everything else -- all the changes are derived by a change in the MA benchmark, or is anything else changing?

DR. STENSLAND: Yes, just the benchmark.

DR. HOADLEY: Okay. And then on Slide 9, what are the -- you said 40 percent of the people are in that last bracket with the 95 percent. What's the spread in the other -- do you know what the spread is on the other three?

MR. GLASS: I'm glad you asked that question. There it is. So the --

[Laughter.]

MR. GLASS: So the ACO beneficiaries are very much in that fourth -- and there's not much difference between MA and fee-for-service anymore. And there used to be a considerable difference. But now the distribution of MA, fee-for-service is about -- in each of the quartiles is about the same, though the people are all in --

DR. HOADLEY: So the people on -- if I'm reading

this --

MR. GLASS: People are more in the fourth.

DR. HOADLEY: If I'm reading this correctly, the people in the first three groups are about 20 percent, plus or minus.

MR. GLASS: Right, a little bit.

DR. HOADLEY: But in the ACO you've got, what, about 75 percent in the --

MR. GLASS: Right.

DR. HOADLEY: Because that was actually -- you anticipated my last question, which is the ACO population. So when we're talking about the point a minute ago that you see on Slide 10 where those ACOs are located --

MR. GLASS: Right.

DR. HOADLEY: -- we really are talking about a large percentage of the population in that last quartile.

MR. GLASS: Yeah, correct

DR. HOADLEY: Okay.

MR. HACKBARTH: And these are the Pioneer ACOs.

MR. GLASS: Right, that were, you know, applied and were selected and all that.

DR. HOADLEY: And your orange in the Pioneer.

MR. GLASS: Yeah.

MR. HACKBARTH: Any other clarifying questions?

DR. HALL: On this slide, can you refresh my memory? The ACOs in the areas of the country that seem to have higher costs, of the successful Pioneers, weren't a lot of these in major academic medical centers, like the University of Michigan and places like that? I'm wondering how much these data are skewed by health care centers that are not in any way representative of the entire country. Michigan bailed?

DR. STENSLAND: We have a pretty good mix, I think, even in the Pioneer ACOs. What you don't have is small rural areas, kind of the onesie, twosie doctors out in little towns. But you have, you know, mid-sized communities, big communities, academic medical centers, IPAs.

MR. HACKBARTH: Yeah, and I agree with that. But in one sense these are by definition atypical organizations that are Pioneer ACOs.

DR. HALL: Right.

MR. HACKBARTH: They have as a group relatively more experience in doing this sort of work. They are

willing to accept some risk as a result. And so it is a cross-section by type, but within those types there is selection in terms of organizations that have experience. So the general ACO, non-Pioneer population, would have a different profile than this group.

Any other clarifying questions?

DR. REDBERG: I think it's clarifying, but we're close to Round 2, so if not, you can count it as Round 2.

MR. HACKBARTH: My thinking on this topic, given the nature of the work, is that rather than going around the table one by one, I think maybe a more free-flowing conversation is the best way to proceed. So don't --

DR. REDBERG: Okay, because mine are a little different than the economics questions, and I'm happy now. Mike's happy. But I'm interested -- and we've talked about some of the features before, so I'm aware of them, but do you have any feeling or data for what are the most common techniques that we're seeing in the ACOs or the MAs to help to reduce costs?

MR. GLASS: Well, the ACOs, I think most of them started with the idea, you know, try to reduce costs for the high-cost beneficiary, care coordination, case management,

that sort of thing. And -- or is it care managers, I guess. And so they started that way. I think a lot of them are realizing that post-acute care actually makes a big difference, and some of them who have beneficiaries -- who take care of beneficiaries for MA plans as well as for in the Pioneer discovered that the use of SNFs, for example, was much higher in the ACO population than it was in the beneficiaries they do for MA plans.

So I think some of them are recognizing that post-acute-care costs may be a source of variation and something they need to do something about.

DR. STENSLAND: And I think you meant length of the SNF stay, not the number of episodes. Right?

MR. GLASS: Yes. Often they discovered that they were going to SNFs where the length of stay was -- this year it was 120 days.

DR. REDBERG: It seems like --

DR. MARK MILLER: One other strategy when they ere rolling through and kept telling us what they were doing was there seemed to be a dimension of people saying it's really about patient engagement and getting that patient well connected to their primary care physician. And they spoke

less about specific places where they were trying to extract their efficiencies. But if you get it connected, get the patient connected to the primary care, then things will flow in the right direction.

And then I don't know if you mentioned it, there was also -- it struck me that some of them at least started out talking about, well, three admissions, but then had to kind of expand their scope into what they were looking at.

DR. REDBERG: Glenn, I --

MR. HACKBARTH: I'm sorry, Rita.

DR. REDBERG: Just to follow up on that, because it seems like following on our conversations yesterday and others, there's a lot of opportunities for reducing costs also in reducing inappropriate or wasteful care. But most providers I think are going to be taking care of patients in fee-for-service where the incentives would be different than in ACOs. And I wonder if any of them are addressing those issues.

DR. STENSLAND: I don't have good data on that. I think as David was saying, they switched from, in essence, at the beginning -- they haven't all switched, but at the beginning they often said, "We're going to go where the

money is," kind of the Willie Sutton idea, we're going to go to stop admissions and readmissions, hospitals where the big money is, and they really weren't that successful at that. And I think the data you see from the Pioneers is very similar to the data you see from the alternative quality contract that they didn't have a material effect on admissions and readmissions, at least in the first year. But they had more of their savings on the ambulatory side in terms of how much ambulatory care you get and where you get it, you know, whether you're getting it at the hospital or at a lower-cost site.

DR. CHERNEW: So I like this type of analysis a lot. I think the big challenge is to understand how to translate the policy questions that you've put up to how folks would behave, because what's not in this analysis, for example, is issues of participation decisions from organizations that aren't yet Pioneers. If you were to change the benchmark, do all the things on your other slide with the quality bonuses, not what would that do for the existing Pioneer if they were to move magically, but what would that do for participation in the program versus not participation in the program -- those type of questions.

And really I think Peter said this when we were talking about the shared savings last time we were here, which is, Do you do that as a path to somewhere else?

So what happens is you're not really -- you're measuring this from a budget perspective, but not necessarily an underlying cost perspective. So if you thought that the ACOs eventually would lower costs, even if the benchmarks were kind of high, we would be sort of on a good path. The same would be true with the MA plans.

So figuring out how to answer your questions, this is a useful input, but it's almost more important to understand how organizations that are not yet ACOs would behave under different benchmark rules and what they would be able to achieve, and organizations that are not, you know, MA plans or becoming -- how that would all play out. And that's particularly hard.

And I do think this speaks to some of the numbers, but it's a little more complicated, obviously, as you know -- I didn't mean to imply that you didn't -- to understand what should guide our decisions about the other questions that you raised.

MR. GLASS: Yeah, and I think the dynamics of it

become interesting. You know, what happens in subsequent years as you go on? Because the ACOs, if they are successful at lowering spending below local fee-for-service, essentially reduce local fee-for-service because they're part of fee-for-service.

DR. CHERNEW: Right, so that's a separate issue about how this is constructed, but if you construct your fee-for-service as the non-ACO portion of fee-for-service, and if you thought those --

MR. GLASS: I don't think you'd want to do that, because I think you want that dynamic of the benchmark going down if the ACOs can reduce it, because that will reduce your MA --

DR. CHERNEW: But I just mean how you score this. So, for example, when you scored your other slide where you had the number of markets, the fee-for-service column was not inclusive of the ACOs. I think it was the --

MR. GLASS: That's right.

DR. CHERNEW: But what I would say is if you thought there really was an ACO effect, over time everyone would move out of the fee-for-service column, and the ACO would always -- ignoring the MA, the ACO would always beat

the fee-for-service column because the randomness would become less important because the ACO effect would grow, if you wanted to impose that they could do a good job.

MR. GLASS: Right, I mean, assuming that --

DR. CHERNEW: But you don't know if they can.

MR. GLASS: Right, assuming that somehow they can do that.

DR. CHERNEW: So if it turns out if you assume they're better, they will look better, which is -- which an economist would do, but most other people wouldn't.

[Laughter.]

MR. GLASS: And if you change benchmarks, you'll get different -- could conceivably get different ACOs entering. Right now people who are extremely efficient in the past have a very tough time doing better; whereas, if you change it to the local fee-for-service benchmark, then the ultra-efficient ACOs would want to join.

DR. CHERNEW: And if you move to the HCC model which you discussed, that's going to penalize a lot of the existing Pioneers that may have been higher because their benchmark was the -- their benchmark was their previous spending. So -- David's looking quizzically.

If you use the HCC model to adjust as opposed to prior fee-for-service spending, many of the existing Pioneers would get less money, I believe, because I believe that the -- I believe that their actual spending was higher than their HCC would have predicted it would be. That's my guess.

MR. GLASS: Okay. I'm not sure why. Jeff, do you have any --

DR. CHERNEW: Because we looked at some data on that, and that's why. So what that means is you would have to worry that they would continue to stay in the program.

DR. MARK MILLER: Yeah, but you guys are saying the same thing. He's saying that, yeah, that's correct, but you might get a different set of actors.

DR. CHERNEW: Exactly.

DR. MARK MILLER: Right.

DR. STENSLAND: And let me just be clear. There's a spread in the Pioneers, so there are some who do better under this because their historical spending was high. There are some who would do much better if you moved to the HCC model because their spending was lower than the county average adjusted for HCC.

So I don't know, maybe it's like 50-50, something on that order would be a reasonable approximation of who would do better under the HCC model.

MR. HACKBARTH: Let me see hands of people who want to get into the discussion. Why don't we just go don this way? Dave was first, and then I'll get Craig, and we'll go down.

DR. NERENZ: Actually this last minute or so discussion covered what I was thinking, the points to make, but maybe let's just make sure I'm getting it clearly. A fairly straightforward option would be to say that some sort of regional spending benchmark should be the comparison essentially for everybody, or at least the ones that are not fee-for-service. And if you do that, there's going to be some winners and losers in the ACO world compared to currently; that is, if you set the regional benchmark as the target, who will come into this because of potential gain are the people who now are out because they're very efficient and they can't figure out how to make savings relative to where they've been. So they come in.

Now, if the people -- so it kind of depends in the end, who do you want in this ACO environment? Do you want

the organizations who are currently very efficient, who may not be in very much now? And then the reason you want them in is you want to draw patients to them, have them expand their pools, have them somehow use the financial gains to build these programs and attract more people? That's one path forward.

The other path forward is very different. It says, you know, just keep doing what you're doing, but don't be an ACO; you're doing fine as you are.

The people we want in are the organizations currently who have the high-cost people, and then we want to set them against their own historical high cost and reward them for bringing it down. That's who you want in the ACO program. But the choice of benchmark is going to take you down two very different paths.

MR. HACKBARTH: And I think that's a very helpful framing of the issue. So on that first path, where you want the efficient -- within any given market, you want the efficient people in. An important part of that sort of dynamic is, well, we want to shift patients to the highest performers within a market, and if that begins to happen, it will evoke a response from the high-cost performers, and

they will want to come down; whereas, in the second model, if you -- where everybody stays where they are and there's no method of shifting patients, no competitive dynamic, you may get some results but different results.

DR. NERENZ: Of course, the point of shifting of patients is a whole other dynamic yet. We haven't established that the lower-cost, efficient providers are more attractive to patients.

MR. HACKBARTH: It is.

DR. NERENZ: Maybe they are, maybe they aren't.

MR. HACKBARTH: That is absolutely true, and right now the way the ACO model is constructed, there's no patient engagement at all. Patients don't choose. They're assigned. And so that's a very helpful framing.

DR. SAMITT: We can move to either slide, I assume, as opposed to -- I'm going to create a new discussion line, if I may. On Slide 13, I have some concerns about -- I'm trying to get my head around the quality element of this and whether there is a quality penalty to now mirror a quality bonus, which is in essence I think what you're asking here. And as I tried to think about this, I recognize that there is one key distinction

here between ACOs and MA plans, which is that the ACOs that are delivering quality, those quality bonuses in essence are being delivered directly to providers. In the MA space, these quality bonuses are primarily being driven to plans. And so my concern is: How do we assure that there's alignment around quality at the sub-plan level? We've talked about that as it relates to MA before. In essence, what you'd want to assure is that the providers within the MA plan that are delivering the higher quality get higher quality bonuses, and the providers that are not would have quality penalties.

Since it's all averaged out in the MA space, it is conceivable, for example, that an MA plan could get a quality penalty, but there are subcomponents of that delivery network that are actually delivering higher quality, and there are no assurances that they would actually be preserved or get a reward.

So that is the big distinction, as I see it, in the quality dimension between ACO and MA and would want to think a little bit more about how the bonuses truly cascade to those that you want to incent for improved performance.

MR. HACKBARTH: Let me try this. So we've got

sort of two open lines of discussion here. Let me just see if there is anybody who wants to pursue one of those two before we open up still new paths of discussion. So I have Kate and Cori and Jack.

[Inaudible comment off microphone.]

MR. HACKBARTH: No. Pursuing one of these two before we get more ideas on the table.

DR. BAICKER: Dave's conversation about where you set the benchmarks seems important to think about who's going to be in which pool, and Mike has raised the issue before that in the long run, if everybody moved out of fee-for-service and you were left with 20 percent of the population in fee-for-service and many more in these other things, then using fee-for-service as a source of benchmarks becomes more and more problematic. And the noisiness will get less bad on the ACO side, but worse on the fee-for-service side, and potentially then move the benchmarks around in ways that you don't want, and how the risk -- you know, the risk adjustment conversation that's coming next seems particularly well placed next to this one. Good, was that coincidence?

DR. MARK MILLER: [off microphone].

DR. BAICKER: That would be increasingly important over time. I'm a little less worried about it now on the fee-for-service side because we're so far away from small numbers in fee-for-service that building a strategy, sitting on the fee-for-service side as the benchmark platform seems pretty reasonable for the foreseeable future. So one doesn't want to be shortsighted, but this seems like a 10-year problem in a good state of the world, and so it seems like a reasonable place to start. But in the long run, that's going to more and more challenging, especially if the risk adjusters can't keep up.

MR. HACKBARTH: So, Jon, is it on Kate's specific point?

DR. CHRISTIANSON: Yeah, I do worry about basing any benchmark strategy on fee-for-service. I think as a Commission we've said for a long time that we don't think fee-for-service is a very good way to pay. And both the ACO strategy and the MA strategy is a fee-for-service-based strategy.

So I think the question that we face is how to move -- how to establish a benchmark that gets us out of the fee-for-service world. That's very difficult. We have kind

of tried to do it.

Mike, did you and Dave want to talk about something?

DR. CHERNEW: David commented earlier, though, ACOs would be counted as fee-for-service to solve this problem, I think in the way that it's currently structured.

DR. CHRISTIANSON: That's correct.

MR. GLASS: And that was my point, that, yeah, if you move them into ACOs, they still count as fee-for-service.

DR. CHRISTIANSON: Still fee-for-service, exactly.

MR. GLASS: So it's a little less of --

DR. CHRISTIANSON: Exactly what I was trying to say, so --

DR. CHERNEW: [off microphone] different.

DR. CHRISTIANSON: So the question is: What is -- in your last slide, wherever that is uninsured there, so to me it's not so much how to establish equal benchmarks, but it's how to establish the right benchmarks. We can -- I think it's a much easier question to say let's equalize, let's synchronize, let's equalize, but at what level? And we sort of deal with that in kind of a way with respect to

the updates every year. We say, okay, let's not just look at margins across the whole field, let's look at efficient providers. So we've gone to some trouble to identify this group of efficient providers, and then we don't feel so bad if we don't give a significant update if it doesn't penalize efficient providers. So we're sort of making a judgment here that we're going to move away strictly looking at the outcomes of a fee-for-service system and we're going to look at the outcomes for a small percentage of folks and say that's okay.

So we need to sort of think about not just -- and I think this is a very good exercise. I think it identifies everything we need to focus on. But I think we need to sort of think about the next step as a Commission, which is how do we convince ourselves that in some sense we have the right benchmarks for an efficient delivery system for Medicare beneficiaries in a fee-for-service world, and I don't think we get there by basing the benchmark on fee-for-service, no matter how we go about doing it.

The second thing, Glenn, I want to say is that my own experience in now the somewhat distant past advising states on how to set benchmarks for Medicaid managed care

plans is that your focus in the last part of the chapter on the details is everything. So the initial number that you come up with is negotiated between the states and the Medicaid plans. But after that sort of the thing that really gets the attention is what's the trend rate. You know, how are we going to do trending forward. That makes all the difference in terms of the profit margins for these plans when they get into three-year contracts. How are we going to do risk adjustment?

So this all looks like the dirty details, but it has an enormous effect on what the right payment level -- not the benchmark but the right ultimate payment level is for these plans.

MR. HACKBARTH: So assuming that the decision was to move to a single benchmark, and Dave's sort of suggesting that, you know, maybe that has some good effects, but it may have some undesirable effects in terms of provider participation, but assuming that the policy decision is a common benchmark, I can think of at least three conceptual possibilities for how to derive that number. One would be to use the fee-for-service cost. A second would be a competitive bid model of some sort. A third would be to

through some mechanism establish a fixed dollar amount and then index that by, you know, some inflator going forward. And there are huge, you know, details in any of those to work out, but I think those are the three basic conceptual possibilities. And we don't have to try to figure out which of the three is the right one, but I just --

DR. CHRISTIANSON: I think that's the right thing to put on the table, and, of course, it's different using a competitive bid model to establish the right price for MA plans as opposed to the right amount to pay for Medicare beneficiaries. So, you know, you find an efficient price. Then what do you do with the fee-for-service Medicare sector?

MR. HACKBARTH: Right.

DR. CHRISTIANSON: Well, one possibility is you project the amount of spending you think will happen going forward, and then you adjust the fees downward if they don't -- but that doesn't seem to work very well --

MR. HACKBARTH: Yeah.

DR. CHRISTIANSON: -- in practice.

MR. HACKBARTH: Let's stop short of that conversation.

DR. CHRISTIANSON: But we've done it. I mean, just to -- we sort of do it in the way that we set rate -- or make rate recommendations, because we identify this sub-group of efficient providers --

MR. HACKBARTH: Right

DR. CHRISTIANSON: -- and we sort of back-door this thing, so we don't really do --

MR. HACKBARTH: Yeah. Okay. So I have Cori and Jack; still we're talking about either the Dave thread or the Craig thread, and Peter also.

MS. UCCELLO: So this is related to the Dave thread, but really on a more basic level. There are some areas that are low fee-for-service spending areas, and in the past, you know, in order -- because there were concerns that some of these areas did not have these MA plans or others, that's why the benchmarks became higher than fee-for-service. And my question is: In these lower fee-for-service areas, are the providers there already doing the things that we think we like about the MA kinds of plans? Are they already doing the things that we want them and need so we don't care as much about these other plans coming in?

MR. HACKBARTH: There was a question there.

Anybody want to react to --

MR. GLASS: Well, I think, you know, in some places where it turns out it's low service use, so it's not just a factor of, you know, how much it costs there, but it's actually low service use, we'd say, yeah, that seems to be correct, that's an efficient place, that fee-for-service is organized efficiently, and it's not broken.

MS. UCCELLO: Right. So I just think we need to kind of keep that in mind when we're thinking about how to array these, and just -- because there are some thoughts that -- not necessarily by us but by others, who say, well, these places, our beneficiaries in these areas don't have access to these plans. And the question is: Well, do they need them to get care that we think is appropriate and well managed?

MR. HACKBARTH: Yeah. I think you've nicely framed an issue, one that's I think been fundamental to this whole debate about Medicare Advantage. I'm not going to go on. We've got other people in line.

DR. SAMITT: Can I just clarify one?

So are you asking, Cori, in the regions that have already low fee-for-service spending, why would we set an MA

benchmark that is higher than that? So what is the need for an incentive to bring MA plans to that region if you already have efficient fee-for-service providers?

MS. UCCELLO: Yes.

MR. HACKBARTH: Why would you pay people to go into a higher cost option, some might ask.

[Laughter.]

MR. HACKBARTH: Jack and then Peter.

DR. HOADLEY: Yeah. I mean, just on this last point, clearly, I mean, it seems like it has been historically an attempt to make sure there's access to these plans and availability, but of course, you also have to ask what -- really understand why these are lower spending areas. Are there access issues? Is there underservice going on? I mean, that's always got to be a question too. That wasn't where I was going to go otherwise.

I did want to pick up on Craig's thread. The thing, I was kind of intrigued by this notion of a more symmetric kind of quality adjustment, but I'm actually quite taken by Craig's comment on how do you really think about the way the quality -- the existing quality system works on the MA side. And we've talked about this at some point in

the past, the fact that the star ratings are based on kind of almost arbitrary sort of unit of analysis, because they are based on contracts, not necessarily all the plans for a given sponsor, but certainly not down below that, any kind of unit, I mean, you're almost going inside of the plan, but a plan sometimes offers multiple kinds of products under their same contract, and they're all scored the same by definition. And so there's definitely some issues there, and if we want to go into this more refining kind of sense of how we use the stars, it may be also time to look at that question. So I think that's -- I mean, that brings back an old issue, but I think that's worth thinking about.

On the other thread, I keep trying to think about -- and maybe we have the luxury that it seems unlikely that anybody is going to make legislative -- going to make dramatic changes in all this benchmark system in the short term. So it's not like we're actually legislating a change that might go into effect next year or something, because it does seem like there's a lot of open questions, both conceptually that we've been talking about but also data questions.

So the analysis is looking -- and people made

these points -- is looking at just the Pioneer ACOs. It really would help to be able to look at the broader array and not just be analyzing that mostly in that one quartile of what's going on. It would certainly be good to have more than a single year or so. What did we have? One year's experience we're looking at the ACOs? It would certainly be good to know and if we're already seeing since that they're evolving and what they're doing before. It seems like before we want to really think about changes in benchmarks, make sure we understand the dynamics more fully.

And the MA side is the same thing. We're still in the midst of a transition to a new system. Do we want to abandon that system, change it drastically, before we completely understood? So I think it's really good that we're thinking about it, and since it's not likely Congress is going to jump in and change this next month, we have the luxury to be able to think it through and then get another round of data and then continue to think it through. We'd be ready to ask the right questions as more data come in.

MR. HACKBARTH: I agree, Jack. The way I think of this conversation is we aren't trying to work towards a recommendation to change the benchmarks next year for the

bidding process, et cetera. The way I conceive of this is that we're trying to look down the road a bit and say what's the ultimate destination or at least the next destination that we want to arrive at 5 to 6 or 8 years or 10 years down the road and then use that beacon, if you will, as a way to start thinking about current policy.

So in the case of MA, we're on a track established by the Affordable Care Act, but there is enormous debate about whether that's even pointing in the right direction or not. So if we can say this is a way to think about the ultimate destination, that's a way of evaluating whether the Affordable Care Act changes of MA are in fact on the right track or the wrong track.

DR. HOADLEY: I think that's all the right way to think about it, and at times, as we have this conversation, it sometimes feels like we're trying to like get to the exact answer, and it's sort of the luxury of not having to get all the way there. We have to understand the tracks, understand the trends, and then be prepared to think about how else we do analysis to get us further.

MR. HACKBARTH: Okay. I want to get Peter in, and then I have several people on this side.

MR. BUTLER: Slide 9. So I showed self-discipline in round one and jumping onto Dave's thread. Hopefully, this is the appropriate -- I've got to grab onto some thread here.

[Laughter.]

MR. BUTLER: Slide 8, I think it is.

Okay. So my perception is that people sign up for MA plans not so much because I have a trusted agent that's going to coordinate my care for me and take care of me when I'm sick. It's more because you're getting more benefits than you are out of the fee-for-service plan, and my question, which I think relates to the benchmarking, is that if you were to -- we have 27 percent or whatever of people are picking MA plans. If you were to show the percentage of people that are in MA plans across these counties, would you show a lot higher percentage on the left-hand side? And it would decrease as you would go to the right, because on the left-hand side, the returning, those benchmark dollars in extra benefits; therefore, the left-hand side is more attractive than the right-hand side? And if that were the case, that would say a lot about un-level playing field.

MR. GLASS: Actually, I think this --

MR. BUTLER: And maybe I'm looking at it wrong, but this is a question more than -- and I think the fee-for-service benchmark does become very relevant.

DR. MARK MILLER: A couple things here. I want some eye contact, Scott.

So I think what -- and David. So what I think his question is, proportionally, do you have more people enrolled on the left than the right.

MR. GLASS: Right.

MR. BUTLER: That's if you look at the percentage very specifically --

DR. MARK MILLER: I'm just trying to get the question straight before --

MR. BUTLER: Very specifically, if you took every dot for every county and just plotted the percent enrolled in MA plans and so you created that line --

DR. MARK MILLER: I hear you.

MR. BUTLER: -- would it go down, or would it go --

DR. MARK MILLER: So what I think it would be -- and I'm getting a one-hand signal. I'm getting a U-shaped. But what I would have said is on my own -- and then we'll

get some clarification. You may need to go to the microphone -- is you get a lot more penetration in the right-hand side of MA plans because that's where they want to go, because fee-for-service is high, right? And so what you also have to keep in mind is where the plans want to place themselves, and the percentage --

DR. CHERNEW: Well, that's a different side of the same coin.

MR. HACKBARTH: I think where the plans want to go is where there's the greatest difference between the benchmark and what they perceive to be the underlying cost.

DR. REDBERG: From a patient point of view.

DR. MARK MILLER: If you look at a dollar for --

MR. BUTLER: The left-hand side, you get the floor and those states that had a minimum of X, and so it's easy, because the underlying fee-for-service business is a lot cheaper.

MR. HACKBARTH: Yeah.

MR. BUTLER: And I can return richer benefits, and then they sign up and --

MR. GLASS: Peter --

MR. HACKBARTH: Go ahead.

MR. GLASS: If you look at this, see the yellow is the MA, the green is the fee-for-service. So they are not massive differentials there. The first quartile, there's a little bit more MA than one might expect if it was equal everywhere, and then the last quartile also, and the other two, the other way around. But it's not a massive effect.

DR. MARK MILLER: Except in the fourth quartile.

MR. GLASS: No. Even there, if you compare the yellow to the green.

DR. MARK MILLER: Oh, right.

MR. GLASS: Yeah. So comparing yellow to green is what we're talking about, MA versus fee-for-service, so the percent of -- I think that's the answer.

DR. CHERNEW: I would have to look again, but I think if you looked at the academic literature, you would find support for the premise that when the benchmark goes up, you get more people. So apart from the descriptive stuff you're doing here, I do think you could at least find somewhat older literature.

I don't know, Kate, if we had to do this for the paper we did, and so now I'm just blanking.

MR. HACKBARTH: When you say when the benchmark

goes up, the benchmark goes up relative to fee-for-service. The gap between the benchmark and fee-for-service are the actual value of the benchmark.

DR. CHERNEW: Holding fee-for-service cost and the benchmark goes higher, that's the -- I think that if you were to -- another way to say that is when they lower benchmarks as they're doing in the Affordable Care Act, you would expect that, all else equal, fewer people would join the MA plans, because of exactly what Peter said. The ability to save money and give back benefits is less, but I don't remember the magnitudes.

DR. STENSLAND: I think it's important to know there's two ways to give back benefits. You're getting money to give back benefits. One is, oh, you have a high benchmark, so you have this extra money to give back benefits, and that might be a low spending area. And another high spending area like Miami, oh, you have a huge amount of -- you know, this really high benchmark, and there's a lot of weight in there in the -- or a lot of waste in the fee-for-service spending, so you can get extra benefits by cutting waste. SO you kind of -- I think that's how you end up with that picture.

DR. MARK MILLER: And I think the picture is the U-shaped. You're a little bit ahead on the fourth quartile and a little bit ahead on the first quartile, and then the middle, not so much.

MR. HACKBARTH: Okay. Peter.

So over here, I had several hands up. Now, are these related to the Dave -- Craig thread, or are we starting a new topic?

DR. CHRISTIANSON: Your comment.

MR. HACKBARTH: My comment.

[Laughter.]

MR. HACKBARTH: Youre last in line.

[Laughter.]

MR. HACKBARTH: Bill, was yours on one of these two threads?

DR. HALL: I can't remember.

[Laughter.]

MR. HACKBARTH: How about Rita? Just, Rita, on one of these two?

DR. REDBERG: I'm looking. Yes, it's definitely related, in my mind at least.

MR. HACKBARTH: Yeah. Okay.

DR. REDBERG: I don't know if it's yours.

I wanted to follow up, and it was actually related to your question on low -- are more lower cost, efficient providers more attractive to patients, and so what would be more attractive to patients is getting more benefits or getting lower copays or lower deductibles, but I don't think we're actually doing that in the ACO plans at all. And so it just seems not to make a lot of sense.

And then also on the provider side, as a specialist, I'm not -- if I participated in an ACO, I don't have any incentive to change my behavior for an ACO patient than for fee-for-service patient where I'm getting paid fee-for-service. So those things don't make sense to me in the ACOs.

MR. HACKBARTH: Okay. Bill and then Jon.

DR. HALL: Okay. So I found this discussion to be confusing, because it seems to show a lot of inconsistencies across the board and no clear-cut distinction in terms of excellence of one plan -- of one method of payment over another. Is that fair or not fair?

DR. STENSLAND: Yes.

DR. HALL: So when I was growing up, part of my

life in Michigan in the country, one of the most prevailing arguments around the community was which pickup truck do you buy, because you've got a choice of a Ford or a Chevy or a Dodge, and you couldn't buy a foreign one, or you would get your tires slashed. So there are just these three choices.

And endless discussions would go forward on why one would pick one over the other, and where I lived, if you didn't buy a Chevrolet, you were considered really odd. But a town down the road might be just the opposite.

So we've concentrated on why do people pick one plan over the other, and we're making hypotheses. I wonder if, as we go through this analyses, we could get to the point where we could say, "Well, what are the quality differences in each of these plans and the similarities that we can take when we start to craft yet maybe a fourth kind of payment system?" like Toyota or something.

And I think there's a lot to be said here. For example, we say, well, people who are sick tend to drop out of MA plans, and there was some suggestion that maybe the plans pushed them a little bit. I'm not really sure we have the data to support that.

What is it about fee-for-service if you're really

sick that people feel is superior? I think there are a number of possibilities in that. Maybe there's much less red tape. Maybe you actually find that you have a better relationship with your primary care doctor. Maybe it's easier to get specialty care.

So what are these elements that are in there? So I think we could learn a lot more from these data in terms of the next iteration of plans, and maybe comparing and making hypotheses of why some of these differences seem to exist. It might be that the characteristics that define excellence are actually perceptible to consumers, and that's what they're doing. But what do I know?

MR. HACKBARTH: So I think this is a hugely important point, Bill, so thanks.

I would think about this in two ways. One, there is the very important issue of patient preferences and what patients value, and I think that there is a lot of heterogeneity in that.

Take a real simple dimension. Some patients highly value free choice of provider on a service-by-service basis, and maybe patients that have complicated medical problems in particular value that. I'm not asserting that,

but that's a possibility.

There may be other patients who value more enhanced benefits, and financial concerns are paramount for them. SO if they can enroll in an option that gives them more complete financial protection at a lower cost, they'll tilt that way. And I think our policy needs to recognize that there is heterogeneity in patient preference.

On the other side of this, the performance side, I think there, too, there is enormous heterogeneity. We talk about these classifications, MA plans. MA plans are incredibly diverse in how they're structured, how well they perform, and so I think the fact that there is heterogeneity and preference and performance is very important in how you think about structuring policy. You want to offer choice for patients and respect that they have differences, and you offer a choice of different models of how to organize care and pay for care, and we try -- then the task it to try to set up an understandable-for-patients system where they can meaningfully exercise that choice.

I don't know if that's at all responsive.

DR. HALL: Yes. That's what I wanted to say.

MR. HACKBARTH: Jon.

DR. COOMBS: I've been waiting to jump in, only on the beneficiary side, so I just thought that maybe I could add something to what was just said.

MR. HACKBARTH: Okay.

DR. COOMBS: So when Craig said something about patients have the best position to decide what is good value, what's best value, and I just want to say something about this whole notion of what beneficiaries might decide is good value on the surface may look like, okay, this is valued. I get a gym membership. I get X, Y, and Z, but I'm not sure that all beneficiaries understand what best quality is in terms of choosing the value of the quality delivered. And that piece doesn't always go hand in hand with decision-making, and so that's a part of the shared decision-making that I think is very important, because I know that in regions, some MA plans will set up a meeting that's in a place that is not accessible for the bus in terms of enrolling, and you have three flights to go. So that automatically eliminates a whole lot of chronic illnesses without an elevator.

So there's just these arrangements with some MA plans where the attractiveness for some groups of patients

might not be on a level playing field, and I think it's really important for us to consider beneficiaries may know what's best value when it comes to those -- I won't say soft things, but those things that are not necessarily correlated with actually making a difference with the disease process, outcomes, and management.

MR. HACKBARTH: Yeah. And I absolutely agree with that, and one way to think about the whole quality bonus thing, if you have a product where the consumers of the product really can be counted on to evaluate options and make really sound decisions about quality, those markets, they don't have quality bonuses, extra payments for quality as a separate thing. Consumers do those tradeoffs for themselves.

One of the reasons in Medicare that we have specific provider bonuses coming from the payer is because we think maybe Medicare can help assess quality issues that patients find it very difficult to judge, and we want to send signals that reward high quality over poor quality.

So I have Jon, and let me just see hands of other people who want to get in here. I think we are just about out of time.

DR. MARK MILLER: No, you have 30 more minutes.

MR. HACKBARTH: Oh, we do. Oh, okay, good.

So I have Jon and then George.

DR. CHRISTIANSON: Okay. So not too long ago, I did some interviews at the UAW offices in Detroit, and the first question I asked when I came in the door is what kind of rental car I had.

[Laughter.]

DR. CHRISTIANSON: Because they were concerned about whether I'd be able to drive out of the lot at the end of the interview, to your point.

I actually agree with you, so it's good that you called me at this point.

[Laughter.]

MR. HACKBARTH: I think that the challenge for us right now is a conceptual challenge and what are our principles going forward in terms of how we want to do it. I think it's great. We've had a lot of talk about if we had done the simulations this way or that way, what column would the folks have ended up, and I think it was a good discussion, because it focused us on all the complicated issues.

And you started out by saying synchronizing policy across payment models is complicated, which I thought was a good way to start your chapter. It certainly is.

But you also said that the principle of fiscal neutrality is, quote, a refinement of our earlier definition of equal program payments, and I think that was at least as important in terms of what you said.

And I think it sort of raises the issue of what are our principles and not just -- so you've sort of -- we've sort of talked about a principle synchronization. There also has to be a set of principles that we think are right in terms of getting us toward something like the right level of payment as well, as a synchronized level of payment.

I sympathize with what you are saying, Jack, in terms of the data is going to come in and we're going to have more information and so forth, but I also have been impressed with how long it takes for some messages to get through. So I don't want to use the data thing as an excuse, if you will, not to really early start -- as a Commission, define what those principles are. Is it synchronization? Is that an important part of the

principle? Is there a principle about how we think fee-for-service should be used in terms of setting an efficient payment level for Medicare beneficiaries?

And I guess I would want to encourage us to talk about that in July, what do we want to do as a Commission in this area, but I don't think we should delay doing that. I think we need to have a message right now that says, irrespective of what the data tell us about how many people fall in which buckets and year to year who is benefitting and who isn't, how do we think this ought to really be done. And it's complicated by the ACOs, and it's going to be even more complicated, potentially, as we get more details about what Senator Wyden wants to do. But there should be a set of things that we can convey to Congress that says, basically, you need to do it this way, and if you deviate from this set of principles, then we need to talk about what the implications are.

MR. GEORGE MILLER: Following up on that and certainly what Bill Hall started with, my discussion was going to be around the theme from the beneficiary standpoint of what would drive or incentivize the patients to choose one of the three plans, and I am struck by the fact that MA

is the only one that advertises to get patients.

So if just one entity advertised and the other two don't, I'm not sure how you drive quality when only one advertises for patients, and you incentivize quality in different ways.

As we look at this, it seems to me that if we're looking at it from the beneficiary standpoint, would we ask these same questions is one of the concerns that I would have, and what is the issue, like Rita was talking about, that drives the quality? How do I drive quality based on what the beneficiary would want versus how we're designing plans? That's the issue I wanted to lay on the table, and Bill was very kind to lead us in that direction, except for I grew up in Ohio which is a lot different than those folks up North.

[Laughter.]

DR. REDBERG: Yesterday was plumbing, and today is cars.

MR. HACKBARTH: So we're starting to open up some new ground here. Let me ask, is there anybody who wants to pursue the thread that George has opened up?

Alice.

DR. COOMBS: I did want to say something, and I guess we'll get to it in risk adjustment, but the whole notion of what each one of these plans look like in terms of what the beneficiaries look like, where do they come from, what are their ratio distributions.

And the ones that we're studying, I know that they're going to have some data for us, Jack, and maybe we'll get some answers about that, but I think I cannot ignore the fact that, regionally, there is a mal-distribution of -- equal distribution of ratio distribution of some of the ACOs in our area, and that has to be improved. Something has to change about that.

MR. BUTLER: A little different topic, if that's okay, so Slide 15. This gets at, I think, some of the last questions.

I'm struggling here. You talked to some of the incentives or you could call it "gaming" in terms of dis-enrolling or enrolling in various -- and you kind of pit MA against Pioneer ACOs. I think one of the things that we ought to consider is those organizations that play in all three themselves. So you have fee-for-service, you have ACO, and then MA, so not ones that are in MA, an

organization that is MA versus one that is an ACO. I would worry about the ones that have an ACO and an MA plan and direct the healthy into the MA versus the -- and you wonder whether an organization ought to be permitted to be in both. That might be -- you know, you've got to do one or the other. It's a thought.

MR. HACKBARTH: An interesting thought. I would think that it's very, very common for people to be playing in all three of the games. In fact, I would think that's the norm, almost, especially -- not the Pioneer ACOs, of course, but the broader ACOs. Over time, everybody will be in all three games.

Mike.

DR. CHERNEW: I'm not 100 percent sure that would work out because of aspects of needing to have an insurance license and do things to be in MA versus not in ACO, but maybe -- and of course, they could play in the -- plans that are ACOs can certainly contract with MA plans, and in that sense --

MR. HACKBARTH: Yes.

DR. CHERNEW: -- be in both in that they have their own model.

MR. HACKBARTH: Right.

DR. CHERNEW: I was going to say something different.

MR. HACKBARTH: Okay. So let me just see. Anybody want to follow up on Peter's thought for a second? Scott.

MR. ARMSTRONG: Actually, skipping back one more to Jon's comments about principles, and that I'm really just been thinking about that. I think that's exactly right. In particular, just a couple of thoughts.

One, we talk about -- and we've been talking a lot about we're trying to improve the synchronization of these different programs, but even there, it's like to what end, and I think we ought to be really clear about that. I mean, it is not just so that we can explain the math and how they do or don't compare to one another, but it's really toward the goal if overseeing payment policy where there are, as you were saying -- there are all these choices, and there are always going to be these choices, but we kind of want to have a point of view on which are the better choices and why and how we can use payment policy to create incentives to move people to the more efficient, top quality, lower cost

direction.

We've been fairly explicit about we have a bias to move kind of upstream from fee-for-service through bundled payments and elsewhere.

So anyway, I just think this conversation is very provocative and really interesting, and I can't -- I don't get it all, but I look forward to continuing it, but it does really beg some, I think, principle questions that I would look forward to having a conversation about.

MR. HACKBARTH: I have Mary and Mike. New topic, Mary? Which one are you --

DR. NAYLOR: Following Jon's --

MR. HACKBARTH: Okay. Why don't you go and --

DR. NAYLOR: I couldn't agree more that I think that this -- first of all, it's been a very rich conversation. A framework for the principles, because people have talked about needing to look at this, and you -- your work said future is going to look at the beneficiary's perspective, provider plans, payers, but the principles and values that seemed to have emerged, that I think could at least be a part of a way to think about how much are we going to weight each of these, around transparency, choice,

efficiency, quality -- it seems to me quality is the common ground we were looking for yesterday, and regardless of what the plans are, we should have common understanding of at least at a high level, population perhaps, what performance is, but -- so to the extent -- but at the same time, you're looking for the kinds of incentives that promote competition and innovation and fairness and equity. Maybe not synchronization as we have been talking about it and financial neutrality.

So it seems this conversation has helped to shape what our goals are and how we might look at it from the multiple lenses with which we need to do that.

MR. HACKBARTH: Yesterday, I think, Mary, you also made this point that, you know, you look at these problems, and I confess that I tend to fall most easily into the payer perspective. How does this look from the Medicare as payer perspective? But a number of comments have here underlined how important it is also to then spin it around and look at all of these things from the patient perspective and what do the options look like. And then Peter's comment illustrates it's also important to spin it around again and look at, okay, what are the provider options, and, you know, what

should be our principles there about guiding what options they should have. And it really -- if we're going to have an enduring set of principles, we've got to look at it from each of those perspectives as we formulate.

DR. CHERNEW: I think principle-wise we should try and tie the discussion loosely to the principles that we use for all the other payment things that we talk about so it's not some broad separate thing. But there are going to be things that I think are not necessarily principles that are uncertainties about mechanisms. So there's what I would call process issues, bidding versus not.

I don't know if there's a principle that would tell you something bidding versus not. There's some analytics that might inform what you think about that. The type of things where I think we're going to really have to worry about principle -- and I want to go back to the Cori thread about why you would ever pay more in a particular area -- relates to this issue you raised about the perspective, which is the savings in these models get distributed differently in various ways. And so one thing that happens is if you're in a low fee-for-service spending area, the benefit of that essentially all accrues to the

Treasury in a variety of ways. And if you're in a high-spending area and one of these organizations comes in, if it's an MA plan and they come in and bid low, the system is basically designed so a portion goes back to the Treasury and a portion goes back to beneficiaries, and the plans are constrained in terms of savings, where if you come in as an ACO and you're efficient in that market, those savings accrue to the ACO and then somewhat to the government.

You might imagine that people in low-cost areas paying -- if we had a uniform national benchmark -- and I'm not advocating it. I want to be very clear. I am not for waste. I am not advocating --

[Laughter.]

DR. CHERNEW: I'm not advocating for uniform national benchmarks. But it would, for example, make people that live in high-cost areas have to bear the brunt of the high-cost areas and people in low-cost areas capture some of the savings. Some of that would go back to beneficiaries. So there is a complicated distributional issue which politically will be very hard to work through, and I don't imply it will. But we're going to have to deal with the same things we deal with on all the other issues in terms of

we're going to care about access, we're going to care about provider viability, we're going to care about quality, and we're going to have to address issues like how much quality are we willing to pay for. If an organization shows it's better, does that mean we just automatically pay more for it?

So those are the type of things we care about, but I think the basic principles of access, sort of provider viability, and being able to enter, those type of things, matter.

My personal view, I don't put very much weight at all on the belief that some organizational form needs to exist in an area just for the sake of having it need to exist in the area. So it doesn't bother me at all if there's an area that has no MA plans generically if the quality and cost there look fine. There is a question about getting beneficiaries to benefit in certain ways, but in any case, I don't think pursuit of some organizational structure, everyone needs to have an ACO because there's some inherent value of that, is not something I would put high on the list in my set of principles compared to the ones we use for the other things.

DR. NERENZ: I also just wanted to say a little bit about this idea of principles. I thank Jon for bringing that up.

It occurs to me that as we think about this particular domain, I can think of three distinct broad principles that might take us in different directions.

One is one that we've talked about in the past that basically says siloing and fragmentation and whatnot are bad, coordination and integration are good, higher forms of coordination and integration are good. And I think we've all seen diagrams showing sort of progression to that, with perhaps ACO in the middle, MA out at the side. That's a principle. That's a set of things that drives decisions.

Then there's the one actually Mike just expressed, that we say, well, actually what we ought to do is be for various rules and regulations that allow or even encourage all these forms to exist simultaneously with the idea then that there should be level playing fields. That's another one of our principles we talk about. And then individuals choose where they want to go, but as Mike just said, one characteristic of that is you try to allow these forms to exist or encourage them to exist in as many places as

possible. That's a different principle.

Then Cori in her comments suggested a third one I hadn't thought about before in that way, and that is that many of these organizational forms have inherent costs. They have infrastructure costs. Care coordination is an activity that has a cost. And registries have costs, things have costs. And if there are areas in which you get low-cost and high-quality care without those costs, then another principle would say you don't encourage putting those costs in if you don't need them. You only put them in where they're needed to solve some kind of problem. And I don't know that we've had much discussion of that principle, but I find some attraction to it. So I just wanted to put that one out there, that that takes us yet in a somewhat different direction.

MR. HACKBARTH: Anybody else want to get in here commenting on Dave before I -- are you going back to Mike's comment, Kate? Okay.

DR. BAICKER: So just a brief addendum to Mike's comment, which I agree with the principle that there's no particular form that we want to make sure every beneficiary necessarily has in his or her area. But your point about

how the benefits are distributed between the beneficiary and the plan highlights that MA plans that are bidding below are returning some extra benefits to beneficiaries. So the people who are enrolled in those plans are getting something that the traditional fee-for-service plan doesn't offer. So beneficiaries in an area that don't have that choice don't have access to those add-on benefits and are implicitly in some ways -- you know, pay -- the beneficiaries who live in areas with those plans are getting more out of the system than beneficiaries who don't.

So while I think there's no particular organizational form that we should be favoring -- and that's part of the principle of neutrality of payments or symmetry of payments, is because we're not trying to push one organizational form or another, we just want beneficiaries to go to where they're getting the best quality, highest value care. We have to keep in mind that limiting -- that when the options are limited, that has distributional implications for who's got access to what extra services.

MR. HACKBARTH: So the people who have been proponents of high Medicare Advantage benchmarks in areas of the country where there are low fee-for-service costs are --

you know, they're not crazy by any stretch. You know, what they're saying is that we pay equal taxes in Medicare, and everyone pays the same Medicare tax rate, et cetera. But in some parts of the country, people are getting a whole lot more health care services for it than in other parts of the country.

As Mike says, in those low-cost areas of the country, all of the savings from the low costs accrue back to the Treasury and people feel like, hey, I'm paying equal taxes and premiums, I'm not getting the same value, and so they look for a mechanism whereby beneficiaries in those places could get extra value in exchange.

And I understand all that, but then the next question is: Is this the sensible way to deal with that perceived inequity? And what are the consequences of dealing with the perceived inequity through higher payments to MA plans? And that's here I start to have my questions about whether that's really the best approach.

DR. BAICKER: Yeah, and that's the challenge of thinking strictly about equity. It's not the same to level up or level down. I don't think the solution to some beneficiaries using more services than others is to just

make sure everybody uses the most services possible, clearly, like that gets rid of inequity and it's not a good solution. So I agree with you absolutely there, and I'm just highlighting do we want to think about the distributional implications as well as the level that we end up with, and both are important.

MR. HACKBARTH: This goes back to Dave's principle. I'm not going to try to formulate the principle right now, but, you know, you want to have that equity, but you want to do it in ways that also encourage the efficient delivery of high-cost medical care.

DR. BAICKER: High quality [off microphone].

MR. HACKBARTH: What did I say [off microphone]?

[Laughter.]

DR. BAICKER: High cost.

DR. CHERNEW: But if you're going to have high-cost care, you want it to be efficient.

DR. MARK MILLER: I thought he was taking Mike's support of waste.

[Laughter.]

MR. HACKBARTH: Right, right. I do not support Mike's position on waste. I'm sorry.

Okay. Who's next?

MS. UCCELLO: I just want to add onto this. I agree with that whole discussion, but I think it's even more complicated that --

DR. BAICKER: [off microphone].

[Laughter.]

MS. UCCELLO: If you think about in these low-spending areas does that mean that then the cost sharing is actually lower for those beneficiaries than maybe in other areas? What are maybe the Medigap premiums in those areas versus other areas? So I think if we're talking about what people are spending overall, we need to think about those things as well as what extra benefits they might be getting.

DR. HOADLEY: Yeah, I was thinking in similar lines. I mean, how you think through the impact on beneficiaries gets complicated. I mean, you could solve the extra benefits problem, you know, if you convert it to cash, which plans have an option to do even though they're mostly not taking that option. But that doesn't really solve it because then you've got sort of cash inequities. And are you telling somebody that lives in a certain area that they're going to pay more? I mean, this happened, but Part

D it's definitely happening. If you live in certain states, you're paying $10 or $15 more a month for the exact same Part D benefit on average, and you may not even be able to pick among plans. You know, it's hard to find a plan that's as cheap in certain areas as it is, you know, the average in the other areas. And so in the end, you're penalized by where you live.

And so you can say that's because the average people are using too many drugs or using too many medical services or it's wasteful or it's whatever. But, you know, unless we want to encourage people to move around in order to shop -- so, I mean, I think we need to think about a lot of dimensions of how the costs -- I mean, we've had this conversation last year in talking about some of the models for how to change the competition and the bidding systems and so forth, and I know you talked about getting back to the beneficiary aspects of this. But they're complicated, and I think that is a very important area we've got to really spend a lot of time on.

MR. HACKBARTH: We're just about the end of our time. Anybody want to get in a final word before we conclude this?

[No response.]

MR. HACKBARTH: Okay. Good work, David and Jeff and Julie, obviously thought provoking.

And so now we turn to risk adjustment.

[Pause.]

DR. ZABINSKI: I'd like to thank everybody for sticking around. My wife usually views risk adjustment as a cure for insomnia, and she'd probably be out of here already.

[Laughter.]

DR. ZABINSKI: Anyway, today we'll discuss risk adjustment in the Medicare program.

Effective risk adjustment is important in Medicare for a number of reasons. First, nearly 30 percent of Medicare beneficiaries are in MA plans, and payments to these plans are risk adjusted. And these payments need to be accurate to reduce any incentives to attract favorable risks, also called selection.

Today we'll talk about risk adjustment within the parameters of the MA program, but keep in mind that all the issues within MA have implications for other sectors within the Medicare program.

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

Also, if providers are asked to take on more risk through mechanisms such as single payments for episodes of care, these payments need to be risk adjusted if they are going to accurately reflect patients' costliness.

First, we'll discuss some background on risk adjustment in Medicare Advantage. In MA, plans receive monthly capitated payments for each enrollee, and these payments are the product of a risk score and a local base rate. And CMS currently uses the CMS-HCC model to risk adjust the MA payments, and the most important feature of that model is it uses beneficiaries' conditions from the previous year to predict beneficiary costs in the current year. And under this model, risk scores and payments are higher for sicker enrollees who are expected to be more costly and lower for healthier enrollees who are expected to be less costly.

Prior to using the CMS-HCC model, CMS used risk adjustment models that weren't nearly as effective. These

models underpaid plans for beneficiaries who had health conditions and overpaid plans for beneficiaries who had no conditions and were healthy. So depending on the risk profile of their enrollees, plans could benefit or be disadvantaged. However, empirical evidence now indicates that how a plan performs financially may not reflect the purported risk profile of their enrollees.

The CMS-HCC model has been successful in addressing underpayments for beneficiaries who have conditions and overpayments for those who have no conditions. And the benefit of that appears to be a large reduction in the extent of favorable selection among beneficiaries who move from fee-for-service to MA.

Another positive result since CMS began using the CMS-HCC model is that the rate that beneficiaries disenroll from MA plans has slowed. But it's difficult to know exactly how much of that result is due to the risk adjustment or the lock-in provision in the MA program.

But despite these improvements, there are ongoing problems as the CMS-HCC model still underpredicts the cost of high-cost beneficiaries and overpredicts costs for low-cost beneficiaries.

Moreover, although the rate of disenrollment from MA plans has declined, the risk profile of disenrollees has gotten worse since CMS began using the CMS-HCC model.

The reason to be concerned about the overpredictions for low-cost beneficiaries and underpredictions for high-cost beneficiaries really boils down to equity both within MA and across the MA, ACO, and fee-for-service sectors.

MA plans that attract a high share of high-cost beneficiaries may be at a disadvantage while those with a high share of low-cost beneficiaries can benefit.

Also, if MA plans are able to attract many low-cost beneficiaries, payments for those organizations may be higher than what their enrollees would cost in fee-for-service Medicare or ACOs, and that goes against the desire for financial neutrality across those sectors.

The inadequate adjustment for high-cost and low-cost beneficiaries puts CMS in something of a conundrum. First, beneficiaries' prior-year costs are a good predictor of their current-year costs, and the CMS-HCC model already uses beneficiaries' prior-year conditions for risk adjustment, and CMS could use the prior-year costs to

improve how well the model predicts costs for both high-cost and low-cost beneficiaries. But CMS chooses not to use that information in the CMS-HCC model, perhaps because of undesirable incentives.

Plans may have less incentive to manage their enrollees' care to hold down costs, and it may penalize plans that do so. And we believe these are legitimate concerns, as do other researchers.

At the same time, plans likely have data on their enrollees' prior-year costs, and they can use it. So they have an information advantage over CMS, and there is a clear incentive for plans to use that information to avoid high-cost beneficiaries for whom they may be underpaid. I'm not saying plans respond to that incentive, but it's clearly present and undesirable.

The issues we've discussed so far are theoretical, but what really matters is how significant the problems are in practice.

Now, theoretically, plans can be disadvantaged if their enrollees have a high risk profile. But a GAO report says that MA plans are profitable on average, and the most profitable are SNPs, which purportedly have a lot of high-

risk enrollees. So financial problems from underpayments for high-cost beneficiaries do not appear to be widespread.

We also know that the costliness of MA disenrollees when they move to fee-for-service has increased over time, and these empirical results might indicate that plans are getting an advantage of a high share of low-cost beneficiaries or a low share of high-cost beneficiaries. And to the extent that's true, Medicare should reduce opportunities for plans to benefit from a favorable mix of risks.

Previous work that we reported in a June 2012 chapter was a small step in addressing that issue. In that analysis, we looked at three possible additions to the CMS-HCC model: adding beneficiaries' race and income; adding the number of conditions that each beneficiary has; and using multiple years of diagnosis data, rather than a single year of data, to define beneficiaries' conditions.

We found that adding beneficiaries' race and income would have a negligible effect among beneficiaries who have several conditions and are, therefore, generally quite sick and high cost, But we found that adding the number of conditions for each beneficiary would improve how

well risk adjustment works for those have several conditions, and also using two years of diagnosis data to define beneficiaries' conditions would also improve risk adjustment for those who have several conditions, but not by as much as adding the number of conditions would.

However, risk adjustment errors for the highest-cost and lowest-cost beneficiaries are quite large, and adding the number of conditions to the model would address only a small part of those errors.

So we reviewed the literature and identified three alternatives that have been suggested for improving risk adjustment for the highest- and lowest-cost beneficiaries, which would address the information advantage held by plans.

One of these is called a hybrid model, which combines what are called prospective and concurrent risk adjustment. And bear with me, I'll define what those two terms mean on the next slide.

A second alternative is adding beneficiaries' prior-year costs to the CMS-HCC model. As we mentioned earlier, this may have an undesirable incentives, and we'll discuss an idea for avoiding that incentive. Also, we should use prior-year costs rather than single-year costs

because that better represents the information that plans might have to identify high-cost and low-cost beneficiaries.

Finally, we examine truncating the enrollee-level costs that plans are responsible for. And for enrollees whose costs exceed some threshold, reinsurance could be used.

Something to understand is that all of these alternatives would add some degree of cost-based payment to an otherwise prospective model.

Now, first, let's talk about the details of a hybrid model.

As I said, it uses concurrent risk adjustment for some beneficiaries and prospective risk adjustment for others.

The idea of concurrent risk adjustment is that it would use beneficiaries' conditions that are diagnosed in the current year to predict their costs in the current year; whereas, a prospective model uses beneficiaries' conditions that are diagnosed last year to predict their costs this year.

The CMS-HCC model uses prospective risk adjustment because there is a concern that concurrent risk adjustment

could increase incentives for plans to upcode conditions, and it may give plans less incentive to manage care to hold down high-cost conditions.

The literature on hybrid models argues that to avoid these adverse incentives, the concurrent part of hybrid risk adjustment should be limited to beneficiaries who have conditions that are chronic, costly, and easy to verify, meaning conditions that are diagnosed through specific test results or a with few well-defined symptoms. And beneficiaries who don't have one of these conditions would be subject to prospective risk adjustment.

So, to summarize, a hybrid model would have concurrent risk adjustment for beneficiaries who have conditions that are chronic, costly, and easy to verify, and then prospective risk adjustment for all others.

The rationale for applying concurrent risk adjustment for some beneficiaries is that it provides quicker payment adjustment when beneficiaries are diagnosed with a condition making them more attractive to plans.

Now, let's turn to the idea of adding beneficiaries' prior-year costs to the CMS-HCC model.

We mentioned earlier that beneficiaries' prior-

year costs are a good predictor of their current-year costs, and they would improve the model's predictive power because they can capture patient severity, patient preferences, and providers' practice styles.

But there have been a lot of warnings against using prior-year costs as a risk adjuster, such as in a paper from the Society of Actuaries. The concern is that it can reduce plans' incentive to manage their enrollees' care to contain costs, and it can penalize plans that do so.

But a recent synthesis paper by Schone and Brown of Mathematica argues for using prior-year costs. And they say that to avoid incentive problems, they suggest using the number of non-preventable hospitalizations in each plan as a proxy.

But implementing the non-preventable hospitalizations may present some challenges because there's no real clear definition of what they are, and it's not known how well they would work as a proxy.

The final method that we identified for improving the CMS-HCC model is limiting the amount of beneficiary-level costs that plans could be responsible for. This option is frequently discussed for addressing the issue of

underpayments for high-cost beneficiaries. But it does add a cost-based feature to MA payments, which can reduce incentives to manage care and hold down costs.

Also, there's a question that would need to be addressed: At what level should the threshold be set? For this analysis, we simply look at two truncation levels: $100,000 and $250,000.

Then to evaluate how well the CMS-HCC model and the alternatives that we've covered predict beneficiaries' costs, we use what's called predictive ratios, which tell us how well costs are predicted for a group of beneficiaries.

They are defined as the ratio of total predicted costs for a group divided by total actual costs for the group. And I've always viewed them as something similar to payment-to-cost ratios.

If a group has a predictive ratio greater than 1.0, then the predicted costs are greater than their actual costs and costs are said to be overpredicted. Whereas, if a group has a predictive ratio less than 1.0, then predicted costs are less than actual costs, and costs are said to be underpredicted.

Then if a group has a predictive ratio equal to

1.0, predicted costs equal actual costs, and that's what we want.

We went on to look at how well the standard CMS-HCC model and the alternatives discussed earlier predict costs for beneficiaries who have specific conditions such as cancer and diabetes. I won't show the results here, but they're in your paper, and all of those models do quite well for conditions in general, meaning that predictive ratios are close to 1.0 in the models for most conditions.

We also examined how well these models predict costs for beneficiaries who have low costs or high costs in the previous year. And we found that the CMS-HCC model underpredicts for the high-cost beneficiaries and overpredicts for the low-cost beneficiaries. And this is consistent with other research.

Some of the alternatives that we evaluated do better in terms of predicting for those groups, but they may present some issues.

Which you can see on this diagram. In this table, we break beneficiaries into percentile categories of their actual costliness in the year before the costs are predicted. We call this prior-year costs, and that's what's

listed in the first column. Across the top of the table, we have the five models that we evaluated.

Each cell in the table tells you the predictive ratio for a particular prior-year spending category under a particular model.

The purpose is to compare the predictive ratios from the standard model, which are in the second column of numbers, and set off by themselves, to predictive ratios for the alternative models.

First, consider the column under the hybrid model, where we have three numbers in a rectangle at the bottom of that column, which are the three highest cost categories.

The predictive ratios in these three groups are lower in the hybrid model than in the standard model, and this tells us the underprediction of costs for these high-cost categories is actually worse under the hybrid model than under the standard model.

Now turn to the column under adding prior-year costs. Compared to the standard model, underprediction for the lowest-cost beneficiaries declines; underprediction for the highest-cost beneficiaries actually becomes an overprediction. But this comes at the expense of

underprediction for the three spending categories in the rectangle in the middle of that column.

Finally, turn to the last two columns, where we have the truncated costs at $250,000 and $100,000. The numbers in the rectangle at the bottom of these columns show essentially no change from the standard model, except for the small to moderate increases in the predictive ratios for the highest-cost categories in the bottom row.

So looking at the big picture of this diagram, the hybrid model appears to exacerbate prediction errors of the standard model. Adding prior-year costs eliminates underprediction for high-cost beneficiaries, reduces overprediction for low-cost beneficiaries, but creates underprediction for those in the middle of the cost distribution.

Truncating costs has small to moderate effects among the high-cost beneficiaries, but does little in the other groups and adds a cost-based feature to a prospective model.

So, in summary, the adjustments to the CMS-HCC model that we evaluated either don't improve how well costs are predicted for the highest-cost and lowest-cost

beneficiaries, or they present other issues.

Given these problems in the models we evaluated, a good question to ask is: How well should risk adjustment models predict current-year spending?

By design, we know that risk adjustment will have payment errors, and there will be underpayments for some people and overpayments for others. And given the payment errors, we need to figure out how to prevent selection problems. One method we haven't discussed is administrative action.

So another question is: How much of selection prevention should be done with risk adjustment and how much with administrative measures?

Administrative options that could be considered are penalizing plans for excessive rates of disenrollment of high-cost beneficiaries or placing catastrophic caps on plans' losses.

So, in summary, what we know is that the CMS-HCC model inaccurately predicts costs for high-cost and low-cost beneficiaries. But it does well for specific conditions. The inaccuracies at the cost levels may cause selection problems in MA and equity problems among the MA, ACO, and

fee-for-service sectors.

We went on to examine some options to address these systematic payment inaccuracies at extreme levels of spending. Some could improve payment accuracies, but other issues could result from them. Therefore, we may want to consider alternative options to address payment inaccuracies at extreme levels of spending.

And that concludes, and I turn things over to the Commission.

MR. HACKBARTH: Clarifying questions for Dan?

DR. HALL: Dan, is it possible to generalize on the attribution of cost in the high-cost categories? My assumption is that they must have hospitalizations somewhere either in the prior year or the current year to make the hit list. Is that right or not?

DR. ZABINSKI: Well, I'm not sure about hospitalizations, but I do know -- and, not surprising, there's a lot of conditions in that high-cost category. The average in what I call the base year in the paper, that's the year from which they draw conditions to do the risk adjustment, they average 6.7 conditions in that highest category; whereas, in the very lowest categories, it's 0.2

conditions. So in that sense, there's some real demarcation between the groups. But I'm not sure about the hospitalization. I'm sure there's quite a bit.

DR. HALL: [off microphone].

DR. ZABINSKI: Okay.

DR. REDBERG: Thanks for the interesting presentation, Dan. On Slide 7, in terms of prior-year costs are a good predictor of current-year costs, can you also tell us something -- or do we have information in terms of how many patients change providers? I'm interested in how much of the difference in cost is patient characteristic driven or provider characteristic driven. Would a reason that a lower-cost patient becomes higher cost because they went to a higher-cost provider in the following year? Or did they have a change in condition?

DR. ZABINSKI: I have absolutely no idea about changing providers. I'm trying to think if there's a straightforward, somewhat easy way to do that, and offhand I can't think of one. Probably could do it. My guess is it would take some work. You know, it's primarily the case of, as I say in the -- what I really know about it is that, you know, it seems to be condition driven, perhaps

hospitalization driven that he brought up as well.

DR. REDBERG: The other -- and this probably could be for answering at a later time, but I'm interested, again, in the low-cost and high-cost patients, if we have some data on how many doctors in the fee-for-service system each of them see or at ACOs, and of those doctors, how many of them are primary care doctors and how many are specialists? Because we know that a lot of patients do see multiple providers even in the same specialty.

DR. ZABINSKI: That would be probably much easier to come up with, just what I know about, you know, claims data, what's on the claims and that sort of thing, and linking up what type providers they are. That's doable.

DR. REDBERG: One more clarifying question. And, again, I think this would require getting back to us, but is it possible for us to get -- besides the number of conditions for those high-cost patients that, for example, $100K and $250K, can you tell us what we're generally spending those -- what are those costs going to? Is it paying hospitals, outpatients, imaging? All that kind of detail.

DR. ZABINSKI: This is sort of -- this is half

sort of a hypothesis more than anything, but I would guess that a lot of it is inpatient care but -- relative to others, but that's, you know, somewhat speculation.

DR. REDBERG: I would guess it is. But if it's possible to break it down into DRG groups or any kind of detail.

DR. NERENZ: Thanks, Dan. This was really good, and I just want to point out the coffee refill I got was not because I really needed it.

[Laughter.]

DR. ZABINSKI: Everybody's still awake.

DR. NERENZ: No, no. This is good.

Also, on the slide we're on, just clarifying how we should interpret the last couple of bullets. You point out here plans have information about their own enrollees, but they don't have information about those who might come to them new. So what does the word "avoid" mean here? What can plans actually do if what they know about are their own current enrollees?

DR. ZABINSKI: Well, some could say that, you know, just the general structure of the plan itself, you know, somebody gets very sick, does the plan have the

structure to, you know, effectively provide the care that's needed and that sort of thing, I would guess. And, you know, it might just be the idea that people who get very sick might find the less restrictive nature of fee-for-service more preferable than a more structured network type system that a plan would offer.

It's not necessarily the plan activity. It's just, you know, the -- or it could be patient driven as well.

DR. NERENZ: Okay, fine. Thank you. I just wanted to know how active this word "avoid" was meant to be taken.

DR. HOADLEY: On Slide 8 you talk about the -- you referenced the literature on fee-for-service costs of disenrollees increasing over time. Has that literature focused on disenrollment specifically to fee-for-service? Or is it also looking at people who switch to other MA plans?

DR. ZABINSKI: What I'm talking about there, it's going to fee-for-service. Primarily I'm thinking the Newhouse, et al., article, I think it was late in 2012. You know, it had sort of two parts where it looked at the

effect, a selection measure for people moving from fee-for-service to MA, then also from MA to fee-for-service, but it didn't really have anything within plans.

DR. HOADLEY: Okay. And my other questions, the call letter for 2015 I think had some risk adjustment stuff in it, but I'm guessing it's more down in the weeds relative to the kinds of issues we're talking about here, do you know?

DR. ZABINSKI: Yeah, that's true. Yeah.

DR. HOADLEY: Okay.

DR. NAYLOR: Great report. Slide 16. So on the one that looks like it may have some benefits for some groups, adding prior-year costs, the literature you referred to suggested using non-preventable hospitalizations as a proxy. How available are data?

DR. ZABINSKI: That's exactly -- you know, I tried to sort of hint at that. You know, I did some digging in that, and it's sort of like -- I view it as a potentially good idea, but we don't know a lot about it. The real firm information, as far as I could gather, isn't really there.

DR. NAYLOR: So really what we have right now is the actual total costs, not --

DR. ZABINSKI: Yeah, literally put in the person's prior-year costs within the model and see how, you know, things shook out from there.

DR. NAYLOR: And a second one. A prior recommendation around total number of conditions, where is that? I mean, has that been embraced and is that part of HCCs?

DR. ZABINSKI: No, it is not. Mark, is there some discussion on the Hill about it at all?

DR. MARK MILLER: We have talked to CMS, we have talked to the Hill about it. You know, everybody understands it. I can't really give you a good explanation as to why or whether CMS is going to contemplate putting it in their model. They can do it without legislation.

DR. NAYLOR: Okay. Thank you

MR. BUTLER: So I'm not sure I understand the slide, but let me try, because it seems a little counterintuitive to what -- when we look at data in our own organization. Chronic illness by itself is not nearly as expensive as when it explodes into an acute episode. I think this is a little bit of Rita's point. And so you might have hypertension, you might be institutionalized, you

might be 90 years old, but it's only when you have the stroke or something that you really kind of shoot the lights out in terms of expenses.

Is that what you're trying to adjust for in the last two columns, and you're saying that's not a good predictor, or --

DR. ZABINSKI: I think that's one -- yeah. Basically, you know, it's just to -- you know, it's a more -- yeah. I'm sort of yammering here. I'm trying not to.

I would say yes, a single-word answer. Okay?

[Laughter.]

DR. MARK MILLER: The way I would think about this, this is almost -- I mean, this is like saying after a certain dollar spent, you're indemnified. It's just that the plan's not at risk. And I think what -- and, Dan, just make sure this is all correct. What those last two columns are telling you is it really doesn't have much effect until you get way up into that last category. You get a shift from 0.71 on the left-hand side to 0.81. You get a little bit better prediction there because you've truncated the cost at some point.

MR. HACKBARTH: So let me ask this: On the final

slide -- and keep this one up, but on the final slide, you say -- and there's a question of how much should we try to accomplish through risk adjustment versus administrative options. And one of the administrative options is a catastrophic cap on plan losses. How is that different from truncating --

DR. ZABINSKI: The idea on the last slide was like sort of a general, you know, plan-wide truncation. This is a beneficiary specific.

MR. HACKBARTH: Okay. That's what I thought.

DR. ZABINSKI: It's a pretty fine line, but they're a little bit different.

MR. HACKBARTH: So just to make sure that I understand, under the administrative option described on the last page, you would look at total plan costs, and when the loss exceeds some threshold, the government would pick up some of it as opposed to this patient's specific limitation.

DR. ZABINSKI: Correct, you know, something like risk corridor idea.

DR. CHERNEW: I have the same sort -- so I understand that if you truncate, you can predict better in the higher cost because the data is -- you've thrown out

these outliers, so it just makes the prediction work better in the tails. But that money still got spent somewhere, so this doesn't tie to a particular policy. This is -- if I understand correctly, this is just a statistical exercise that shows if you throw some of the particularly noisy observations, you can predict the particularly problematic cells better. But it's not tied at all to your question about then those -- that money was actually really spent and someone has to pay for it. That doesn't tie to whether that's the plan or an administrative option or anything like that, if I understand the exchange you just had.

MR. HACKBARTH: I assume that the implication of this is that the government would pick up the amount above $250,000 per patient.

DR. ZABINSKI: Correct.

MR. HACKBARTH: And so it would -- and so they would -- somehow the plan would not be held responsible.

DR. CHERNEW: Let me ask a clarifying question then. The differences between, say, the standard model and the truncated model, you could run the exact same model, keeping the dependent variable exactly the way it is, no truncation or anything, and then you could put the

administrative overlay on it and ask what happens, or you could go into the actual statistical model you ran, truncate the spending in an individual level way, and then rerun the statistics.

I thought you did the latter, that you were actually changing the data in the statistical model you ran as opposed to simulating a reinsurance model overlaid on top of the original standard model.

DR. ZABINSKI: Well, you're right, Mike. Okay. Each person, if somebody exceeded a threshold, their left-hand side variable stop -- you know, like if somebody exceeded $100,000, it was just 100K, and then you get new coefficients. But then people who exceed the threshold, then the government steps in and pays the plan. If it was $105,000 per person, the government would step in and pay the plan, $5,000 for that person.

DR. CHERNEW: But they could do that using either the model you estimated on the far right or the model you estimated on the far left. The difference between the far left and the far right is that the coefficient is a little different because the way you did the statistics. But you could have the reinsurance scheme you just described using

either of the models.

DR. ZABINSKI: Correct. Yes.

DR. BAICKER: There's a difference in saying how -- the difference you're trying to draw is in one version, you're trying to predict something that's easier to predict, because you've made in less noisy. In the other one, you're saying the things that we mis-predict, we will cover you for, but we're still scoring our prediction model based on trying to predict the full spectrum versus saying we're cutting off the really high stuff and then trying to predict.

DR. CHERNEW: What I would have said is saying that the model on the right is better statistically doesn't really make sense, because you're not just changing the model. You're also changing this other policy variable, and so it is better not just because of the model. You're adding on this other thing.

If you want to say how bad is the plan, you could do the model on the left, and it might predict a lot better, too, if you had the reinsurance component.

DR. MARK MILLER: I think the point is, at least in the statistical concept, statistical -- doesn't make much

difference.

DR. CHERNEW: That, we agree on.

MR. GRADISON: May I pick up on that one?

MR. HACKBARTH: You are welcome to pick that up any time you want.

MR. GRADISON: To the extent that even with the best of efforts, risk adjustment is going to have its limitation, some form of reinsurance or outlier payment is certainly going to be necessary as a correction, at least that's the way I think about it.

I wish you could do a little more work with perhaps the addition to the possibility that there be some degree of risk retention. The 100 or the 250 is kind of -- it's fine, but it assumes 100 percent above the cap, and I don't know if there's any literature available that might shed some light on this, but there might be, because it doesn't have to be 100 percent, and it might be useful to consider at a later stage in our discussion.

The other thing I wanted to ask you about is sort of an operational question, but maybe it's a little bit more to this. My understanding is that the predictive value of knowing expenditures for the year 2010 -- pardon me -- for

the year 2011 was improved by knowing about the actual expenditures in the year before.

DR. ZABINSKI: Correct.

MR. GRADISON: That's a point.

Operationally, knowing that and let's say you want to do something about it, what would you do? That is to say, how long does it take to get that data? Would it mean in effect that the additional adjustment, plus or minus, would be made at the end of 2011, or into 2012? You don't know January 1st, 2011, the actual expenditures in 2010, so just tell me how you operationalize that idea, if you wanted to.

DR. ZABINSKI: Okay. I'm not trying to get off track, but CMS already faces somewhat of a problem with that with the conditions.

MR. GRADISON: Yes.

DR. ZABINSKI: They don't know at the -- at the start of 2011, they don't know all the conditions that existed in 2010 till sometime -- but it's a few months. I'm not sure how long it is exactly.

I think probably the cost data, it would probably take about the same amount of time, but it's not like till

the end of 2011. It's a little while in.

MR. GRADISON: Thank you.

MR. HACKBARTH: So, Dan, the statistics are beyond me. I might have at best a little understanding of that part of it.

What I'm trying to figure out is what the policy implications are here, and here's the story that I'm hearing, and tell me if I've got it right or where I've missed.

You describe a history of significant improvement over time in the risk adjustment system used. In our previous report, we identified a couple -- seemingly to me, some pretty easy additional fixes, like the multiple conditions, et cetera, which would improve things still further.

We've also had a change in the administrative framework, including annual open enrollment, which has also contributed to reducing the selection problem.

You went through -- summarized here some different ways to modify the model, and none of them look like they're clear, dramatic improvements in what we've got.

And then on the final page, you say that there are

some other administrative options here. The message, I think I'm hearing is this problem is diminishing over time, and we ought to be careful to the ill effects of trying to get further improvements. They don't come free, so to speak, and so we may want to do some easier things to do. Like our old recommendations of a year or two ago, it may be these administrative things.

Am I hearing the story --

DR. ZABINSKI: I couldn't have said it better myself. I mean, that's pretty spot on.

I think one other thing to add to that is the GAO report about the profitability of the plans and who is most profitable, are the SNFs supposed to be the ones that have the high-cost people who are supposed to be underpaid for, and that's one more thing to add to that and consider throughout all this. Things in terms of what's actually going on don't look too bad.

MR. HACKBARTH: Okay.

DR. MARK MILLER: And I thought you did that really well, and I think some of the question for us is do we want as a Commission and staff -- should we be spending lots more time trying to grind through models and figuring

stuff out, or maybe the conversation should open up and talk about what about around, if you will, in the administrative structure, the MA plans might be more constructive.

So for example, in addition to the stuff that's set up here, some people have been talking about opening up longer periods for enrollment as opposed to what's happening now where you have sort of the annual enrollment period. That could have implications we've seen in those types of questions.

DR. CHERNEW: I have a round two.

MR. HACKBARTH: Yeah. We are now into round two. So I have Mike. Let me see other hands for round two. We'll go this way this time. Jack, Cori, Alice, and then over here.

DR. CHERNEW: This is sort of a borderline question, round one, two, but my question is the predictive ratios I am most interested are not predictive ratios that you have reported, which would be the plans have some mix of the lowest decile and the highest decile people, and the extent to which the under-over prediction matters, as you write in the chapter, depends on the extent to which some plans systematically get people in the upper decile or lower

decile groups.

And do you -- and in fact, really, that makes sense, which they can even manipulate that. But do you have the ability to do predictive ratios with existing plan composition as opposed to subgroups of people in different deciles of spending? The real question about how bad this is, is if you looked at a plan's predictive ratio as opposed to a beneficiary subgroup's predicted ratio.

DR. ZABINSKI: Let's see. The only thing that gives me pause to say yes is just knowing -- you need to know what individual-level costs are, and that's not yet available. Scott is shaking no, not coming anytime soon.

I could make some effort at a simulation, find people in fee-for-service that sort of match up to what a plan has, that sort of thing. Something like that might be possible.

DR. HOADLEY: Yeah. I come down very much where you were going, Glenn, in the sense that it feels like this is an area where it's not particularly broken.

Some of the things we're talking about here as potential solutions are things that were addressed, for example, in Part D at the beginning to say, okay, yeah,

let's do a bunch of reinsurance and risk corridors and things to make sure we get plans in the market. We've got plans in this market. Unless we have clear evidence that plans are struggling to sort of live within the risk adjustment -- but obviously, it would be nice to have it work as well as possible. But it strikes me that a number of the solutions we've got here sort of go beyond the scope of the problem.

On the administrative measure side, the one, I guess, that kind of intrigues me is this notion of what's going on with the disenrollees, and whether that's something where we ought to do some more analysis, update -- I know you did some analysis at some point in the past. I don't know how many years ago that was and what year's date was that. Do you know what year's data that was based on?

DR. ZABINSKI: Right, right. I think it was '07, '08.

DR. HOADLEY: So if there's an ability to look at much more current data and see -- obviously, we look at Newhouse's work and so forth, but -- and possibly be looking at both then disenrollees to fee-for-service, which is maybe the only thing we can look at, but to the extent that we can

look at least a little bit at the kinds of people who disenrolled to other plans, so if some plans are shedding people to other plans, but getting a better sense of is that a sign of a problem, and therefore, is that kind of an administrative measure, I think that's a helpful analysis. And it's just useful to kind of get a sense, anyway, of what the patterns of exist and entry -- and this would be the exit side -- are in general. So, I mean, I think that's useful information, even if it doesn't lead us to a particular change in how we handle this issue.

MS. UCCELLO: So, yeah, I would agree with both Jack and what you were saying, and I think it might be helpful just to kind of step back and think about -- you know, there were kind of two reasons why we care about risk adjustment. One is we want to pay plans according to the risk that they're bearing, and if we don't, that means they're either going to suffer losses or windfall gains. And the way to look at that is kind of what Mike -- the analysis that Mike suggested that we may or may not be able to do kind of on an aggregate plan level.

The other reason we care is because we don't want plans to systematically avoid or target people that are --

they know they will either gain from and avoid the people that they would lose from. So in terms of selection, we care, but we care about that really only to the extent that these factors are known ahead of time.

So looking at something on a concurrent level, on a concurrent basis, well you can't select on that, so it doesn't make any sense from that -- if you're trying to worry about selection issues, that doesn't make sense.

And just looking overall, it's not clear at this slide that any of these models are necessarily any better than what we have, especially considering the potential bad effects that we would be worried about.

In terms of the administrative options, I, too, am curious about these disenrollment penalties.

In terms of these catastrophic caps, these are, as you said, essentially risk corridors, and I think this might be the third meeting in a row that I've talked about risk corridors and how you really only need risk corridors when there is a lot of uncertainty, when the plans have a lot of uncertainty and who they are going to enroll and what those costs are going to be for those people. MA plans have been around a long time now. There shouldn't be a real high

level of this uncertainty when they are pricing their products, so I don't think that that's necessarily somewhere we want to go. But this disenrollment, this seems to make more sense to pursue.

DR. COOMBS: So I have two questions, Dan. Is CMS actually looking at other risk-adjustor instruments, other than HCC?

DR. ZABINSKI: Not that I'm aware of. I think this is what they're -- they did a lot of work initially before implementing this, and I think they feel good about it. So I'm not aware of them going in any other direction.

DR. COOMBS: Okay. And then the other question or concern I had about the penalties on disenrollees is the acquired information that's gathered from the plans in terms of what information is accrued as a result and how a plan might be able to better select who is more likely to disenroll. It may influence decision-making on the front side of a plan, beneficiary entry into the plans.

DR. SAMITT: So I have two questions. I'm not so sure I'd be ready to kind of give up on improving the risk adjustment methodology, and I guess my question is, if we look beyond CMS to again the private sector, is there any

progress being made in predictive modeling? That perhaps there are other factors here that would correlate more effectively to predictive futures, and would it be worth understanding if anyone has come up with a better mousetrap in that regard and modeling based upon additional variables that we have yet to identify?

DR. ZABINSKI: There's other models. In the private sector and in the Medicaid, there's other models that are used, and personally, I haven't looked at them in terms of how well they would do in Medicare relative to the CMS-HCC.

They do have -- there is some degree of similarity among those other models relative to the CMS-HCC. They don't typically use conditions from the previous year, although the big difference is how they are organized oftentimes. It might be worthwhile looking at how they perform, because I'm not aware of anything that's been done really recently on it, so --

MR. HACKBARTH: So they are available. They're not proprietary?

DR. ZABINSKI: No, I don't think so.

DR. CHERNEW: There is a proprietary, more

detailed version of this model. There's other versions by the same company of this that are used in a whole bunch of ways, and there's a bunch of other models as well. I'm not sure they're better. This one is I think the one done by -- originally, it was Verisk, so there's a lot of work going on in the private sector. I don't think any stunningly better.

DR. SAMITT: I guess I'd be most interested, especially in the upper -- the more complex patients, what additional variables in that echelon are missing, aside from just measuring prior year cost, that can really account for that, you know, is there a higher penetration of dual eligibles that fall into that category or other variables that would potentially create this discrepancy, but you guys would certainly know better.

My second question, I want to tag on to Jack's comments about sort of understanding the themes in disenrollment. I'd be very curious to hear about that as well, and I wonder whether there's capacity to do so, not just objectively but subjectively. Do we do disenrollment surveys of beneficiaries who either change plans or shift from MA plans back to fee-for-service? I'd be curious to hear what the beneficiaries say and whether that provides

useful information about where they are coming from, where they are going do, and what some of the drivers are.

DR. MARK MILLER: Carlos, do you want to -- you can get Joan to do it, if you'd like.

[Laughter.]

MR. ZARABOZO: Now that I understand your question, I think Joan should answer it, so, Joan?

[Laughter.]

MR. ZARABOZO: There is -- disenrollment rates is part of the star rating system, so they do track the disenrollments, and there are also reasons they are coded for why are you disenrolling.

Now, the rates that they report in the stars include not just going to fee-for-service but also going to another plan.

This year, they will be doing disenrollment surveys to get more information about why people are disenrolling, and we have asked to get the currently available information, which is the coding on why these people disenrolled, and so presumably, when they do, there's a disenrollment survey. We'll also get more information from CMS about what the major reasons are for people

disenrolling.

DR. SAMITT: Great. Thank you.

DR. MARK MILLER: And I feel like a thread that is forming up here based on some comments here and here is that maybe a step for us is to both quantitatively, you know, look at the disenrollment data, and then also go through some of the CAHPS stuff and whatever else we can find and see what we're hearing on this issue.

DR. REDBERG: I wanted to agree with you, Glenn, that the way I read the chapters and your presentation is that we seem to be doing pretty well on risk adjustment, and I'm not sure how much time it's worth to kind of change it around the margins, because there's never a perfect risk adjustment models. And I do think it's worth looking a little more at disenrollment figures and learning what we can from that.

But I did want to state my serious concerns about the suggestion that the plans cap at 100K or 250K and not have responsibility past that, because I feel like that's not consistent with our principles that we've been talking about just as recently as yesterday about paying appropriately for care that helps our beneficiaries. And

that's why I was asking those questions, that I think we need to understand a little more about what we are paying for on those high-cost enrollees, because we do know that a large portion of Medicare costs are in the last 6 months of life, and we also know that a lot of those costs are not consistent with patients' own preferences, and that most patients that say they do not want aggressive care at the end of life and would prefer to die at home for reasons that do not involve informed consent and shared decision-making die very expensive deaths in the hospital. And I just think we need to know more about those high-cost beneficiaries before we just say to plans, "We'll cover you for all this care," and then we could evaluate those options.

MR. HACKBARTH: Others?

DR. BAICKER: So I really liked Cori's framework of thinking about why we care about risk adjustment and why we might want to have reinsurance or not, and I find the reinsurance a little baffling. If it were just that you want to provide -- make sure there is no disincentive for enrolling sick people, then it's about how predictable those expenses are.

I have to think that on a plan pool basis, there

is very little reinsurable risk. Yes, there's some very expensive people, but these plans cover enough people that they should be able to weather that risk, except if they are cherrypicking to avoid it, in which case that needs to be built in. So I am even less concerned in some ways about when we're over-predicting on the low and not so well predicting on the high end. That seems okay as long as they're doing the same.

I also think it's really more promising to drill down into the disenrollment, because that seems like the margin in which selection is still taking place the most strongly. The HCC model seems to have done a good job on the enrollment selection. There's always room for improvement, but I, too, am hesitant about building in things that are more endogenous, because I think you're then -- the solution may be worse than the cure.

But the solution may be worse than the problem. Cures are good; problems are bad. Fraud, totally bad. Waste, the jury is still out.

MR. HACKBARTH: [Off microphone.]

[Laughter.]

DR. BAICKER: So the -- you're never going to live

that down.

The disenrollment margin, on the other hand, it seems like there is still evidence that there may be substantial activity in selection on disenrollment, and that's not only bad for overpaying potentially. It's also bad from the point of view of care for beneficiaries, that that may be a place where people are having transitions at just the time where transitions are not good for their health and where it's bad for coordination, and so this seems like the place where I would devote more energy to understanding what's going on and to seeing if the solutions are better than the problems.

MR. GRADISON: I'd just like to say how pleased I am to hear the discussion about trying to examine the data that is available with regard to disenrollment. I'd like to cast that in a broader context. I hope over time, we are also able to learn more about what leads people who have the fee-for-service option to decide to go into the plans, not just to leave them, and also how that may vary from the new cohort of folks that are becoming eligible for Medicare for the first time as against those who have been subject -- covered by the fee-for-service system for some time in the

past.

With regard to the -- I guess I brought up particularly the matter of reinsurance and outliers. It wasn't with the thought that necessarily anything ought to be done there, but that it ought to be examined. And that's why I use the word "retention," the question being to what degree should some portion of that risk for the very expensive cases remain with the plans, how to balance that. Maybe zero. I understand your point, but I'm not sure.

That question also could have a differential impact, arguably, on whether new plans want to come into a market, because if you're small -- if you're new and potentially small, the averaging may not work very well for you and might in itself be an impediment to even entering a market. I'm not trying to argue the case one way or the other, but to frankly encourage the staff to give some thought to that issue.

MR. HACKBARTH: So on that question of entry, what do we know about new entrants into the market, not the same organization offering new places, but completely new entry into the Medicare Advantage program? Do we have any information?

MR. ZARABOZO: Beneficiaries or plans?

MR. HACKBARTH: Plans.

DR. MARK MILLER: I'll tell you what, Carlos, don't go to the microphone.

Actually, we have some information that came in like the day before the meeting, and there were some e-mail exchanges among us, and we're not quite gelled on this, okay? And so what I'd like to do is answer your question but not do a smash-and-grab right here.

MR. HACKBARTH: Okay.

DR. MARK MILLER: Okay.

DR. HALL: I think Craig mentioned is there still room for another widget in risk adjustment, and something that I've been thinking about for other reasons was that there's been a lot of clinical literature this past year on, if you will, kind of the epidemiology of 30-day readmissions after initial hospitalization. This is because under the ACA, hospitals started being penalized for readmissions above a certain rate, and even more so in 2014. So there's a lot of data on 30-day readmission.

What's interested me in that is if you look at Medicare recipients who get re-hospitalized within 30 days,

in three major categories at the present time, which would be heart attack, heart failure, or pneumonia, about 20 percent of them are actually readmitted. And I think that forms one of the groups of very, very high-risk people.

But the interesting thing is that in the vast majority of instances, they are admitted with ICD-9 diagnoses that are totally different than the initial admission. So that while the intent of looking at 30-day readmissions was to identify bad care and insufficient care, what I think it's identifying is a category of Medicare recipients who really have just basically very bad protoplasm, and the ancillary literature to this has demonstrated that the various things that we've tried in terms of post-acute care, different models of care in the hospital, it doesn't seem to make a great deal of difference.

So I would wonder if we're doing this either prospectively or concurrently, if we could just take a very quick look at 30-day readmissions as another indicator. It's very available now. Virtually, every hospital in the country has to look at this carefully, but I think we're identifying a new kind of phase of aging that I think we

kind of missed in the past. So I'd like to throw that out as a suggestion.

MR. HACKBARTH: Okay. Any additional comments or questions? Jack?

DR. HOADLEY: I am going to make a quick follow-up on Bill Gradison's point and Mark's response.

I'm not sure quite what you were looking at, but one of the questions that I would have in my hypothesis is that the new enrolls in a new plan -- enrollees in a new plan tend to be healthier on average, and I don't know if that's what you were thinking you can bring in, but that's the kind of question I have about new entries.

MR. HACKBARTH: And I detect in Bill's comments, a question about whether now the beneficiaries newly aging into Medicare might be different on various dimensions, including potentially that one. So to the extent that newly eligible beneficiaries have become used to various types of managed care during their working lives, they may both enroll in larger numbers and with a different risk profile than beneficiaries who were accustomed to fee-for-service.

MR. GRADISON: The issue that leads me to wonder about this is I had expected the proportion of Medicare

beneficiaries covered by MA plans to go down. I don't think I was alone in that anticipation, but at any way, it's been going up. And I'm wondering why is it going up and who are these folks and why are they doing it.

If it is as -- and my hypothesis is, just as you're suggesting, it's folks for whom the MA plans are closer to their experience during their younger years, and I know the staff is giving some thought to trying to understand that. I very much appreciate the conversations I've had with them about that.

The implications of that to me are quite enormous, because if there's anything to that, then to me, it opens up a whole series of questions about whether we offer enough options for people under Medicare to match their previous experience, or to say it another way -- I don't want to use the term "premium support," but whether if somebody chooses to stay, let's say, with their employer's concurrence in their retirement years, could a sum of money follow that, which would be reasonably related to the risk profile but not out of line with the normal fee-for-service payment. I mean, if that door opens with regard to the data, then I think it opens to some, I think, very important questions,

which is one of the reasons I was talking yesterday about the question of the COD [phonetic].

DR. MARK MILLER: I'm talking away from the immediate conversation for work -- and this is not to dismiss other comments but just the priorities. I think we are going to do a fairly deep dive on disenrollment. We are going to come back to you on a new entrant's type of question from two dimensions.

We do have some new information on new organizations not quite gelled, and we'll grind through that and make sure that it's wired. And then we have already launched on an analysis of the person who are coming in, are they headed more to managed care plans, and what do they look like, and so that thread is running as well.

There are some other things that were said here. I'm not dismissing them. I have taken notes on all of those, but I would definitely expect to see those three things to show up in front of you again at some point in the future.

MR. HACKBARTH: I think we're at the end of this one, unless anybody wants to make one last final comment.

[No response.]

MR. HACKBARTH: Seeing none, thank you, Dan. It was enjoyable. We're all awake, even stimulated.

Okay. We will now have our public comment period.

[No response.]

MR. HACKBARTH: Seeing none, thank you all, and see you in April.

[Whereupon, at 11:29 a.m., the Commission meeting was concluded.]