MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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9:36 a.m.

COMMISSIONERS PRESENT:
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PETER W. BUTLER, MHSA
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AGENDA PAGE

P R O C E E D I N G S [9:36 a.m.]

MR. HACKBARTH: Okay. It is time for us to get started. We have two items this morning, the first of which is to begin our work on a mandated report -- that is, a report requested by the Congress on the impact of the home health payment rebasing on beneficiary access to care and quality of care. And then the second item is another discussion, a follow-up on the topic of -- actually, I'm sorry. This one is on team-based primary care, not on payment to primary care. Sorry for that confusion.

Evan, home health. Take it away.

MR. CHRISTMAN: Good morning.

As Glenn mentioned, we begin with home health, and the PPACA included a requirement for the Commission to assess how payment reductions in the act, referred to as "rebasing," will affect agency supply, access to care, and quality for home health care. The mandate requires that we consider the impact for for-profit, nonprofit, urban, and rural agencies.

This presentation begins our review for this report. First, I will review the justification for and implementation of the PPACA rebasing policy, and then we

will look at the experience of past payment changes to inform our analysis of how the PPACA changes will affect the benefit.

Before we begin, I just want to remind you of some of the issues with the home health benefit. Home health is an important part of the continuum for serving frail, community-dwelling Medicare beneficiaries. Properly targeted, it can be a tool for keeping beneficiaries out of the hospital or other more costly sites of care. However, eligibility for the benefit is broadly defined and does not encourage efficient use.

The benefit also has an unfortunate history of fraud and abuse, and there are many areas with aberrant patterns of utilization. In addition, providers in this sector also have a history of tailoring services to reflect the financial incentives under Medicare payment.

As another reminder, here is a brief review of utilization for 2012. Medicare spent about $18 billion on home health services. There were over 12,000 agencies. The program provided about 6.7 million episodes to 3.4 million beneficiaries.

The rebasing policy included in the PPACA

originated from a 2010 recommendation from MedPAC. The Commission recommended rebasing for a number of reasons.

First, the margins for home health agencies have been excessive since the PPS was established in 2001, averaging greater then 17 percent. Even these margins could be too low, as a recent audit by CMS found that costs were overstated in 2011. If this overstatement were corrected for, margins in 2011 would have been over 20 percent.

Second, in this period there has been a rapid growth in episode volume and supply, and it is not clear that much of this growth contributed to access.

Third, Medicare has attempted to address the high margins with reductions to the market basket or other incremental cuts, but despite these reductions margins have remained high.

For these reasons, the Commission concluded that the program needed to rebase the home health rates using current information on episode costs and not relying on incremental payment changes or other out-of-date assumptions that do not reflect agencies' current costs.

One of the reasons Medicare margins have remained so high is that past cuts to home health payments have been

offset by increases in the case-mix reported by home health agencies. In 11 of the last 12 years, Medicare has implemented some form of reduction to the payment update, and in three of those years the reduction has been large enough to lower the base rate.

However, in most years the reported case-mix has increased. Since the episode payment is computed by multiplying the base rate by the case-mix value, these higher reported case-mix values increase Medicare payment. In years when the base rate has been reduced, an increase in reported case-mix has helped to offset these cuts. In years when the base rate has increased, the rise in reported case-mix has compounded growth in average payment per episode.

Normally we would expect that growth in reported case-mix reflects growth in patient severity and higher costs per episode. However, CMS' analysis of the change in reported case-mix for home health did not find that patient severity has increased significantly under PPS. They concluded that over 90 percent of the rise in case-mix was attributable to changes in agency coding practices, not patient severity.

This next slide shows how average payment per

episode, the top line, and the home health base rate, the bottom line, have changed cumulatively since 2001. I am going to focus on the bottom line, the base rate, first. You can see that the base rate has moved around but has not changed significantly. This is because of the numerous cuts to the market basket, administrative reductions, and other policies intended to reduce home health margins. Though the base rate has not changed significantly across this period, average margins remained very high throughout it, ranging from 14 to 23 percent.

The top line, which shows the cumulative change in average payment per episode, explains some of why margins have not declined. While the base rate has not changed significantly, the average payment per episode, driven primarily by the rise in reported case-mix, has increased in most years. And in years where average payment per episode has declined, it has often declined by less than the decline in the base rate, again reflecting growth in reported case-mix.

The higher reported case-mix has blunted and in some years completely offset the impact of the base rate cuts and helped to keep agency margins well above adequate.

These trends also underscore that reductions in the base rate do not always result in reductions in the base rate do not always result in reductions in average payment per episode.

Turning to the mandate, the PPACA included a policy intended to rebase payments, but followed a different approach than the one the Commission recommended.

First, the PPACA phases the reduction in over four years. Our policy said no more than two. In addition, the PPACA set a limit on the reduction that allows it to equal no more then $81 a year, and CMS set it at this maximum amount. Our policy did not set a limit and would have permitted steeper reductions.

The PPACA includes a payment update that averages about $70 a year that offsets about 86 percent of the cut. Our recommendation did not include the payment update, as increasing payments is contrary to the goal of rebasing.

The net effect is that the episode base rate in 2017, the last year of rebasing, will be 1.6 percent less than 2013. If the sequester were in effect, payments in 2017 would be 3.6 percent lower.

Our mandate requires the Commission to consider

the impact of PPACA reductions on agency supply, access to care, and quality. The report is due in January of 2015, before data that will allow us to assess the payment changes will become available. Consequently, for this report we plan to examine how payment changes in 2001 through 2012 affected these parameters.

In short, the question we are asking is: How are past changes in average episode payment related to the changes in supply, access, and quality that we have observed in this period?

This chart shows how the average episode payment has changed. The periods colored in red indicate years that the episode payment declined. The blue years indicate periods that experienced increases. Average episode payments decreased in 2003, 2011, and 2012 and increased in all other years. Urban, rural, for-profit, and nonprofit providers each had similar trends for changes in annual episode payment that you see here.

The second column shows the average margins, and they give you a sense of how margins have remained high through this period, regardless of how payment per episode has changed.

We begin our look at the data for the mandated report with a review of supply. This chart shows how agency supply has changed in this period, and the years with a decline in average payment per episode are shaded. All other years experienced increases in average episode payment.

The overall supply of agencies doubled across this period, driven by a rapid increase in for-profit and urban agencies. The increase in for-profit and urban agencies occurred regardless of the direction of payment policy; it increased in years that payments rose or fell. Preliminary data for 2013 indicate that this entry has continued.

Nonprofit and rural agencies experienced a decline in most years during this period. They declined in years that payments increased and decreased. These trends suggest that changes in supply are not highly correlated with changes in the average episode payment.

For-profit and urban agencies increased each year regardless of the direction of payment policy; non-profit and rural agencies declined.

With all of these changes in supply, it does not appear that beneficiary access to care has changed

significantly. From 2004 and in each of the following years, we have reported that 99 percent of beneficiaries live in an areas served by home health. In many areas, beneficiaries can choose from multiple agencies. As I will show you in a moment, utilization in urban and rural areas has been comparable.

Next we are going to take a look at how access, as measured through utilization, has changed during this period.

As an overview, total episodes for home health have more then doubled during this period. The share of beneficiaries using home health has risen 50 percent, and the episodes per user have increased 30 percent. Most of this growth has been driven by for-profit agencies, and the rates of growth have been comparable in rural and urban agencies.

This next slide emphasizes that last point. It compares how the number of home health episodes per 100 beneficiaries and payments per episode have changed. Again, the shaded areas indicate periods that average payment per episode declined. The two lines are almost indistinguishable, indicating that urban and rural areas

have had similar trends in the rate of growth of episodes per 100 beneficiaries.

Utilization on a per beneficiary basis increased through 2010, regardless of the direction of episode payment, but it declined slightly in 2011 and 2012.

The declines in utilization for 2011 and 2012 coincide with years that average payment per episode declined, but there are reasons to believe that other factors influenced these trends.

First, the declines are small, less than 5 percent from the peak in 2010. About three-quarters of this decline was due to utilization falling in Florida, Louisiana, Oklahoma, Mississippi, and Texas -- five states that have exhibited abnormally high rates of utilization. Without these states, utilization in 2012 would have been just 2.8 percent below its peak.

Second, changes were occurring during this period that likely affected the demand for home health. Economy-wide, the rate of growth in health care spending has been slowing during this period, and this slowdown may have affected the demand for home health.

Medicare inpatient discharges, an important source

of referrals, fell during this period. A new requirement for a face-to-face visit before ordering home health went into effect, and the Department of Justice and other government agencies expanded their efforts to combat fraud, waste, and abuse.

To summarize, this data leads us to expect rebasing to have a limited impact, if any, on access. Access is very high right now, with utilization more than double what it was at the beginning of PPS.

The small size of the reductions, less than half a percent a year, suggest that they should not significantly change the financial incentives for utilization.

The experience of recent years suggest that factors other than payment can have a significant effect on utilization. If policies to drive down fraud, waste, and abuse continue to be implemented, utilization could drop. If other trends, such as the decline in IPPS admissions, continue, this too could drive utilization down.

Next we are going to examine quality. We will look at quality on three measures: hospitalization during the home health stay, and two functional measures that examine improvement in walking and improvement in

transferring at discharge.

Looking at hospitalization, we see that the rates are mostly unchanged even though payments increased significantly. The hospitalization rate was 28.1 percent in 2003. Average payments in this period increased 22 percent, but the hospitalization rate barely changed, at 28.9 percent in 2010.

The steep increase in payments contrasts with the relatively flat rate of hospitalization and suggest that there was not a relationship between payment and hospitalization during this period.

This chart shows how the annual rates of improvement reported for transferring and walking have changed, and again periods of payment decline have been shaded. We have displayed rates for all agencies, as each of the four categories in this report followed similar trends.

These rates increased in most years throughout this period, regardless of the direction of payment policy. The one exception was the transferring rate for 2009. In this year the rate declined slightly while average payments per episode increased 3 percent.

Overall, these trends suggest that changes in the functional rates of improvement were not highly correlated with changes in payment. The rates of improvement increased in 2011 and 2012 when payment fell, and the only year with a decrease, the rates for transferring in 2009, was a period that average episode payment increased.

In terms of the mandated report, the results for both hospitalization and functional improvement suggest no tie to quality, and so consequently we would not expect the reductions in PPACA to cause a decline.

Based on our analysis so far, we expect rebasing to have a limited impact on the three areas we were asked to review. The rebasing cut is small, as the cuts are counteracted by the annual update. The sequester would slightly increase the size of the reduction, but it would be smaller than reductions the industry has faced in the past.

Past history suggests that some or all of this cut will be offset by growth in case-mix, so the payment reduction may be even smaller than expected.

We would note that agencies have been able to sustain their high margins in the face of past cuts to the base rate, by increasing case-mix as mentioned earlier. But

they have also been effective at controlling costs. For example, when PPS was implemented, they reduced the number of visits provided in an episode by one-third.

There is also reason to believe that margins could be higher than we reported as CMS found that in 2011 agencies overstated their costs by 8 percent.

The key message of this presentation is that past payment changes have not had a significant impact on access, supply, or quality.

The supply of agencies has increased overall, regardless of the direction of payment policy. Urban and for-profit agencies increased while nonprofit and rural agencies decreased.

Utilization has increased in aggregate and on a per beneficiary basis, and though it has declined recently, factors other than payment policy likely account for much of this decline. And throughout this period, our quality indicators did not appear to change in tandem with the direction of payment policy. The rate of hospitalization was unchanged, and the functional measures generally increased every year regardless of the direction of payment policy.

This completes our initial review under the mandate, but I want to take a moment to mention some of the industry concerns about rebasing.

Last year CMS released an estimate that suggested 43 percent of home health agencies would have negative margins in 2017. This higher rate is unlikely for reasons I will describe in a moment, but I would note that a rate of 40 percent is in the range of other provider categories with adequate access and even lower than some categories such as hospitals.

In any payment system we expect there to be efficient and inefficient providers and consequently expect some providers to have negative margins.

I would also note that the higher rate assumes agencies do not fully adjust their cost structures to reflect the lower payments, which seems unlikely given the small size of the remaining cuts.

The estimate also assumes that lower-margin agencies do not leave the program and higher-margin agencies do not enter during this period, even though past experience supports this trend.

Some margins reported by publicly traded agencies

are lower than those in the MedPAC report, reportedly as low as 2 or 3 percent. These margins include non-Medicare-covered costs and sometimes include non-Medicare-covered services.

In addition, the majority of home health agencies are not publicly traded, so their data do not reflect the financial performance of most agencies. Our reported margins reflect agency cost under all of Medicare's home health requirements.

The industry has also noted that PPACA includes other cuts in addition to rebasing that have or will reduce payments by tens of billions of dollars. I would note that our past analysis and future estimates of home health include the effect of all of these policies. Our estimates for 2014, the first year rebasing is in effect, projects that margins will equal 11.4 percent.

The industry also contends that episode cost growth will push down margins significantly. This is contrary to the history of the benefit. In the past, home health agencies have been nimble in adjusting costs when payments change. Cost growth has averaged about 1 percent a year, with many years showing declines. For example, in

2012, we reported that average cost per episode fell 1.4 percent.

This completes my presentation. I hope it is useful for informing your discussion, and I look forward to your questions.

MR. HACKBARTH: Okay, Evan. Thank you. Good job.

So I propose that we have two rounds of discussion on this; the first, a clarifying-question round with "clarifying" defined narrowly, what does row two on column three mean, that sort of question. And then for the second round, rather than going around the table, I propose that we have more of a free-flowing discussion, much as we did at the last meeting on a couple of the topics, and I will invite a couple commissioners to make initial points, and then we will see if people want to pursue those threads and take that for now, and see if we need to open up new topics for discussion.

In the fall, when we get closer to doing the final report, we will do a round two where we go around the table, so that everybody has a chance to be on record with their questions and comments before we finalize the report. I think for our first discussion, a more fluid conversation

for round two is probably more useful.

So that's my plan. Let me invite round one clarifying question, and we will start on this side with Herb and Alice.

MR. KUHN: Evan, thank you very much for that report.

So the three quick clarifying questions, one is on page 20 when you talk about rebasing the cut, a small 1.6 percent, is that consistent with what CBO scored this at when PPCACA was passed?

MR. CHRISTMAN: No. It's lower.

MR. KUHN: It's lower. Okay.

So what has happened from when their initial score to kind of where we are now?

MR. CHRISTMAN: Well, let's see if I can get this right. What they assumed in the original scoring is that it would take down payments by -- they would reduce the base rate in 2014 through -- excuse me -- 2014 through 2017 by 3.5 percent of the base rate in effect in each of those years, and that's the way people have long assumed that this would be implemented.

In the process of putting the reg into operation,

when they released the proposed reg, that was the way they showed these cuts, and then in the process of taking comments and reviewing the comments on the proposed reg, CMS changed its interpretation of the law to mean that it could only be 3.5 percent of the base rate in effect in 2010. And so that means it could only take out $81 a year. So because the size of the base rate has grown marginally since then, the actual cut is less than 3.5 percent a year.

MR. KUHN: Thank you. That's helpful.

The other thing in the read-in, you talked about growth primarily in five states: Texas, Florida, Louisiana, Oklahoma, and Mississippi. What percent of total growth is attributable to those five states?

MR. CHRISTMAN: It's a good share. I can't pull that off the top of my head. You know, they probably have led the area in growth -- the nation in growth. I wouldn't be surprised if they account for the majority of growth, but this -- the interesting thing is that I think we're -- you know, we're starting to see a shift.

I mean, a good example is 25, 30 states had increases in 2012, and one of the fastest-growing states was California. So I think what we're saying maybe is a slowing

in some areas and possibly an acceleration in others.

MR. KUHN: And then my final kind of question on this is on Slide 14, you talked about access issues and how rural access or I guess growth in rural areas has been about the same as in the urban areas, and I'm just curious how that works, because in the rural areas I am most familiar with, you have got greater distances to travel. And so it's harder to get the same number of visits per day as you might have in some more concentrated urban areas. So how are we seeing with perhaps fewer rural providers -- obviously, I know 99 percent have one in a zip code. So any other kind of thoughts behind the scene why we might have that equalization, given those greater distances of travel?

MR. CHRISTMAN: I think when we've looked at this in the past, in general, it's mattered less whether you are urban or rural but whether you're in a state or region that has high use and low use. So the example we always use is something like South Dakota has probably the home health utilization in the country, and that's true for both urban and rural areas, and Texas is the reverse, very high in both urban and rural areas. And I will come to your point in a second.

There are some areas that have lower utilization. That's true, but the term "rural" is too broad, I guess, in some sense. There are 13, 14 states where the rural utilization is higher than the urban utilization. It is just not a good way of splitting this.

And so to kind of get at this a little bit -- this is mentioned in the paper -- we looked are rural areas that had relatively few providers, three or fewer providers, and compared the rates of growth and utilization in those areas to other rural areas, and they generally grew at about the same rate.

Now, the level of utilization was very different. It was about half, and so it's true that there are some areas with low use, but I wouldn't be surprised if they are areas with low use to other services.

In general, some of you may recall the table we put out in the March report that shows the 25 highest-spending countries. Twenty of those are rural; a handful of them are even classified as so-called "frontier." So I think that there are some areas where perhaps the access is not the same. It may be relatively low, but it's a class. The rural areas are generally comparable with the urban

ones.

DR. COOMBS: Just a question about the 43 percent which are negative margins. Do we know anything about if they fit into the LUPA categories? You did a nice job with Table 3 on page 16, and I am wondering if we can say anything about the negative-margin home health.

MR. CHRISTMAN: Sure. The general story on margins and home health is when we've looked at it, we looked at patient severity. We looked at the types of services offered, and really, the biggest difference between high- and low-margin agencies is their cost per visit. It is almost like if you tell me your cost per visit, I can tell you your margin. It is a relatively strong correlation.

Generally, the negative-margin agencies generally have a much higher cost per visit, and it's not apparent that they serve more severe patients. They tend not to be disproportionately urban or rural. They do tend to be smaller, and so to our extent, it doesn't suggest there is a gross imbalance in the payment system that is unfairly making those agencies negative.

Now, that said, one of the things we've

recommended, we recommended removing -- changing the way Medicare pays for therapy in home health. Right now, it is based in part on the number of visits you provide. More visits equal more dollars. We believe that system has led to some abuse, and we have suggested that Medicare pay for therapy services the way it pays for everything else, just looking at the patient's characteristics. And that would have the effect of moving some dollars for what had in the past been high-margin agencies to the relatively low-margin agencies.

Now, we didn't recommend it for that reason. We recommended it because we thought that there were signs that this system was being abused and driving up volume, but the bottom line is we don't think that the payment system is really that unfairly stacked against the negative agencies. They would receive some help if Medicare implemented the changes we recommended.

DR. COOMBS: So, in essence, your costs are higher in these negative-margin entities.

MR. CHRISTMAN: Exactly.

DR. COOMBS: Okay.

MR. HACKBARTH: Clarifying questions. Any more on

this side? Peter and then Mary -- oh, a number of people. Peter first and then Bill, Bill, Mary, Jon.

MR. BUTLER: Slide 13. I am trying to get a picture now again of this access question. The bullet says 99 percent of beneficiaries have lived in a zip code served by home health since 2004. So I'm trying to relate that to today. If somebody -- what percentage of Medicare beneficiaries, if they called up and said "I need health care" can get it? Is it 99 percent? How should we look at the extent of the access issue, if there is any at all? Because this sentence, it doesn't quite sit with me.

MR. HACKBARTH: Yes. The sentence is sort of oddly structured. So does this mean that each year since 2004, we've measured this variable, and every year, we have found that at least 99 percent have had an agency operating in their zip code?

MR. CHRISTMAN: Right. And the point, I guess, we're just trying to make is that the number of agencies in that year was somewhere around 7,000, and today, we're pushing around 13,000. And the question is sort of if 99 percent of beneficiaries lived in an area served by home health in 2004 when there are 7,000 agencies, there wasn't a

lot of room to push that number up when you added 6,000.

MR. BUTLER: So Tom Dean must have the other 1 percent or something like that, our former commissioner --

[Laughter.]

MR. BUTLER: -- because he was the one that always said, "Not in my state. I got issues." But if it's in every zip code virtually, there is home care.

MR. CHRISTMAN: And it is a fair observation that the presence of an agency doesn't mean that every patient who seeks home health is going to necessarily get accepted, but there are a lot of areas where there are multiple agencies. I believe the number is somewhere around 86 percent of beneficiaries live in an area served by five or more home health agencies.

DR. HALL: I wondered if in your analysis of this topic whether there was any rebuttal from the industry on this. I am thinking of some of the quality measures of transferring and walking, which showed a dramatic improvement from the early 2000s up until the present and then a slight dip in the last year. Is an alternative argument that the growth and availability of services is actually positively reflected in quality measures that we

have been looking at very carefully over the last couple of months?

MR. CHRISTMAN: I guess I'm a little confused by your question. I mean, the rates of growth have dipped a little bit. The numbers have generally turned it up.

I guess I would simply say that these measures, we look at them, and I think one of the things that's striking to us is that the patterns of change are relatively consistent, no matter what's going on in the benefit. And it's also a little bit mysterious to us how hospitalization can be flat and the functional measures can increase.

So these measures have the advantage of -- you know, Medicare is one of the few places -- excuse me -- home health is one of the few places where we are measuring function in admission and discharge and can get that information, but these data suggest that they're generally invariant across time, the trends are, and it makes it hard to think about what it could be related to. The supply of agencies is roughly doubling over this period, but it doesn't appear to be -- regardless of that, though, that pool of agencies' reporting is changing; the trends aren't.

MR. HACKBARTH: Bill Gradison.

MR. GRADISON: Three, hopefully, quick questions. First, it seems like we are seeing an increased number of states and, in some instances, municipalities setting their own minimum wage at levels above the federal rate, sometimes significantly. Are these adjusted? Are the payments to these agencies, many of which hire people at relatively low ages, adjusted annually?

MR. CHRISTMAN: They do get an annual payment update, like all of the systems. Some years, it's reduced.

MR. GRADISON: On page 8, at the bottom, talking about margins, it says even the individual provider categories -- for- profit, not-for-profit -- that have been rural have margins greater than 11 percent, not shown. If you have the data, I would suggest you include it in the final report.

MR. CHRISTMAN: Okay.

MR. GRADISON: Thank you.

And finally, the only reference I saw in here with regard to the experience if MA plans is on page 27, and it's very helpful. It has to do with qualitative issues. Do you have any sources of information in terms of MA plans, but they're actually paying for home health care, as compared

with the Medicare payment rates for home health care?

MR. CHRISTMAN: My understanding is that in general, they pay for it very differently. They pay for it on a per-visit basis often, and they'll use some sort of preapproval process where you get a certain number of visits, and then they'll come back and reauthorize you if you think they're necessary.

Historically, we have also heard complaints that Medicare Advantage rates are lower than fee-for-service rates, which shouldn't come as a surprise. Some have suggested as Medicare's rates have gotten ratcheted down that some of that has gone away, but in the past, that's something that the industry has complained about and said that -- we don't agree with this argument, but they've said one thing higher fee-for-service payments do is subsidize lower MA payments.

MR. GRADISON: Finally, on that same point about MA plans, it says here on page 27, the latter, that's MA beneficiaries, account for about 15 percent of beneficiaries, including the data. I was very struck by that 15 percent, since more than a quarter of all Medicare beneficiaries are covered by MA plans. I don't quite know

how to interpret that, whether how much of it may be relating to a lack of adequate risk adjustment of some kind or a different attitude in terms of the willingness to provide home health care in the MA plans on average as compared with traditional fee-for-service.

MR. CHRISTMAN: And this has been something we have talked about quite a bit, and to sort of mention something that I know the commissioners are very interested in, the MA encounter data will finally allow us to sort of get a sense of what home health utilization looks like. We are kicking around trying to use the OASIS data that is collected for MA as a way to sort of look at the differences between MA and fee-for-service utilization of the service. Given the vagaries and inconsistencies in how some OASIS data is recorded, I think that the encounter data will have much greater utility for that.

But this difference between MA and fee-for-service is definitely something that we're trying to figure out how to look at.

MR. GRADISON: Thank you.

MR. HACKBARTH: Craig, Scott, anything you want to add on how MA plans approach home health? Don't feel

obliged to if you don't have anything, but I just wanted to give you the opportunity.

MR. ARMSTRONG: Well, I just would comment that for us, home health is a big cost center. I mean, we employ our own home health staff for big metropolitan markets, so it's hard to really relate to the payment issues. And honestly, I don't know how we structure the relationship where we do purchase those services in other markets.

But we see, to a large degree, this is kind of a return on our investment, what are costs that we're preventing or avoiding by virtue of investing in home care services.

DR. SAMITT: Beyond just the single instance, I think it highlights the opportunity that exists in a more bundled payment environment where in essence, where we say if there are areas there there's opportunity for greater efficiencies, we capture those efficiencies and redeploy the dollars to where there is greater need of primary care or other sorts of investments in a similar mode.

So similarly, we have the freedom to restructure our relationships with home care agencies, so that we can capture those efficiencies and redeploy them.

DR. NAYLOR: So you mentioned you didn't have re-housed [phonetic] data for 2011 and 2012, and I'm wondering if that is going to be available before this report is completed.

MR. CHRISTMAN: The short answer is absolutely, and we are breaking out MA and fee-for-service populations as well, so we can look specifically at fee-for-service.

DR. NAYLOR: Terrific.

And on Table 3, I guess the only group as you're looking at the issue of impact of rebasing on access and so on, drilling down the non-profit versus for-profit agencies and the negative changes cumulative from 2001, 2012, on episodes per 100 fee-for-service beneficiaries, I'm wondering if that suggests really that we need to really explore more deeply the differences between for-profit, not-for-profit, particularly going forward.

MR. CHRISTMAN: The difference in the trend is striking, and the basic message is that the for-profits in terms of total volume have held constant, and the number of those agencies have dwindled. And the number of for-profits has increased, and the number of those agencies has increased. And it just starts to look like a situation

where you have a secular shift almost going on.

In general, they have had similar margins on the freestanding side. It is not a case where we see the not-for-profits having -- you know, not being able to provide more episodes because they are unprofitable. They have generally had margins that are comparable to the for-profit agencies, and so sort of getting more of that, given the differences in the rates of non-profit across the country, some of it probably comes down to the vagaries of what's going on in different markets.

DR. NAYLOR: I think it focused on the issue of access and where you're seeing fewer home health users in episodes, whether or not that's a trigger for --

MR. CHRISTMAN: So maybe what we could do is look at areas, you know, with flat or declining utilization and see if the shift of -- are they served disproportionately by nonprofits? Is that kind of what you're --

DR. NAYLOR: Exactly [off microphone].

MR. CHRISTMAN: Okay.

DR. SAMITT: Can I ask one clarifying question on this? In terms of the dwindling not-for-profits, are these agencies closing their doors? Or what is the M&A

experience? Are these agencies being acquired by the for-profits?

MR. CHRISTMAN: Some of that can be really hard to get at. I think -- my understanding is, you know, in general, I think they've been closing. Some may have been acquired or switched their status to for-profit. That may have occurred. But based on my conversations, I think most of them have been folks closing, and they're probably closing in areas where for-profits may be opening.

DR. CHRISTIANSON: I think the last two discussants pretty much covered my questions. I was wondering why we don't have margins for nonprofits. We have nonprofit comparisons in most of the other tables, and the issues that just have been raised by Craig and others I think are worth spending some more time on. I don't kind of get my hands around or head around -- or hands -- why given margins are over 10 percent we have -- I understand why there's a declining percent of episodes delivered by nonprofits, because the for-profits are expanding so rapidly. What I don't understand is why we don't have equal expansion in nonprofit agencies given that kind of a margin. So that's kind of the question that's raised for me.

And a lot of these tables show, you know, -- well, they almost all show better performance on the part of nonprofits, not dramatically better in terms of the numbers but better. So we have a declining portion of the industry that has been delivering the highest quality care, and that's a little bit concerning, I guess. I'd like to understand kind of what's going on here. And Evan is saying it's hard to figure out, but I think it's worth some effort to try to figure that out.

MR. HACKBARTH: So let me just pick up on a question that -- or Evan's response to Alice's question earlier. So, Evan, I think you said that, in looking at financial performance, the critical variable is the variation in cost per unit of service.

MR. CHRISTMAN: Cost per visit.

MR. HACKBARTH: Cost per visit, which is important. It's not cost per episode. It's cost per visit, is the critical variable. So remind me what analysis we've done in the past about what are the patterns in variation in cost per visit.

MR. CHRISTMAN: Okay. So about four years ago, we did a chapter comparing the characteristics of high-margin

and low-margin home health agencies, and that's primarily what I'm cribbing for here. And in that chapter, you know, we wound up looking at cost per visit, number of episodes provided in a -- number of visits provided in an episode, beneficiary characteristics, and those types of things. And the biggest difference in absolute terms and percentage terms was the low-margin agencies and the high-margin agencies were very different on cost per visit, and that difference was somewhere around 30 percent. You know, sort of digging into my memory banks here, I believe the nonprofit -- the highest-margin performers had cost per visit of somewhere around $90, and the low-margin agencies had a cost per visit of somewhere around $120. And so there was a demonstrable difference.

DR. CHERNEW: I want to ask a clarifying question on Glenn's clarifying question. When you talk about cost per visit, that's an average cost per visit using all costs as opposed to an actual marginal cost of what was spent in the visit, so agencies that have a big fixed cost and a lot of visits could have a low cost per visit, but that doesn't mean the actual cost of doing the visit is necessarily different --

MR. CHRISTMAN: It was not a marginal cost number we did, so that's right.

MR. HACKBARTH: Were you able to decompose the cost per visit, how much of the variation is attributable to wages versus, you know, G&A expense versus other things?

MR. CHRISTMAN: I can't remember if we looked at that work, but I would say that the salaries -- the direct or indirect portion that are salaries in this business is somewhere around 70, 80 percent. So it would suggest to me that at least, you know, a piece of that would have to be that. Some of it would likely be in the overhead. You know, the fact that high-margin agencies tended to be much larger than low-margin agencies suggests there was maybe some overhead differences as well.

MR. HACKBARTH: So this is where I wanted to go. So if I heard you correctly, you're saying 70 to 80 percent, to your recollection, was attributable to wage differences as opposed to differences in overhead expense or travel expense.

MR. CHRISTMAN: And maybe I spoke a bit too fast. I guess what I was saying is if you look at the cost of a visit, about 70 to 80 percent of it is wages of some sort.

MR. HACKBARTH: Oh, I'm sorry.

MR. CHRISTMAN: We haven't decomposed the differences as you suggested, not that I recall. But, you know, the fact that such a high share are wages suggests that some of the differences has to be wages.

Another piece of it, of course, you know, could be some overhead because we did notice that high-margin agencies were larger, suggesting -- you know, and that would generally suggest they have lower overhead costs per visit.

MR. HACKBARTH: Okay. Well, I won't pursue this further now, but it seems to me that given that the cost per visit is a critical performance variable here, understanding a little bit more about that variation may shed some light on things.

DR. CHERNEW: I was going to make a completely different set of comments.

MR. HACKBARTH: Okay. Well, let me invite you to do that. We'll kick off Round 2 and take it from there.

DR. CHERNEW: I had broad, different comments, but the first point I'd make is I understand from personal experience, some research stuff we've done, and general anecdotes that the value of home care to the patients that

are receiving it in general is beyond question. So, you know, I want to start by a strong general shout-out to home care.

That said, I want to make two sort of broad points that transcend home are per se. The first one is: As a general rule, it's possible to overpay even for high-value services, so evidence that something is high value doesn't simply we need to pay more of it. And I think we have to have a set of criteria, again, beyond home care, to know when we should stop. What's the right way to measure?

And so my broad comment is I applaud the aspects of this chapter, which essentially applies in somewhat more detail our general criteria for payment, which I like very much, to this area, and I'm supportive of the general conclusions that while there are a lot of issues that are important in this area, as there are in many other high-value areas, it strikes me that the general criteria that we would posit remains supportive of the notion of rebasing, and that's basically where I come down. And I want to be clear. That's not because I think home care is invaluable or it's not -- you know, it just it seems to me that the payment is adequate.

MR. HACKBARTH: So let me ask if -- you don't have to build on Mike at this point. I want to get a couple comments out. Then we can decide where the interest is and where we want the conversation to go.

MR. KUHN: I just kind of want to reflect a little bit on the nature of this report a little bit and the fact that many of the things that are in PPACA that are going to come forward don't begin until 2015 on the rebasing, and so we're kind of in a situation here where we're trying to predict what we think is going to happen here. This is kind of more a prospective report. So my guess is, as this is -- whatever we put out this year is something we're going to have to come back and look at every year on an on going basis as part of that.

But the thing that I find interesting here as we go forward is if we're going to have to come back and revisit this stuff in the future, what's kind of the best surveillance tools? Obviously we have a set here that we've used for a number of years to talk about the annual update, and that's reflected in what we talked about here. But are there other surveillance tools that we can use to look at the issues that we're charged with here in terms of

beneficiary access and quality of care? Obviously we've talked about the MA encounter data, something that's going to be coming soon that's out there. But what I'm concerned about here a little bit is the fact that we've got high growth, over 50 percent of the growth in five states. And I just worry about a bifurcation of if we're lumping everything together nationally in terms of these numbers, what happens in certain regions of the country as we continue to move forward? And can we disaggregate the data to really kind of understand and more micro-target where we think there might be access issues, there might be quality issues as we continue to look in this area?

So obviously some of the surveillance stuff that's used out there right now or the quality improvement organizations -- or I guess they're changing now, they're going to be called QINs now, quality improvement networks I think is the new term. It's an improvement. Of course, we've got the MACs, the Medicare administrative contractors, which hear things and see data that's out there. Obviously the CMS regional offices or HHS regional offices get calls from beneficiaries and others.

But I just am trying to think about being the

prospective nature of this report, given though that we have high activity in some parts of the country, how do we make sure that in aggregate numbers we don't overlook other parts as we go forward?

MR. HACKBARTH: Just a couple reactions to that, Herb.

First of all, on your initial point, one of the sort of odd things about this mandate is that in point of fact every year, as part of the update process, we look at access and quality of care, not just for home health, for every provider, and make a recommendation about whether the payment rates are adequate to assure access to quality care. So in that sense, this is a redundant request, and we won't do it just once. We won't respond to this mandated report just once. We will do it every year. That's our job. And I think that bears emphasis.

On the second point of losing information, having it buried in averages, in recent years Evan -- in part in response to Tom Dean's insistence and relentless effort to get us to look beyond the averages, you know, we've broken down these numbers into a lot of different sub-categories to try to identify just that problem, that, oh, the rates may

be good on average, but there are identifiable pockets where they are not and where access is problematic as a result.

Despite our ongoing efforts to slice and dice the data in different ways, we have been unable to find significant patterns of that sort.

Now, I hasten to add that does not mean that there are not potential areas of the country that might have a problem, including Tom Dean's home area. But it does mean that if there are problems of that sort, they are very specific circumstances that need to be addressed with very targeted policies, not by holding the base rate high for the whole country of home health providers.

So I agree that you can lose information in aggregation, important information, and we need to slice it and look at it different ways. And we've tried to do that in recent years. We're open to still more ways, if people can make specific suggestions on how to do it. But it still doesn't lead to a policy conclusion that high rates for everybody are the response to narrow, targeted problems. That is never a proper policy response.

DR. NAYLOR: So just building briefly on Mike's comment, I think that we don't want to overvalue high-value

services, but we also want to make sure that we're targeting policies to the highest performers among those.

Here's what I think this could -- where this could go that's a little bit different, and it builds on Herb's comment. We could think about this as a framework for looking at access and quality which is what the report has done, that also helps us to understand how other PPACA initiatives that are ongoing integrate with access and quality. So not just thinking about the work that we do each year, but here what impact will bundled payments and the innovations that are going on, how do they integrate to affect access and quality, which is -- you know, so here are the questions about rebasing access and quality, but a framework could be developed that said we need to be taking a look at numbers of efforts simultaneously to really understand access and quality. Rebasing is happening as part of that.

I'm not a dead record on this one, but I do think taking a look at post-acute versus community-based as a way -- and you have done that in earlier reports -- in looking at access and quality is very important, especially given the data that we've seen about differences in use of

services that are post-acute following hospitalization and those that start from the community. And I certainly think that the not-for-profit/for-profit conversation that we began to talk about is another part of the framework.

I guess the last is a question for you again, but on the issue of case-mix and the report, CMS' report, you know, have we come to a tipping point on that, meaning -- or is this something we need to continually monitor?

MR. CHRISTMAN: I mean, I guess you're talking about the growth in case-mix, and, you know, the growth in case-mix has slowed in recent years. But one of the things that -- you know, two things that drive it, like anything else, are the rate of coded conditions -- and, you know, we may see that continue to grow in the future. The second piece is the increase in therapy. And CMS has done some things administratively to try and ratchet down on the growth in therapy, but they've only applied those safeguards to a subset of episodes. And what we've seen is, you know, that the share of episodes qualifying for extra therapy payments continues to increase.

There has been concern from the industry, from CMS, from everyone, that some of this growth is

inappropriate, and so I think there is a chance we will continue to see some case-mix growth continue in the future.

MR. HACKBARTH: Okay. So I know several other people have had their hands up, but what I would like to do now is we've got sort of three different initial comments out there: Mike with his memorable phrase that -- what's your slogan now, Mike?

DR. CHERNEW: You forgot my memorable phrase?

MR. HACKBARTH: Yeah, right.

[Laughter.]

MR. HACKBARTH: I just can't --

DR. CHERNEW: That you can overpay for even high-value things.

MR. HACKBARTH: There you go. So that's one. Herb opened the door to trying to understand the variation in performance, including cost and margins, better. Mary opened a couple different ones, but her initial one was, you know, thinking forward about how policy in this area fits with future payment reform. So I'd invite comments on one of those three and identify, you know, where you're taking us. So I have Dave and Craig and George and Cori.

DR. NERENZ: I guess this would be on the Herb

line of thought, and it just follows on some of the excellent discussion we've already had about the low-margin providers and the highest cost, and just what I'd like to focus on are the consistently low margins among the facility-based providers. It's an observation we've made before. We've seen it in other domains.

The question would be whether there is any evidence of any corresponding benefit in either the quality or subsequent cost domains in that particular class of providers. The report talks about how part of the negative margin may simply be a cost allocation issue or the parent hospital simply decides to put some costs over there, and maybe it's as simple as that. And if so, then not a big problem. It may be that it's a unit cost issue, and if so, I'd kind of be interested in knowing more, as we've already said.

What actually is that difference? And why would that be true for facility-based agencies as a class? But that question has already been asked.

As a matter of philosophy, in a number of domains, we've said that we favor integration, integration is good, connections among silos and parts of the system are good.

So this would seem to be an example. A facility-based home health agency would seem to be a structural example of integration as opposed to freestanding.

But there doesn't seem to be any evidence that it's good. So the question is: Is there any evidence that it's good by any metric we can find?

MR. HACKBARTH: So there are a couple different things that I hear in that. Let's break them apart for Evan's response.

So the first is a question about what we know in this particular instance, home health, about the performance of facility-based providers, why their costs are higher, why they have margins. Evan, do you want to address that first?

MR. CHRISTMAN: The main point has always been that they have costs per visit that are just so much higher than free-standing agencies. That's always been the biggest difference. And we have decomposed that in the past, and frankly, I don't have it top of mind, but we can certainly dredge that up.

In terms of the patients, we haven't observed huge differences in the patients, and so the main piece has been that cost per visit, but we can take a look at that and see

-- sort of break it out in the direct and indirect and see what it does.

MR. HACKBARTH: And then the second issue, this is an example of integration. I guess I would take issue with that a little bit. I don't think our view -- and I'm only one member of the group, but I've never thought of our position as being, oh, integration is good in particular corporate structures and ownership relationships, but rather that we favor payment models that create clinical and financial responsibility for defined populations, and that responsibility can be organized in a lot of different ways. And so I'm not sure that I think our position, to be real blunt about it, has been hospital ownership of all the lines of service is a good thing inherently.

DR. NERENZ: No, that's okay, and actually, we're not that far apart.

I was sort of reaching for evidence, perhaps, of clinical integration or care coordination or something that I think we've been a little more consistently favoring without specifically saying this is the organizational form with which you reach it. I'm sort of -- but still here looking for that kind of evidence, and there may be none.

DR. CHERNEW: The interesting thing would be if the margin facilities were doing worse, for whatever reason, any argument for integration in that particular case wouldn't hold as much water.

I mean, the purpose of integration was going to be there's some economies of scope, some savings, a bunch of other things. That might not be true broadly across the board, and this might be an example where that's not the case, or it could just be the accounting things that you talked about before or any one of a number of other unmeasured factors that great facilities differently.

MR. HACKBARTH: So Dave has picked up on the Herb thread of the cost structure and what do we know about it, with a particular interest in the hospital-based facilities. Anybody else want to go down that path right now? Any other questions for Evan about how costs vary? It doesn't have to be about hospital-based facilities, but the cost structure and why some have higher unit costs than others. Anybody else have questions on that?

George.

MR. GEORGE MILLER: I don't have a question. I do support Herb's thinking, particularly in the rural areas,

and to Dr. Dean's concern, but I agree with you that it seems that the evidence doesn't support that issue.

I lived in a rural area in a small town of about 8,000, and we had 43 home health agencies. I mean, it was just incredible.

MR. HACKBARTH: You're talking about the gas station-based home health agencies.

MR. GEORGE MILLER: Yeah, yeah.

[Laughter.]

MR. GEORGE MILLER: Now, Dr. Dean is a different issue.

MR. HACKBARTH: Facility-based for --

[Laughter.]

MR. GEORGE MILLER: Didn't have cost allocation like we do in the hospital.

MR. HACKBARTH: Anybody else on this thread of why costs vary?

Craig, you want to take us in a different thread?

DR. SAMITT: Sure. So I don't know whether it's Mary or Michael's. It could be a little bit of both, but it's really about a future framework for us to really evaluate overpayment of high-value services, because I think

the challenge that we face is we're not talking about a comparison of overpayment of high-value services to low-value services. We are not thinking of a shift there. We need to do a comparison of overpaid high-value services with underpaid high-value services, and I'm just not sure that we have got a clear framework that enables us to say, all right, we look at these margins in home health payment. Can we comparatively say for all of the other high-value services -- hospitals, physicians -- or anything else that equally matters that we have a comparator, so that when we look and stare at these things, we can say we need to begin to redeploy resources to other high-value services? I'm just not sure that we've got an effective framework yet to really make those comparisons.

The one striking thing for me that I began to think about as we were talking about the 42 percent here is, remember, when we were talking about hospital payment. We were looking at the efficient hospitals as the pay setters. We were concerned when the efficient providers were achieving negative margins. So I'm less concerned about looking at when the inefficient providers are hitting negative margins.

So I wonder if a framework should be we constantly focus on the efficient provider in each sector as the benchmark, and those are the folks we're worried about, and we try to get every other provider to achieve a level of efficiency at a comparable level as that gold standard.

MR. HACKBARTH: Evan, I recall that we have tried to identify efficient home health agencies and do an analysis of that. Do you want to fresh our recollection on what we found?

MR. CHRISTMAN: Sure. We've published this now in the March report for 2 or 3 years, and we use the same criteria, general criteria that we use for hospitals and the other efficient provider categories. We look at a home health agency's performance on measures of cost and quality over a 3-year period, and we identify agencies that have done well on one or both measures. In general, we find that these agencies are a little bit bigger than average. They have lower cost per visit, and the bottom line is their Medicare margins tend to be about 5 percentage points better than the national average.

And so I think you are absolutely right, Craig, in the sense that that 43 percent is looking at the average

provider, and if you sort of reframed it to look at the efficient provider, it would be significantly lower.

MR. HACKBARTH: Okay. Anyone else want to build no this thread? Bill?

MR. GRADISON: I didn't bring it with me, but I took our March report and went through and just tried to write down on one sheet of paper, our estimate of the average margin for 2014 for each of the siloes in which we have cost information. Man, it is all over the lot, and it ended up -- I was pretty sobered by this, actually, because we had started with negative for the hospitals, and some of the others run up to 15, 20 percent, I think. I was going to work it out in a few minutes, but I didn't bring it with me. I think it's something -- in addition to the other points we're making about looking across, it might be worth taking a look at it.

I'm not recommending public utility pricing or anything of that sort, but somehow I think we ought to have a rationale if we're saying that our recommendation would produce 15 percent average profit for this silo and negative for some other silo of importance, like hospitals. Why? I mean, why don't we justify the differences? I've never

heard a discussion of that here.

MR. HACKBARTH: Well, to be clear, our recommendations for, say, home health would not lead to 15 percent margin.

MR. GRADISON: [Off microphone.]

MR. HACKBARTH: It's Congress' action that has led to a 15 percent margin, and the fact that they have rejected or not accepted our recommendations on rebasing, and when they did so, they did rebasing, they did the much milder version that Evan described at the beginning of this.

MR. GRADISON: Well, SNFs may be a better example.

MR. HACKBARTH: The same there.

DR. MARK MILLER: That's the same story.

MR. HACKBARTH: That's the exact same story.

So the variations that you see -- and we report this each January when we lay out our framework on payment adequacy and the updates, and we show that the margins are in fact, as you say, very variable, that is not a reflection of MedPAC's policy. That's the reality that exists based on what Congress decides to do with our a recommendation or fails to do with our recommendations.

Our recommendations, if our recommendations were

pursued, that variation would be substantially reduced.

DR. MARK MILLER: Can I just say --

MR. HACKBARTH: We don't think it's a good thing. That's the big point.

DR. MARK MILLER: Right.

MR. HACKBARTH: I don't want anybody to come to this meeting and think, oh, MedPAC thinks that this variation is okay and we have not tried to tackle it. The opposite.

DR. MARK MILLER: I just want to make one addendum, which is although margins are important, I don't want us to get too focused on margins as being our primary criterion for paying. There's others across the sectors.

MR. HACKBARTH: Okay. So anybody else want to go in this direction, or do we want to open up some new terrain here?

I'm sorry?

MR. BUTLER: Mary and Cori wants to say something.

MR. HACKBARTH: Okay. Cori just put her hand up. Cori, did --

MS. UCCELLO: I'm just going to --

MR. HACKBARTH: You have got the ball. Just say

which of these threads you want to pursue.

MS. UCCELLO: I'm going to do what I want.

[Laughter.]

MR. HACKBARTH: Label it first.

MS. UCCELLO: Okay. I just want to echo what Mike suggested. I mean, I think -- yes, we agree that there is a high value of home health, but we shouldn't be overpaying for that. And I think he put that very well.

And I was frustrated reading this chapter in how we're devoting so much time and attention to accumulative reduction that's smaller than what's happened in the past in one year alone. So I just think that we can even more strongly -- although I don't know how much strongly we can say it -- argue for stronger rebasing.

But as Evan went through his presentation, he really highlighted how the case-mix increases can affect the overall payments, and it's made me start thinking, well, rebasing alone may not be enough, and we need to do more to think about how to address the case-mix changes when there aren't -- that we can tell changes in the underlying severity.

MR. HACKBARTH: Okay. Peter, I think, wants to

take it in a different direction. Do you want to precede Mary?

MR. BUTLER: I want to join Mary's alliance.

MR. HACKBARTH: Yeah, okay. So --

MR. BUTLER: I don't want to get voted off the island.

MR. HACKBARTH: Okay. So we're going to move on to Mary's thread now. Peter?

MR. BUTLER: Hi, Mary.

[Laughter.]

MR. BUTLER: So three quick comments. One is that, obviously, I think we're paying enough, and there's pretty darn good access, and there's still utilization issues in some pockets and some markets and some -- so those are kind of the natural things that we address.

So I think what we don't address enough of is a little bit more of Mary's themes and what does a high-value home health program look like that contributes to the bigger picture continuum of care, because I sit and say this is at $18 billion the biggest complement, supplement to kind of being a trusted agent for the beneficiary compared to the institutional options, whether it's SNF or LTACs or IRFs.

And I'm not sure we paint enough of a picture, not of, you know, getting at the bad actors. We do all that, but what is a high-value one look like that really truly does help manage the bigger picture? Can we paint that profile and reward that kind of institution, beyond just looking at efficient -- whether they're efficient or they -- but there is a series of metrics, and you have some of them in here, like hospitalization rates. But if we had a really good profile that helped guide those kinds of agencies that help the bigger picture and reward them or at least shine a light on what they contribute beyond just being an efficient home health program, I think that that would be a real added plus of what we could do.

DR. MARK MILLER: Can I say something about that or not?

MR. HACKBARTH: Yeah, you can.

DR. MARK MILLER: I mean, what I would propose to try and do that, what's -- one of the things that's been most striking to me in the last, say, few months of discussion with home health providers, I think a distinction -- and this is a little bit of a variant, I think, on Mike's point -- is home health can be an incredibly valuable tool

if it's in the context where it's used that way. I think you put it out in fee-for-service, you shouldn't necessarily assume you'll get that value.

And what has been striking to me is conversations with people. We've brought in a lot of ACOs, and the ACOs are starting to focus on post-acute care, and they are decidedly seeing home health as one of the mechanisms that can help them get -- figure out what's going on with the patient, but the mindset of the home health agencies that are coming in and talking about this is decidedly different. They talk about their mission and what they're doing differently, and that's the long way around to maybe we'll try and figure out the answer to your question by talking to how people -- the home health agencies dealing with the ACOs are reconfiguring their approach to things. Maybe that's a way to get to your idea.

MR. HACKBARTH: Yeah. See, this is why I didn't want to let you talk, because you were going to steal my point.

[Laughter.]

DR. MARK MILLER: Well, you wrote it down, and so --

MR. HACKBARTH: Take my work here.

MR. BUTLER: Can I add one --

MR. HACKBARTH: Just a second here. Just a second.

DR. MARK MILLER: He's after me now.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: [Off microphone.]

MR. HACKBARTH: So I want to pick up on Mary's point and Peter's and Mark's now, and, you know, just to be provocative, I think the idea of a separate payment silo for home health was just a bad idea from the beginning, and then to compound the error by moving to a per-case payment system, which creates seams in care delivery and all sorts of wrong incentives.

Home health is an extraordinarily valuable service, but by definition, it needs to be integrated with other types of care. And we are never going to get to identifying and rewarding the high-performing home health agencies and eliminating the poor-performing ones by manipulating home health per-episode payments. That is a fool's errand, and what we need to do is move towards payment systems where home health is properly integrated in

care delivery, where it becomes, as Scott has so often said, an extraordinarily valuable tool for not just managing cost but improving patients' lives.

And we could analyze data till the cows come home and make proposals on pay for performance for this or that facet of home health. We're just wasting time, money, political capital. We need to move towards integration. That's my speech.

I saw Alice's hand.

What's that?

MR. BUTLER: We're done.

MR. HACKBARTH: We're done.

I saw Alice, and then let's see where Alice wants to go, and then we'll invite some other --

DR. COOMBS: I know the Chair is watching the clock, and you have 4-1/2 minutes, but I just wanted to say this and get it out there. Some of the things that resonated with me is, one, Mary and Peter's, what do you get for what you are paying, and one of the key essential things, I think has happened, is the readmissions have gone down. And you're looking for ways in which this home health is actually making a difference with, first of all, de novo

admissions and then readmissions.

And then I think one of the key features I would say is that if you could go back and look at what would be defined as efficient home health agencies and then look at what the readmissions were for those groups, because that's where the rubber meets the road, and so that little pilot in and of itself would actually propel some benchmarks in terms of this is the average cost of a home health group that actually makes a difference with de novo admissions and readmissions.

And I would think that it would be important to see first-time admissions because of the trend that Evan has so nicely described. The engagement in home health is not necessarily from the hospital, and so because home health engagement now is a neighborhood, a community effort, it's real important because you're lowing thresholds for getting home health, but at the same time, you want that threshold for productivity in terms of what they actually do to move a meter with quality for a given dollar to really change in implementation.

MR. HACKBARTH: So we're down to our last 3 minutes or so here, and I saw a few other hands up. I just

want to give everybody a quick chance to get comments out. You don't have to pursue any particular thread, but if there are urgent comments people want to make. Herb and then George, Rita, and Jack.

MR. KUHN: I would just say, picking up on the themes that we're talking about, this one in particular, the things that you said, Glenn, is one of the issues I think we got to explore part of this is the homebound requirement within home health, so that might be part of the future conversation.

MR. GEORGE MILLER: Yeah. Herb just mentioned the one I was going to mention, which is the homebound component. If you really want to change the system and being very provocative about changing the system, that is one of the criteria that needs to be looked at.

And I was struck in reading the paper, the chapter, all through the chapter, although it didn't say it, there is still a lot of fraud and abuse in this sector, and while I support Michael's statement about rebasing, what we really -- you know, my view is that the Secretary has the capability of putting more terms, and we've got access. We've got quality, and with that growth, why do we need more

agencies? It seems to me at some point, we need to cut the spigot off and deal with it, so that's one thread that hadn't been put on the table.

And in my home state, which is one of them, that we just need to stop agencies in those five states, and I think someone asked the question what percentage. I think Herb asked the question what percentage of the growth is concentrated on those five states, and we should start there with a recommendation in addition to rebasing, but stop the supply. Cut it off.

MR. HACKBARTH: Remind me, Evan. I think based in part on a past MedPAC recommendation, the Congress did give the Secretary authority --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- to stop enrolling new agencies in selected areas, and as I recall, she's exercised that authority in some parts of the country.

MR. CHRISTMAN: Yes. Let's see if I can do this right. She's exercised it in Miami, and I believe the Chicago area, and I think Houston as well. But, you know, they've been very cautious and frankly slow in rolling those out.

MR. HACKBARTH: I have Rita and Jack, and then we need to move on.

DR. REDBERG: I'll be brief, because you said what I was going to say, Glenn.

But I do think it's -- I know. That the more I think about it, it really is a question of integration, which I think David also said, and to think about -- because right now, it's just perverse incentives. It's essentially this freestanding fee-for-service. They get rewarded for high volume but not for value and care, where if it was an integrated system like Scott described it working at Group Health, of course, you would have home health care used, because it would decrease readmissions. It would improve health, and that would all be good for the organization.

But in this freestanding sense, it just encourages high volume, not high value, and certainly the things like case-mix going up without any change in patient severity really underlines that that is a big problem. And I don't see -- you know, just treating it by itself, it's very hard to get out the bad actors without punishing the whole group, and that's why I think we need to think more, as you said, toward integration and thinking as a system rather than

having it separated out.

DR. HOADLEY: And this relates to that same integration point. I think the chapter has a couple of sentences that we could really, I think, do more with where we talk about ACOs. And Mark referenced having some of these conversations, and what's interesting is it actually says that there are some ACOs that say they could better target and lower utilization of home health, while others said that higher utilization, it makes sense. I think the more we can sort of understand what's going on in the ACO side as well as the MA side, as has already been talked about, may get us to that point of what's the outcome we'd expect in the integrated environments we have now, even if we don't get all the way to the goal that you articulated.

MR. HACKBARTH: Right now, we've got a toxic mix. We've got this freestanding home health benefit. We've got a payment system that allows for very high profits, and we've got an absence of clear clinical standards about who should get what services and when. And you combine those things together and it's an invitation for overuse and, in a worst case, for fraud.

And as I said before, I don't think solving that

problem is a matter of manipulating payment rates. I do think we should rebase and bring the rates down, but much more fundamental changes in payment and care delivery are necessary to get the maximum value for this really important service.

Thank you, Evan. More on this, come fall.

Our next item before lunch is team-based primary care.

MS. BLONIARZ: Okay. So Katelyn and I are going to talk about team-based models of primary care, and the motivation is as follows:

First is the importance of primary care. Ensuring adequate access to primary care is crucial to delivery system reform, and the Commission's view is that Medicare's fee schedule undervalues primary care relative to other services.

Second, care is poorly coordinated, often poorly coordinated, in fee-for-service. Services are fragmented across providers, and information is often lost as beneficiaries move from one setting to another. There are also very few explicit payments in fee-for-service for non-face-to-face activities.

Third, primary care in an elderly population often entails managing many comorbid, chronic and acute conditions, confounded by psychosocial factors such as mental impairment or lack of social supports.

So, overall, we feel that there are opportunities for beneficiaries to get better care, and team-based models are one potential option.

So the question that we start with is, what is Medicare's role in supporting team-based primary care?

Just to give a little preview of what we find, we find many groups adopting team-based models and finding a lot of benefit, but there is significant variability. So the implications for Medicare's regulatory approach is a little unclear.

So related work includes the Commission's 2008 chapter on primary care, recent chapters on care coordination and federally qualified health centers and your discussion on services provided by nurse practitioners and physician assistants.

And, most importantly, this work directly implicates your discussion this afternoon on a per beneficiary payment for primary care. It does so in two

ways. The first is as you consider practice requirements, and the second is whether a per beneficiary payment could allow team-based primary care to flourish because it doesn't require a face-to-face visit.

So the outline is as follows: First, I'll cover Medicare's payment rules that would be pertinent to team-based care and discuss the medical home model. Katelyn will talk about some other team-based primary care models, describe our findings from interviews with physician and nurse practitioner-led practices and then conclude.

So Medicare's rules for how service is provided by medical professionals -- that's this slide.

Medicare fee-for-service covers nearly all medical services delivered by certain types of providers who are spelled out in statute. For example, physicians, advance practice nurses and physician assistants can deliver all medical services within the scope of their professional license and subject to state law, which may be more restrictive. And there are a few exceptions, particularly in terms of certifying or ordering post-acute care and supplies.

The second germane rule is that nearly all

services under Medicare's fee schedule require a face-to-face visit as part of the service.

And the third rule that's germane here is the incident-to provisions. That means that services are covered when they are delivered by staff under the direct supervision of a physician, advance practice nurse or physician assistant, and the services are covered and paid for like they were delivered by the clinician directly.

So how does this fit into your discussion comparing across payment systems -- fee-for-service, Medicare Advantage and ACOs?

This graphic is a way to try to provide some context, and you can think about it from the perspective of the Medicare program and consider how prescriptive the rules are with respect to clinician or integration and organization.

So models such as capitation or Medicare Advantage generally do not require clinicians to organize themselves in a certain way. That's on the left-hand side -- the least restrictive approach.

An insurer may adopt a certain model, such as a staff model HMO, but that's the insurer's prerogative.

Fee-for-service, including ACOs, requires a provider to meet certain standards to have their services covered, but fee-for-service doesn't specifically tell the clinicians what practice model they have to have. So that's in the middle.

In the more restrictive area, on the right, are models such as the patient-centered medical home. These models do generally require a team-based approach and otherwise are fairly prescriptive.

So the medical home model, as laid out in the organizations that certify them, must include a couple of features. First, they have to have a team-based model with a designated primary care provider and must be able to describe their team structure and communication process. They must incorporate enhanced access, care coordination, comprehensive care, have systems-based approaches to improving quality and safety and must have strategies for partnering with patients.

NCQA, which offers one medical home certification, just released new standards that reiterate the team-based model and include requirements for defining team member roles and responsibilities.

So what did the study show with respect to outcomes associated with the development of a medical home? Generally, they're mixed. Some studies have shown reductions in hospitalizations. Others have shown very little change in utilization or spending. And the evidence on medical homes is markedly more positive in integrated delivery systems than it is in traditional fee-for-service.

An interesting example are two articles recently released at a southeastern Pennsylvania medical home project. The first showed that for the overall population there were no detected changes in spending, utilization or outcomes, and only a few improvements in process measures.

Shortly thereafter, another study came out of the same project, reporting that there were reductions in cost for the highest spending cohort.

Observers have asserted that the medical home model can work if it incorporates things like identifying these high-cost, high-needs beneficiaries and targeting them for more services, providing feedback to practices and incorporating risk arrangements, but these are hard things to do.

So I'm going to turn it over to Katelyn now to

describe a few other models in practice and the results from our interviews.

MS. SMALLEY: As Kate mentioned, certification as a medical home is just one of many strategies to support team-based primary care. We go into more detail about these models in your mailing materials, and we are happy to answer any questions you may have.

Starting in 2010, the VHA established a nationwide initiative to adopt a patient-centered medical home model in its 900 primary care clinics serving 5 million veterans nationwide. The Veterans Health Administration's medical home model entails a four-person, patient-aligned care team, or PACT, with responsibility for a panel of patients.

While two sites reported significant improvement in patient wait times, some sites reported that even with the additional funding they couldn't staff up to the four-person levels and so had some staff on multiple teams.

Similar to the experience with medical homes that Kate just described, there is little additional evidence regarding quality improvements with this new approach.

HRSA certifies nonprofit freestanding clinics called federally qualified health centers to provide primary

care and preventive services to all patients regardless of ability to pay. The majority of FQHC patients are either Medicaid enrollees or are uninsured although some privately insured patients and Medicare beneficiaries are also served at FQHCs.

The statute for FQHCs contemplates a team-based approach to care, requiring a team equipped to provide primary, preventive and enabling care such as onsite mental health care services, translation, transportation and referrals to social services.

As defied in PPACA, nurse-managed clinics are practices managed by advance practice nurses and provide primary care or wellness services to underserved or vulnerable populations. PPACA authorized a $50 million grant program to NMHCs, and HRSA has disbursed grants totaling $15 million to date.

We also contracted with NORC to conduct interviews of team-based primary care practices around the country. The discussion focused on how clinician teams organize themselves, how they carry out their work and how IT and payment policies affect what they do. Practices were chosen because they identified themselves as team-based. In other

words, these are already practices that have made an effort to identify as a team and not a random sample of all practices.

We found that teams vary in how they organize themselves, with some groups identifying the team as the entire staff, or a large share of the staff, and others identifying two medical assistants along with a clinician as a team. It seems that the team is defined by the panel of patients it is responsible for, but the size of each team could vary.

Smaller teams tended to express a collaborative all-in-this-together attitude whereas larger organizations stressed the need for clearly defined roles to maintain accountability.

Medical assistants received extra training in patient education and follow-up, or lab techniques, and they were expected to flag areas of concern for the clinician in the patient history and to schedule and follow up on preventive care needs. Some practices had their MAs stay in the patient room throughout the visit in order to clarify issues for the patient after the clinician leaves the room. MAs themselves report strong feelings of accomplishment for

being able to take on these expanded roles.

At nearly every practice we interviewed, we spoke with an office or practice manager. Team-based practice seems to be more administratively complex than traditional primary care, and the coordination efforts to keep the practice running smoothly are often done by someone other than the clinician team leader. A few practices have even hired someone to deal specifically with informatics and data analysis.

Some practices made use of other staff to manage their more complex patients, like RN care managers, social workers, behavioral health counselors and nutritionists. These professionals are not typically fully integrated in the team but are called upon as needed.

One point that practices reiterated was that communication is key but that meetings must be targeted and short because they do take away from direct patient care.

The EHR has become an important tool for many practices to streamline their work day and communicate among team members. Some teams put reminders in the EHR to assign tasks, and others use it to manage the flow of visits by highlighting who needs to see the patient next and what

needs to be done.

Many practices mentioned that they believe that their team-based model is improving the quality of care that they deliver, but this is not necessarily reflected in outcomes data.

On the other hand, teams acknowledge that there are other reasons for organizing their care in a collaborative way. Physicians and NPs were able to delegate nonclinical tasks and spend more time in patient care. MAs and customer service representatives were able to be more involved with the patients. And patients themselves had more time to ask questions and plan their care.

In all, it seems that the variation in the ways that different clinical teams do their work seems to be dependent to a significant extent on the size of the team and the personalities of the team members rather than the clinical training of the team leaders. For some, a more informal chat-in-the-hallway approach was most efficient, and for others, regularly scheduled meetings and clearly defined roles maintained accountability and boosted the confidence of the team members.

An overarching theme of this project is that there

is wide variation in what team-based care looks like. It is not clear that any one model of team-based care is best.

On the other hand, teams require expanded roles for nonclinical staff, more communication among staff members and may imply the investment of significant financial resources in order to put it into practice.

The experiences of the Veterans Health Administration also illustrates the difficulty of trying to implement a uniform team-based policy across many different sites because of how tightly practice design seems to be tied to the specific members of the practice.

So, in conclusion, because of the variability of team structure, staff responsibilities and activities performed, it is difficult to generalize about what kinds of teams work best. Practices we interviewed often cited the personalities of team leaders as one reason why they felt the team functioned well. Given this variation, it is difficult to envision what kind of regulatory structure the Medicare program might consider in order to promote team-based care.

One area in which Medicare could remove an impediment to the formation of teams would be regarding the

face-to-face requirement in traditional fee-for-service Medicare. This could be addressed by the per beneficiary payment for primary care that Julie and Kevin will discuss with you after lunch, which could provide payment to support the non-face-to-face coordination of activities that are a critical part of primary care.

With that, we look forward to your discussion and to answering any questions you may have.

MR. HACKBARTH: Okay. Thank you, Kate and Katelyn.

Let's do round one clarifying questions, starting on this side.

We did pretty well in round one clarifying questions last time, but I think we can do better. Very specific and narrow clarifying questions -- I think that's important in fairness to commissioners who do exercise discipline and wait.

So narrow round one clarifying questions, starting on this side. Anybody?

Bill.

MR. GRADISON: I'm frightened.

[Laughter.]

MR. HACKBARTH: That's what I wanted to accomplish.

MR. GRADISON: You've accomplished it. Let's see if it works.

[Laughter.]

MR. HACKBARTH: Touché.

MR. GRADISON: I read this through, and I ask myself, how would this work, or even could it work, in a really small practice, and I can't figure out how it would work -- not that there are that many left, but the two or three doctors and some folks that make sure they get paid.

Could you comment on that, please?

MS. SMALLEY: We actually interviewed a couple of practices like that. A lot of the smaller practices that we talked to are actually nurse practitioner-led, and they did kind of have a more informal team structure. It was kind of a collaborative approach.

A lot of the practices we spoke with mentioned that they kind of adopted an attitude of everyone is your patient and all of the practitioners kind of collaborated. They kind of had one panel of patients that they all kind of collaborated on.

MR. GRADISON: And my final point, on page 12, there's a sentence at the bottom: "In fee-for-service payment systems, provided the entity receiving the fee meets the standards set out in regulation in a qualified provider category, Medicare is not particularly restrictive regarding how the care is delivered and by whom as long as the provider meets state licensing requirements and a service entails a face-to-face visit."

I understand that's correct, but I tried rewriting this, and I want to explain how it reads -- the same point read a different way. And there's a definite point I want to make about it.

Medicare is restrictive regarding how care is delivered and by whom, requiring that the provider meets state licensing requirement and the service is face-to-face.

The reason I do that is to raise a larger point. I've been, from time to time, in meetings talking about looking at things from the beneficiary's point of view and suggesting that might even be a topic for the July meeting.

But, in this instance -- and I don't pretend to know exactly how this works, but I ask myself, is this a national program?

If I'm visiting my daughter in Oregon and I get sick, I don't think my first action is to look for a doctor in Oregon. It's to call my doctor back home and describe the symptoms, and they may lead to the writing of a prescription.

I don't know if that -- I presume somehow or another I get the prescription filled, maybe on the theory that they're phoning it into their local Washington-based CVS or Rite Aid and then it's filled by somebody out in another state.

But my point is there are changes taking place among Medicare beneficiaries in particular, growing mobility, which are hampered by these state requirements.

I'm not suggesting there shouldn't be state requirements. I am suggesting that we should take a look at what other institutions, like the VA, do in trying to deal with limitations of this kind.

I might not have made this point if the ACA hadn't been passed, but if the federal government is willing to federalize insurance standards around the country, I don't think it's asking a whole lot to say that if you get sick away from home and you call your provider, your provider of

record if you have one, that they can prescribe and interview you and maybe even look at you on television to try to further your health.

MR. HACKBARTH: Kate, did you have something?

MS. BLONIARZ: I was just going to say VA is a little bit of a different situation because it's actually also the provider of services and so a little different than being a payer across state lines like Medicare.

MR. HACKBARTH: Bill Hall, did I see your hand?

DR. HALL: Well, I think this is a wonderful start on something that's going to turn out to be very central as we look at organizing care more.

When I read through the narrative, though, I was really struck by that there really is no definition of team. And you mentioned that some teams are very informal. It's almost like if they happen to see them at the water cooler we'll talk about something.

This, at least to me, culturally, is a little hard because real functional teams in hospitals have very, very defined relationships that are very important. Everybody has to adhere to the same standards.

A good example would be the leg-off phenomenon,

that we don't cut off the wrong leg so much anymore. This means that physicians and surgeons have to respect whoever is the team member who says, I don't care what your degree is or where you went to medical school; unless you tell me that this is the correct leg, you're not going to go forward with this.

So it's a nonhierarchical arrangement.

So what did you learn from this?

Do any of these teams say, well, we're just kind of really cool; we hang out together and all that?

Is there any evidence that that positively influences the medical care the way we want it to?

MS. BLONIARZ: Well, so let me say a couple of things in response.

One is that some researchers -- Tom Bodenheimer has described why this is a particular issue in primary care -- the question of defining what the team is, that in situations like a hospital surgical team the roles are very clear and they are basically the same people do the same thing every time the surgery happens.

And that's not the case in primary care -- that the roles are more fluid. The responsibilities are more

fluid. And so defining what a team means in primary care is more difficult.

And that's what we've found in our interviews.

MR. HACKBARTH: So what I hear you saying, Kate, is that Tom Bodenheimer's point is the nature of primary care is different from an operation.

MS. BLONIARZ: That's right.

MR. HACKBARTH: It's more variable, and so it's more challenging to have the very clear strict definition of roles.

Did I hear you correctly?

MS. BLONIARZ: That's right.

DR. HALL: I understand that, and it's probably the wrong analogy.

On the other hand, if we're really going to take seriously, teams, I think we have to take a look at organizational structure. And I think teams are the wave of the future for medical care, so just to add that to your list of things to do.

MR. HACKBARTH: Okay, clarifying questions on this side.

Jon.

DR. CHRISTIANSON: I also think this is a good start and introduction to this topic. I would make two suggestions that I think, as moving forward, might strengthen it.

One is I really like the fact that you distinguished between health care homes and team care. I mean, those are two different things. I think too often they get conflated, and people, when they think about team care, they say that's health care homes. Well, a team care can happen in a lot of different models and environments.

So I like that.

I think the literature -- there's one place where you try to describe the literature results, for instance, on patient-centered medical homes. That literature is rapidly developing, and there are findings from Vermont and from our own group in evaluating the health care home program in Minnesota that suggest improvements in quality and some suggestion of lower cost. So they aren't the same as you've cited here.

And I think you're going to have to look beyond the peer-reviewed literature, given how quickly this is developing, and look at some of the evaluations that are

being commissioned by states and present, if you're going to do a literature review, a really kind of up-to-date discussion of the different kinds of results because we're getting different results depending on the different criteria that are imposed on patient-centered medical homes.

The second thing I would suggest is on team care. I think you rely a lot on these interviews, which I think is a good way of kind of getting your hands around what's involved in team care, but in fact, there's a fairly literature on team care and a growing literature on team care and health care.

And we've done some of that research in the Annals of Internal Medicine and other places that does connect team care and what it is with patient results.

So the chapter kind of gives the impression that there's nothing. You know, you summarize the literature on patient-centered medical homes. You really don't do it for team care. You cite three or four conceptual pieces where people talk conceptually about team care.

You cite two pieces in the chapter that aren't in the references -- the Kasper piece and the Wagner piece are not actually in the references. So I'm not sure where --

you know, whether those are conceptual or not conceptual pieces.

But I will say both within health care and outside of health care there is a vast literature on teams -- how teams function effectively, what are the components of teamwork.

I mean, you don't need to start this discussion with five interviews here and five interviews there.

There is a remarkably large literature on this, and I think if we're going to be balanced in terms of the discussion we have to go that published literature as well.

MR. HACKBARTH: Good. So, if you have some particular leads that you'd like to share, that would be welcome.

Clarifying questions on this side?

George.

MR. GEORGE MILLER: Yes, on slide 8.

And I agree with Jon's comments about team and the difference between PCMH and team, but I'll save that for round two.

On this slide, you mentioned that you had done some studies and that some had done very well and some did

not do well as far as improving. Do you know over what period of time that study was, and do you understand what the reasons were that they did not do well on, I believe it was, the Pennsylvania study?

MS. BLONIARZ: So the Pennsylvania was -- you know, all of these are relatively recent because the PCMH model is relatively new.

MR. GEORGE MILLER: Yes.

MS. BLONIARZ: The two studies that looked at the same site used slightly different ways of establishing a comparison group. So you might have expected to see some differences there.

But the big point was just the very high utilizers. The second study did find a reduction in spending for them --

MR. GEORGE MILLER: Right.

MS. BLONIARZ: -- in utilization, which could be completely consistent with the other study. They're not necessarily inconsistent.

MR. GEORGE MILLER: Okay. So it's too early to tell.

I was struck by this, and maybe I misinterpreted

the reference from what you're describing there, that there was not evidence it saved money or improved qualified, one study over the other. Did I miss that?

MS. BLONIARZ: So the assertion -- from what I understand of the studies, the first one did not detect differences in spending or outcomes measures. They found a few improvements in process measures.

MR. GEORGE MILLER: Okay.

MS. BLONIARZ: The second reported that they saw a decrease in spending for the highest group of beneficiaries.

The question of whether overall the investments save money, that was kind of outside of the scope.

MR. GEORGE MILLER: Okay.

MS. BLONIARZ: They didn't measure kind of the cost and the savings against each other.

MR. GEORGE MILLER: Okay. I will wait until round two and then follow up.

MR. HACKBARTH: Clarifying questions?

Alice.

DR. COOMBS: I was just kind of curious. Did you see any studies dealing with physician assistants leading team-based primary care, where there were a collection of

physician assistants in an office?

MS. BLONIARZ: So we did not interview any physician assistant-led teams.

My understanding of their training and practice style is they generally work in practices with physicians. They are much more likely to do so than nurse practitioners. So we didn't have enough -- we just didn't find any.

DR. COOMBS: So you didn't find any, okay.

MS. BLONIARZ: But, again, we didn't do an exhaustive look.

DR. COOMBS: Okay.

MS. BLONIARZ: We were just looking.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: This isn't a clarifying question but just an observation with a question mark at the end, sort of a tentative observation, if you will.

The labeling, team care, I think is a bit problematic, and I think it's almost, you know, a service slogan that is tossed about. And I don't know a better label.

But it seems to me that the essence is that the

premise is that primary care is not a single homogeneous activity but actually a cluster of various types of activities that often vary depending on the patient characteristics, needs, et cetera, and that there can be specialization. Not all of those activities require an M.D.

And to the extent that you have a team with people specializing in bringing different skills, you can actually, potentially, deliver a better product and maybe even deliver it more efficiently, using the physician to do things that only physicians can uniquely do and other people to do other things. Perhaps they can even do better than a physician can.

So it's really a model of specialization. I think this is where the notion of people practicing to the top of their license comes from.

And it's particularly useful when you're talking about a product like primary care that is so variable depending on circumstance. It isn't as homogeneous as a surgical operation, for example. So you need this sort of team with various capabilities and specialization.

Does that make sense, Mary?

DR. NAYLOR: So, first of all, I think this is a

very important focal point, and just to acknowledge, I've spent the last couple of years chairing an IOM group that's looked at team-based care, so I will be flooding your mailbox, as Jon will, with stuff, and we've worked on trying to look at high-performing teams and what characterized them in primary care.

And so I think -- what I think is challenging is that here, we're looking at multiple policy issues. How is it that you promote and reward and recognize and create accountability for team-based care? At the same time, how is it that you create an environment in which everyone who is on the team is able to really optimize their contributions and function to the top of their license?

So it may be that we're talking -- and also, how is it that you recognize the whole nature of services that are needed to delivery care? So we're trying to, I think, really get at multiple critical policy issues in this work, and I applaud you for taking it on.

I also want to recognize it is evolving. The VHA work really is just -- it's work in progress, an effort by the Veterans Health Administration to say how are we going to get the 5,000 nurse practitioners and others who are

there to be able to function the same way in all 50 states, so as a provider system they can go to do that, but that's just a work in progress. And so I don't think the challenges are necessarily just getting four team members. It's really getting agreement across a country that we have to create environments everywhere where people can maximize the contribution.

I thought one of the pieces from the VHA, because we just had a report from them, is that their value is that efficient use of NPs is going to help to eliminate 50 percent of the primary care shortage in that environment by 2025. So they're trying to tackle multiple opportunities here at the same time.

That all said, I think this is a vitally important area for us, and there are policy opportunities and ways in which we should be thinking about creating a primary care context that allows for effective team-based care to be delivered.

The last thing I'll say, because we just had the most compelling day last week, where we need to also think about beneficiaries as members of these teams. We were blown away. We had this wonderful group of every health

profession represented around the table, and this beneficiary comes in to tell us, "You know what, you guys don't get it. You need to figure out how we are a part of this whole process," and I think that that changes the nature.

So anyway, I -- that build on Bill's comment, but I think this is a vitally important area. I think it's multidimensional, and thinking about it, starting with a really good definition and concept and all of the evidence associated with it will really help us uncover ways to get to better primary care.

MR. HACKBARTH: Mary, you briefly alluded to you think that there are policies that are appropriate, if not necessary, to encourage the further development of team-based care. Do you want to just quickly throw out a couple of those, so that people may wish to pick up on them?

DR. NAYLOR: Well, again, depending on the dimension of team base, so recognizing and rewarding teams is not the same thing as recognizing and rewarding so-called "team leader." So what are the team-based measures? What are the measures of effective teams? What are the outcomes, the performance expectations? And so I think, you know, our

system has said we reward physicians, hospitals, different sectors. Now is there a policy model that will enable us to reward and recognize and hold accountable teams?

So I have a ton of stuff, but I'm happy to -- I mean, I think on every dimension, we have opportunities here.

MR. HACKBARTH: Okay. So let me get a couple other ideas out on the table. I have Craig and then Scott and Alice, and then we'll try to build from there.

DR. SAMITT: Is it too early to tag onto Mary?

DR. NAYLOR: Never.

MR. HACKBARTH: Why don't you hold onto that, and we'll come back to it.

DR. SAMITT: All right, and it's related.

MR. HACKBARTH: Do you want to start something new or build, Alice, a new thought to put on the table?

DR. COOMBS: So I like the report, excellent job, but I think this whole notion of teams is in an infancy period, but it's going in a good place, and we've got some best practices on the surgical side in terms of what we do with collaboration and communication, and there is a great program that we've implemented in our hospital called "Team

Steps," where you're actually bound to everyone in the room. And most of the time, this occurs in crisis situations, but certainly, actually it's teaching us a new way in which we relate to each other in a group.

I would like to caution us about teams in the sense that you can still have siloes and operation in isolated pockets, whereby there is not that healthy exchange of the peer review engagement, so that that's one of the things that I would be concerned about early on.

There's a nice review in the New England Journal about nurse practitioners, and 80 percent of them are aligned with a physician in a team system currently. And when I say it's in its infancy, I mean that we don't have the robust literature to actually address some of the issues, especially with the physician assistants. I'm going to be talking with Jon, maybe off record, about the physician assistants. But I think the piece of it that really matters is the cost and quality in terms of what you see.

It's possible that things can go either way, regardless of who leads the team, and MedPAC position has been one of a provider accountability. I think we get into

a difficult place when we say let's look at the leadership within the team and endorse a type of leadership in the team. I think that's a very gray zone.

What we should look at is the products in terms of cost and equality and go from there. So I don't want this to be a discussion where we are talking about one provider leading a team versus another provider. We should look at the net effects.

And recently, one of my mentors has pointed out that, okay, this team thing is really good, but when it comes down to basics, it's who is accountable for this patient's outcome, who is actually seeing the patient, because I can envision 10 years from now -- and it may be where some of the other countries are going -- is looking at, well, what's the cheapest way you can care for this group, this population.

I mean, theoretically, you could actually have a whole bunch of medical assistants in an office and have telemedicine in operation and have an NP or a PA in operation. I'm just saying some of the envisioning that we might have, and that may be very different in what beneficiaries may expect or come to choose.

MR. HACKBARTH: Okay. I have Craig and Scott also. Do you want to pick up on Mary's thread? So we can do that. Anybody want to get on line in Alice's thread? You want to follow Craig and --

DR. HOADLEY: On Mary's or a little bit of a different take on --

MR. HACKBARTH: Okay. So let's do Craig and Scott and --

DR. SAMITT: So I'll start with a bias, which is that I have spent my career in organizations and personally promoting team-based care, so you know where I stand, that it is one of the most important things that we should do, although I'm concerned as we look at the preliminary literature that people will interpret it as teams not working. And I think that that is a flawed interpretation, and the reason why I think it's a flawed interpretation is from my experience, what I would imagine we will find when we look at the literature is that high-performing organizations necessitate the formation of teams, but formation of teams don't necessarily generate high-performing organizations.

And so at the end of the day, it's less about just

rewarding the formation of a team, and it's more about aligning the appropriate incentives on a population basis to say we want your team, we want your organization to deliver high quality, high service-efficient results, and that will lead optimally to the formation of high-performing teams.

So I am nervous about just simply having a policy that looks at whether a team is in place, and rewarding for it, I think that's backwards. I think that's a tail wagging the dog.

MR. HACKBARTH: Scott, did you --

DR. CHERNEW: I wanted to pick up on Craig, but I can wait.

MR. HACKBARTH: Okay. Scott.

MR. ARMSTRONG: So building on Mary's point, actually Craig's point as well, I will just, first of all, acknowledge I also work for an organization that's highly focused on and leverages tremendous value from particularly in primary care but elsewhere this team-based orientation. Just I think the point I would make is to amplify the fact that this issue that staff has raised around Medicare's face-to-face requirements as being an impediment to helping us pay for and, therefore, organize on the ground around

effective teams is an excellent point. I don't know what the solution is, but we do need to push that forward.

For an organization like ours, for example, there are services that we are performing in ways that are much more expensive because of these regulations and because we don't want to have different standards of how we organize these services for Medicare versus everyone else. The cost is higher for everyone else we care for as well. So there's just -- I think it's a really important issue, and that I would encourage just to move forward with that.

The one other point I would make is that this is -- this is evolutionary. I mean, it's constantly in motion. Our organization, 6, 8 years ago, published research, contributed to the literature on our own experiment and deployment of primary care model changes, and we're already in the process of completely redoing it. And it's a very objective, data-driven process, but that makes the policy questions, as Mary was saying before, very difficult to answer.

MR. HACKBARTH: Mike, before we get too far from Craig, do you want to make your comments?

DR. CHERNEW: I agree exactly with what Craig

said, and I think in general, we ask questions like what is the impact of something like team-based care, patient-centered medical homes, or what is the best way to do X like, what is the best way to have team-based care or medical home or something. And I think those are bad questions, because there's just not a unique answer to those questions. It depends very much on the incentives around it and the environment, and I think at the end of the day, it's simply not going to be the place for MedPAC or CMS in general to answer those questions broadly. Instead, it's to set up a set of rules that allow organizations some flexibility to do what's best in their environment, should they be there.

So I think the policy questions are what rules are an impediment to success as opposed to let's look at all the literature and figure out that this is good or bad and make everyone look that way, and that's what I took from the chapter, this incredible heterogeneity in organizations, all of which might be very different but very good or --

MR. HACKBARTH: So, George, do you want to build on this, or do you want to go in a new direction?

MR. GEORGE MILLER: No. Build.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: Yeah. Michael said it very well, and that's what I struck from -- got from the chapter as well, that we certainly want to encourage the opportunity for different organizations to do things very well, build on the impediments that keep them from doing things very well.

Someone has already said about especially about the payment for face-to-face meeting and the impediment that requires. Our organization as well builds on teams and trying to do that, and I think Mary described it very well. And we want to create the atmosphere where different organizations -- because health care is local, but on what works best for them. It could be led by a physician. It could be led by a nurse practitioner or a PA or a group of providers coming together.

The team concept has so much better traction than individual siloes, although Bill talked about the silo timeouts, that that may not be applicable for primary care. But the application is applicable to primary care, where just say a scrub nurse -- I don't mean just a scrub nurse, but a scrub nurse could stop a surgery if we don't have the right place. And I -- quite frankly, running a hospital,

I've seen that done where we had the wrong eye on a patient and stopped them cold. The surgeon is getting ready to proceed and stopped them cold. So the group concept can work, where it may not be applicable in that particular setting, that example, but from the team base to make sure we got the right patient, all the right information, the right resources are available for that patient to get a better care.

The key thing is the communication piece, and that is that if multiple people are repeating to that patient the same thing, the physician or provider may have communicated one issue, but someone else down the line explained what is necessary for that patient to get the best care, the optimal care. I would get the other resources to deal with care.

I talked earlier about poverty and then some issues around care not related to health care. It could be transportation. It could be housing. It could be other issues, and that team can help solve all of those problems from a multiple perspective.

MR. HACKBARTH: Okay. Before we go in any new directions, Jack, do you want to build on this? Okay.

DR. HOADLEY: So the whole question what are the

impediments was striking to me. We talked about the face-to-face, and I have been trying to think about are there other things within Medicare's rules, and clinicians can do a better job than I can of sort of thinking, but I was thinking about such things as is the incident to kind of policy flexible enough that it kind of covers the situations that arise. So, okay, that's a basic policy that says the other staff can do various things under the general supervision of is that adequately flexible to cover the kind of situations that come up in these team settings.

Another one that struck me as possible was rules on coding E&M visits. So if those have all that business about the time and intensity and so forth, is there something about the fact that if mostly it isn't the doctor or the nurse practitioner seeing the patient and the staff is doing more of that, does that restrict the level of the visit and therefore means less money comes in to kind of cover what's going on?

And then, you know, I've heard in other settings, questions about group visits, so a group counseling session and whether the Medicare rules are adequately flexible to cover those kinds of things. So those are just examples I

can think of from conversations that I have -- and others can probably do better, but I think we could think about what sort of belongs on that list, where some flexibility and rules can -- rather than try to say what we think the team needs to be, as several people have said, but where are the current rules, meaning they can't do certain things.

MR. HACKBARTH: So let me try to pull together Jack's observation and Craig's.

So what I heard Craig, with others agreeing, say is that if we want to use payment policy to try to encourage more and more effective team-based care, the way we want to do that is not try to write regulations on what constitutes appropriate team-based care and pay a bonus for it. Rather, we want an approach that creates broad clinical and financial responsibility for defined populations, create an environment where team-based care can prosper. So that's sort of one policy path.

What I hear Jack saying is something that's not inconsistent with that but potentially complementary, that even within the current fee-for-service system, short of new payment models, there may be some policies that you can look at, like incident to and how that works, et cetera, that

might create less of an impediment to the development of team-based care.

So I think those are two useful ideas that are complementary to one another.

So anybody want to take us in a different direction? Peter?

MR. BUTLER: Just one more piece on this, and I'm not sure we're defining the problem quite yet right. I think the problem is superb access to coordinated primary care. It's not even limited to team-based. If we're just trying to create an environment where you have a flexible team, it doesn't answer the -- there's technology. There are all kinds of other ways that you are going to interface to create primary care capacity beyond just what -- this sounds like it's all on a labor issue and how to mix and match the right people for your environment, and there are other ways that you are going to engage with the beneficiary that are really not just people and how they're organized. So I think there is a -- I think we are trying to solve a primary care issue, not a team-based care issue by itself.

MR. HACKBARTH: Other comments, either picking up on Peter or on a preceding thread? Dave?

DR. NERENZ: This is just a quick follow-up on Jack's point, which I think that it's consistent with Craig and others, about the rules and how that's the place to focus.

I am thinking about some other things in our purview, like the requirement for physician authorization of a series of physical therapy visits. I'm wondering if we should look through that and see the extent to which those things are more specific than they need to be, that perhaps it's not literally physician authorization, but it's some other more flexible authorization that might ultimately legally run up to the physician but also could be done more efficiently in a team context. Those would seem to be squarely within our purview.

MR. HACKBARTH: Mary?

DR. NAYLOR: I feel like I want to wrap up the blog because I totally agree with the ways in which the evidence about effective team-based care have evolved is they have in common, measurable outcomes that are focused on patients and populations of patients.

So to Greg's point, this is not about everybody tuning up to be a great team. It's about everybody being in

position to be able to achieve great outcomes on behalf of the people they are serving.

Communication. It was also seen as essential for team functioning, so these things, but there are a set of things that go on right now that prevent people on a team, who are well positioned to do it, to be able to refer for home health, to be able to get people who need early access to the right set of services at the right time they need it, and they represent, you know, things we can do today.

I totally also agree with your position about leadership of teams is not relevant. I mean, that actually changes as the needs of people change over time, but capacity of people to lead accountable care systems, I think is something we can be looking at, so --

DR. CHRISTIANSON: I just want to say I think Peter really hit the nail on the head with his comments, and that's what we should be about. And I think -- and that's complicated enough, because I think when we talk about what constitutes good primary care, there are conflicting advocates of improving primary care, don't always say things that are consistent. You have one group that says good primary care means establishing a longitudinal relationship

with your physicians and freeing up the physician to have more face time with patients, and then that's sort of different than having everybody practice to the top of their license, so that as a physician, you only see a patient when something really bad needs to be taken care of, and you don't really establish that long-term relationship.

So there's lots of discussion on what's best for primary care, and I think overall, we don't necessarily want to endorse one particular thing but try to enjoin the general principle, like Peter was kind of laying out, so I was really struck with his comments, I think, about what we should be thinking about as the Commission.

MR. HACKBARTH: Okay. Other comments either on one of the preceding threads or a new direction? Bill.

DR. HALL: Just looking ahead to the future as we look upon teams, maybe we ought to also put in some other impediments to team functioning, no matter how the team is constructed.

One is the almost sure, a crushing patient load that is coming down the pike in terms of people aging up, and the other is the incredible regulatory apparatus that we're going to be talking about a little bit later that

makes time, which is probably the most important commodity to give to the health system, the one that is in the last supply.

So if we could do some modeling somewhere along the way and say how are we going to be responsible for quality of care of Medicare patients in the future, what are some of the issues that would lend themselves to a team approach? And I would say the pressure for more patients, but even more than that, one complaint that man, many patients have throughout the system and all through the health care system is that the communication is really quite marginal. And sometimes this results in really bad problems, but it also results in a lot of patient dissatisfaction. They don't know what their expectations should be from an evolving health care system, which seems to be pressured, pushing people through very, very fast.

So I would say as we look, let's take as a final analysis, our perspective is what is our obligation to the consumers that we are serving for high-quality care but also care that still has a modicum of direct communication. I think if we don't have that, we're going to be just evolving in another kind of regulatory fashion.

Maybe we should ask the consumers, as some people have mentioned here, what's wrong with their care right now, and I bet you, you would find that in well-functioning teams, a lot of these problems have disappeared.

DR. CHERNEW: I think one of the things that is this constant tension building on both of these comments is the actual organization of practice be at the labor portion or the stuff that was Peter -- that happens in organizations that are sort of below where we actually operate, and so I think it's really important for us to understand how what we do affects that level where the care is actually delivered, because ultimately that's what we're concerned about.

But our tools are removed from the actual care delivery process, and so in the spirit of I think a lot of the comments is focusing on how to get -- I mean, I would have said it hasn't really come up nearly as much -- the basic payment mechanisms that are prescriptive on a fee-for-service as opposed to not as a fundamental way, you know, that we influence how practices develop. And I think the more we can change payment and some of these other rules to allow that flexibility is okay. And we only really need to know what works well to the extent that we understand how

our payments and rule systems can influence that.

MR. HACKBARTH: Okay. Any final word? Craig.

DR. SAMITT: I just want to make another analogy, because there are other things that we really want to encourage all clinicians to do, beyond just the formation of teams that produce high results, and the danger is when you start to reward at the sub level as opposed to at the population level. And the other characteristic example is actually technology and meaningful use, that we are adding greater complexities to assure that folks are using technology correctly, when in all reality, if we rewarded outcomes effectively, you would imagine that people would use technology appropriately and meaningfully use the technologies that are available.

So there are other similar examples that are like this that we should pay attention to as we think about this too.

MR. HACKBARTH: Yeah. I think that's an interesting example.

So many years ago now, when MedPAC looked at electronic medical records and what Medicare policy ought to be, actually we took the position that Medicare ought not

subsidize it, because with subsidies inevitably come things like meaningful use, and it becomes very regulatory in nature. And that if Medicare really wanted to promote this technology, the best thing would be to move toward performance-based payment and then create a market for it, and then people will buy it and adapt it to that task, that goal, that objective.

George.

MR. GEORGE MILLER: Yeah. One final thing, I wanted to highlight a golden nugget that Mary mentioned in her meeting, and sometimes we get so busy in doing things to patients, we forget this, and that is, she said that we need to make sure that we include the patient as part of the team. Listening and having that patient involved and involved in the process and involved in their care is a huge thing, and quite frankly, it's a revolutionary changing shift in care.

I just happen to -- someone sent me an e-mail about a patient. In fact, it was a mother who did a compelling story about her child died because everybody did not listen to her explain, "There's something wrong with my child." She was 5 years old. It happened in a very

prestigious institution. I won't call their names, but listening to that, that patient, listening to what we do, all the things we do for them, sometimes we miss what they are trying to say to us. And there are some things that we don't necessarily need to do if we listen to them very carefully, so I wanted to highlight that point, that golden nugget that Mary mentioned.

MR. HACKBARTH: And I agree with that, George.

It seems to me that one of the implications of that is even if you've got a very well-developed team that's been in place and performs at a high level, actually it needs to adapt to individual patients, and so there may be patients that, you know, really need to talk to a physician or they may really interact better with the nurse practitioner about an issue. And you need to adapt to that. It's not an, okay, now we've got our roles and everybody does the same thing for every patient every time. It's an adaptive organism if it's really a well-functioning team, and the patient needs to be at the core.

Okay. Thank you, Kate and Katelyn. We'll now have our public comment period.

Let me ask people who want to make comments to go

the microphone so I can see how many of you there are.

Four? Okay. So let me just briefly review the rules. First, begin by introducing yourself and the organization that you are affiliated with. You'll each have two minutes. When the red light comes back on, that signifies the end of the period. And I would emphasize, as I always do, that the best opportunity to influence the work of the Commission is, in fact, to interact with our staff or to send letters to Commissioners -- we do read those letters -- or to post comments on our website.

So, with those provisos, sir?

MR. AMERY: Hello. My name is Mike Amery. I represent the American Academy of Neurology. Neurologists are the doctors that handle Alzheimer's, ALS, Parkinson's, epilepsy, MS. Since you're talking a lot about primary care, I decided I would stop by and make a couple of comments about our positions on that.

Neurologists continue to be very concerned about the Commission's emphasis on primary care and lack of recognition for cognitive physicians, those specialists who sit down face to face with complex patients and primarily provide evaluation and management care.

As an example, the most recent Commission report stated that the physician fee schedule must be rebalanced to achieve greater equity of payments between primary care and other specialists.

We completely agree that something must be done to improve the practice climate for primary care providers, but we think that the more appropriate distinction in accomplishing this is between cognitive care and procedural care. We have shared with staff current data showing that cognitive specialists are in the same crisis as primary care. Physicians such as neurologists, rheumatologists, endocrinologists, and infectious disease doctors have billed the same evaluation and management codes as primary care physicians, have similar incomes, and face the same recruiting problems.

The National Commission on Physician Payment Reform stated in March 2012, "While the discussion about reimbursement has generally focused on services performed by primary care physicians, the Commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E&M services as contrasted with procedural services."

Portions of the ACA, such as the Medicaid bump in the primary care bonus, are set to expire in the near future. This distinction will be essential not just for improving access to primary care providers, but also access to physicians essential to some of America's highest-need, highest-cost Medicare beneficiaries. We strongly urge you to support improvement of payment for evaluation and management for physicians who primarily bill E&M and not just those who are designated as primary care.

MS. BEALOR: Hi, I'm Lindsay Bealor with the McManus Group, representing the American Occupational Therapy Association, and I'm here to comment on the primary care team topic and ask that MedPAC include occupational therapists in your discussion about this subject.

Occupational therapists can make significant contributions by focusing on self-empowerment and self-management for conditions such as diabetes. OT is uniquely qualified to look at contextual factors that contribute to health, such as the home environment for safety and fall prevention, as well as habits and routines that are essential to achieving a healthy lifestyle.

We appreciate your interest in this topic and hope

you keep us in mind. Thanks.

MR. PYLES: I'm Jim Pyles. I'm a member of the Board of the American Academy of Home Care Medicine, and I was intrigued by the discussion of team-based care because nearly every one of the elements that you discussed is included in the independence at home primary care model that is mandated by Section 3024 as a Medicare demo, 3024 of the Affordable Care Act. It has physician- or nurse practitioner-led teams. The teams are tailored to the patient's conditions and the patient's wishes as well. It is focused on the 5 to 10 percent of the most costly patients, and it is very similar to the VA's home-based primary care program, which has been operating for, I believe, over a decade, has average daily census of 30,000, very, very high cost people with multiple chronic conditions, and has achieved savings of 15 percent in this very high cost patient population, reduced hospitalizations by nearly 60 percent and nursing home stays by 90 percent. So this is a well-proven model. We expect to have results from CMS on the first year of the demo within the next few weeks.

So I would urge you to include that as one of your

models, because it is the only provision out of 971 provisions in the Affordable Care Act that requires any level of savings as a condition of participation.

We also know, we have seen that this model, the independence at home model, is now being picked up by ACOs. As a matter of fact, the top-performing ACOs, pioneer ACOs, both used independence at home models to achieve savings. It is compatible with every other care delivery model. And Medicare Advantage programs are picking it up. There are hundreds of these programs operating across the country, physician-led teams focused on the highest-cost beneficiaries.

I'd just like to say very quickly, too, I also represent the VNA of New Jersey. VNA has been operating since 1912, a nonprofit organization, and they are just asking you for a little breathing room before you go imposing or recommending too many more requirements for home health. They are doing everything that's being asked of home health under the Affordable Care Act: transition teams, face to face is very costly, care coordination demos. They're in all of these things. But further cuts from rebasing added sequestration is really causing financial

strain for that organization, and it is a really -- it serves the entire State of New Jersey and has done a great job for years.

But one of the ways -- I will just wrap up by saying --

MR. HACKBARTH: Thank you. Your time is up.

MR. PYLES: Okay. Both of the comments really are fit together because home health is also useful in IH.

MR. HACKBARTH: Thank you.

MR. MASON: Dave Mason on behalf of the National Association of Pediatric Nurse Practitioners and the National Nursing Centers Consortiums. Thank you for a very rich discussion, for taking up this topic. We agree that it's one of the most important you could be dealing with. And particularly thank you for the inclusion of nurse-led clinics in your discussion. Obviously we see that as one of the models -- not the only model but one of those models -- for providing primary care to underserved populations, and also to provide really important clinical training opportunities for the primary care providers we need.

I want to also echo your comments on the variation in team structure and urge you in your thinking on this to

simply avoid regulations or requirements that would restrict innovative practices. I think we have run into Medicare policies in both statute and regulation that have been restrictive in moving those kind of innovations forward.

Along that same line, we are grateful for the recognition of the amount of resources, both financial and team time, that goes into creating these structures and again would urge you to think about creating payment -- or recommending payment structures that incentivize the kind of behavior you want to see put in place. So if you think of it that way, regulations that don't restrict, payment structures that create appropriate incentives.

We appreciate the discussion of face-to-face requirements, and in that area as well think about the restrictive policies for certification of certain services, not so much the face-to-face examination themselves but the bureaucracy around it that can cause additional costs and delays in the system.

And then, finally, we didn't have a lot of discussion about Incident 2 billing, but we certainly think that's an area that requires more close examination, not just in terms of how it can function more efficiently, but

as we move to more quality-based payment, making sure that we know who is providing the services and that that accountability is clear and not masked in a billing structure.

So we look forward to working with you as you go forward with these considerations, and, again, thanks for the discussion.

MR. HACKBARTH: Okay. Thank you. We'll adjourn for lunch and reconvene at 1:45.

[Whereupon, at 12:12 p.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day.]

AFTERNOON SESSION [1:46 p.m.]

MR. HACKBARTH: Okay. This afternoon we lead off with payment for primary care services, and then follow that with a discussion of quality, measuring quality.

So who in this illustrious group is going to lead?

DR. SOMERS: I'll start. Good afternoon. In this session, Kevin, Katelyn, and I would like to continue the Commission's discussion about creating a per beneficiary payment for primary care practitioners in the fee-for-service Medicare program.

As discussed at previous meetings, the primary care bonus program created under PPACA expires at the end of 2015. Last November, the Commission had an initial discussion about replacing it, when it expires, with a per beneficiary payment for primary care. In March, the Commission had a longer discussion about a per beneficiary payment with a focus on how to design and fund such a payment. Based on those discussions, we are in the process of preparing a chapter on the topic for the June report.

For today, we would like to review the outline for the June chapter, an outline which should be reflective of the Commission's discussions to date. We would like to get

your feedback and learn if you have additional comments or clarifications to make, or if there are other issues that you think should be included in the chapter.

The Commission could also indicate if it has preferences for some of the design and funding options over others that it would like reflected in the June report chapter.

There will be no recommendations in June, but the Commission's discussions this cycle and the June report chapter should well position the Commission to consider recommendations in the next cycle.

The outline and your reading materials reflect the Commission's discussions to date about replacing the primary care bonus payment with a per beneficiary payment. Doing so would be a step away from the fee-for-service volume-oriented approach and a move toward a beneficiary-centered approach that encourages non-face-to-face activities critical to care coordination.

Of course, to establish a per beneficiary payment for primary care, decisions would need to be made on several design issues. The chapter explores these issues including: What should be the amount of payment? How should

beneficiaries be attributed to practitioners? And what types of requirements should practices have to satisfy to be eligible for the payment? Finally, the chapter discusses a few approaches to fund a per beneficiary payment.

The first design issue considered in the chapter is how much to pay. To motivate the discussion, recall the experience with the primary care bonus payment. 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 $664 million. About 200,000 practitioners were eligible for the bonus, accounting for about 20 percent of practitioners billing 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.

The chapter considers funding a per beneficiary payment with the same level of funding as the primary care bonus program. The $664 million in bonus payments were paid to primary care practitioners for providing 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.

Kevin will explain in a moment how the payment amount could also be higher and could rise over time with funding from other services in the fee schedule. Also note in the example considered here, beneficiaries would not pay cost sharing.

Today the Commission may want to continue their discussion on payment amounts with a focus on preferred amounts and sources of funding.

Our second design issue is 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 designate their primary care practitioner. A second option is for CMS to attribute beneficiaries to primary care practitioners based on who furnished the majority of their primary care

services. Under this second option, beneficiaries could be attributed prospectively or retrospectively, a topic I'll turn to in a moment.

But before doing that, consider the first option for beneficiary attribution. Having a beneficiary designate her primary care practitioner could encourage a dialogue between the beneficiary and the practitioner about responsibilities for providing coordinated, patient-centered primary care. However, a beneficiary could indicate one practitioner as her primary care practitioner, but receive care by another primary care practitioner throughout the year. In that case, the per beneficiary payment would not be well targeted. In addition, having practitioners ask beneficiaries to sign designation forms may inadvertently place beneficiaries in awkward situations in which they feel pressured to sign.

In the second option, CMS could prospectively attribute beneficiaries to practitioners. In prospective attribution, beneficiaries are attributed to practitioners at the beginning of the performance year based on primary care services furnished in the previous year. In this case, the practitioner could be paid throughout the year and may

be better positioned to make front-end investments in infrastructure and staffing that facilitate care coordination. However, practitioners could also be paid for beneficiaries no longer under their care.

In a variant of the second option, CMS could retrospectively attribute beneficiaries to practitioners.

In retrospective attribution, beneficiaries are attributed to practitioners at the end of the performance year based on primary care services furnished in that year. In this case, the practitioner would only be paid for beneficiaries under his or her care. But the per beneficiary payment would have to be paid after year's end, which would make it difficult to make front-end investments in the practice.

Today the Commission could continue its discussion on attributing beneficiaries to practitioners through beneficiary designation, prospective attribution by CMS, or retrospective attribution by CMS.

Our third design issue concerns practice requirements. The chapter will discuss examples of requirements such as improving access. Improving access could include increasing office hours, maintaining 24-hour

phone coverage, or offering other opportunities for patient-caregiver communication such as e-mailing or text messaging. Other potential requirements discussed in the chapter include adopting a team-based approach to care and requiring a specific staffing mix, for example, requiring teams that consist of nurse practitioners and care managers.

However, the chapter will also caution that practice requirements could add to costs and may not necessarily add to value, as Kate and Katelyn discussed this morning.

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.

Today the Commission could continue its discussions on whether or not there should be any practice requirements. And if so, what type of requirements should they be and how should compliance be ensured?

Now I'll turn it over to Kevin to discuss options to be considered in the June chapter for funding a per beneficiary payment.

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.

One option is to protect the services eligible for the primary care bonus but reduce the payments for all other services. The savings would then be redistributed as the per beneficiary payment.

Let me say a few words now about how this funding mechanism could work.

Recall the requirements for receipt of the bonus: It's applied to the payments for a subset of evaluation and management services, such as office visits. The bonus is available to certain practitioners, such as physicians in internal medicine and 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.

As Julie said, the bonus equates to a per beneficiary payment of about $2.60 per month. With that level of funding as an example, we can see with this graphic

what would happen if the primary care services eligible for the bonus are protected and payments are reduced for everything in the fee schedule -- services and practitioners -- not eligible for the bonus. This is the option shown on the left side of the 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.

A variant on this option is to protect all bonus-eligible E&M services, regardless of specialty and regardless of whether primary care services account for at least 60 percent of a practitioner's allowed charges. This is the option shown on the right side of the graphic. In this case, funding would come from about 75 percent of the fee schedule. Because the funding would be coming from this smaller source of funding, the reduction would be a bit larger -- 1.4 percent.

Another option for funding the per beneficiary payment is to reduce the fees 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. Those

recommendations include the one in our letter on repeal of the SGR which said that the payment reductions should achieve an annual numeric goal for each of five consecutive years of at least 1 percent of the fee schedule.

If that annual 1 percent savings were redistributed to fund the per beneficiary payment for primary care, the monthly payment for primary care would start at $2.60 and rise over five years to $13.

Is it feasible to generate such savings from overpriced services? PPACA requires that the Secretary validate the fee schedule's relative value units, or RVUs, and make appropriate adjustments.

To support this effort, the Commission has recommended collection of validation data from a cohort of efficient practices. CMS, for its part, is working with contractors for proof on concept on methods to validate RVUs. In the interim, pending validation of the fee schedule's RVUs, there is a potentially misvalued services initiative now underway that can serve as a source of savings to fund a per beneficiary payment for primary care.

Under this initiative, CMS is working with the American Medical Association Specialty Society Relative

Value Scale Update Committee, or RUC, to identify and review services that meet certain screening criteria.

It has been argued that the initiative has already captured most of the potential savings from overpriced services. The assertion is that the services not yet reviewed represent low-volume services or services with moderate RVUs and, therefore, their review would not have a high impact on fee schedule spending.

However, there are several reasons why the potentially misvalued services initiative remains an important source of savings. As shown in this chart, the services not yet reviewed do account for a meaningful share of fee-schedule spending -- 34 percent.

Even among those services already reviewed, further savings may be possible. According to the AMA, a total of 1,366 services have been reviewed. Work RVUs were decreased for 485 services, but they were either increased or maintained for another 551 services.

Now, on these numbers, we received yesterday an update on them. The numbers are a bit higher. Some of you may also have received this update, from what we understand. Nonetheless, the number of services with work RVUs decreases

are still on a par with what -- or a bit higher -- services with decreases in work RVUs are on a par or a bit lower than the number with maintained or increased work RVUs.

DR. MARK MILLER: In other words, Kevin, the numbers may have changed, but the story remains the same.

DR. HAYES: Correct. Thank you.

Getting back to the slide and its second bullet point --

[Laughter.]

DR. HAYES: Recall that at last month's meeting, we noted that even among the services with decreases, it is possible that the decreases could be larger. The statute defines the work of physicians and other health professionals as consisting of time and intensity.

There is a time estimate for each service in the fee schedule. Over the course of the potentially misvalued services initiative, the time estimates for a number of services have gone down. However, their work RVUs have tended to go down much less. Such a disparity could arise if the RUC is offsetting some of the decreases in time by increasing 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 instead be redistributed to the payment for primary care. In addition to providing a funding source, doing so would help rebalance the fee schedule.

To summarize, this is the outline for the June report chapter. It begins with discussion of a per beneficiary payment for primary care as a replacement for the expiring primary care bonus.

Then there's discussion of three design issues: the amount of the per beneficiary payment, attributing a beneficiaries to practitioners, and requirements that practices would have to meet to receive the payment. From

there, we discuss options for funding the per beneficiary payment.

For your discussion today, you could direct your conversation toward issues covered in our presentation such as those listed here:

The per beneficiary payment, specifically the amount of the payment and the source of funding, with options such as protecting services eligible for the primary care bonus but reducing the payments for all other services in the fee schedule, versus reducing the payments for overpriced services.

We addressed beneficiary attribution, which raises questions of whether beneficiaries should be asked to designate a primary care practitioner or whether CMS should attribute beneficiaries to practitioners, either prospectively or retrospectively.

And we covered the issue of practice requirements. Should the per beneficiary be contingent on meeting such requirements? If so, are there specific requirements that should be discussed in the chapter? Based on your discussion, we will revise the chapter accordingly. We anticipate that the chapter can then form the basis for

further work on this topic and possibly recommendations during the next report cycle.

Thank you.

MR. HACKBARTH: Okay. Thank you.

So let me just underline the comments made about where we are in the process. So we will have the June chapter. My plan is that, assuming we see some degree of consensus in today's discussion, in the fall I would bring back a draft recommendation and then we'll discuss that as we usually do and make any further necessary revisions for a final vote sometime in the fall.

And in terms of the process for this discussion, what I'm going to suggest is that we have our round of clarifying questions, again, narrowly defined clarifying questions. And then for Round 2, what I suggest is that we go through these three sets of issues on Slide 20. And what I'll do is, you know, open up discussion on per beneficiary payment, and we can discuss that and then go through the three issues.

Now, I recognize that there may be some interaction among those, and so there may be a need for a little skipping around. But I would like to make sure that

we have sufficient discussion of each of these three issues. That's why I want to sort of march through them.

So that's my plan. Let me invite clarifying questions. Over here, Herb, and then Cori and Mike.

MR. KUHN: Kevin, just to be sure that I understand this right, for the additional payment, the bonus that they receive right now, there is no expectation on the Medicare program for a particular outcome or a particular service to be delivered. It truly is just an additional bonus to remunerate primary care physicians more for their services. Is that correct?

DR. HAYES: Well, that's right. But when you said "service," it is contingent on service. So the bonus is payable on allowed charges for services eligible for the bonus -- the office visits, visits to patients in nursing facilities, and home visits, that kind of thing.

MR. KUHN: Thank you.

MS. UCCELLO: That was one of my questions.

Another one is just to confirm, so that 10 percent that's already in effect is through 2015. So can you tell me, in terms of the overpriced services, how long does it take to do that evaluation? So would there be money and

time to start in 2016 and use the money to pay for it?

DR. HAYES: Sure. The current, potentially misvalued services initiative started to affect payments, effective in 2009, and it's an ongoing initiative. CMS is working with the RUC to continue to identify services, to make payment adjustments to them. So, you know, as we show in the presentation, it's possible, you know, even over the next few years to continue to identify services and make adjustments accordingly.

At some point, one would like to see what the Commission recommended actually happen in terms of going out and collecting data and validating RVUs and making adjustments that way. That will take some time to get that effort underway. CMS is working with contractors now to figure out how to do that.

I might also add that in the SGR patch legislation that the Congress recently passed, that the President signed, has requirements in it for doing the kind of data collection that the Commission recommended.

So the short answer to your question, I mean, it would seem like, you know, it's feasible. I mean, there's still a lot of work to be done. It's not to minimize the

effort required and the difficulty of doing this and the contentious nature of making these adjustments and all that, but it would seem like the tools are there, the mechanisms are there to do something.

MR. ARMSTRONG: I understand -- within the area of beneficiary attribution, I understand the concern around the beneficiary designating a primary care practitioner themselves, the concern being that, well, if they switch providers during the year, that would be inaccurate.

But we also often talk about this awkwardness of feeling pressured to sign, and I'm just wondering, is that just a feeling that we have, or is there some information that we have about that? How do we know that?

And I would just say based on my experience, it's really not a problem, but --

DR. SOMERS: I am looking at Mark a bit. I believe it's feedback from some of the ASO discussions or in the ASO world.

DR. MARK MILLER: Yeah. And I want to be clear. I don't think there's a ton of science assigned to this. This is things that we have heard, and it stood to reason to us that somebody sitting across from their doctor and says

would you sign this, there might be some tension there. And we are also a little concerned that it might be that you go from one office to the next office, and then you get asked again. Then what do you do? Whereas, in your world, that would not happen, because you would pick.

Now, to that point, Julie, the e-mail that you sent last night, Mike asked the question when we were running him through the overview -- and I think it's relevant at this point -- and said, well, how many different physicians do you -- primary care physicians do you see, so that I think would inform your question too.

Julie? Now I'm looking at Julie.

[Laughter.]

DR. SOMERS: I see how that works.

Yeah. So there's a 2000 study in the New England Journal of Medicine by Dr. Pham who did a study of Medicare beneficiaries and found that at the median, beneficiaries saw one primary care provider for evaluation and management services, and at the 25th percentile and the 75th percentile, they saw one to two primary care providers. The number of providers go up if you expand it to all services or to all types of providers.

In your reading materials when we talk about attribution, we talked about attributing beneficiaries to primary care practitioners solely and based on the number of evaluation and management services. So we need to look at more recent data and verify that, but it looks like they are not seeing that many primary care practitioners.

MR. HACKBARTH: So, Julie, did you say that was a 2000 study?

DR. SOMERS: This study was in 2007.

MR. HACKBARTH: Oh, 2007.

DR. SOMERS: I believe the data was quite a bit older, like 2002.

MR. HACKBARTH: Yeah. Now, do you know what Mai Pham used as the definition of a primary care physician for that?

DR. SOMERS: I don't remember which specialties --

MR. HACKBARTH: Because she could have been using a different definition than we're using, which would mean that her account isn't what you would get using our definition.

DR. SOMERS: That's true. It may not be exact, and we're working back in the office to do it on the 2012

data.

MR. HACKBARTH: Okay, good. Thank you.

So we're still on clarifying questions. I have Mike next, and who over here? Peter, Jack, and Bill.

DR. CHERNEW: In the mailing materials on page 14, there is this textbox about Medicaid, and I couldn't figure out how Medicaid does the attribution. There's a bunch of per -beneficiary payments that you talk about that Medicaid makes, but I wasn't sure how those programs -- there's one in Alabama and one in North Carolina. I'm not sure how those programs do solve this attribution problem.

MS. SMALLEY: Well, because they are Medicaid programs, they do vary state by state. I think a lot of the states have gotten around this problem, because they are Medicaid managed care, and so they have to designated a provider.

MR. BUTLER: So attribution does seem to be kind of a logistical key to this. So tell me the number, the percentage of patients, if you can, beneficiaries that would be attributed to -- how many change year over year? Whether they may not see anybody or they switch providers, whatever the method, how much shift is there likely to occur in a

given year? Do you have an idea?

DR. SOMERS: Right now, for a given year, I can just repeat this 2007 paper that, you know, at least 50 percent of beneficiaries see only one or two primary care providers.

MR. BUTLER: Yeah. I'm looking, though, that change year over year, so --

DR. SOMERS: Oh, from one year to another?

MR. BUTLER: One year to next, because, you know, then you'd be moving dollars from one provider to another.

DR. SOMERS: Yeah. No, we'd have to look into that.

DR. HAYES: It's a good point, though. You are asking about essentially continuity. Well, it's got an attribution dimension to it.

MR. BUTLER: It's the continuity thing, yeah.

MS. SMALLEY: And I can say at least from the ACO world, the turnover has not been insignificant.

MR. BUTLER: Like 20 percent or something, then I go whoa. It's a whole different answer than like 8.

DR. HOADLEY: I'm actually following up to what Cori was asking about. On the RUC kind of overvalued

procedures, what -- a lot of what you talked about in your answer, Kevin, was things that are being done under current activity. So for this to be a scorable savings, what would be the new trigger for getting something to score that was new?

DR. HAYES: It would be the data collection along the lines of what the Commission has recommended, so it would be a matter of going out to what the Commission has talked about is efficient practices and collecting data.

In working with contractors, we have come up with a way to do this that we think is workable. There's a lot of talk about things like going out and doing time and motion studies and all this kind of thing, which would be pretty cumbersome, and you'd be concerned about bias and all. But what the Commission has recommended is a data collection activity that could go along the lines of collecting data on two things, the actual hours worked of practitioners and then their volume of services by CPT code. And it would be then a pretty straightforward thing to compare the fee schedules' time estimates with actual hours worked.

Going that way, it wouldn't be possible to

identify specific services, but you could kind of say, "Well, the practitioners that tend to provide this service also tend to have the biggest -- you know, so it is workable, and CMS is working with contractors now to develop the methods for doing just that.

MR. HACKBARTH: I apologize. I just need to sort of go through this one more time to make sure that I understand it.

So PPAC included a requirement that CMS re --

DR. HAYES: -- validate.

MR. HACKBARTH: -- revalidate -- that's the term I'm searching for -- RVUs. We came along a little bit later and said, you know, CMS ought to be developing new sources of data to revalidate RVUs. As the normal part of the annual work of CMS and with input from the RUC for these amounts of revaluation have occurred.

To this point, though, all of that has been done on a budget-neutral basis. The first time that it would be done on a non-budget-neutral basis will be the work done as a result of the law that just passed that established a specific target, correct?

DR. HAYES: Yes. As long as the amount of

redistribution of dollars achieves a numeric target; in this case, of a half a percent of spending.

MR. HACKBARTH: Yes. So that's sort of the bell that rings, is that the normal process is budget-neutral redistribution unless the Congress says -- enacts law that says this revaluation is going to be non-budget-neutral, and so if we were going to use that as the source of funds for this, the bell would have to be rung, and Congress would pass a piece of legislation that says do some revaluation and dedicate money to this purpose.

And then, of course, there is the issue that they have already said they want to take a piece of that to refund the patch for the SGR, and so it would have to be new stuff beyond that target dollar amount.

So clarifying questions --

DR. SOMERS: Sorry. Could I jump in and respond to Peter? The New England Journal of Medicine article did do an analysis of year-to-year changeover in beneficiary assignment, so I was just looking that up. And based on assigning beneficiaries to primary care practitioners, based on E&M visits, 20 percent of beneficiaries were reassigned from one year to another.

MR. GRADISON: On page 10 at the bottom, it says that the number of practitioners eligible increased from 157,000 the first year to 194,000 the second year, which is an increase of 24 percent in one year. It struck me as a rather dramatic change. What's going on there? I mean, are they modifying their reporting or their coding or something in order to qualify, and how much further could it go?

DR. SOMERS: I don't know. I --

MR. GRADISON: I would appreciate it if you'd take a look at --

DR. SOMERS: Yeah. I don't want to speculate.

MR. GRADISON: I mean, frankly, I read it a couple of times and thought, well, maybe it's a misprint, because it's such a major change in one year.

MR. HACKBARTH: My recollection, this is a passive exercise for physicians. It's not like they have to file any paperwork to qualify for the bonus. This happens automatically based on an analysis of claims; is that correct?

DR. HAYES: That's correct.

DR. SOMERS: That's right.

MR. HACKBARTH: And so that, in a way, sort of

makes it even more puzzling that there would be such a big change in one year.

DR. HAYES: The one thing, though, to remember is that 2011, the base year that we're talking about, was the first year for the bonus. So one could imagine that there was a little bit of a shakeout period during that first year, just from an administrative standpoint and how the bonus was working.

MR. GRADISON: I think I -- I don't understand what you just said. I mean, where is the shakeout? At the administrative end? I mean, that they didn't interpret the data correctly? I didn't understand what you meant.

DR. SOMERS: Well, I would add as well, it's based on the practitioner's designation --

MR. GRADISON: Yes.

DR. SOMERS: -- a specialty designation. So there could be learning over time, and its' also based on if 60 percent of their allowed charges are on these eligible E&M services. So becoming aware that there is a bonus out there, you could do more things to make yourself eligible.

MR. GRADISON: That's what I was wondering, if 55 or 58 percent, you might just change a little coding here

and there to qualify.

Okay, thanks.

MR. HACKBARTH: When in doubt --

DR. MARK MILLER: We will get into this. We'll give you an answer. That's the most important thing we take from this, and we will look over time and get all of this updated.

The other phenomenon that's gone on here is I think people might have in their minds, physicians increasing, but the PAs and NPs are growing at a little bit faster rate in their billing, and they might be falling into this bucket a little bit faster than you might thing the physicians are falling into this bucket. But we'll parse that out and get you an answer.

MR. HACKBARTH: Any other clarifying questions? Alice.

DR. COOMBS: On page 24, the 1 percent number for redistribution and how that came about to be correlated with overpriced services, can you give me a little history on that piece?

DR. HAYES: What page? Page 24 of the mailing materials. And say a little bit more about the question?

DR. COOMBS: Where does that 1 percent number come from? Knowing that the 664 was the target --

DR. HAYES: Right.

DR. COOMBS: -- but that's a historical number.

DR. HAYES: Sure, sure, sure.

DR. COOMBS: That's not from now.

DR. HAYES: Right. The 1 percent figure came from the Commission's recommendation in its SGR repeal letter, and it was a judgment on the part of the Commission that 1 percent was achievable in terms of a level of savings. The experience at the time was that savings from changes and work RVUs that year or the immediately preceding year were in the area -- if memory serves correctly, it was like .4 percent, and then there were some savings due to changes in practice expense, RVUs, and the total worked out to be 1.2 percent of fee schedule spending, and so the Commission felt like a 1 percent goal would be realistic.

DR. COOMBS: That didn't have to do with upcoding or anything else? It was purely overvalued services at that time?

DR. HAYES: That's right. That's right.

MR. HACKBARTH: Okay. Seeing no other clarifying

questions, let's shift to round two, and let's focus first on the per beneficiary payment. I will welcome comments on both issues here, the amount and source of funding. Anybody want to lead off on that? Rita.

DR. REDBERG: I suppose the idea of a per beneficiary payment, because I think it's kind of consistent with the other goals that we have talked about in sort of integrating care and improving quality. And it is not tied to the fee schedule, which we are trying to move away from.

In terms of source of funding, certainly it's identified a bit in the graph, but there are a lot of overpriced services and high volume of overpriced services that I don't know -- and I think Cori already addressed how long it would take, but certainly that would seem a good place to start.

I'll just add, in terms of -- oh, go on.

MR. HACKBARTH: I was just going to ask you the amount, the amount of the per beneficiary payment.

Let me put up a straw man for people to react to. My inclination at this point -- and this is subject to change -- would be to say let's do a per beneficiary payment in the amount, equivalent amount to the current 10 percent

bonus, and at the last meeting, we discussed at length about how small that number is, and it's not likely to change the supply of primary care services, and all of that is true.

Having said that, we impose on ourselves as a matter of self -discipline that we have to figure out how to fund whatever we suggest in terms of a bonus, and when you look at both the sources of those potential funds and the other demand for those potential funds, including like fund SGR repeal, I'm inclined to stick with the current dollar target based on the 10 percent. I'd love it to be bigger, but that's my gut on where to come down.

Feel free to disagree with that and argue against it, but I just want to sort of give people a target to shoot at.

Rita.

DR. REDBERG: I think that's a great target and a starting point to go with the 10 percent, basically, as what it was in the current primary care bonus.

MR. HACKBARTH: The other thing I would mention -- and this was something that hadn't occurred to me that really came out of our last discussion -- is that there are a lot of other things happening out in the marketplace that

are effectively increasing the rewards for primary care, things outside of Medicare, where the practice is being purchased and private payers changing. So it's not like Medicare has to carry the full burden of changing the economics of primary care.

Medicare is a big purchaser, obviously, and the more Medicare can do the better. But there are some other things going on that are also pushing in a proper direction, and we need to keep that in mind.

DR. REDBERG: I was just going to comment on the other two points.

MR. HACKBARTH: Before you do, let's just stay on the payment amount and funding for a second. I invite that other comments on that.

I have Jack and then Mary.

DR. HOADLEY: So I think your base proposal, you know, has a good logic to it.

I think the two things I would comment on -- one is we should probably make sure we talk in the chapter about sort of the argument you were just talking about.

It's a small amount. Where does it get some punch -- which is, yes, there are other things going on

simultaneously. The symbolism kind of argument that we're not letting this go away -- it's in the bonus now. We're maintaining it. You know, we think that's important.

We think it has -- I mean, those kinds of arguments, I think, should be very specifically talked about.

The other thing I guess is, when you talk about the funding, if we go with the overvalued procedures, which has a certain nice logic to it, the option that's laid out in the chapter talks about those accelerating. If you get one round of these every year, you actually build that amount.

And so I think we need -- if we want to limit it to the $2.60 or whatever that number is that would come out of the first years, do we link that correctly to that as the funding source?

Do we say that other money should be used for something else?

Or, do we scale down the level of expectation on the overvalued procedure option?

MR. HACKBARTH: On that escalating savings from revaluation, that does not include the effect of the just

passed legislation, which will take a piece of that.

DR. HOADLEY: Okay.

MR. HACKBARTH: So it will basically cut those numbers in half. Is that correct, Kevin?

DR. HOADLEY: You could actually say that --

MR. HACKBARTH: There would still be an upward trend.

DR. HOADLEY: So if you're building in an amount for the per beneficiary payment, that might start -- instead of at $2.60, if we use the number that's up on the slide there, you know, and started it at $1.50 because of the other legislation -- I'm making up a number, obviously -- but then allow it to accelerate over time. We'd actually be getting a bigger per beneficiary payment by years three, four, five and so forth, if that's the thing.

So I'm just trying to -- I'm not sure I'm saying a preference here as much as just we've got to think that through.

DR. NAYLOR: I also support the move from bonus to per beneficiary payment.

In terms of payment, I like the idea of starting at 10 percent and thinking about this as a path to next

place but maybe building in some opportunities to evaluate within a year or two how well is that level of payment driving us along with other opportunities to promote primary care, to achieving our goals.

And, in terms of payment, I don't know why we couldn't think of a mix here of the opportunities to look at overvalued services as a source as well as non-EMS. I would be less inclined to think about any EMS services by anybody given what the goals of EMS services are and the definition of primary care.

So I don't know if we've thought about a mix, but that's where I'd look.

DR. CHRISTIANSON: Can we go back to the end slide of the discussion questions, please.

So, yeah, I think the per beneficiary payment, breaking the link with fee-for-service makes sense.

The amount I don't think we can even talk about until we -- it's definitely linked to the decision about practice requirements.

If the purpose of this is to say we think primary care physicians deserve more compensation or -- that's wrong.

If we think primary care services deserve more compensation, then it's pretty arbitrary, and 10 percent, since that's what's already in the budget, is a good place to start.

If we say we want to tie it to practice requirements, then we have to think about, well, what's the cost of doing this? And I don't want to do that because I was discouraged by the chapter in terms of the two examples that were provided, in terms of what you might tie it to.

One was team-based, hitting some parameters of team-based care. I mean, that would be very complicated. I'm not sure that we know what the cost of doing that. It's going to vary across different institutions and so forth.

But to ask what the amount should be without actually talking about are we tying that amount to requiring practices to do something, with the idea that this would provide them with investment money to do it, doesn't make sense to me.

MR. HACKBARTH: And I definitely see your logic. So, again, let me just throw out my thinking, and I invite yours and others' reaction to it.

As I said at the last public meeting, I don't see

a lot of hard evidence for various types of requirement -- that, oh, this really makes care better for patients.

And, as we discussed this morning on team-based care, that whole model of thinking about these things -- well, let's require certain things to be done and then pay bonuses for it -- I find troubling and unproductive.

So, while I certainly agree if you're going to have burdensome regulatory requirements that you need to increase the dollar amount, given that I don't see a whole lot of data to support the regulatory requirements, I sort of give then more predominance to, frankly, what can we afford and what do we know how to pay for. And that's how I sort of shift the problem around.

And feel free, Jon, to disagree with that, and anybody else.

DR. COOMBS: I agree, Glenn. That resonates with me because, as Jon said, I think if you're going to give a small incremental increase as we are doing and then invoke certain requirements, it would be more burdensome as is well outlined in the chapter. So that resonates with me.

MR. KUHN: I, too, would -- you know, as I think about this, what is it you're going to pay for, you know, if

you did something like that. And I think there is the burden -- the nature of -- the passive nature of the payment now.

But, you know, just think if -- obviously, this isn't necessarily primary care, but just think oncology and say you really wanted to pay for better pain, nausea, fatigue, different things like that. You know, there would be specific things you're paying for. So it gets a little difficult on that.

But on the issue of the per beneficiary payment, I think the key here is that this bonus, I think, is important. It sends a strong signal, a strong message, to primary care physicians.

And I think the work to retain, as we've been discussing about here and last month, and continuing to have at least as a threshold, the 10 percent I think makes a lot of sense. It sends the right signals, I think, to the physician community, and it's a good support for the Medicare program.

In terms of the source of funding, as we heard, this was paid for with new money. That's going to be difficult in the future. So I think this notion of looking

at the overpriced procedures seems to make the most sense to me to try to drive that.

And I do appreciate the letter that the Commission received from Dr. Levy, who's head of the RUC, but I think also if you do focus it on overpriced procedures it continues to send the incentive to the RUC that they need to continue to work in this particular area since that would be the funding source to help fund this particular bonus out there. So I think it keeps the pressure on them to continue the good work that Dr. Levy laid out in her letter.

So I think that would be helpful.

MR. HACKBARTH: Others?

Cori.

MS. UCCELLO: Yeah, I agree with what everybody has said so far, but I just kind of want to step back again.

I'm not sure if it was this go-round or previously that we first stepped back and said, well, what is the goal of this? Is it to direct more resources to primary care, or is it to facilitate a redesign of primary care?

And there is some overlap there, but it doesn't -- it's not necessarily complete.

MR. HACKBARTH: Cori, could you just say again;

what was the first of the two goals?

MS. UCCELLO: Directing more resources to primary care.

And so I'm trying to think about those goals as I think about, you know, what dollar amount.

And there's an overlap between the dollar amount and the requirements, as we've already said.

But, even when we think about redesign, we're not redesigning for redesign's sake. We're redesigning for outcomes' sake.

So I guess I'm just struggling with how to kind of sort all this stuff in my head.

That said, I think moving off of -- I mean, it certainly makes sense to move off from that 10 percent add-on to a per-member payment. Using the dollars from that 10 percent and converting them seems to be a reasonable starting point.

And, for funding, to the extent feasible, it seems -- you know, we talk about targeting a lot. In this instance, it would be targeting those overvalued services or overpriced services as the right way to do it. So, to the extent that that is actually workable, that would be my

preference.

MR. HACKBARTH: Those two goals -- I think those are two goals.

And, on the redesign goal, the way I'm thinking of this, consistent with our conversation earlier about team care, is let's begin moving, albeit incrementally, towards a payment method that enables redesign, better enables it than fee-for-service payment where you have churn out visits and meet various tests to get the dollars.

Now it doesn't guarantee redesign, but it enables. And, hopefully, there are other forces at work, both in Medicare payment policy and on the private side, that will cause physicians to say, oh, I'll use my enabling redesign to actually start working on a new way to provide value of care.

But it won't guarantee it, and I think that's what you were after.

Dave, George and Mike.

DR. NERENZ: This is a minor technical question, I think, but it's just on this concept of making the per beneficiary amount equivalent to, or the same as, the current bonus.

And there has to be some transformation function just because they're different metrics -- the bonus as a per-service add-on of 10 percent.

So, in doing that calculation, I'm just curious. From a budget point of view, you might say you've got a certain amount of pool. And then you guess, or you calculate, the number of attributed people that it would be.

But then now the question: As soon as you do that, you put some new incentives in place. Presumably, the incentives encourage the creation of these relationships, which we think probably is a good thing. But, if you set it equivalent to the current scenario, then you may end up actually spending more money if these relationships kick in.

And then you say, well, okay, that's just a good thing. That's fine.

Or, do you try to take that in through some fudge factor at the beginning and say, well, we're going to have to set it a little low because we actually have more of these relationships to reward?

I'm just curious. It's a fine point. How do you think about that?

MR. HACKBARTH: I understand your point.

I have no idea how I would think about it.

And also important would be how would CBO score it actually.

DR. CHERNEW: Yeah, I think the CBO scoring point is important, but I actually would have thought the other. Before, you were paying a bonus per visit, and so you were encouraging more visits. Now you're getting away from the visits.

So you could have the opposite going true, that this actually ends up being -- because you have fewer visits being paid out, you pay --

DR. NERENZ: But a drop there wouldn't affect the bonus account. It would affect just the fee-for-service.

DR. CHERNEW: Yes. So at the end of the day --

DR. NERENZ: How do you calculate all these --

DR. CHERNEW: Well, my guess is the margin just gets rounded out and you let CBO deal with it. I don't even think you could assign which way you'd want the fudge factor to go.

DR. NERENZ: Yeah, and actually, the effects may be small enough. It's not worth worrying about. I just --

MR. HACKBARTH: George.

MR. GEORGE MILLER: Yeah, my thoughts are along with Dave, but let me see if I can say it a different way.

If the value of having primary care physicians and move more to the model of a patient-centered medical home, then should this be looked at as an investment, like the 1115 waiver, to really transform health care?

Is the goal to really transform health care or just move more folks into a primary care?

If the ultimate goal is transform health care and then save monies down the road, maybe this should be looked at as an investment.

Based on the outcome, we'll spend less money overall in the system. We would decrease all the things that we just talked about that were valued services. There would not be a need to have as many x-rays for low back pain because they would never get to that point.

So should we look at it from that standpoint? I don't know the answer.

You picked an appropriate -- what can we afford today?

The question may be, what can we afford 10 years from now, and how can we get there?

Maybe we need to spend a little more by rewarding primary care physicians that will lead to us spending less money 10 years from now, but I don't know the answer to how would you pay for it in the interim.

MR. HACKBARTH: And so certainly my hope -- and based on our past conversations, I think almost everybody's hope -- would be that by moving away from the fee-for-service model you prompt a transformational change in practice, but it is no more than a hope at this point for two reasons.

First of all, we're not talking about a huge amount of money, probably not enough wattage to fundamentally change how people think about practice.

But beyond that, the research is still coming in on the effect of primary care-based initiatives like medical home, for example, and it's mixed at this point.

So, even though the goal is transformational change that could yield big savings and quality improvement down the road, I don't think we can be confident enough about those to say we ought to budget on that basis and jack up the payment because we know that the dividends are going to come.

MR. GEORGE MILLER: But I think that with -- well, that's true, but one could take the speculation that we could then not pay for overvalue of services like, again, back pain. I use that one as the example. I mean, there are way too many imaging studies on low back pain or for migraine headaches. We're doing way too many studies on that.

There are enough things I believe we can identify and quantify to at least make a difference. Now is it enough to pay for moving the ship? I don't know, but we'd have to do that study.

I mean, Rita alone has identified enough of them that we can make a compelling argument.

MR. HACKBARTH: And, you know, I think again that there's general agreement that there probably is a lot of money out there. The question is how you reap and how you gain those savings before you start spending them on something else.

DR. REDBERG: The IOM report identified almost a trillion dollars in waste, which is a little bit different.

We're talking about overvalued services, but I think there's potential.

MR. HACKBARTH: Yes. Yeah, and we are mixing our lingo a little bit -- overpriced services versus utilization that is marginal in value.

I have Mike and then Jon. Then I want to move on to our beneficiary attribution issue.

DR. CHERNEW: So, quickly, the most important thing to start with is whether or not we believe or not that primary care is underpaid. And I do believe that primary care is underpaid, particularly if you got rid of the bonus, although I just would say that the evidence of that is somewhat indirect and the effects of paying even more is somewhat underdeveloped.

But all of that said, if one has to make a decision to start with the premise of primary care is underpaid, it makes sense that we want to pay them. And I think the 10 percent number is reasonable just because it's a good anchoring point.

The question then arises: How would you like them to get paid? And my view is if you're going to pay more I would much rather see it in a PMPM than in a tack-on to the fee schedule just because I tend to like broader, more flexible money as opposed to things tacked onto the fee

schedule. So that pushes you towards a PMPM.

We'll deal with some of the nuances, I think, in a bit.

So I'll just jump to how to pay for it, and I think the principle that I would apply is if there's a service we think is appropriately priced I would not want to lower the price of that simply to fund something else.

You know, I don't want to make one exacerbate -- create some other error to solve something.

So I think, conceptually, finding overpriced services or areas of waste is much more appealing.

And the only question is somewhat of a technical one. Can we find enough in the overpriced services, given the nuances of the scoring and rules and what they've already taken for the SGR and issues of the timing and the date and the process, to actually pay for this? I'm not sure.

So we're going to end up doing something that's noisy.

I actually would probably jump to other types of inefficiencies or savings we've identified as a way of paying for something that is good as opposed to believing it

all inherently has to come out of the physician fee schedule.

Or, put another way, I see no reason why if we think primary care is underpaid, and we want to increase payment for primary care, we have to limit our savings to fund that from the physician fee schedule per se if there are other areas in the system that we think are overpaid and wasteful.

I think a general rule is if we have to pay for things, which we often -- that are good, which we often do, the best way to do that is to find things we're paying for which we shouldn't and move that money around. There's a lot of, I think, political and other challenges to doing that.

So, within the realm of how this conversation goes, I prefer overpriced fees. I'm fine with the relatively small reductions across the board in non-E&M services. I think they are small enough and there's enough overpayment there that I would be okay with that as well.

But, more broadly, reducing overpaid or wasteful spending is the best way to pay for good things.

MR. HACKBARTH: And, you know, Mike as usual I

think has pointed out there's an artificiality in the notion that this money needs to be found within the physician fee schedule. That's a purely self-imposed thing. When Congress enacted the bonus originally, it wasn't funded at all. It was new money, so to speak. And so conceptually we could certainly say, well, this could be funded not just from the physician fee schedule but anywhere in Medicare. And where's Kate? You know, last time we talked about this, I think we had $100-plus billion over ten years' worth of MedPAC-endorsed recommendations that have not been enacted by the Congress. So we've identifying lots of potential sources.

DR. CHERNEW: Right.

MR. HACKBARTH: The problem is that there's also out there SGR repeal that leaves a hole bigger than $100 billion, and so is our money already allocated? And it gets into, you know, like, "how many angels can dance on the head of a pin" sort of discussion pretty quickly.

Let's see. Where's my list? I have Peter, Bill, and Jon, and then we really need to move on to attribution.

MR. BUTLER: So I think we need to be practical because you need a recommendation for this fall so that

we're not going to boil the ocean here. So I do think the 10 percent is the right number. I think that using overpriced services in the short run is a realistic answer. I think if you had more money -- I think that's kind of the mode answer that you're getting around the table, but if you had more money, I think there are too many questions around attribution or other things that you may screw it up if you really tried to put too much.

But I think the alignment issue that says these are my patients by itself is a building block and a positive thing to build upon. And you can always flex up the incentives or the money in various ways. But the idea that these are my patients that I'm responsible for I think is a good attribute.

DR. HALL: Glenn, after the session, if you really still want to know how many angels can dance on a pin, I can help you with that.

[Laughter.]

DR. HALL: When I talk to primary care physicians in my neighborhood, I don't find them saying that the 10 percent bonus was the panacea that people thought. However, they thought it was in the right direction, obviously.

So I think if we -- right now we have sort of a place hold on that, which is about to go away. So I think the priority here is to replace that with something that doesn't just let things revert to no bonus of any kind. So I think the number is not really important. I don't think the number's important to attract people into primary care. But I think dropping this without a substitute is certainly not an incentive for people to go into it, into primary care. Then we can work with it.

Then as far as where do we get the money, I also agree that Dr. Levy's letter from the RUC seemed to suggest an interest in taking a much more in-depth look at various fee schedules, some that we feel have been neglected in the long run. And I think this telegraphs to the RUC which direction we're going into, saying at least one of the possibilities is that there will be a redistribution of physician fees from potentially overpriced services.

So, you know, I think we should do this. I think it's really, really important. But I don't think we should get stuck on how much is actually going to be transferred at this point.

MR. HACKBARTH: Jon, last comment on this before

we move to the next issue, set of issues.

DR. CHRISTIANSON: Yeah, two comments, I guess. One is that conceptually I like the idea of doing it on overpriced services, but there's a part of me that says it sounds a lot like financing stuff by reducing fraud, waste, and abuse. I mean, it sounds good, but it's sound like -- it's squiddy squishy to me. I mean, it sounds like a promise out there that somehow we're going to identify these services and we're going to reduce and we're going to price them right and the money's going to flow back and all that. I think we can feel good about wanting to do it that way, but I would be more comfortable if there was something more specific. You kind of brought all this up and saying have we already spent this, and so I think it's a real problem, even though conceptually we all like it.

In terms of back to what people said about, well, you know, this -- what's going to happen to the money when it gets to the practices, there's a little story on that. We don't know, we won't know, we can't control it. The U.K. not too long ago did a pay-for-performance program where they put $3 billion into the system for three years for their GPs, and they put the benchmarks at the wrong level,

so they spent all the money in the first year, basically. And that represented a substantial increase in payments to primary care practices for some GPs. And so what happened to the money? Some of it was spent for all sorts of good things, but there was -- you know, they had a research project where they went out and interviewed people and tried to figure out what happened to the money. And there apparently was a significant number of cases in which the GPs put it in their pockets because they deserved a raise. And the problem that caused was that a lot of the work was done by the nurses in the practice to get the money. And so it created a lot of friction within the practice. But the notion was we're underpaid primary care docs, this represents money that we deserve, we've been underpaid for years. And that's where it went.

Now, not for everyone, but just as a reminder that we don't know what's going to happen to this money. We don't agree that we want to tie it -- I mean, we generally think we don't want to tie it to practice requirements. So we should be prepared to live with whatever happens to it.

MR. HACKBARTH: Okay. Let's move to beneficiary attribution. Thoughts on this?

DR. SAMITT: So I think none of the three options are perfect. You know, I'll throw out something that maybe a compromise, but it may be too administratively complex, which is: Would we ever think of a prospective attribution with a retrospective adjustment so that at least the funding is provided up front? Which is the flaw of the retrospective, but a reconciliation is done after the fact for any of the 20 percent or so of the change. So that's what I'd put out there as a straw man. If that's not feasible, I probably -- I think the best of all the evils would be prospectively, even though there is a change. So the funding is available for the PCPs but doesn't put the beneficiary in a tough spot. So if I were to pick one, that's the one I would pick. But I would rather have a blended approach.

DR. NERENZ: Just a question. The article that was cited from New England Journal of 2007 about the median of two, does it break down exactly how those two play out? I'm thinking, for example, if there are partners in a primary care practice and they essentially share responsibility for the patient, you have a clear attribution to the practice, but you have an unclear attribution to the

individual provider.

Now, I guess if they bill under the same number, maybe it comes out okay. But do we know how this two or larger than two sorts out, what it means?

DR. SOMERS: I don't know if they come from the same practice, the two.

DR. MARK MILLER: But you should also know that that question came up yesterday when we were running through things with Glenn and Mike, and Mike asked the question. And so we're going to try and go through -- ten versus the NPI I guess is the language, and we're going to try and break some of that out, because we did kind of fall upon that issue.

DR. NERENZ: Yeah, I was just thinking, at least around the edges there may be some of these attribution problems that go away if we just think a little differently about what we're attributing to.

DR. MARK MILLER: It's a good observation and we're going to run it through [off microphone].

MR. ARMSTRONG: Just a couple of things.

First, I recognize that the beneficiary attribution issue is way bigger than just this particular

primary care payment. And so maybe this isn't the time to really get too creative and solve it. But I really like Craig's suggestion. I mean, that's not uncommon, and it's practical. Just the one last point I would make is that, whether it's on this or many other issues that we're facing around payment policy, we're going to have to deal with the many arguments, some of which I think are data driven and some of which are political and some of which are just from somewhere, that prevent us from this prospective engagement of beneficiaries in a dialogue and a relationship with their providers.

I know we worry that it reeks of limiting choice, but it creates the relationship that's the foundation for managing care and reducing expense trends over the course of time. And so this may not be the time to solve that, but it's getting bagged, and somehow somewhere I hope our agenda going forward finds some time for that.

MR. HACKBARTH: I agree with that point, and, in fact, that has been one of the themes of our thinking about ACO as opposed to this passive assignment that the beneficiaries don't know about and maybe even understand less, if Cori's mom is an example.

You know, we've consistently said the beneficiaries need to be engaged as part of this ACO, and that in that context makes a lot of sense to me.

Now, this is a bit different context, and it's not entirely clear to me that it carries over to this.

In the case of the ACO, by definition, you have an organization, including the associated clinicians, who are saying, "We're going to assume responsibility. We will be accountable." And I think part of that naturally should be the beneficiaries need to be brought into that process.

Here we're outside of that accountability framework. You know, this is still fee-for-service Medicare, the hallmark of which is, you know, free choice of provider for better or for worse and people jumping around all over the place. And so the context here is different than in more organized settings.

MR. ARMSTRONG: I understand your point, and I actually agree with it. It was, nonetheless, a good moment to make my argument.

[Laughter.]

DR. CHERNEW: Well, I should say I also agree with Scott's view. In fact, the numbers that you presented from

the article are sort of more encouraging than I would have thought, because it was the 75th percentile to get to two, and that could be just the doc, not the practice. So there's a general question about how much you would be willing to risk, there being -- you know, if there were 5 percent of people that felt bad, that's going to be a lot of newspaper stories, a lot of confusion about asking people to do things. So the question is: What would it take for you to want to go there?

I like very much the idea that beneficiaries should be encouraged to designate a provider. I think it just helps us move towards an accountable system broadly. But this may or may not be the place.

I just want to say between the retrospective and prospective, I will say two things:

One, I'm relatively ambivalent because even if there's misattribution, it may net out. So it doesn't matter if 20 percent of your patients leave and so you're getting paid for people that you didn't serve; you may also be serving people you didn't get paid for because other people came in. And so I tend to prefer prospective because you get the money up front to do things as opposed to

retrospective. But it's not the single mispayment that matters. It's sort of the net when you give the PMPM. So as long as your panel size of Medicare beneficiaries, if you're a primary care practice -- and I want to emphasize "practice" not "physician," if you're a primary care practice. If that panel size isn't changing dramatically, you should roughly have those numbers basically balance out, and I wouldn't worry about them. And if you're not going to go to a designation model for all these other reasons, I would probably just go prospective and call it a day.

MR. HACKBARTH: We'll just go down the row, Peter, then Rita [off microphone].

MR. BUTLER: So a blended, as Craig suggested, maybe could work, but I on balance favor retrospective because it encourages the physician to do a good job, retain members, if you will, and keep continuity in care, where prospective has got an incentive to do the reverse -- not that you want to lose patients, but I like the incentive of do a good job, keep your patients, and get paid for it.

DR. REDBERG: I'll agree with some of my colleagues and not all. But I think that we should let the beneficiary designate the practitioner, but at some -- you

know, after two months or three months, then have Medicare just assign a primary care practitioner if the beneficiary hasn't designated one. And I would do it prospectively because although I appreciate that there could be advantages to retrospective, I think there are more advantages to doing it prospectively. And I think as someone else has already said, in the end I don't think it makes that much of a difference. If someone has had the opportunity to choose a primary care and they didn't choose one, perhaps they didn't care that much or -- and it's not like they can't change. And I think the important thing is to have a primary care doctor and, you know, we'll assume they're all pretty good, as long as we're in the right geographic area. So I would just -- and I don't think -- I wouldn't spend a lot of Medicare resources on time and whatever studies. I think we should just assign one, and there are other things to spend time and money on than figuring out the right primary care practitioner, because it's like college roommates. I think just kind of it works or it doesn't.

[Laughter.]

DR. REDBERG: I don't think all that online -- all that online stuff, I don't think anyone showed it did any

better than just doing it.

DR. BAICKER: I think one of the main advantages to the prospective assignment is getting the resources up front, but I suspect the bigger one is having the physicians engage in "this is my patient for the year to come" and being on alert ahead of time that that patient's course of care is going to matter, particularly for that physician.

And I think we asked last meeting about the degree to which the prospective assignment might get it wrong, how if you did retrospective squaring up, how many would you actually have to change, and really the right number isn't how many people would you have to change but how wrong would you be on average. If it turned out that you were 10 percent of the people who a physician -- if it's 10 percent wrong in a sort of symmetric way, you worry about that less than if it happens to be that the assignment is typically wrong for the sickest patients, then you worry more about selection. So it would be good to know how much retrospective squaring up would really help things, and if it's just around the edges, then maybe everybody can just live with a prospective assignment, especially if it creates that increased engagement; whereas, if it is of a

quantitatively important magnitude, then you want to do the truing up at the end.

DR. CHERNEW: Can I say, on average, of course, if I lose a very sick person because they're getting assigned to somebody else but I got paid for the sick person. there's some other person that now has that person. So it's a --

DR. BAICKER: It's zero sum in total [off microphone].

DR. CHERNEW: Right, in total.

DR. HOADLEY: I was just going to -- I mean, I think I'm in a very similar place. I mean, this is only about a PMPM payment. It's not the ACO. It's not attributing money based on the implications of what they do. So, you know, like a couple people now have said, we just got to kind of get it about right. So I think the notion of doing something that involves a transaction or a signature, a designation, a record, it starts to just add enough hassle that we're talking about low amounts of money, that that doesn't seem the right way to go, either retrospective, prospective. I think we could even say in the discussion of this that there are merits to both. We come down on the other, or, you know, the hybrid method or whatever. But if

we sort of raise it all, you know, we sound like we're writing the statute at this point.

DR. HALL: I think there's strong arguments both ways, but I guess I come down to that there's something about the profession, practitioners or caregivers. It's important for patients to know who that person is. Bill just said when he had trouble somewhere, you didn't want to know who was in the emergency room, you wanted to call your doctor, right? And I think we all have that feeling.

So if we're going to keep this as a profession, I think some kind of prospective attribution has a lot of merit to it.

MR. GRADISON: I prefer the retrospective approach.

[Laughter.]

MR. GRADISON: Just to make it interesting. Let me point out that there's only a one-year lag in payment if you have an on going relationship. And so I recognize that one year that might be a little awkward. But I think that tying the payment more to who you're actually serving during the year makes more sense to me, and I think the cash flow thing at this level of payment won't break the bank or cause

these folks not to be able to pay their rent.

On a more personal basis, I have got to say this. If somebody asked me to designate my primary care physician, the doctor I would designate I see probably every five years. If I have a condition, I call his office, and he tells me which specialist to go to. I go to that specialist, and I make sure that specialist sends copies of the reports to my primary care physician so that if, God forbid, I got in a situation where I was really in a jam or I go in to see him because of something unexpected that isn't covered by the specialist, then he's got all the records. And that may be just Bill Gradison and nobody else in the world, but I'm a little bit confused by, you know, what this really means. As a practical matter, personally I probably think that I get more ongoing coverage from the cardiologist that I see once every year than from the person I would actually designate.

So, again, that may be a total outlier, and I'll stop at that point.

MR. HACKBARTH: Jon, did you have -- I do want to the practice requirements, so --

DR. CHRISTIANSON: I like the way that Jack sort

of laid it out, and I like the blended approach.

I am not convinced that the prospective approach is needed to convince physicians to engage with their patients. If it is, I'm very sad about my physician, frankly. And from the practice managers and physicians I've talked to, they feel the same way. They're being measured. They're being paid for performance. They're being taught in medical school -- I mean, the whole notion is that you engage with your patient, and the idea that a 10 percent bonus on your Medicare payment is somehow going to make you engage with your patient which you wouldn't do otherwise doesn't ring very true to me or to the people I talk with. So I'm not so worried about prospective from that point of view.

I understand the designation. That's a different thing, patients knowing who they said their primary care doc is, than sort of using it as a motivating factor to become a better primary care doc. If that does it, I'm sad.

MR. HACKBARTH: I'm sorry. I missed you [off microphone].

DR. NAYLOR: So I'm sad that we're still talking about only physicians, but, nonetheless, that all being

said, I don't know that we do know what way to go, and I would be very much swayed by the current knowledge of what proportion -- I think you suggested it was not insignificant -- of people who change primary care physicians each year.

I would also suggest that it needs to be as simple as possible, and while it would make a lot of sense to do prospective and readjust, I'm not sure it's worth it and all that would cost.

I do think tracking attrition, if we move prospectively -- and I do like the idea of prospectively encouraging the conversation with people to let them know who is their primary care clinician is a good principle. So I'll look forward to the data to see which way we might go going forward.

MR. HACKBARTH: Okay. So let's turn to practice requirements, and I welcome thoughts that Commissioners have on that issue.

DR. MARK MILLER: Can I just make one clarification [off microphone]? Mary, your concern was the vocabulary that we used throughout this conversation. The policy would apply to all practitioners. It's just the concern -- and it's a fair concern. The concern was that--

DR. NAYLOR: I mean, it's just to recognize -- we're trying as a Commission to raise awareness to beneficiaries about who's available to deliver primary care services to them, and I think our language does count.

DR. MARK MILLER: I agree, and I wanted to make sure that the public knew that we're talking about the whole crew. And you're right, the language needs to be cleaned up.

DR. SAMITT: So if we are going to have practice requirements, the ones that I would most certainly encourage us to have are the ones that are closest to outcomes that we want to accomplish, not process, so going back to the discussions we had earlier that, you know, structuring something that would have to define and prove that folks have a team-based care model or other process-related metrics are going to be hard to measure, and there are going to be so many iterations, and it would make no sense. So one of the suggestions that I would put on the table is: Is it conceivable to structure out of existing measures a stars-like equivalent that says that an individual physician or clinician needs to have a certain minimum stars performance from an outcomes perspective to qualify for the

population-based bonus? So if we're to do anything, I would err on the side of something like that.

MR. HACKBARTH: Okay. But you say "if we were to do anything, and one of the questions here is should we do anything, given the magnitude of the bonus, et cetera, et cetera, et cetera.

DR. SAMITT: I would say yes. It not only shifts us away from the fee schedule, but also shifts us from a volume-based approach to care to a value-based approach to care, and we need to measure value in that regard.

MR. HACKBARTH: So I hear your preference is that we do make it contingent, but it's not on operating characteristics, it's on performance. And then the obvious question is: Where do the measures of performance come from that are valid at the level of individual clinicians?

DR. SAMITT: Well, that would come in the next session that we have.

MR. HACKBARTH: Oh, okay. I'll look forward to that conversation.

[Laughter.]

MR. HACKBARTH: On practice requirements, George?

MR. GEORGE MILLER: Yeah. Yeah, I would just

challenge -- the concern with the amount of money we're talking about and what it would cost to do any measures at this point in time until we get to the next discussion would be my question and raise it.

MR. HACKBARTH: You would err on the side of -- and let's not make this --

MR. GEORGE MILLER: At this point in time, if the goal is to deal with primary care, to improve that, at this time I would not put measures on, until we get to a significant amount of money, because it will cost -- whatever you put on it is going to cost additional money. So I would not.

MR. HACKBARTH: Yeah. So I see Herb and Cori on this side. Go ahead, Herb.

MR. KUHN: Yeah, I would be like George. I'm really reluctant to ask for anything that would put a practice requirement at $2.60 a month in terms of payment. I think at the last meeting we talked about what different PMPMs were, and they were on the order of magnitude of three or four times that, if not even greater -- in fact, probably much higher -- and had a whole host of requirements.

So I think at this, to me this is just a signal

that undervalued codes, we're trying to continue this bonus that's in place here, but to ask for anything beyond that, even though I think it makes sense and I agree with what Craig said that we need to think about that in the future. At this payment rate I just - -I think physicians would find it insulting, quite frankly.

MS. UCCELLO: Yeah, I agree with that, and if we do go the route of the overpriced and we do ramp that up, we may want to revisit this question. And if we do, I would again go back with the feedback that we're getting from some of these focus groups that they are saying that some of the main impediments to coordination results from communication breakdowns between the primary care docs and the other folks. So I would suggest trying to look at that area somehow for thinking requirements.

DR. SOMERS: Do you have ideas, Cori? Just --

MS. UCCELLO: I have ideas.

[Laughter.]

DR. SOMERS: Just thinking that fixing that problem, you would have to go after the specialists and the hospitals, that it would be hard for the primary care practitioners --

MS. UCCELLO: Yes.

DR. SOMERS: -- to fix that problem. That was as thought.

MS. UCCELLO: I think that's correct.

DR. CHRISTIANSON: Mark, Medicare already measures physician performance, right? The PQRS system?

DR. MARK MILLER: Yeah [off microphone].

DR. CHRISTIANSON: So if you wanted to --

MR. HACKBARTH: However imperfect.

DR. CHRISTIANSON: Which I don't, but if I wanted to, there's no new measurement -- there would be no new measure -- you could think about it as not having any new measures, no new collection requirements, et cetera, you ought to build off that.

DR. MARK MILLER: That statement is true. You should keep in mind -- and maybe this is going to come up in the next session when we start talking about quality. There have been concerns raised among the Commissioners about the accuracy when you measure at the individual physician level, those sets of issues, the fact that the variability -- our specialty society made really great rigorous ones, yours didn't, those kinds of arguments. And there's a lot of

concerns that kind of surround how that's happening right now. And I suspect some of that will come out in the next--

DR. CHRISTIANSON: All part of the reasons why I don't want to go that route, but I'm saying if we did go that route, I don't think it's as onerous if you build off the existing platform that Medicare has established.

MR. GRADISON: I'd associate myself with comments by George, Herb, and others. I would prefer not to have any requirements at this time.

I would suggest consideration of adding some language to recognize on the subject of requirements that some of them would not probably be realistic in relatively small practices. I would call attention, for example, on page 17 to the possible requirement of a care manager on staff to assist patients in self-management and monitor patient progress, and on page 30, separate from the one I just read, one or more advanced practice nurse, registered nurses, or PAs to provide chronic care management services. I think those are great ideas, but they're not going to fit even a moderate size practice because of the expense of hiring people with that skill level.

So I agree with the conclusion, but in terms of

the language, I think you might want to consider some language that recognizes that some of these requirements, frankly, are a hell of a lot more expensive -- or inexpensive -- than others.

MR. HACKBARTH: I think Jack is next. Am I missing anybody on this row?

DR. HOADLEY: So I'm in the same place. I mean, Herb put it well. I think, you know, with this small amount of money, you know, trying to add a bunch of process kind of measures doesn't make any sense. You know, I think the notion of a bonus has some attractiveness, especially if at some point we're talking about more money. But we've also got to make sure we've got something that can be measured in a way that works, and we're probably not there yet.

And the only other thing I would add is, you know, I don't know if this chapter could be the place or the chapter next year with the recommendations could be the place to sort of pick up some of the things that we talked a little bit about in this morning's session about things that would release burden that occurs relative to some of the team-based activities and whether we might want to link this to saying, okay, and in addition to this money thing, you

know, we're recommending something, if by then we can figure out what the something should be, about the process of some of the rules around face to face or those other kinds of things. So it might be a good place to flag something like that.

MR. BUTLER: Back to my practical January 1st, the path of least resistance is 10 percent increase, just keep it going probably. I don't think they're going to take money away -- Congress take money away from primary care. So whatever we do has got to be a simple -- the money is small, as it says, but trying to have other hooks on this, I just don't think it has a chance of getting through Congress. So something simple, and maybe I'm changing my mind more to prospective because you give money up front, but something simple like that that can be an alternative to just continuing the 10 percent is, I think, the one most likely to be supported by Congress.

DR. CHERNEW: I think the administrative burden and measurement issues are sufficiently complex that I'd prefer not to have it tied to any particular requirements.

MR. HACKBARTH: Okay. More on this come fall. Thank you, Julie, Kevin, and Katelyn.

And we'll now move on to measuring quality of care.

[Pause.]

MR. HACKBARTH: Whenever you're ready, John.

MR. RICHARDSON: Thank you. Good afternoon, everybody.

At its November 2013 and March 2014 meetings, the Commission discussed potential alternatives to Medicare's current policy on measuring the quality of care provided to the program's beneficiaries. In today's presentation, I will summarize the main points of the Commission's discussions in November and March and present some new discussion questions for you to continue your ongoing dialogue on the topic.

The results of today's discussion, along with the analyses and discussions from November and March, will form the basis of an informational chapter in the Commission's June 2014 report to the Congress and the Commission's ongoing discussions of these issues in the next report cycle.

The Commission had made a number of recommendations on quality measurement of Medicare over the

last several years, including quality reporting and pay-for-performance or value-based purchasing programs for some types of fee-for-service providers, such as hospitals and dialysis facilities and for Medicare Advantage plans where it seemed the measurement technology would allow measurement without imposing on sustainable administrative costs or opportunity costs on either providers or CMS.

Over the past 10 years, the Congress has enacted quality reporting programs for almost all of the major fee-for-service provider types and also mandated pay-for-performance or value-based purchasing for inpatient hospitals, dialysis facilities, MA plans, and physicians. Quality-based payments are also a central component of the ACOs operating under the Medicare Shared Savings and Pioneer ACO programs.

As Medicare's quality measurement programs have grown in size and complexity, the Commission and other observers have become increasingly concerned that for all of this activity, Medicare still does not focus enough on evaluating how providers are performing at improving beneficiaries' health outcomes. Instead, fee-for-service Medicare in particular relies on multiple clinical process

measures that reinforce the existing undesirable incentives in that payment model to increase the volume of services that the system compels providers to focus on the delivery of care, only within their own silo of care, and that it is costly to administer.

There also is a body of published research finding that providers' performance on many of the clinical process measures used by Medicare, particularly for hospital care, has little or no association with their performance on clinical outcome measures. For example, several of the process measures used by Medicare to assess the quality of care for heart failure, heart attack, and pneumonia do not predict overall short-term mortality in a large hospital quality improvement demonstration program.

Another recent paper found little relationship between hospital's compliance with processes of care and variation in adverse outcomes, such as mortality and surgical complications, for several types of high-risk surgical procedures that are still relatively common in the Medicare population.

In light of these concerns with the status quo, staff presented and Commissioners discussed in November and

March a population-based approach to measure on quality for fee-for-service Medicare, MA plans, and ACOs. Under this approach, Medicare would use a small set of patient-focused outcome measures, such as those listed on the slide, to assess the quality of care in each of the three payment models within a local area. In March, staff also presented an analysis using rates of potentially inappropriate use of imaging studies to illustrate the potential applicability of overuse measures. As some of you have pointed out, overuse measures could be applied as quality-of-care measures in any of the three payment models, whether fee-for-service, MA plans, or ASOs.

This diagram presents a simplified picture of what we mean when we talk about the three payment models in a local area. ACOs 1 and 2 are the triangles, comprise the ACO payment model in the area, and the MA plans, labeled A, B, and C, together are the MA payment model. And all around the ACOs and the MA plans is fee-for-service Medicare, which is made up of many individual and frequently uncoordinated providers of care. Some of these providers may, of course, also see patients attributed to one or both of the ACOs or who are enrolled in one or more of the MA plans that are

operating in the area.

I also want to emphasize that this diagram shows how Medicare as a payer might look at quality across these three payment models. Beneficiaries probably would be more interested in, and look more closely at, the quality of the individual providers in fee-for-service and the ACOs and at the quality of the plans in MA.

So the initial notion of population-based quality measurement as we began to discuss it was to calculate the suggested outcome measures that I just talked about or that I just showed you on the other slide for each definable population in the three payment models. So, for example, Medicare would calculate potentially preventable admissions and ED visit rates separately for MA plans A, B, and C and for each of the ACOs, and then for fee-for-service would base those calculations on the population of beneficiaries who reside in the area who are not enrolled in any of the MA plans nor attributed to either of the ACOs.

However, in your discussions in November and March, you seem to make a split between how most of you viewed the feasibility of using population-based outcome measures for, on the one hand, public reporting of quality

and, on the other, quality-based payment policy. I want to be clear for the public and for you that this is the staff's current understanding of what we think we heard you say, but we expect there will be much more discussion among you today and ongoing in the development of these key points as we proceed.

So for reporting, we think we heard support for Medicare calculating and publicly reporting on population-based outcome measures to allow beneficiaries and policymakers to compare quality across fee-for-service Medicare as an entity, across individual MA plans, and across individual ACOs in a local area. However, for payment purposes, several of you expressed support for using the results of these outcome measures to make payment adjustments among MA plans and the ACOs in a local area but did not support applying them to fee-for-service Medicare.

The reason for the latter point not using population-based outcome measures for payment policy and fee-for-service Medicare is the concern among many of you that in fee-for-service Medicare, there is no identifiable organization or agent to hold accountable for the population-wide performance on these measures. While the

combined performance of each individual fee-for-service provider would in aggregate determine the performance of the fee-for-service Medicare payment model in that area, several of you observed there simply would not be any entity to hold accountable for those results.

Another concern expressed is that such an approach would unfairly combine the performance of both high- and low-performing providers, which would mask any existing quality differences between providers in the area and potentially unfairly benefit poor performers at the expense of high performers. However, just as another footnote, another way of looking at that latter result is that it also could be useful to encourage in areas as high-performing providers to leave fee-for-service Medicare and either join or form an ACO or contract with one or more of the MA plans in the area.

If we reject, however, using population-based quality measurement to adjust fee-for-service Medicare payments and continue the current policy of using provider-level quality measures, we have to grapple with the significant drawbacks that many of you have also mentioned in provider-level measurement; for example, the incentive it

creates for providers to teach to the test and focus only on what is being measured within their own silo of care at the expense of other potentially useful quality-improving activities; the fact that there are gaps in current quality measure sets, because meaningful quality measures either do not exist or are in their infancy for key types of clinical care providers, in particular many physician specialties. Third, providers that do not treat a large number of Medicare beneficiaries may not have a sufficient number of cases to establish a reasonable degree of statistical reliability for their measurement results; and last, the cost and administrative burden on providers of using quality measures that require the extraction of medical chart data could be considerable.

Nonetheless, just to summarize, we think we heard a direction that looks something like this. For reporting and comparing quality on the basis of population-level outcome measures, Medicare, specifically CMS, would measure and report outcome measure results across all three payment models with each MA plan and ACO as its own measured entity.

For payment, fee-for-service would be separated, and provider-level measurement would be applied. But as I

noted, there would be some gaps in those measures, and not all providers in fee-for-service would be measured.

For ACOs and MA plans, we could apply population-based outcome measures, either to redistribute payments across the ACOs in an area and separately across the MA plans in the area or potentially -- and this is an option that we look for you to discuss -- between the ACOs and the MA plans.

Now, given your express concerns about using fee-for-service provider-level measurement, some of the principles that could guide Medicare would be to use quality measures that are developed by independent third parties and not by the providers to whom the measures will be applied. Medicare could reduce the number of measures used for each provider type and exercise restraint when considering the addition of any new measures. Medicare could retire any clinical process measures when research finds no association between performance on them and performance on the outcomes, such as mortality, readmissions, and complications, and always, always, Medicare could focus measurement on outcomes.

So I will tee up a series of discussion questions

and look forward to you discussing them. We have four questions here. First, if population-based outcome measures would be used to adjust payments to MA plans and ACOs, one question is, Should that be done only within those two payment models, that is, across ACOs and across MA plans, or possibly across them?

Second, do you support the way we presented the use of population-based outcome measures for fee-for-service Medicare in a local area; that is, to use them for public reporting but not for fee-for-service payment adjustments?

Third, if we must continue to use provider-level quality measurement to redistribute payments within fee-for-service provider types, what principles might guide Medicare in overcoming the current technical limitations on provider-level quality measurement? I outlined a few of those a moment ago, and there certainly could be others.

And fourth, how might Medicare fund quality-based payments? In the past, the Commission has recommended withholding and then distributing a small percentage of base payments within each fee-for-service provider category or within MA plans. Are you still comfortable with that approach, or are there others that we should explore, such

as redistributing funding across all three of the payment models or just across MA plans and ACOs but excluding fee-for-service?

Thank you for listening, and we look forward to your guidance for the June report chapter and beyond.

MR. HACKBARTH: Okay. thank you, John.

So when we get around two, again, I am going to ask that we focus on these issues. My sense of how to tackle them is in the following order. First, would you put up the preceding slide, John? I would tackle the second bullet here as the first issue. We got into this conversation, asking the question does it make sense to move to population-based -- more to population-based measurement based on what we've heard from you, we've heard some qualms about applying that to fee-for-service, and so we've tried to address those concerns. And one of the key issues is the second bullet here, so I welcome your feedback on that.

The second issue I would discuss is then the third bullet. If in fact we elect not to hold providers in fee-for-service accountable for population-based measure, what is our guidance on the provider-specific measurement?

And then I see the first bullet here and the

bullet on the next pages related to one another. How do you fund, and what are the pools for redistributing dollars? So I would tackle them in that order, if that makes sense to you.

Let me emphasize again, what we tried to do is, based on the last discussion at the last meeting, come up with a framework that addresses issues that we heard. I'm not sure we accomplished it, so please feel free to yank at threads or knock down the whole edifice, but then suggest an alternative. I will have high expectations for you.

Okay. So let's do round one, clarifying questions. Craig.

DR. SAMITT: So if you could turn to Slide 10, please. On the right-hand side of the slide, can you clarify how the comparative payment between MA plans and ACO plans that you're suggesting is different than what exists today? So with MA plans today, there's differential payment for stars, and for ACOs today, there's differential payment for 33 quality measures. So doesn't that already exist today, and is the real question about going across? Because my sense is that it already exists going down.

MR. RICHARDSON: That's correct. This arrow, the

one across, is the question --

DR. SAMITT: Is the question.

MR. RICHARDSON: -- for you to discuss. This is existing, the up and down is existing policy.

DR. SAMITT: Great, thank you.

DR. MARK MILLER: Although you could change the measure set and still do up and down, but what you said is correct.

MR. HACKBARTH: Okay. Clarifying questions. Dave and Mary.

DR. NERENZ: Okay. Thanks, John. This is very nice.

Slide 6, if we could.

I just want to make sure we're all on the same page in terms of the use of the term "population-based." In reading this, I assumed it is synonymous with geographically based, but I guess there's my question. Is it synonymous with geographically based? Nobody nodded, so okay. That --

MR. RICHARDSON: No. You would have to define a geographic area in order to do the calculation. I shouldn't say -- you wouldn't have to. The way we're envisioning is we're connecting it to the Commission's recommendation about

MA payment areas, but you could do it at any number of geographic levels.

MR. HACKBARTH: But the addition I would make to that is that for purposes of defining the population for an MA plan, it is the enrolled population. The population for an ACO is the assigned population. The population for fee-for-service would be a geographic unit, for example, based on what we recommended for the MA areas.

Do you agree with that, John?

MR. RICHARDSON: That's right. The only distinction I would make -- or not a distinction. I forget the word. So, for example, with the MA plans, one of the things we talked about in 2010 was that sometimes at the contract level, they cover multiple deliveries' markets, health care delivery markets, and it may make more sense --

MR. HACKBARTH: Yeah. So it would be the MA plans within that area for the care they are providing for the population --

MR. RICHARDSON: Of their enrollees --

MR. HACKBARTH: -- of that market.

MR. RICHARDSON: -- in the ACOs, there are attributed patients in that area, but we're not trying to

say this is the right geographic unit. We are, however, relating it back to the recommendation we made, which gives us a starting point, anyway.

MR. HACKBARTH: Did we --

DR. NERENZ: Just to restate to make sure I'm clear, so as we look at this diagram, all those individuals in Plan A are a population. The individuals in MA collectively are a population.

MR. HACKBARTH: Yeah.

DR. NERENZ: Those attributed to either ACOs to the combining of ACOs are a population, and then those who live in the defined region, whatever it is, in fee-for-service are a population, but these populations are not defined all in the same way. They are defined in different ways.

MR. HACKBARTH: Right.

DR. NERENZ: One is geography; the other are not geography.

MR. HACKBARTH: Right.

DR. NERENZ: Okay, fine.

MR. HACKBARTH: Right. And the last point that I think John was making is the MA plan here for comparison

purposes, it would be the population served within this defined geography as opposed to on a contract basis that might include that MA plan's enrollees in a lot of different geographic areas.

MR. RICHARDSON: Exactly right.

MR. HACKBARTH: Okay. Mary.

DR. NAYLOR: My question was asked and answered.

MR. HACKBARTH: Okay. Other clarifying questions? Peter.

MR. BUTLER: Ten, is it?

MR. RICHARDSON: The infamous diagram?

MR. BUTLER: Yeah. Give me the whole enchilada there.

MR. RICHARDSON: Okay.

[Laughter.]

MR. BUTLER: So the stars on the right-hand side for the MA plans, the 33 measures for the ACOs, we do have measures already in the fee-for-service that kind of are like readmission rates, which is one of our suggested population ones, is in the provider side right now, right? What gets tricky is it actually applies to your patients that are in the ACO too. So these are not quite as clean a

silos as they appear to be, and they suggested -- what complicates further is we have in the chapter of six or seven ones that we, I think, are suggestion would replace the stars, would replace the 33 ACO measures, right?

MR. HACKBARTH: Just say more what you mean.

MR. BUTLER: Well, in the chapter, we have population-based outcome measures for comparing quality, and so there's a suggested set of six or seven of those --

MR. HACKBARTH: Yes.

MR. BUTLER: -- which actually we would be thinking about having those potentially replace the columns as shown.

MR. HACKBARTH: Yes.

MR. BUTLER: Right? Is that the right way to think about it?

And then just to further -- I'm clarifying in my own mind, maybe. In another year, the medical spending per beneficiary number also comes into value-based purchasing for providers. That, too, takes the 30-day beyond, is a population measure that is kind of -- treads into this other water too. So this first column is very messy.

MR. HACKBARTH: Yeah. So let me just try a couple

things. You referred to the readmission measure as it is currently used in the hospital payment system as a population measure. I wouldn't think of it as a population measure there. It is measuring the performance of a group of patients that come to a particular institution. It is not related to performance in the whole population in the defined geographic area.

An ACO, if we apply a readmission measure, it would not be for any -- necessarily for any particular hospital. The ACO may include more than one hospital. It would be the measure for the ACO's assigned population.

So the same measure --

MR. BUTLER: I understand. I'm crystal-clear on columns 2 and 3. I'm not sure what the population is then in column 1, those that are not attributed to an ACO or not in an MAN plan. Those --

MR. HACKBARTH: I'm not sure how your attributing columns. You are saying this column?

MR. BUTLER: Yes, the fee-for-service column. That one currently is subjected to readmission rate penalties.

MR. HACKBARTH: Right.

MR. HACKBARTH: As is column 2. The ACO ones happen to be right now.

But the question is do you include -- you know, you're trying to get at did we mean what we say last meeting, and that is not have some of those population-based measures in column 1, and I'm saying I think some of them are already there one way or another. And you might even do some combination around 2 where you have some population and some other ones that are sitting in -- right now, I'm just trying to get it clear in my mind, though.

DR. MARK MILLER: So let me try this, and I'm going to simplify this. So we are only talking about readmissions. You are absolutely right, and I am only talking about the payment side of the picture for the moment.

So just for the moment, I think what we're saying is, is in that fee-for-service, I think you called it "column." Is that what you were saying there?

MR. BUTLER: Yeah.

DR. MARK MILLER: Just assume it's the readmission penalty as constructed now, and then in the other two for ACO and MA, it would be a readmission calculation based on

the people who are attributed to that, not the hospital. And that's the only distinction.

And what we're asking you guys -- and this is how I think the clarification is -- is that what you meant when you said you didn't want to apply population-based measures to fee-for-service?

Now, in your mind, you might think, well, wait a second, I'm sure that line is a bit blurry, but our question to you guys is we thought we heard you saying draw a line -- that's that dotted line -- between fee-for-service, and don't use the same measures.

MR. BUTLER: Okay. So for readmission rate, I'd say I'm okay with using the same measure, but if you say healthy days at home, I'd say a doctor or a hospital, how can they -- that's very different.

DR. MARK MILLER: And what the staff would say to you is we're viewing the readmission on the fee-for-service in this conversation as a provider-based measure. It's your hospital as opposed to a population of people.

MR. BUTLER: I understand.

MR. HACKBARTH: Jack, you look like --

DR. HOADLEY: Yeah. I guess I am trying to

clarify the clarification. Just the way you were just talking about that on the readmission rate with all those caveats, under sort of our default assumption here, would we be subtracting out the patients who belong to an ACO? IN other words, not use the measure that Peter's hospital might use today as a hospital, but to measure the sector, if we were going to do this, we would take his hospital and the other hospitals in the geography minus the patients who go through that hospital. They're attached to one of these other people in the other, or is that just --

MR. HACKBARTH: So this is the point. John raised earlier that any given provider may be participating in all these columns, and one patient falls in the MA column. Another one is fee-for-service. Another one is ACO, and that's the reality of our complicated world. I think we would get all tied in knots if we tried to segment out and subtract this one and that one.

So if we're talking about the provider-level measurement in fee-for-service Medicare, I think we probably just want to say for all of the patients served by that hospital, how are they doing, to maximize the calculation.

DR. HOADLEY: So it's the status quo measure of

what's out there today, essentially.

DR. MARK MILLER: Well, the other thing I would say to you guys in this conversation, what we're trying to do is figure out conceptually where you are, and then there are probably whole rippling sets of questions below that, that then say, okay, which measures and how technically do you get to it. But there were fairly strong statements that said don't use a population measure in fee-for-service, we're trying to nail that down, and then if it becomes a technical issue of what's the denominator in each instance, there's probably sets of conversations there. So I would say the goal for this conversation is when that statement -- did you mean it when you said it, and how many of you and all that? I'm trying to be --

[Laughter.]

MR. HACKBARTH: Do you wish to reconsider?

DR. MARK MILLER: Right. Do you wish to reconsider? Yeah.

And if this is conceptually where you are, then we have a raft of work that we have to come in behind and make it actually workable, so --

MR. HACKBARTH: I have John and then other

clarification questions here.

DR. CHRISTIANSON: So, yeah, hopefully, this is clarifying too.

[Laughter.]

DR. CHRISTIANSON: My objection was coming up with a population-based measure on fee-for-service and assigning it to every hospital or every provider and paying based on that. So you get penalized if you're a good provider. You get unfairly rewarded if you're a bad provider. That is the problem. That is different than sort of saying, oh, I can measure readmissions at a per-hospital level for fee-for-service. Okay, that's a different kind of measure. That's not a population-based measure, right?

MR. HACKBARTH: Right.

DR. CHRISTIANSON: Okay. That was why the column under fee-for-service Medicare has the dotted line by it, I think.

DR. MARK MILLER: Exactly.

MR. HACKBARTH: You got it.

DR. MARK MILLER: You got it.

MR. RICHARDSON: Just to clarify one, provider-based measures for fee-for-service, and that's the kind of

measure we're talking about, provider-based; population-based measures for MA plans and ACOs as individual entities.

MR. HACKBARTH: Go ahead.

DR. CHERNEW: This is really a round one.

MR. HACKBARTH: Then hold it then to --

DR. CHERNEW: Well, it's blurred. I'll save mine.

MR. HACKBARTH: Okay, hold it then.

Round one, clarifying. Bill?

DR. HALL: I'm starting to see the light here. I guess I got confused, the term "population measures." So I'm thinking population measures, like the Dartmouth Atlas, which shows variability in all kinds of medical practices and outcomes across the country. That's not how we're using the term "population."

MR. HACKBARTH: That's right.

DR. HALL: We're looking at cohorts within a given geographic area and comparing them to each other and to perhaps other forms of health care delivery, ACO, MA, fee-for-service; is that right?

MR. HACKBARTH: I think in our last discussion, this was one of the issues that arose, was we didn't have a common notion of what we meant by population measures, and

somebody was thinking geographic, Dartmouth Atlas sort of things, and others of us were thinking accountable populations for which an organization has assumed accountability.

And so one of the things that we're trying to accomplish here is to emphasize that we're thinking about population in the latter sense.

DR. HALL: Right.

MR. HACKBARTH: Now, in the case of fee-for-service, they have not assumed any population accountability. So there, what we're doing is measuring in a defined geographic area, but we would not be holding providers responsible and adjusting their payment rates for something that they have not agreed to assume accountability for.

DR. HALL: Right.

MR. HACKBARTH: And that's how we're trying to bring these threads together.

DR. HALL: So one thing is if we're having some confusion here, I don't know whether out population that reads what we write are going to understand this any better.

MR. HACKBARTH: Yeah. Well --

MR. HACKBARTH: We'll have to figure that out some way.

MR. HACKBARTH: Yeah. And we invite suggestions on the lingo to use, the framework, because obviously it's difficult.

DR. CHERNEW: Yeah. Well, I was just going to say, but Dartmouth is -- they just have fee-for-service Medicare claims, and this model includes ACOs because of the way fee-for-service works, but that aside. So in some sense, for the fee-for-service portion of this, it is relatively analogous to the Dartmouth use of the word "population." The part that's different is when you move to the MA plan side. Then it's clearly -- just because they didn't have it in their sample.

And when we think of ACOs, there's this awkwardness of ACOs, which is they're organizations that have assumed accountability as suggested by the name, but they fit administratively in the fee-for-service world. I think the distinction is when we -- when I think of population-based, the alternative to population-based is provider-specific, and so a provider-specific measure says Hospital 1, 2, 3, 4. A population-based measure says for a

group of people, either in an MA plan or in a geographic area, this is what the readmissions rate is or whatever.

MR. HACKBARTH: My sense is we're making some headway in terms of getting on the same conceptual framework. It may not be all the way there, but I feel -- Kate, do you have something?

DR. BAICKER: [Off microphone.]

MR. HACKBARTH: I'm ready to move into round two, if there are no more clarifying questions.

Okay. Are you going to address them in my order?

[Laughter.]

MR. HACKBARTH: Aha! I gotcha.

DR. BAICKER: Yes, I will.

MR. HACKBARTH: All right.

[Simultaneous discussion.]

DR. BAICKER: What's he going to do if I don't.

[Laughter.]

MR. HACKBARTH: Right.

DR. BAICKER: So if you can actually go back to the picture, that is not actually what I had in mind last time, and so either what I had in mind is to -- it is more complicated than I thought it was or I'm not quite

understanding this framework.

Here's what I had in mind.

MR. HACKBARTH: We're not as smart as you thought we were.

DR. BAICKER: I don't think that's it.

So there are two uses for the kind of measures and information we're producing. The first is for enrollees to have information about choosing a plan, for the public to know what's working and what's not working, for an overall picture of how dollars are being spent more effectively or less effectively in different types of organizations. That is the left-hand side for me, and I would think that beneficiaries would want to know how is MA doing relative to fee-for-service. Do I want to leave fee-for-service and choose an MA plan, and if I am choosing an MA plan, which one is doing best by its enrollees? So having these aggregate kind of -- I would still call them "population-based measures" -- gives both beneficiaries and the general public a sense of how the sector is performing, what's going on in an area. In my part of the country, how is MA doing? Do I want to pick this MA plan? Is it doing better or worse than I would do if I made a different choice? So all of

those makes sense to me, and I think that that requires both siloed reporting and comparative reporting within the siloes, and I think we're all on the same page for that.

Then the question is, How does that information feed into payments? And payments, there's some extra constraints. First of all, we don't have -- we can't pay fee-for-service as a sector. We pay individual providers within there, and there are all these limitations to how we can pay individual providers, given small sample sizes, and thin patient panels. We don't want to make providers fully responsible for the idiosyncrasies of what might happen to their patient panel in a given year, so there's some limitations to that. But fundamentally, we are saying we want to use the information on the right-hand side to pay more for better quality care, to align payment incentives to high-value care, and that's about what the benchmark is.

And I think in the past, Mike has made this point, that we want to pay the entity who has some control and responsibility. In the case of an ACO, it's the ACO. In the case of MA, it's the MA plan. In the case of fee-for-service, it's the individual provider or provider group, so that just happens to result in different levels of

aggregation.

And what we want to evaluate their performance relative to, that's where we're drawing a line. Should the line just be within each silo? Do we evaluate MA plan performance relative to other MA plans, or do we evaluate MA plans relative to a fee-for-service benchmark? And that's about how we set the benchmark expectations for performance in that responsible entity-based payment.

So to me, that is treating everyone symmetrically in terms of the level of aggregation at which we're making the payments, the payment calculation, and it's just a matter of whether we want them to have a common benchmark or different benchmarks to feed into that formula.

Now, maybe those words I said actually look like that. They are not so arrow-y in my head.

[Laughter.]

DR. CHERNEW: I think the words you said are intended -- that picture is intended to match the words that you said, and I think the issue in my mind is if you are going to pay MA plans or ACOs a certain -- for quality, I think you want to make sure that you pay them relative to a common benchmark, which I like being fee-for-service. And

so if all the MA plans were really bad, for example, I would not want to give the best of the bad lot a bonus, and if all of them were really terrific, I would not want to penalize the worst of the terrific ones. The same holds true for ACOs. I would like them all to have to beat some general benchmark, and I like that benchmark broadly being fee-for-service, at least as long as there's enough people in fee-for-service -- we had some of this discussion earlier -- because that is our standard benchmark for savings and a whole variety of things.

So I think that if I were drawing arrow-y things, I would actually have ascended the horizontal arrow even a little bit further. Fee-for-service would not be paid any different. They are the benchmarks. So by definition, they are not paid more or less, but everyone else in the ACO or MA columns, they are paid, more or less, relative to a common benchmark relative to each other. That would be my sense of how we would achieve some harmony across this and set the benchmark standards.

DR. BAICKER: Well, and so that suggests in some ways that there isn't such a dotted line in between them -- wait, wait, wait -- and that there is some horizontal line

that is going across it that is benchmark. And it's not so different even in the fee-for-service world if you start thinking about paying for, you know, achieving goals like lower readmission rates that are calculated based on what you would expect in fee-for-service, even for fee-for-service. There is still some quality threshold benchmark performance that is going on in all three columns.

DR. MARK MILLER: So what I would like to do is try to -- before anyone reacts to that, just a little bit more mechanically, operationalize what you said and see if you agree with it. Okay?

And to the transcriptionist, I'm sorry. I'm going to walk to the board, and if that makes your day --

So what I think Kate could be saying, looking for a response here, is you're saying you measure fee-for-service on a population basis, and anybody over here on a population measure has to do better than at least that in their market to get any reward. And the reason that I went here instead of here is this still, notwithstanding Peter's "Wait a second, they aren't so always different," this could be very micro. This could be the physician's aspirin or, you know, hospital's aspirin after a heart attack type of

measure. And if you're talking about a benchmark, I think the benchmark -- and I do think what you're -- I follow what you're saying is -- to get in this game at all, to get an extra payment, you got to be at least better than the fee-for-service environment that you're working in.

MR. HACKBARTH: So one of the connections I want people to make is to think to our series of conversations about leveling the playing field, and that's what we're talking about here in the specific realm of quality.

We talk about having common benchmarks financially, so that we're not rewarding one sector differently than another, and here within the quality realm, we need a benchmark. And the proposal that we're making is fee-for-service, the ambient level of fee-for-service in the population, and that community becomes the benchmark. And you earn reward as an ACO or MA by beating that.

Just like in the MA program, if we had our way, you would earn your rewards by reducing your cost below the fee-for-service level of costs in the area, and so that's the parallel structure that we're trying to create.

DR. BAICKER: So I like Mark's way of framing it, just to wrap up, that the benchmark -- that everybody on the

right-hand that's going onto the calculations on everybody on the right-hand side is from the fee-for-service population on the left-hand side. The only friendly amendment is that I wouldn't necessarily be right now so prescriptive as to get any quality, you have to be above this thing. What I mean is that that's the key input, and that key benchmark input, whatever the functional form that comes thereafter, should be the same benchmark for everybody on the right, and everybody on the right is getting paid at the unit of the responsible entity, which is an MA plan, an ACO, or an individual provider or provider group. That same benchmark is feeding in for all of those entities.

DR. MARK MILLER: Okay, I got you.

DR. BAICKER: So that key.

MR. HACKBARTH: Okay. Let me go over here. Jack.

DR. HOADLEY: So one question, I go back to the question I asked in the early round when I was doing it on the wrong place. I was doing it on the right-hand side of this picture. If we are measuring this benchmark on the left-hand side now -- and I like that clarification -- fee-for-service now, it sounds like the way we're talking about it -- would mean fee-for-service that's not in ACOs. It's

the pure fee-for-service.

Now, you could presumably say no, we actually mean -- what we traditionally mean is fee-for-service, which is all of those two sides, even though we would apply it differently to ACOs from non-ACO fee-for-service, but it sounds like at the moment at least what we're talking about -- and this does go more to sort of Mike's point about that may shrink, that could actually in some areas get pretty small.

DR. CHERNEW: I think some of this is sort of convenience, and in an ideal world, you'd be able to have sort of an average across all the systems, and that would set the benchmark. That's just hard to do. We've done it with the Medicare Advantage in counterclaims, for example. There's issues of attribution that might make putting the ACOs in or out sort of complicated. So I think the broader point is coming up with a benchmark that you can get to.

I think if there was no fee-for-service in an area, outside of the ACO portion of fee-for-service, you'd need to move to this broader --

DR. HOADLEY: Right.

DR. CHERNEW: -- benchmark. And I do think that's

true. I just don't think in general, we're there yet, but to the extent we were, the notion of having an area-level benchmark and then folks competing against.

DR. BAICKER: A single benchmark.

DR. CHERNEW: Yeah.

DR. HOADLEY: Yeah.

And I guess the other thing that came up the way that some of the questions were phrased in the chapter a little differently than were phrased on the slide, talked about money ultimately moving across the -- to use the term "siloes" in this macro sense, and as I'm hearing it talked about now and which I think is a better way is it's not so much that money is moving across the siloes as that money is going up or down based on a comparison. And maybe one area actually ends up getting paid more because they've got a lot of high-performing institutions, and some of their area gets paid less. But we're not necessarily making zero-sum, so that if the MA plans are all doing really well, they're getting money that's coming out of some pot that's measured at the geographic areas.

So I think what this -- and what I think makes sense is the MA plans in this particular geographic area get

bonuses if they perform well, and if all of them perform well, they could all get bonuses. That doesn't necessarily come out of the hide of fee-for-service or ACOs. But those are, it seems like, some of the complexities. We got to make sure to --

MR. HACKBARTH: So the funding thing is complicated, and it's complicated in part by the fact that, again, we try to apply this discipline to our work that we don't recommend more money without saying where it's going to come from in a constrained environment.

In the abstract, my preference and I think Mike's preference would be to say it's new money. If MA plan, for example, performs outstandingly well against this common benchmark that we have established, that it doesn't have to come from someplace else necessarily, because maybe all the MA plans are performing well, but if that's the case, we've got this budget constraint to deal with. And I don't know how to fix that problem.

DR. CHERNEW: And I would say I don't see why -- if we thought fee-for-service payment levels were right according to our criteria, I wouldn't lower them all because all the MA plans were great, or I wouldn't raise them all

because all the MA plans were horrible. And I would say if we want to pay for quality, we should actually be willing to pay for quality.

But we do a political version of this, which makes it hard across all of these things, and that's a separate issue. But I wouldn't distort prices in one area just because someone else is doing good or bad.

MR. HACKBARTH: Okay. Mary.

DR. NAYLOR: So I want to first -- this conversation is really helpful. I just wanted to make sure that I was in the ball park. Are we thinking -- and actually, I'd like to go to the discussion point, because the diagram is challenging for me, because I think if you have population-based measures, you have population-based measures, and so I'm wondering if language here is also getting in the way.

As I understand it, you would take a medical service area. You would have aggregate measures of traditional fee-for-service on six dimensions -- hospitalization, re-hospitalization, healthy days at home, patient experience, et cetera. That would be the set of benchmarks aligned with our goals to simplify everything,

make it parsimonious and get to the real important high-level quality metrics against which payment goes to other payments, and there's where you get alignment.

Do we have the capacity? I mean, I know we're working on healthy days at home and other measures, but can we do all that right now on index hospitalizations, on re-hospitalizations, on patient's experience? And is that what you are talking about, an aggregate measure of quality for traditional fee-for-service in an MSA, the six of which we would use to benchmark and allow payments to be adjusted for the other payment models achieving alignment?

MR. RICHARDSON: Yeah. The measures that we are talking about with -- I thank you for that caveat on healthy days at home, because that one is certainly under development, although in some ways, that one is 365 days minus the number of days a beneficiary in the population was deceased, hospitalized, and then you could in the EDs, you know, on home health, and those kinds of things.

DR. NAYLOR: Acute?

MR. RICHARDSON: Yeah, right. We could argue about -- or discuss that, rather.

But all the rest of them at least conceptually --

and again, there would be some discussion about this -- could be done with claims data, and then you run into questions about risk adjustment, and would you have enough information to do that without medical chart data. And again, that would be another complication we would have to discuss.

So in terms of the -- let's call those more utilization-based quality measures, the admission rates, the ED visit rates, re-hospitalizations, and healthy days at home, characterized that way, you could do all that with claims data.

The CAHPS is also available for a fee-for-service. Medicare did do that for a while, and they used that to compare MA to fee-for-service in geographic areas. So that technology exists as well. So all of it seems like things that you could do relatively -- not easily.

I like the way Kevin characterized it earlier when he was talking about the other issue where the technology exists, but it doesn't mean it would be easy. But, you know, it's feasible.

DR. NAYLOR: I really like it.

MR. HACKBARTH: Jon and then Alice.

DR. CHRISTIANSON: So I think where we want to be is to have -- to not double-count beneficiaries. I'm not sure this is worth the effort, unless we think we can get to that point, because I think the reporting, I think the knowledge there is if you look at beneficiaries that are in fee-for-service and you compare them to beneficiaries of ACOs and you compare them to beneficiaries that are in MA plans, what do you find out?

Right now, if I understand your comments, Glenn, we can't distinguish or won't distinguish beneficiaries that are in fee-for-service Medicare or in ACOs. They're all going to be -- so is that correct, or can we in fact apportion beneficiaries to those who are in fee-for-service, not in an ACO, not in an MA plan?

MR. HACKBARTH: So what I was trying to say, Jon, is I agree with your goal that we ought not have double counting, and the reality is that right now, we've got all this overlap, the patients. But I agree with your conceptual point.

I don't know the answer, how quickly we can get to eliminating the double counting. That's just not my thing.

DR. CHRISTIANSON: Yeah. Do you think it's

impossible to do that in that way?

MR. HACKBARTH: I wouldn't think it's impossible, no.

DR. MARK MILLER: Well, and remember the flow of the conversation. So when we came in last time, what we were saying -- there was all this. We were reacting to too many measures, overbuilding, can't get measures down to the micro level, you know, we are making ourselves crazy, that kind of thing.

So one of the simple -- and it's not, but just simple as we're going to try that --

MR. HACKBARTH: Simpler.

DR. MARK MILLER: Simpler solutions is to come out of the blocks on the left-hand side and say okay, we're going to measure avoidable emergency room visits on three populations that are separable. I know who is in an ACO. I know who is in an MA, and I know who's left. And there's your three measures, and you measure them across the three vectors. And people were mostly like okay, I could see that.

And then came the question of, but do you move money around on that basis, and then things kind of broke

apart. And that's what brought us into the fee-for-service.

And I think your question becomes a complicating question in that environment, because then that measure is a provider-based measure, and then you have to kind of go in and pull out the ACO people and the MA people. You could probably do it, but it may create issues and other issues that may complicate how well you can end up measuring given what you have left, if you see what I'm --

DR. CHRISTIANSON: Yeah, I see. So there are two objectives here, and it seems like what you're saying is the reporting objective is doable. It's going to require some programming, but we can do it. The payment objective is a lot more complicated in terms of using this, and we're not sure that we can do it at this point.

DR. MARK MILLER: Yeah. And I think what I was pleading for earlier is if people get a conceptual path in mind, then our next task would be to dive in and figure out what's the next level of technical --

DR. CHRISTIANSON: I would be very happy if we could make progress on the reporting, and I think in doing that, we are going to at the same time reach some resolution on the payment, but --

DR. COOMBS: So I don't know if we have a slide of the Figure 1 that was in the handout. I think you --

So I think combining this with the other is a bit confusing. I don't have a problem with the population-based analysis for reporting. That seems to be straightforward.

The issue comes up when you look at what the fee-for-service looks like compared to the Medicare Advantage. Do those patients look the same? And that's a real issue for me, because it actually leads us to what kind of funding initiative you are going to have. If those patients don't look alike, then I am more apt to agree with the first bullet on funding quality-based payments, which is across-the-board allocations, because if you take off the super -- the best at the top, the foam, and then you have this big sea of all kind of patients, I think your data is going to be so skewed in some fashion, especially in places where the ACO penetration and the MA penetration is much more robust.

MR. HACKBARTH: I absolutely agree with that, and that's an issue not unique to this discussion, but with MA payment policy, how do we make sure we're paying fairly, and we have risk adjustment tools that we use to try to calculate, estimate what that payment would have cost had he

or she remained in traditional Medicare? Are those tools perfect? No, they are not, although as Dan Zabinski reported, on a risk adjustment for payment side, the belief is that those tools have gotten better over time, and we're doing a more accurate job in paying for patients on an apples-to-applies basis. We will never get to the point where we can adjust for every different characteristic, though, so there will be some slack in this system.

Scott.

MR. ARMSTRONG: So it's possible this is not a relevant comment to this, and maybe it's just one more time taking advantage of the moment, but --

[Laughter.]

MR. ARMSTRONG: I really like the prospect of advancing this ability to compare on the basis of certain quality measures, the effectiveness of our different care delivery models, and then ultimately paying differentially on that information.

But someone made a comment earlier that I was just thinking about, and that is that it's possible that actually the differences between fee-for-service, ACO, and Medicare Advantage in a geographic market dwarfs the differences in

these outcomes between different geographic markets. And so it does beg the question how could the problem we're solving for better comparative information actually be used not just for this purpose, but more broadly to reconcile other variations in the Medicare program.

MR. KUHN: Yeah. On that, on this theme that Kate kind of started us down, because that's kind of the way I was thinking about this issue as well, and the opportunity to really begin to showcase I think more effectively integration, care coordination versus fee-for-service -- and I think Scott was getting at that as well -- is how we can find a way, so beneficiaries and others can kind of see the value of the two -- of the three kind of areas that are out there. So on the reporting side, I'm there.

On the payment side, though, I'm troubled by that one, because I think the technical nature of it is very difficult. The fact that we still have MA plans that are overpaid, working that through the system and all those areas, I just think it makes it very, very difficult technically. So I kind of understand conceptually what we are trying to achieve. I just don't know technically how it would work, and so I want to kind of reserve judgment on

that one for now.

MR. GEORGE MILLER: Just quickly, hearing that last conversation, if I am a beneficiary and I want to look at this and determine where is the best value for me, could I be able to look at the quality measures for an ACO or MA or fee-for-service and determine where is the best place for me to go, especially around the geographic variations? So that if I am in one market, I would be able to determine that, but if I went to a different market, it would be a different solution. Is that what we are trying to do? Is that what Kate described, or am I --

MR. HACKBARTH: So on the left side, the reporting side, within a market, we'd like for a beneficiary to be able to say if I say in fee-for-service, the average level of quality for fee-for-service in my community is this. I have got managed care -- Medicare Advantage Plan A that actually produces better results than that. Plan B produces --

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: -- worse, ACO 1 better, and so it gives some context for them to evaluate the ACO and Medicare Advantage scores.

Now, if they choose to remain in fee-for-service, obviously what determines that patient's quality of care is not going to be the ambient level of fee-for-service quality, but which providers do they go to, specifically. And then that sort of gets us --

Mike, did you want to jump in?

DR. CHERNEW: No. Go on. I was just going to say --

MR. HACKBARTH: So in the payment side of this, we're still recognizing, we would still be recognizing that in the fee-for-service column, there is still work to do to be done to elevate the level of quality --

DR. CHERNEW: Yeah.

MR. HACKBARTH: -- and we'll need some provider-specific measures of performance. We may want to do some pay-for-performance to advance quality within the fee-for-service, but none of that is going to be measured on a population basis, as we've used the term. It's all going to be for their patients.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: That's the --

DR. CHERNEW: Can I just -- it actually turns out

that in an MA plan, it also depends on which providers you go to, because the MA plan could have a lot of different providers.

MR. HACKBARTH: You had to make this more --

DR. CHERNEW: No, I was just going to say, what I would say is we should just for the purposes of this discussion and my opinion avoid the use -- the more complicated question about how to tell beneficiaries or how to aid beneficiaries in choosing a particular provider. This is useful in choosing a system potentially. It's useful for monitoring the system in a variety of ways. I don't think the quality measures yet are able to solve this other problem of you should go to Dr. Miller versus Dr. Redberg and whatever the --

MR. GEORGE MILLER: [Off microphone.]

[Laughter.]

DR. CHERNEW: Yeah, but anyway --

DR. REDBERG: Well, so it's --

MR. HACKBARTH: So Craig had the ball next.

DR. REDBERG: Okay. I just wanted to address that point that Mike and George just made very quickly.

MR. HACKBARTH: Go ahead, Rita.

DR. REDBERG: Because it's been bothering me since we started this discussion, and I know I heard what Mike just said, but I can justify that we could treat MA and ACO all the same, because there is some common unifying theme. But fee-for-service, I am having a very hard time with population-based measures, because you could have -- you know, as a patient, there is no unifying theme, and if you choose X or Y, you are not going to get the average. You are going to get X or Y, and so I have a hard time with the population-based, I think. I don't see how it's going to be useful really for patients at all, because I think providers are very consistent, but they're probably -- you know, they stay where they are, and averaging them all is not really accurate for reporting.

MR. GEORGE MILLER: And my problem with it, there's such geographic variation, and how do we address that? And I thought we were on the path to address that, but I'm not sure now.

MR. HACKBARTH: Okay. Craig has been very patient here. I've got Jack and Bill Gradison waiting on this side. And then after we go through those, I'm going to want to try to march through some of the questions here so we can get

some guidance.

DR. SAMITT: All right. So I see this in two phases. So Phase 1 of this evolution is absolutely on the left side. I think in all reality, whenever you change payment, you want to change reporting first so that the various groups and providers understand on which basis the payment is based. So at a minimum, let's do the left because we haven't done the left well, and let's look for data that enables us to harmonize across the groups, at least from a reporting standpoint.

For me, what's also in Phase 1, just to kind of bundle the concepts, would be to address and revise the provider-based measures in the manner that has been described in the deck. I think that also can be done in Phase 1.

In Phase 2, I do then think we want to seek to harmonize payment across the various groups, and I couldn't end the day without being provocative, which is I'm not so oppose to looking at population health measures for the fee-for-service population overall, and the reason I'm not opposed is if we believe that we're going to see differences in quality or outcomes, wouldn't we want to instigate

providers to shift from the fee-for-service world to either the ACO world or the MA world? Yes, it's not fair that providers are being or clinicians are being bundled together in a non-accountable group. But wouldn't there be some merit to say there are added bonuses for real measures of population-based quality if you're in these other two models? And so it would encourage that if you want to get access to those bonuses, you would need to shift into those types of models.

MR. HACKBARTH: So what I hear you saying, Craig, is that you would be open to the idea of saying not only do we report population-based fee-for-service measures, but we also link some portion of fee-for-service payment to that population-based assessment.

DR. SAMITT: Yes.

MR. HACKBARTH: And so I invite reactions to that. What we heard last time was the preponderance -- I think you made a very good case for it, but the preponderance of opinion we heard last time was against that point --

DR. CHERNEW: What's the benchmark in that case? Say you were going to reward fee-for-service for good fee-for-service or bad fee-for-service performance. What's the

benchmark against which they would be rewarded collectively?

DR. SAMITT: My issue with the right is that, you know, if the payments for the ACOs and the MAs, even after they're harmonized, is an add-on to fee-for-service -- we already talked about the performance would be benchmarked to fee-for-service. My question is: Would the payments be supplemental to fee-for-service? Or would the fee-for-service group have their own separate set of quality measures? You know, fee-for-service providers could make an equal quality bonus, but they're apples to oranges. You know, fee-for-service providers are paid apples quality measures, which may be more process measures, and ACOs and MAs are paid oranges for population measures, which are more outcome based, as we'd prefer.

So that's why -- is that the kind of dynamic we want to set up? Or if it were a zero based -- you know, fee-for-service was zero base but MAs and ACOs were supplemental, as long as they showed population performance that was favorable to the fee-for-service population overall, then I'm good. I retract my comments. But I got the sense that we were creating two separate quality payment pools.

DR. MARK MILLER: And what I [off microphone] when we came out of the box trying to capture what was said, that is what we were saying, that it's kind of two different ball games on the different side of the dotted line. Then there was the Kate amendment that said, Hmm, but wait a minute, maybe you should put a benchmark in that -- and then I took it too far and said so MA and ACO don't get a reward unless they're better than fee-for-service, which I could -- so what I think I'm trying to say is the way you described the right initially, that is what was happening on the right-hand side, kind of two different ball games. With a benchmark, there is some leveling up, although the measures could still be different. You know, you could still have outcome, population-based process on the other side. I think there's a question as to whether you say -- you even go further and say your last point, which is as long as I outperform fee-for-service, then I get a bonus, that was kind of your last comment. And that could still work off of the Kate amendment, but you didn't go that far.

DR. BAICKER: And I don't think that my conceptualization of it necessarily said there are only upside bonuses. You could get lower payment if you were

blow a benchmark. Rather, it was that everybody should have a common benchmark, so apples to apples.

But I still think that those payment benchmarks, however the formula looks based on those benchmarks, should still be made at the level of the responsible entity. So I'm comfortable with an idea of a fee-for-service bonus or decrement if that sector is performing well or not performing well, because then I think pretty soon you're in SGR world where no individual actor is actually in control of his or her -- the achievement of the bonus payment for the sector. And I think it loses power that way. So I like having the benchmark calculated based on the whole fee-for-service population in the area. But then the payments should still be based on one's own performance to the extent that we're able to measure it, with the understanding that we're not going to be able to perfectly measure it for very small groups and we don't want to build in too much risk for noise there.

So that's where I think the big vertical line makes a lot of sense, and I was trying to erase the dotted line.

DR. MARK MILLER: She, I think, ends up with a bit

of the apples-to-oranges [off microphone] thing where the measure on the left-hand side of the dotted line could be different than the measures on the right-hand side of the dotted line.

DR. BAICKER: The left-hand side --

DR. MARK MILLER: The dotted line now.

DR. BAICKER: The dotted line.

DR. CHERNEW: Well, on the left-hand side of the dotted line, there's sort of provider-specific measures within fee-for-service that are serving a somewhat different purpose and might be at a different level of granularity in ways that you couldn't do in the MA world, say you don't have encounter claims, for example. So I do think there's some provider-specific measurement system which serves a somewhat different purpose than this discussion, and that could have different provider-specific measures. I could see that, and it wouldn't bother me. It's just that's different --

DR. BAICKER: Right, there are some nitty-gritty detail based on the level of granularity of the data available that I was abstracting from with the overall concept being that everybody should be evaluated against the

same set of benchmarks. It's just that our method of applying the data to that evaluation is going to be a bit flavored by the data that's available, the unit at which it's observed, all of that.

MR. HACKBARTH: So my sense is that we need to move on here, that we've sort of gotten focused on some pretty highly conceptual points, and we're starting to -- some people are starting to lose the thread of the discussion. So what I want to do is go through the remainder of my list here. Peter, Jack, and Bill Gradison are the people that I have right now.

MR. BUTLER: I'll do my best to counter the concern you have. Okay. So I have about six conclusions.

One is we want to measure -- are you laughing at me? It's quick, it's quick. We want a common measurement of performance across these three payment mechanisms. We want to focus on quality. We want to use population-based measures. There are some six or seven or eight such measures suggested. We all agree that they ought to be done in a reporting way across at a minimum,.

And then where it gets trickier, but I think I'm clear now, you can't do it in fee-for-service -- I'm sorry.

Fee-for-service should be a benchmark or the benchmark for the others to exceed to get payments. You can't do it in fee-for-service even if you want to because they're all -- you can't give it to an entity. So you can't, by definition, use it directly. But I think we would endorse moving away from process measures, and we would look carefully at what we would use for, call it value-based purchasing, incentives for the individual providers, in the fee-for-service sector, with in mind those things that we think would help influence the population-based outcome measures, even though some of them can't be tied to a direct provider. That sector can, therefore, continue to improve even though they're not getting, quote, a payment in the same way that the ACOs or MAs -- I think that would work.

DR. HOADLEY: I think I like a lot what Peter said there, and I think it captured it pretty well. The point I was going to make was a little bit smaller on the reporting side. There was discussion earlier, sort of Rita and George and Mike's conversation about sort of how the reporting gets used by beneficiaries. And I think it's important to keep in mind that reporting -- while we often think about reporting to beneficiaries for making decisions, reporting

really is serving a broader purpose. We as consumers of the reporting, we in the policy community, will get a lot out of this notion that as a whole fee-for-service is doing better or worse than ACOs, which are doing better or worse than MA. I don't think an individual beneficiary who has to decide where to go is going to care about that sort of very abstracted thing, because they're not even doing a very good job, I think any of us in individual -- as individuals picking ourselves health plans struggle with the notion of how to use performance measures to decide that I want to be in MA Plan A versus B, even, which is at least a little easier to figure out than do I want to be in one sector versus another.

So I think it's not an argument against doing the reporting and having it have a lot of value. I just think we need to be careful we're not selling it as a real decision tool, which I don't think it accomplishes.

MR. GRADISON: I'm troubled by where we are on this. Some people define economists as people who are troubled by things that work in practice but don't work in principle. In my opinion, my worry is that this works in principle but won't work in practice. And the reason I say

that is that we're comparing these groups with different measures. At least that's my understanding. We've got three different measures. And so I don't know at the end of the day what we really know -- what we'll learn from this.

I think about the baseball analogy. Let's see, we're going to -- while we're looking at the baseball game, we're going to look at, let's say, the pitchers. That will be the earned run average. The fielders will be error rate. The batters might be RBIs or something like that. And then at the end of the game, we're going to draw a conclusion about which is the better -- doing the better job.

I'll be very specific. I think before I can great real excited about this thing -- maybe I'm sounding excited now, but --

[Laughter.]

MR. GRADISON: But before I can get very positive about this thing, I'd like to see a run of the numbers for a couple of metropolitan areas and see what they look like. And that's not to slow anything down, but there's a leap of faith here without having data, and I don't think that -- and it doesn't seem to me unrealistic to suggest we should have data before we go much further.

MR. HACKBARTH: And so sort of the first question is: What are those data that we show? And, in fact, the objective of this is to get away from trying to compare based on RBIs and error rates and earned run averages and actually have a common metric -- and we're trying to conceptualize what that is. So then we could say, okay, let's look at some real data in this conceptual framework.

So I fully agree we've got to get to where you want us to go, but this is just one of the steps we have to make along the way.

DR. NERENZ: Well, just in response to Bill's comment. I may have missed something along the way. I was on the assumption that in order for fee-for-service to serve as a benchmark for comparison, the measures would have to be the same across these domains so we're not comparing ERA to RBI to what-not. Baseball, you lose the analogy, because they have to be different. But I assume they would be comparable -- [off microphone] not comparable, the same.

MR. GRADISON: I must have missed something. My understanding is that the ACOs would be judged on the basis of the criteria that are already in effect today. Isn't that what I heard?

MR. HACKBARTH: No, what we're trying to find is what could be a measurement framework that would allow apples-to-apples comparisons across the different sectors. So that means breaking out to some degree of the current frameworks for assessing quality to try to move towards a common set of benchmarks. That's the goal.

DR. NERENZ: On that same line, presumably -- and these wouldn't necessarily be the final examples. Something like a hospital readmission rate works across these domains. Something like a preventable admission rate works across the domains, and those are both outcomes. And there may be other, better examples, but that's just so we're all on the same page.

DR. MARK MILLER: I was just going to remind people, although it's a bit far back, we did grind through some of this data and sort of show you how it behaved a bit. We didn't get this far because we didn't have quite the same input at that time from where you were going, because we were trying to figure out what your thinking was at that point. Now that everything is perfectly clear --

[Laughter.]

DR. MARK MILLER: -- we might actually be able, as

John was suggestions, at least on the left-hand side of the picture, begin to make some passes at things and start to break things out, although the ACO stuff is a bit tricky right at the moment.

MR. RICHARDSON: Nor do we have data for MA plans.

MR. GEORGE MILLER: Start with Bill.

DR. MARK MILLER: I swear to God that's supposed to happen.

MR. GEORGE MILLER: Start with Bill with the economist statement. That's where you start.

MR. HACKBARTH: We're down to our last ten minutes. Could you put up the issues slide? So let me start with my idiosyncratic way of ordering these.

Except for Craig, I think on the second bullet I've heard basically the same message that we heard last time, that although we want to measure population-based outcomes for the, quote, fee-for-service sector, we don't want to penalize providers for perceived poor performance because they haven't assumed population-based accountability. And so that's what I'm hearing as affirmation of that point.

I think Craig makes a logical argument, and John

made the same argument in his presentation, why it might be good to have a penalty, but that's not what the consensus of the group is. So that's that issue.

The last bullet, if fee-for-service Medicare must use provider-level measures, how might current limitations on measurement technology be overcome? Here, again, I'm hearing the message that we want to move away from, you know, sort of narrow, unvalidated measures of process to measures of outcomes where those are available, recognizing that that means that there are going to be big elements of fee-for-service care delivery where we don't have really any measures, because we don't have risk-adjusted outcomes, the ends may be too small, et cetera. And I don't hear anybody taking issue with that. And this is where you chime in and say, "Glenn, no, you're deaf." Okay?

DR. NERENZ: Glenn?

MR. HACKBARTH: Yeah?

DR. NERENZ: I'm sorry. No, not deaf at all, but given the invitation, just to reinforce an excellent point that Alice made. If part of the thinking here is to focus much more heavily on outcome measures, and particularly, I think, the word "broad" has been used in the past, I'd just

observe that the more we go in that direction, the more it is important to take into account the characteristics of the beneficiaries who are on each of these three areas. They will not always be comparable, and the differences will matter.

MR. HACKBARTH: Yes, and I think that is a really important point that Alice and Dave are making. In fact, one of the reasons that Medicare started on this track of a lot of process measures and one of the reasons that others like NCQA have is because they sort of moot some of the risk adjustment issues that come up with outcome measurement. And so, you know, there's a tradeoff. There are simpler in that sense, but now we've accumulated some experience and more understanding of process measures, and I think I hear this group, as well as others, saying, boy, that's a lot of effort to produce things that are of relatively low value.

And so it's not to say all process measures are bad, but we need to sort of clean the closet a little bit and identify those that have a real strong, proven link to outcomes and, where possible, do properly risk-adjusted outcome measures of performance. I think that's the message I'm hearing. And that will mean there are big holes in the

measurement system.

DR. BAICKER: And one complement to that point is, picking up on something that Scott and Mike had both highlighted, I think, that one also wants to not be enslaved to the geographic variation that we see now and say, okay, we're going to have a population-based fee-for-service measure, metric, benchmark for everyone in this area, and if it happens to be twice as high as everywhere else, that's fine, and everybody's going to get paid more. If it happens to be a really efficient area, everybody's getting paid less. In some sense, the right benchmark has to take into account population characteristics and the risks -- the different risks of the enrolled panel. But it also has to abstract from the endogenous high spending that we don't want to enshrine in payment going forward. And that goes to Mike's point about everything not having to be zero sum within the area. If the whole area is doing well, that should be recognized. And if the whole area is doing badly, that should not be encouraged.

MR. HACKBARTH: This point that we've been dwelling on here, you know, this is pushing against the tide. There's sort of a festival of measurement in recent

years. The more, the better, oh, let's have bonuses for everything; everybody needs to have measures so everybody can earn bonuses. And --

DR. REDBERG: Not from the clinician's point of view.

MR. HACKBARTH: Pardon me?

DR. REDBERG: Not from the clinician's point of view.

MR. HACKBARTH: I know, but I'm talking mostly about the policy world, and, you know, I hear people talking about this --

DR. REDBERG: [off microphone] quality --

MR. HACKBARTH: -- you know, oh, we got to have more measures and equal opportunities, if you will, to earn bonuses for quality. And what we've done is, in our eagerness to have measures, we've created enormous burden, but also dug so deep into the barrel of measurement that a lot of the stuff that is being offered isn't all that high quality, really isn't providing much true signal as opposed to who's a good performer. And so we would be, you know, quite explicitly pushing back against what has been the recent momentum.

So now going to the first bullet, use population-based outcomes to adjust payments within each model, but not across them. You know, we touched on this. I'm not sure that I heard a clear message from today's conversation. Could you put up the graph?

So this is that far-right column, and the question here I think is: Do we have the cross line? So right now the Medicare Advantage star system is within the Medicare Advantage who's relatively better than others. If you fall in the top quartile or whatever, you get, you know, more stars. It's a Medicare Advantage system. The idea that we're raising here is that within the accountable sector, organizations that have assumed population accountability, it shouldn't just be Medicare Advantage plan to Medicare Advantage plan. It should be Medicare Advantage plan compared to ACOs, et cetera, and there should be a larger comparison.

MR. BUTLER: Yes [off microphone].

MR. HACKBARTH: And Peter says, yes, he thinks that makes sense. Is there anybody who disagrees with that approach?

DR. SAMITT: Well, I wouldn't necessarily

disagree, but I guess I'd be interested in understanding how would we harmonize the two. The ACO metrics are much more clinician centric, and the star measures are a blend, which makes me think that there are multiple things that can be accomplished here, which is, you know, I've suggested previously that the star measures should be allowed at a sub-plan level to distinguish between provider differences within an MA plan. So it seems like you could harmonize the providers within an MA plan with ACOs, but it would be harder to harmonize the current MA star metrics with ACOs.

MR. HACKBARTH: So what I hear is not an objection in principle, but a question how exactly would you do this.

DR. SAMITT: Right [off microphone].

MR. HACKBARTH: Jack.

DR. HOADLEY: I'm not sure that I object in principle either. My first thought is it's too early. The ACOs are barely operational. I mean, they're operational, but they're barely at a point where we understand what they're doing. And it seems like until we get a couple years further that we shouldn't even begin. Now, I know we're not really talking about something we're going to implement tomorrow.

And I think, you know, going to Craig's point, to the extent that we're talking about doing this over those much more global kinds of measures that were in the paper, you know, that seems more feasible with some of the caveats that Craig put up there as well. But I just want to be, you know -- we need to better understand where ACOs are going to end up before we start to lock something in.

MR. HACKBARTH: Absolutely. In fact, this is a point that I think is worth highlighting for the audience. This is part of our effort to look down the road, not try to revamp the system tomorrow, but figure out more strategically where we ought to seek to be, you know, five or ten years down the road, so that we can gradually bring a payment policy and quality measurement into conformance and get the sort of synchronization across sectors that we're seeking. So none of this is quickly operational. That's not the goal of this conversation.

DR. MARK MILLER: And I know there are hands up and we're behind, but the other thing that you two have both said -- and maybe some others have said -- is also sending a signal that maybe the road that we're currently on needs to slow down.

MR. HACKBARTH: Right.

MR. ARMSTRONG: Glenn?

MR. HACKBARTH: So I had a couple of hands here. Mary and then Jon.

DR. NAYLOR: Just briefly, this chapter piece, will that be explicit? Will people know that, you know, we're on a path ultimately to build a crosswalk across these various payment programs that ultimately could influence payment and the distribution of resources? Even though we're not there yet, I think that we've got to lay that out.

MR. HACKBARTH: Yeah, I think we need to be careful about the framing so people don't misconstrue what we're up to.

DR. CHRISTIANSON: Yeah, despite what Jack said, I think there is an area where we might be able to do something more quickly, even if we don't know what ACOs are doing, and that's get comparable data on patient experiences in these three arenas. That takes money, obviously, to do that kind of survey, but we should be able to pull out beneficiaries by those three silos, and I think that's information that's very relevant to Medicare and to policymakers right now, is what is the experience in this

attributed world of ACOs relative to the selected world of MA plans and traditional Medicare. And I think a lot of this stuff we've been talking about in terms of complications have to do with clinical measures and not so much the patient experience measures.

DR. HOADLEY: Jon, do you mean that to be on the reporting side or a payment side?

DR. CHRISTIANSON: Reporting side initially.

DR. HOADLEY: Yeah, I think reporting is another story. I thought we were kind of moving on to payment.

MR. ARMSTRONG: I think very briefly, a related but slightly different point you came close to making, and that is that -- I like the word "harmonize," but I think what we need to be careful about is we're looking, you know, five years down the road, and we're looking at ways of bringing this together. We're not talking about breaking down things that actually are really well built and are working very well at the same time.

And I don't know about the 32 measures in the ACOs, but I know a lot about the measures below the five-star for Medicare Advantage plans, and there's a lot of merit in there that we should be very cautious about messing

too much with as we go forward.

MR. HACKBARTH: Okay. Then would you put up the last slide, John?

So I may be getting tired here, but I think this bullet raises sort of similar issues to what we just talked about. One of the issues is when we're trying to figure how to generate funds to pay bonuses, what is the source of those funds? And do we redistribute within categories or across categories? And that, of course, is inextricably linked to our ability to measure accurately across the categories.

As I said, I'm getting tired here. So what are people's thoughts? Again, this is not something that we really talked much about here. Do people think that we should be striving in the future to redistribute dollars across these categories once we've got the measurements in place? And, Mark, feel free to jump in here, or John, in framing this issue. I don't feel like I'm doing it very well. Herb.

MR. KUHN: The only reflection I would make here is kind of something that Mike had referenced earlier--is that you don't want to distort prices in one area to finance

another, if I understood your point that you were making, which really rang true for me.

The other thing--and we've talked about this in pervious times--is that some of the organizations that actually need the financing in order to drive their quality up--could they be perpetually starved as a result of something like this? Because they start from behind and then their numbers look bad, how do they ever kind of play catch up in something like this?

This is something I think we have to be cognizant of.

MR. ARMSTRONG: I would just say this gets a little technical when we're talking about withhold and redistribute.

Maybe a little bit more generally, I would say we're doing this ultimately to pay more for better outcomes and less for worse outcomes. And I think there's a lot of ways in which you could move money around to accomplish that goal.

DR. CHERNEW: This strikes me as an area where, as Bill Gradison said, knowing how much was on the table and what ways. If the distribution was ACOs and MA plans were

all substantially better than fee-for-service, it's going to be a lot more expensive than if the distribution is wide. So knowing how much money is on the table would help figure out how we would have to finance it.

MR. HACKBARTH: So what I hear you saying is it's a difficult issue to resolve in the abstract.

DR. CHERNEW: Right.

MR. HACKBARTH: Okay. I'm happy to leave it at that. We are a few minutes over time already.

So thank you, John.

I think we made some headway today. It's not an easy conversation to have. It's pretty abstract.

So we will now turn to our public comment period.

So, if you would, hold on for just a second.

So just one moving to the microphone? Okay.

Please begin by identifying yourself and your organization, and when the red light comes back on, that signifies the end of your two minutes.

MS. COOKE: Okay. My name is Kaitlin Cooke, and I'm with the American Society for Clinical Pathology, and I'm very hands-on with the fee-for-service quality reporting. We actually had a meeting with Patrick Conway

and his quality reporting group at CMS, and we talked about a lot of our concerns.

And I guess my initial response in response to this presentation is I don't think the goal should so much be comparison across these different systems but more so about incentivizing a transition toward ACOs, both from MA and fee-for-service.

And I think that MA and fee-for-service really shouldn't be compared. They're different patient populations with different payer mixes. MA is obviously geographic. Fee-for-service is based on the patient panel for the provider or for the hospital. So I don't think they're quite comparable.

And I think the challenges with the fee-for-service is that the measure requirements are so granular because they have to be auditable via billing data.

So, especially for pathologists, which we don't fare well in a lot of these quality reporting programs, they have to be, well, a subspecialty-based -- and there are 30 subspecialties of pathology -- then condition, then treatment-based. So it will be years before we all have measures.

I think, really, we need to transition to ACOs within these. And we need to realize that in fee-for-service, as far as defining a population, there's population-based reporting already happening at the group level at the TIN. And that's one thing, and that has nothing to do with the practice level accountability. And then there's also population-based measures to be considered.

And when we spoke with CMS prior, we talked about a movement towards structural measures like, for example, at the laboratory level, test turnaround time, accuracy of test results, et cetera.

So I think within certain subentities of the fee-for-service system it makes sense to have more structural levels, or measures, because their impact is on a laboratory level or hospital level or what not. And I think eventually going from those subentity measurements you would go more towards episode-based measurements.

And we're actually responding to the specialty payment RFI right now, and we are talking about actually doing like sub-bundles -- diagnostic, treatment and then management sub-bundles -- because outcome-based -- and I

think this is probably the last thing I want to emphasize. It's ideal to have outcome-based measures, but it's nearly impossible.

And we know that procedural-based measures aren't translating.

But, how do you really measure outcomes and especially at different points along the care continuum? For a laboratory, you know, diagnostic is the key, the epicenter, the foundation, of the treatment plan, but you can't possibly trace back outcomes from diagnosis.

So, at some points it is appropriate to have outcome-based measures, and in others it's more -- it's just naturally going to be procedure-level.

And it's, basically, is it going to happen across an entity? Are the outcomes going to occur across an entity, or are they going to be patient and provider-specific?

MR. HACKBARTH: Thank you.

We will reconvene tomorrow at 8:30.

[Whereupon, at 5:55 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, April 4, 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, April 4, 2014
8:30 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
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 [8:30 a.m.]

MR. HACKBARTH: Okay. It's time to start. First up this morning is beneficiary decision making.

DR. LEE: Good morning.

For the past several years, the Commission has been considering ways to encourage Medicare beneficiaries to make cost-conscious choices about their health care. In those policy contexts, the role of beneficiaries is important.

In our June 2012 report, the Commission recommended changes to improve the fee-for-service benefit. And in our June 2013 report, the Commission explored an alternative model based on government contributions toward purchasing Medicare coverage, which we called competitively determined plan contributions, or CPCs. And in the past several months, the Commission has discussed synchronizing Medicare policy across different payment models.

Those discussions centered broadly on creating incentives for beneficiaries who would then respond appropriately to those incentives. The challenge in designing such policies is that you have to come up with the right incentives and beneficiaries have to respond

accordingly, which is very difficult to achieve without also creating unintended consequences.

In today's presentation, we explore a set of related issues that would help us better understand how beneficiaries actually make decisions.

First, we'll look at our analysis of plan switching under Part D.

Second, we'll review qualitative findings from our focus groups and interviews about beneficiaries' experience making plan choices under Part D.

And finally, we'll discuss some insights from the psychology and behavioral economics literature on how beneficiaries actually make choices when faced with complex decision making.

So let's begin with what we see in Part D data of beneficiaries' plan switching during the annual open enrollment period. As you know, Part D uses private plans to deliver the Medicare prescription drug benefit, and beneficiaries must decide whether to enroll and in which Part D plan to enroll. And as plan premiums and benefit designs change each year, they can reevaluate and decide whether to change their plan choices. In fact, their

willingness to switch creates incentives for plans to compete for enrollees through premiums and other factors.

Our analysis of plan switching is based on Part D data from two annual election periods: 2010 and 2011. The analysis focused on voluntary switchers -- in other words, enrollees who chose to switch, rather than those who were automatically assigned. Consequently, we excluded from the analysis Part D enrollees who were receiving the low-income subsidy and who were enrolled in employer group plans.

Also, switching due to plan termination or service area reductions was defined as not voluntary, so those enrollees were excluded from voluntary switchers. So let's look at some results.

This table shows the percent of Part D enrollees who voluntarily switched plans during the 2010 and 2011 election periods. Reading the first line of the table, 13.6 percent of the non-LIS enrollees in our analysis voluntarily switched plans between 2009 and 2010, and 13 percent switched between 2010 and 2011. And most of them switched to plans of the same type.

For instance, looking at PDP enrollees, 13 percent switched plans in 2010, with 10 percent switching to another

PDP. And among MA-PD enrollees, 15 percent switched plans, with 13 percent switching to another MA-PD.

This table compares average annual drug utilization by voluntary switchers vs. non-switchers. This is the PDP half of Table 2 in your mailing materials.

Let's focus on the last column, which shows the change between 2009 and 2010. First, total drug spending went up by $53 for PDP enrollees who switched, whereas it went up by $39 for non-switchers. Not surprisingly, the number of prescriptions increased between the two years by 2.2 scripts for switchers compared with 1.5 for non-switchers.

However, the out-of-pocket drug spending for switchers actually went down, by $32, even though their total drug spending and the number of prescriptions went up between the two years. There are many different possible reasons for this result. For example, a brand name drug that was not covered under the previous plan might be on the preferred brand list under the new plan.

By contrast, looking at non-switchers, their out-of-pocket spending on drugs went up by $7.

The results for MA-PD enrollees were a little

different, but still generally consistent. We can go over those results on question.

To summarize, our findings in these two tables suggest two things.

First, some Part D enrollees seem to reevaluate their plan choices from time to time. The share of enrollees reevaluating plans is likely to be higher than the 13 percent who are actually switching plans since not all reevaluations would lead to switching.

Second, Part D enrollees seem to make switching decisions strategically, trying to lower their out-of-pocket spending. Our findings don't say, however, whether beneficiaries are making the best possible choice. In other words, are they lowering their out-of-pocket spending as much as possible?

Even if they want to minimize their total out-of-pocket spending -- including the plan premium plus the expected out-of-pocket drug spending -- it may be too difficult for beneficiaries to accurately assess the costs of competing plans. Our findings from focus groups suggest that beneficiaries often find the process for selecting or changing plans complicated and confusing.

Our understanding of beneficiary perspectives comes from several sources. Every year, we do beneficiary and physician focus groups, and periodically we do interviews with beneficiary counselors. And in 2006, we did a beneficiary telephone survey on Part D implementation.

At the beginning of the Part D program, we were interested in three questions: How did beneficiaries learn about the drug benefit? How did they make their choice? And what factors affected their enrollment decisions?

Overall, beneficiaries' goal was financial: to save money on prescription drugs and avoid the late enrollment penalty.

In their decision making, beneficiaries looked first at plan premiums and then looked at whether specific drugs were covered and how much they had to pay for them. Beneficiaries also found it difficult to compare plans and calculate total cost.

Since 2006, some things have changed. For the Medicare population in general, beneficiaries are more familiar with and comfortable using computers, especially in their research and decision making process. They're also more willing to discuss the cost of drugs with their doctors

and more accepting of using generic drugs.

Some changes are due to beneficiaries' experience with Part D. With the number of years on the program, they become familiar with the terms and what they mean. But still, beneficiaries seem to want validation and reassurance that they are getting the best deal. Some beneficiaries revisit their plan choices each year, while other beneficiaries find the process difficult and don't want to revisit their choice.

In contrast to Part D beneficiaries at the implementation, new beneficiaries just aging into the program show different attitudes and knowledge.

First of all, the Medicare program requires more choices by beneficiaries than before, and new beneficiaries are unfamiliar with Medicare in general, not just Part D. They want to know if they should enroll in Part D, especially those who are taking few or no medications. They are less likely to know about the late enrollment penalty.

To understand new beneficiaries' perspectives on what they need, we interviewed SHIP counselors in 10 different states. Here's a summary of our findings.

New beneficiaries need the basics of how Medicare

works, especially the difference between MA vs. traditional fee-for-service and Medigap.

Also, transitioning into Medicare from health insurance they had before Medicare can be confusing, especially if they need to coordinate benefits with other sources of coverage, such as employer-sponsored retiree benefits or the VA benefits.

And they also find the sheer amount of information from Medicare confusing. According to the counselors, new beneficiaries seem to need simpler and less, but appropriate, information from Medicare.

Overall, our findings from focus groups and interviews suggest that there's continuing need for information support. For experienced beneficiaries, their questions evolve over time in the program. And new beneficiaries need basic program information. As a result, all beneficiaries need continuing support from Medicare to help them in their decision making.

Traditional economic theory emphasizes the rationality of the individual making a choice. Typically, she's either maximizing or minimizing some value, such as costs, given certain constraints. This model of choice is

necessarily based on simplifying assumptions that may not be realistic.

Recent developments in psychology and behavioral economics provide refinements to the model, explaining why our behavior might deviate from the traditional model. We included three factors in the paper that seem to have particular relevance to Medicare beneficiaries.

Very briefly, choice overload is illustrated by studies that show that workers' participation in retirement plans goes down when too many mutual fund choices are offered or that our ideal number of salad dressings is six to ten, not 40.

Framing effects mean how a choice is presented and described strongly affects the choice. They're illustrated by how people perceive a difference between stating the likelihood of survival as a 10 percent chance you are going to die vs. a 90 percent chance you are going to live.

Finally, elderly decision making as a factor is illustrated by studies that show that the elderly tend to spend more time processing information, and they may have cognitive or physical impairments affecting their ability to analyze information.

As an illustrative example of these ideas in the context of a common beneficiary experience, I went shopping for my Medicare coverage on Medicare.gov. I presented the simplest case possible: a new beneficiary from D.C., with no current need for prescription drugs. I was not eligible for any extra subsidies, such as Part D LIS or Medicare savings programs. I was looking for Medicare coverage including drug benefit, but no Medigap, and I wasn't looking for a special needs plan.

My search showed eight options in total: seven MA plans and traditional fee-for-service. There were 34 PDPs for Part D coverage to work with fee-for-service. MA plan premiums ranged from $0 to $113 per month. In addition, Part B premium for 2014 is $104.90 a month.

This slide is a very stripped-down excerpt from Medicare plan finder. I deleted many rows of information, but on what's shown on this slide, I kept the exact wording and display. So let me make just a few observations.

With respect to choice overload, eight possible options weren't overwhelming. In this respect, I'm lucky to be in D.C. because a similar search in Miami-Dade would have turned up 40 MA plans with Part D coverage.

Of the eight possible options, I compared three on the plan finder: traditional fee-for-service (or original Medicare), Kaiser Permanente Medicare Plus Standard, and MedStar Medicare Choice.

The system allowed only three options to compare at a time, so choice overload wasn't an issue at this stage. However, if I wanted to compare more than three plans ultimately -- especially if I had more than eight options to choose from -- how I sequenced my comparisons seemed important -- in particular, the first three options chosen for the comparison.

The plan finder displays two types of premiums: the Part B and plan premiums. In the case of the D.C. options I was looking at, the Part B premium is $104.90 a month across all options. Any plan premium is expressed as an additional premium above the Part B premium.

The plan finder also shows expected costs on services based on average use as the default setting for the service use; and total monthly estimated costs, which is the sum of premium and estimated service costs, on average. As a result, it's possible to see the difference between premium and total estimated cost amounts across plans.

I'll stop here for now, but can go over in more detail on question.

To summarize, today's presentation focused on three take-aways.

First, some beneficiaries switch plans under Part D in response to incentives, such as cost sharing. Our analysis on plan switching didn't look at LIS enrollees. Because they're automatically enrolled in benchmark plans, their decision making under Part D is quite different.

Second, both experienced and new beneficiaries need continuing support of appropriate information and counseling.

And, third, the psychology and behavioral economics literature informs as to what and how much information beneficiaries need in their decision making.

That concludes our presentation, and we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Julie. I think there are a lot of interesting things here to talk about. So let's have Round 1 clarifying questions.

MR. KUHN: Julie, thank you. You talked about the SHIPs and the counselors. What's the funding for the SHIP

program now. Has it been stable over the last several years? Has it gone up because of new enrollees? What's the current status there?

DR. SOKOLOVSKY: I don't remember the exact number, but it's stable or going up.

MR. KUHN: Okay. Thank you.

MS. UCCELLO: So on Slide 6, there's the lines for out-of-pocket drug spending, and I was just trying to clarify. Is that truly just out-of-pocket cost sharing? Or does it include the premiums?

DR. LEE: Just the cost sharing.

MS. UCCELLO: Okay. And in the mailing materials, the paper references the Abaluck and Gruber work and says that people may not be optimizing their switching. And I was just wondering if you had any sense of the degree of loss, because we talk later about, you know, the costs of making these changes in terms of time and stuff. So I just didn't know if these were kind of minor non-optimizations or if they're big.

DR. LEE: It was not small. I don't think the results were stated as in dollar figures, but it was in percentage terms. I think it was like a 20 percent loss.

But that is assuming that they had the full information and then were actually calculating.

DR. MARK MILLER: I'll just put a marker down. That's something that if you choose to talk about, there may be people at the table who have things to say about that. Because when I look at this data, it strikes me that they're making decisions that maximize their -- I mean, not maximize, that move in the direction of their interest. How much loss there is I think is a much more complex question.

MR. GEORGE MILLER: On Slide 6 also, I'm just trying to understand from the reason for the increase in drug spending was the cost of the drugs, different drugs moving from one class of the drugs or was the comparison the exact same drug that just went up in price. What's the reason for the shift in the drug utilization, the top line? And then they consciously made the choice, those who voluntarily switch with the out-of-pocket drug spending was because they -- their option with the -- was the choice lower, the out-of-pocket spending?

DR. SOKOLOVSKY: As far as the first question is concerned, generally speaking, it's because they're taking more drugs.

MR. GEORGE MILLER: Okay, okay.

DR. SOKOLOVSKY: I lost the second question.

MR. GEORGE MILLER: But by taking more drugs, they still lowered their out-of-pocket spending?

DR. SOKOLOVSKY: Yeah, which -- you know, if you put it another way, they increased Medicare spending.

MR. GEORGE MILLER: Right, right. Okay.

DR. REDBERG: I have a question, but I would guess that most of them changed because they were prescribed a new drug and then found the plan that had a lower out-of-pocket and covered more of it, and that's why their out-of-pocket went up, drug went up at the same time. So it was a very interesting mix of psychology and economics.

But my questions were just on Slide 14. I think you were able to get your total monthly estimated cost, but you said that was on a model. I assume, could you also put in, for example, the specific drugs that you were taking and get the cost for each of the plan on those 5 years?

DR. LEE: That is correct.

DR. REDBERG: And the other question, I noted you said it was a good thing you didn't live in Florida, because there were 40 different choices. Is there a lot of

variation state-to-state or county-to-county on Medicare drug plans and --

DR. LEE: That's -- yes.

DR. REDBERG: If you could comment on the numbers?

DR. LEE: Because it depends on what the companies decide to offer based on their expected payment rates.

DR. HOADLEY: So back on Slide 6, this is probably more of a sort of rhetorical question, but you said when talking about some of the differences in the change, situations where somebody had a drug that was all formulary in the first plan and maybe that was on formulary, they picked a plan that covered that drug. So the spending, if they bought the drug off formulary, presumably isn't showing up as part of these numbers because it's not part of the Part D. So that could actually be a bigger change in the drug spending line and a more -- and more downward change in the out-of-pocket line if we knew the fact that somebody was buying that drug out-of-pocket and therefore not showing up in the data, if that makes sense.

And my other specific question on this table was does this -- this is all people, including those who switch from PDP to PDP as well as those who switch from a PDP to an

MA?

I see Julie is nodding yes on that.

DR. LEE: Right. This is PDP, who had PDP plans in 2009.

DR. HOADLEY: Right. So they started in the PDP, but they could have gone to the MA, and there is some value maybe in looking at the people who only switch from a PDP to a PDP, because the ones who switch in MA are going to have potentially somewhat different factors because of that.

And then on Slide 14, am I right that this does not include the drug side of analysis? This is only their A, B situation? Because the -- and the drug premium went up included in this at this point?

DR. LEE: Actually, the plan premium is that total of --

DR. HOADLEY: A, B plus D?

DR. LEE: -- A, B, and D.

DR. HOADLEY: Okay. And the estimated costs are counting the -- you said your example was no drugs --

DR. LEE: I did not enter --

DR. HOADLEY: Did you put in no drugs, and therefore, they are adding no out-of-pocket for drugs?

DR. LEE: I did not put in any drugs, so that that's most likely.

DR. HOADLEY: Okay.

DR. CHERNEW: I think if you put in no drugs, they still assume you might use some drugs? Is that --

DR. HOADLEY: I mean, if you -- the drug plan finder by itself without the A, B part, if you put in no drugs, you are going to get the cost for exactly what you put in, but in the A, B side, you put yourself in the category of just allowing average use to go in. That's where I'm not sure what -- which they would be showing in this particular display.

DR. LEE: So the estimated cost on services, that the plan finder shows the four categories. Inpatient, outpatient -- oh, it does have outpatient prescription drugs.

DR. HOADLEY: Okay.

DR. LEE: Dental and all other services. So those are the four categories.

DR. HOADLEY: So has it assumed an average drugs, or is it assuming a zero?

DR. LEE: It's using average use.

DR. HOADLEY: Okay.

DR. LEE: But also the plan finder does allow if you are high-cost category, like diabetes, CHF. Then it does give additional ranges.

DR. HOADLEY: Thank you.

Fascinating chapter, and very, very well done.

In looking at the psychology of people who switch and having enlightened self-interest of having the lowest cost for the same benefit, could you put a dollar figure on that? I mean, are we talking about $100, $5? The reason I ask is that during the early days of the HMO movement, it was said that people will switch doctors for a $7 difference in price. Is there any way to look at that?

DR. LEE: So to some data points from when we talked to MA plan benefit, the product design people, they said usually if $20 difference in their change in their MA plan premium could usually get people to think about their plans, but that's from, you know, their market research data or rule of thumb in that industry.

MR. HACKBARTH: And I assume that's $20 per month?

DR. LEE: That's correct.

MR. ARMSTRONG: Just as a rule of thumb, we work

with -- when you have a narrow network versus a broader network, a 10 to 15 percent differential in out-of-pocket monthly premiums is kind of the switching point. Closer to 15 percent, but we haven't tried to apply that to a -- as a whole.

DR. BAICKER: But I think my recollection of the Gruber and Abaluck line of research is that people respond more to the premium than they do to what their cost would be under the plan, because it's really salient. It's the price tag listed.

And that in answer to your question, I recall it being somewhere in the hundreds of dollars left on the table for people who, if they switched to a different Part D plan, would have had lower copays. The failure to optimize is in the range of hundreds of dollars, not tens of dollars, but that hundreds of dollars, you have to go through entering all the different drugs and figuring it out, so it's not as salient as the -- your premium goes up by $10, and people respond more to the premium price change than they respond to the copay price change.

DR. CHERNOW: Can I just -- so it's roughly 20 percent, I think, in Gruber, Abaluck, which is what -- and

it's not just that they respond to the current premium versus future drug costs. They also don't respond to the variance insurance component of it very much, so they're not just dealing with the "Oh, I'd rather save money now, and I know I'm going to have to" -- there's a risk par associated with that, and they don't respond to the risk the way economists would think that they might.

DR. MARK MILLER: Just to staff, I'd like to say I told you.

[Laughter.]

DR. SOKOLOVSKY: Could I just add one point? Something that I found very surprising that's not reflected in the paper, but the counselors, not even just the beneficiaries, considered that any drug that the beneficiary had a prescription for, that the plan used any kind of utilization management, they treated it as all formulary, and I'm not sure that the analyses that say that -- you know, that list how much money, I'm not sure that they necessarily take that into account in terms of how much money you could save.

MR. GRADISON: I, too, want to compliment you. I'm quite fascinated with that, in part because -- well,

Part D, insurance like this did not exist in nature. There were no prescription-only plans, at least that I was aware of at the time, so people didn't have experience in doing this during their working years until they became eligible.

What I've wondered is whether -- in your thinking and work on this, whether there was any tendency of people who made a choice and had been on a plan for a period of time, to review their choices less often as years went by. I'm thinking of, for example, the 401(k) analogy. I mean, some people probably do that every month, but I've wondered really whether somebody gets satisfied with their distribution. Presumably, they're trying to maximize their long-term return with a lot of uncertainties, and that's true here as well. I just wonder if there's any evidence about the longer you're on the plan, whether you're still in whatever, the 13 percent, or as you become more familiar with it and more comfortable, perhaps with what you already have, whether you are less likely to even review it, let's say, once a year.

DR. SOKOLOVSKY: I don't think we can fully answer that question yet, but one thing that we do know is that the people from 65 to 70 are most likely to review their choices

and switch compared to people that are older, but the difference is not that great. They are more likely -- they're at, say, 14 percent, and the people 80 and over are 10 percent, so there is a difference, but it's not huge, and -- yeah. I guess that's all.

MR. HACKBARTH: Mary or Jon, clarifying questions? No?

Oh, Peter.

MR. BUTLER: On this Slide 14, so at the risk of fueling the economist fire here, but the plan premium, you said ranges from zero to 113. You show examples that is 15 and zero here. So what is the range in the estimated annual cost between the plans, and if the premium is higher, do you tend -- what's the correlation, the total actual? Are you getting lower?

Like the example on Kaiser is the lowest of the three in total estimated cost, even though the premium is $15 rather than zero. Is that --

DR. LEE: There is a general tradeoff between higher premium and lower cost-sharing, so the lower cost-sharing will be reflected in the lower expected -- the cost on services. But as to just from looking at premiums and

whether I can guess how much lower that cost-sharing cost might be, I'm not sure about that, whether there was a clear relationship.

MR. BUTLER: Okay. Then the other question, the range in total estimated cost, here you go from $2,420 up to $3,310. What's the range among the eight plans? Is it a lot more than that?

DR. LEE: So the lowest is $2,420. So the two MA plans shown, they were in terms of a total to estimated annual cost. They were the two lowest out of the eight.

Now, on the -- I don't know what the upper bound was.

MR. BUTLER: Okay.

MR. HACKBARTH: Any other clarifying questions?

So for round two, I think we will use the format that we were using yesterday where we have a few topics on the table and then see who wants to pursue those.

Let me raise one area -- actually two areas that I'm interested in learning more about. One is -- on Slide 9, Slide 9 talks about what's happening over time, and this interests me. I've seen references to articles which I haven't read or wouldn't understand even if I did read them

that there is evidence that the decisions are getting better over time in Part D specifically, and I wonder if anybody knows about that literature and whether that's in fact true. And better, I assume in this case means more rational, closer to people making choices that are in their economic interests.

And related to that, I am interested in learning more from our economist colleagues about what better means. We typically use it inappropriately to say are beneficiaries making choices that suit their needs, do they choose drug plans that lower their costs, et cetera, but there is another way of thinking about better, and that is how much good decision-making, if you will, is necessary to discipline the market and make the market function well enough to achieve the competitive model that Part D is based on. And my understanding is that that doesn't -- you don't need everybody making rational decisions to have a well-functioning competitive market. It can be less than that, and so those are two things I'd like to learn about. Is there evidence that choices are getting better over time, and looked at from the economist perspective, are we having enough switching, et cetera, to truly discipline this market

and make that competitive marble work?

DR. SOKOLOVSKY: As far as the first question is concerned, I'm not aware of literature that really addresses that. I do know that this is one of the things that we hear from the counselors and in the focus groups is that somebody who has chosen a plan may -- and this is why there may be more switching at the beginning. They may choose based on premium, and then after a while, they understand that that's not the most important thing, that total out-of-pocket is what they should be thinking about. That's the only thing I can --

DR. CHRISTIANSON: I think we need to be a little bit careful instead of reaching the judgment that if people are moving to lower cost plans, that that's better, and people can look at a lot of different dimensions of a plan and for each individual. I may want to buy a Group Health at Puget Sound product when I retire because I'm very familiar with that. My transactions costs are low, because I understand how that plan works and how it's likely to work, and heaven forbid, I may have to pay more. But that doesn't indicate a rational decision-making on the part of consumers.

So I think this whole issue of are consumers making the right decisions by looking at out-of-pocket cost and premiums together is a road we need to be a little careful going down.

DR. HALL: So I think a lot of the decisions that are made, people use different sources of information. Medicare.gov, at least to my experience, is very good, and in addition to being good, it's very uniform. So any part of the country, if you go to Medicare.gov, you are getting the information presented in the exact same format, and so there's some virtue in that, I think.

But a lot of the decision-making is in concert with one's health care provider and that's always considered a very reliable source of information.

In addition, a lot of senior groups, this is a topic of discussion, and it really comes down to I like this plan because of X, Y, and Z. But one of the X's or Y's or the Z's is often the amount of advertising that goes on during enrollment periods. If you walk into any pharmacy or supermarket or open your mail, I don't scrutinize this information all that carefully, but it's not uniform, to say the least, and different adjectives are used. And I don't

know whether that's really any of our business here or not, but I think that's an important factor in how these decisions are made. It is kind of the informal network, which works among seniors in making all kinds of decisions in their lives.

DR. HALL: So I think you hit on two of the themes that I was interested in. On the overtime thing, I think the literature is much less conclusive than the one that you are recalling. There was one article that got a fair amount of attention that did suggest that decision-making improved over time in terms of sort of optimizing dollars, and I actually think that that article is significantly flawed by having an insufficient database.

DR. CHERNEW: [Off microphone.]

DR. HOADLEY: Yeah. I mean, it really only worked with plans owned by one plan sponsor or managed by one PBM, and so it really didn't have -- and it only looked at, compared two points in time, and so I think what it saw as improved decision-making was just a changed decision environment within a very constrained set of choices.

The Abaluck and Gruber's second article sort of goes to some of that point. I don't want to get down in the

weeds too much here, but it does not see the kind of improvement in decision-making, and there is some ongoing literature on this.

We looked at how many people across a 5-year period were making a switch in plans, and we actually found that 72 percent of PDP enrollees who were in the PDP world for 5 years never made a switch in that entire 5-year period. Now, that doesn't necessarily mean they were making bad choices. Like Jon says, they maybe have picked a plan for reasons of comfort, for reasons of brand loyalty, for reasons of good service, and are sticking with it. So, I mean, I think there's a lot to try to think through on that.

I think the other kind of thing that I think about, to your other question of how much is the way decision-making being done sort of relate to whether things are good enough to make choices -- and I look at things like when people are facing a 20 percent -- a $20 higher premium, yes, they are more likely to switch than those who don't face that -- premium increase, I should say. But still, a significant majority of people who face a $20 premium don't make a switch, and so we have seen response in the marketplace where there are a lot of plans who have really

raised their premium and seem to be acting on the basis that we know once we got people captured, that we're going to hang onto them, regardless of how much more expensive our plans get, so we've had plans that have tripled in price over the 5 years or 8 years of the program and have held onto a significant base of their enrollment as a result.

And then when you look at whether people seem to switch in response to star ratings, so is quality sort of entering into that, it is hard to find much evidence that they are switching to higher rated plans, so again, a place where you might want to see.

Now, it is certainly true, as staff has pointed out, that the results suggest that people are getting more savvy about it, but whether they are necessarily getting to better choices and whether there's enough switching behavior to sort of discipline the market in a way there, I'm still unsure but skeptical.

DR. CHERNEW: I just want to share the sort of unsure but skeptical tag line in the sense that there's sort of a framing question here about you see things may be getting better, but you started pretty bad, and so I think the evidence that they're getting better is a little

controversial. But even so, I don't think that anyone would say they're particularly good. I think the broader question is: Well, what would we do if we accepted that? And I think that's a much harder question.

There's a few quick things. One is better information. I think there is some low-hanging fruit. If I understand correctly, on the slide that you put up of your choices, if a plan rebated more dollars in the Part B, offered a negative Part B, I actually don't think that shows up here. I think you have to look more in-depth in order to find that. So as a result, you see a huge clumping at zero premium plans, and I think that suggest that you could provide a bigger incentive or information for people to actually rebate the Part B premium if they wanted to. At least that's my understanding of how this works.

DR. LEE: That's correct. For example, plans in Miami-Dade that we looked at, it will show Part B premium as zero. But that still requires you to go one level down to find that.

One thing that is not -- I thought that will kind of bring attention to it is they list the Part B premium and plan premium, and both things I added into total cost.

DR. CHERNEW: Right.

DR. LEE: But they did not have a line that says a total premium or your total premium or something like that. That will at least -- if you are just reading down those columns, that will at least bring attention to it.

DR. CHERNEW: Right. So apart from the detail, there's that. There's how they frame it, there's how they count any rebates beyond the Part B premium. But I think in general, the information stuff one could go back and forth on. I think the common economist default is to how to get better when you end up in the place where Jack was, skeptical, is we often have sort of auto-default kind of rules that we -- auto-assignment kind of rules, and those are tricky for a bunch of ways because you're pushing people to do things that they might not want to do. But I think it's worth thinking about how you would present information to people that would say, you know, if you're not looking -- like Bill said, you might get a flag or something that says, oh, you could have saved this much money if you just looked again, or some version of that.

Now, I'm not advocating that because I think there's a lot of complexity as to how we do that. But at

least I think it's something to think about.

The other thing that I think is really important to think about here comes out -- and you cite the McWilliams paper on it, and I think it's important. Some populations in Medicare aren't going to have the capacity to make the set of choices that one would expect them to make even if you had the website working exactly, you know, better than I think I could or anyone could really design it. And I think thinking about those populations and what choice means for those populations is also really important. And I think the role of auto-assignment is going to play a role. But that's a little -- could be a little heavy-handed, and we might not have the comfort to go very far down that road.

DR. NERENZ: I just wanted to follow up quickly on Rita's comment about the coming out of a new drug as being a trigger for switching. And I'm curious then how we take that into account in doing some of these analyses about how good people's decisions are, because clearly you have to -- at open enrollment you make a decision about the drugs you know about now. And even if you do that perfectly, you cannot perfectly predict the drugs you'll be on next year. And if in our analysis we look at choices and then we look

at the expense in the subsequent year -- and I'm sort of making that a question -- inevitably it must be imperfect, even if the decision given the knowledge at the time was perfect.

So how does this work when you look at how good or bad these decisions are?

DR. LEE: So the right decision at the point you are making them are that it's expected -- given the information you have, are you making the best or rational choice at that point, and that that will be on -- out-of-pocket spending, that will be on expected out-of-pocket spending. So if you are at the end of the following year looking back, of course, those are two actual versus expected would be different.

So I think one of the -- in terms of what's the loss from not optimizing, I think the weakness of the current way of calculating, you know, ex post of, you know, having full information, I think that assumption is not realistic. But that kind of still -- I think the idea is that how big is that amount, then you try to infer in terms of expected spending, was that likely the right decision or not.

DR. CHRISTIANSON: Well, I'm going to go back to what I said earlier. I think it's tricky business to assume that people aren't optimizing because they're not buying the lowest-cost plan. I object to that sort of assumption. On our part we're imposing our own values in terms of what we think people ought to be doing and everybody ought to be picking a low-cost plan and that's optimizing. That's not optimizing the utility function of these people. They have other things they care about than cost.

And another comment maybe about something that hasn't quite come up, but I think Mike raised it, and I agree with what he said. The term "choice overload" is often used in this literature. This is not a unique situation for people buying drug plans. Any day that you want to buy an automobile, you will have more options than in any drug plan market in the United States, but somehow you deal with that and buy an automobile. And you deal with that by applying your own individual heuristics, like: I'm only going to look at choices of automobiles that gets 30 miles per gallon or more; only going to look at automobiles that are under $15,000.

If there are heuristics that are fairly easy for

people to apply to get that choice set down to where it isn't choice overload -- and we do this all the time in our decisions that we made -- then it's better, in my opinion, to let them do it than have us impose on them our heuristics, whether our heuristics say low cost or a plan that has been five-star or whatever, right?

Now, if, on the other hand, as Mike Suggested, the problem is that people are not making any choice at all because they're just overwhelmed by t his, then you might want to go towards or make an argument towards some sort of auto-assignment kind of situation based on our belief about what people ought to be thinking about when they make choices.

So Medicare has in the past tried to go a standardized route with Medigap plans, so that's a standardized benefit, but there can still be a lot of plans in the market offering these standardized benefits. So I think it's easy to confuse the notion that Medicare has gone this route of restriction before. And they have in a sense to try to avoid confusion. You can have a lot of plans offering a particular benefit package at different prices and with different other objectives.

So what I'm trying to say here is it's very tricky to deal with choice overload by saying that we are going to have our heuristics, our decision role to impose on everybody and say, okay, we're going to get it down to eight plans. Imagine the pushback. Okay? So our decision, the eight lowest-cost plans in the market, and then the ninth plan costs one dollar more, but I'm sorry, you're not the eighth lowest cost plan, I just -- I think when you start talking about choice overload, the logical extension of that is let's eliminate choices. And how we do that is, of course, the tricky part of the business, and I don't think it's the way we should go. I like the suggestions that Mike made.

MR. HACKBARTH: On your first point, Jon, about analyses looking only at cost being flawed, that sounds right to me. I think you've made a compelling point.

Does that mean that there is just no way to analyze the quality of choice because it can always be determined by something you're not measuring and you just have to accept the choices or the choices?

DR. CHRISTIANSON: In this case pretty much, because, you know, the economist's fallback is always if --

you don't worry about it, if people have good enough information to make choices on these different dimensions. We don't think they do, and Mike is skeptical that we can get there with this group, at least all segments of this group, and that's probably right.

DR. BAICKER: I do think there is something fundamentally different about the stand-alone drug plans versus an MA plan or a choice of a much more complicated package, where I think Jon's argument is especially strong when there are all sorts of different dimensions of the care that's being generated and you care very much about your doctor and your -- the network that's included in all of that is so multi-faceted that it's hard to say from any choice set, well, that's probably not the optimal choice for that person. Even though there are surely non-optimal choices being made, we can't identify them.

I think that looking separately at just the Part D stand-alone planes, it's harder for me to think that the money left on the table by beneficiaries by choosing a package that doesn't have their drugs included is more of a rational "I really like the quality of the envelope in which I get this drug from the mail-order pharmacy." You know,

really it seems as though people are consuming much more similar, the same bundle of goods, and it's easier for me to be persuaded that if you're leaving a lot of money on the table, maybe presenting the information in a better way would give you the option not to do that. And I am, you know, very much in favor of people having lots of choices, but having the information given to them in a way that's actually useful as opposed to overwhelming along the lines Mike was saying.

Now, I'm as big a fan of the insurance value of insurance as anyone in the room, I would venture to say, and, you know -- yes, that was an understatement. But there's the question of are people rationally saying, well, this bundle of drugs that I'm consuming happens to have a higher price, but I'm getting better insurance protection from this policy.

My understanding of the necessarily limited analyses of the packages is that that doesn't seem to be the case either. It's not that people are choosing plans that happen to have higher combined out-of-pocket costs and premiums, but those plans are offering better backstops. They look to have similar backstops, and it's really about

the formularies that are included.

So I do feel like we can make some qualitative statements about people not making the choices that they would if they were fully informed and able to process the sometimes overwhelming amount of information that's available.

What does that mean we should do about it? There's a case to be made for defaulting people, but it's very hard to know which things to default them into, and maybe one would want to start with thinking about populations where the decision-making process is more likely to be impaired and thinking about if there's a productive way to default people into plans there.

I also think that there's some -- that that suggests it would be helpful to know a little bit about who's switching and who's leaving money on the table. And I know there's a limited amount of information on that available, but just some quantitative statements about the type of person who's more likely to switch. Is it more disadvantaged populations who are leaving more money on the table? Is it more cognitively impaired populations, older populations, populations in certain areas of the country?

I think that would help us know how targeted a problem this is and how much return there might be to improving the choice architecture there.

Last point. You asked, Do we have enough competition to actually enforce market discipline, and you don't need everyone to switch when plan prices aren't as low as they could be to drive prices down. You need a critical mass to switch. And I don't know if we have that critical mass here. The fact that people switch disproportionately to lower-cost plans shows there's some force in that direction. Is it enough force? I think it depends on the stickiness of plan choices for drug plans versus other plans, and I think people are more likely to switch, as Rita pointed out, when they have a new drug come online and they have a shock to their prices. We know people respond to changes more than, you know, if I've been happy in my plan going along and some new low-cost plan enters and I'm just not paying attention to that, I might not switch even though I am now leaving more money on the table than I would have otherwise; whereas, if I get a new drug and suddenly my costs go up, that does prompt people to look around a little more.

So I think there's some hope and some evidence, albeit oblique, from the trajectory of premium increases that we've seen in the Part D plans that there is some market discipline being enacted by the switching -- imposed by the switching. But I don't know if it's nearly as much as there could be.

MR. HACKBARTH: So I'll let Mike jump in ahead of Bill, and then I want to do Bill, and then I want to open up the possibility of going in a completely different direction here.

DR. CHERNEW: The problem with this sort of market discipline discussion, it's not something you have or you don't. And so what is, I think, very clear from the literature is there's clear competition, and it works better than if there were no competition. And there's a lot of evidence that it doesn't discipline the market to the maximal degree that it could, if you believe in perfect competition. And the question that's going to be on the table is: Is the disease -- in other words, the imperfect aspect of competition -- worse than the cure? And we don't know what that cure is. And that's the really hard question. In order to answer that, it's not just a matter

of knowing how well competition is working, because it's working some. But it also has to be compared to a particular cure, which will also have a whole series of problems associated with it. So don't assume that the cure is costless either. And that's going to be the issue. We have to list what the cure is.

MR. GRADISON: One of the things that fascinates this whole discussion for me is the emphasis on the beneficiary's point of view. It's one of many we're doing, and I think that's extremely valuable.

With regard to Jon's comment, somehow or other I think we need to take into account the fact that it takes time and effort to do these things, and, you know, how much time are we willing to spend to save $10 a month? I mean, some people with a lot of money would do it; some people with no money won't do it. I mean, there's a lot of factors involved, but there is a time value here, a consideration which I think adds substance to the point that Jon was making.

I was involved actively in the restructuring of the Medigap market. It was very disorganized. There was a lot of double-selling and a lot of improper things going on

at the time. We've had that around in a structured way for some time with additions to the original A to J options and so forth. And it would be interesting to take a look -- and maybe others have done this, but to take a look and see, with the same kind of analysis, what can be learned about choices that are made of Medigap, which is a fairly high-dollar cost for the people who buy it each year. And broadly speaking, it's pretty expensive insurance. It's more like prepayment than insurance in some respects.

What I want to mention in particular is what I think is an enormous opportunity for an analysis -- and maybe it's already underway -- with regard to the choices being made through the exchanges, not just demographic factors, which would be extremely interesting in terms of trying to cast some light on bronze versus platinum and in between, but also the question that kind of fascinates me is whether there are material differences, holding demographics constant, to the choices that are made based upon whether people had insurance before or didn't have insurance, and do they have any familiarity -- they might have had some familiarity with it that would make them, arguably, better consumers and able to make better choices, a factor which

doesn't come into play -- or didn't originally -- well, still doesn't come into play really with regard to Part D because even today, as when Part D first got started, people in their working years haven't experienced or are very unlikely to have experienced drug-only plans and, therefore, have a basis of prior experience to help them in making their choices.

So I don't know whether this question of analyzing as data becomes available the ACA choices -- there's probably a lot of people out there doing it, but I think it would be extremely help to the Commission in the future to be taking a look at that from the point of view that you use right here in trying to think through the choices that are made with regard to prescription drugs.

Thank you.

MR. HACKBARTH: So I've seen three hands here: Craig, who has been waiting quite a while, Jon, and Rita. Craig, do you want to go in this general area, or do you want to go in a new direction?

DR. SAMITT: I'll probably go along with Bill a little bit [off microphone].

MR. HACKBARTH: Okay. And so why don't you go

ahead. We'll do Craig and then Jon and Rita. Is there anybody that wants to take us in a completely different direction who has been waiting patiently? Okay.

DR. SAMITT: So I think I have two things. One is the chapter was fascinating as well, and, in fact, it leads to my first point, because it just made me think about additional information that we need. I loved the chapter, but I wasn't satisfied because it probably raised more questions than it did answers.

You know, I'd be very interested in extending the focus groups -- and this may be to Kate's point -- beyond just Part D choices. I'd be interested in understanding what motivates people to change from one MA plan to another MA plan or go from fee-for-service to MA or from MA to fee-for-service. I think we're going to get a much greater depth of understanding of what motivates choices if we can ask all of those groups and monitor switching. I think Mary referenced that yesterday. I, too, am very interested in switchers because it tells us a whole lot. So I'd be very interested in looking at that.

The second point that I would want to make is about a decision-making methodology. I agree completely

with Jon. We can't limit decisions, but I'm not so sure I agree with auto-assignment either. I mean, I think that there's a lot that our industry potentially could learn from other industries. Seniors make choices, purchasing choices all the time, whether it's cars or homes or computers, that are very difficult decisions that have thousands of choices. So isn't there a methodology that we can help seniors sequence their priorities. I mean, do we ask seniors, "What's important to you? Is it cost? Is it your physician? Is it network choice? Is it drugs?" So that as folks go to make choices, we can guide them to the best choices based upon their prioritized needs.

So I don't know if that is even feasible. That may be where an exchange-like methodology in the Medicare space has some relevance, because does that methodology apply in this instance as well when seniors need to make choices?

Those would be my two thoughts.

DR. CHRISTIANSON: Okay, real quick, I think -- I did a paper recently where I tried to look at the literature and figure out, to your question, Glenn, what percentage of consumers need to be actively shopping to drive the market,

and I couldn't find empirical analyses of that. I found conceptual papers. Maybe the rest of you know some papers.

But I think -- I suspect, and the conceptual papers suggest, it's going to vary fairly dramatically across what kind of product you're talking about.

And then I would continue my previous argument and sort of build on what Bill said. I think even if it's comparing Part D, which I agree is an easier comparison, there is a network component in terms of pharmacies available and so forth as a formulary component. So there are things that people will -- and also, there's a transaction costs component. I keep coming back to that.

So I may, as Bill suggested pay more and know I'm paying more, know I'm likely paying more, simply because I don't want to spend the time or because I've had BlueCross all these years. I'm really comfortable with BlueCross. I know they're not going to screw me. I don't know the names of all these other plans, which are really kind of weird-sounding -- you know, Extra Gold, Blue Select. You know. So maybe I'll just, you know, avoid all that and stay with something I'm comfortable with.

Well, there's an anxiety reduction value to that.

So I think even if you're just thinking of Part D there are other things that consumers will naturally consider.

DR. REDBERG: I was just going to add that I'm not sure the converse is true, that if you stop a drug that people are as likely to make that change. It would be interesting, and I don't know if there are any data.

Just the way human nature works, I think people tend to stay in the plans they are unless -- and I'm just -- but, my actual comment.

I've been thinking a lot about the ACA and the exchanges during the whole discussion, and I thought, well, I don't want to distract us. But as Bill mentioned it, because in particular I'm really curious whether the same insights -- and I assume they will -- will apply although the demographics clearly are different for people entering the exchanges.

But the point that I think will be very interesting to watch is sort of related to the discussion of people make the decision on premiums. But it seems, just like for the Part D plans, the lowest premiums plans are having the highest out-of-pocket costs. I suspect there's

going to be a lot of surprise and changing when people realize what the out-of-pocket costs are in the plan because I think they are now focusing the premiums.

It's also, of course, a little harder to predict what your medical needs will be in the next year, and so that will determine a lot of what your out-of-pocket costs are. But I think we're going to be learning a lot in the next years about exactly the topics you've outlined for us so well on the Part D plans.

DR. BAICKER: Can I jump the queue?

One piece of information just to add to Jon's comment was I think it's important to consider some of the evidence on the presentation of information as evidence that people are not making that kind of choice based on quality or other intangibles and that there's this study from -- was it Michigan or Minnesota?

One of those M states. It's not Massachusetts. Where they gave people just information on a slightly different format, and there was substantial switching of plans. It was the exact same information that's available in Medicare Compare, but it was presented in a slightly different way, and it induced switching.

And that kind of behavior suggests that if that marginal change in framing is changing behavior the original behavior was probably not optimal.

MR. KUHN: Yeah, back in 2006, when Part D was launched, you know, and the development of the Plan Finder web site, the whole ideas was to help beneficiaries make choices.

So you would go into some states, and we would be all part of the rollout team, and you would have 57 choices.

And seniors would look at you and say, how in the world can I make a choice between 57?

I said, you can't. It's impossible. But with Plan Finder we can get it down to three. And can you make a choice from three?

And they would say, yes.

And then through Plan Finder you would make those determinations of what's important to you. Was it important to you to have a retail pharmacy within five miles -- or all those kinds of things that Jon has been talking about, both tangible as well as nontangible, to help them get to a point where they could make an informed decision as part of the process.

And so what I keep thinking about as I'm listening to this is: What have been the innovations in Plan Finder since it was launched, and have they refined it? Are there more refinements that need to go forward?

What have been the refinements with the SHIPs, and are they counseling people differently now than they did six years? What have they learned as part of the process?

Likewise, I have to think about the recent marketplace rollout, and obviously, it got off to a rocky start, but they have a web site. But they also have deployed a number of different folks in the field, whether it's navigators or certified application counselors. What are they doing differently in the marketplace to inform people, to help make choices?

So there's a lot of things going on here.

I just don't know if there's an opportunity to steal that information, to find out kind of what are the best practices, both technology as well as the kind of organizations they found

When CMS does future contracts, either with navigators or with SHIPs, are there certain performance metrics in those programs that they want to have that help

people make better decisions as part of the process -- because it does sound like from the evidence you've shared that one-on-one contact for a lot of Medicare beneficiaries makes a big difference as part of that.

The other thing, going back to what Craig was talking about, in terms of looking at other areas where we make decisions in the Medicare program -- and I think all the examples he used were interesting and I think would be helpful.

Another one I'd be interested in is to go back and look at the old ACE, the acute care episode demonstration, which had kind of some different motivations.

And, as I recall, because beneficiaries, if those chose one of those particular entities or organizations, not only did -- you know, they got the assurance of quality and volumes and all this activity, but they actually got a rebate check back as part of the process. And how did that motivate them to maybe make that decision, to go in that direction as well?

So it would be interesting to look at that one as part of the process, too.

DR. HOADLEY: So I've been trying to think a lot

about sort of, where do you go with some of this stuff?

I mean, I think we've hit some of these themes already.

You know, this notion of should there be some kind of automated choice or default choice. I mean, I think there are variants on that that are not as sort of problematic as sort of saying, well, we're going to move you because we've had some experience with that on the LIS side that has been random and, therefore, not helpful in this respect.

But, I mean, I've tried to think about things like when you get your notice that open season is coming, could you provide the beneficiary -- and it's a little like -- it's the example Kate was using.

Could you reframe the issues?

Could you provide the beneficiary -- here are the three choices that on -- and we can worry about what the criteria we want to put into this, but either the lowest cost for you or figure out some other.

And even give them as much as -- in the old days, you would have had a postcard to return. Now maybe you automate or something like that. But give them a means, not

necessarily give them a default choice and say you're in it unless you choose otherwise, but give them a very easy way to make a switch if they want to make it.

So things like that that you could do -- I mean, it's sort of the book nudge. Try to call about a lot of ways you could go in and give somebody an easy way to make a choice, not necessarily make it for them.

I think there are things we should think about in terms of standardizing. I mean, CMS has actually done a fair amount in the last several years to try to further standardize Part D.

But maybe if we kind of like the notion under the ACA of the metal levels -- right now, if you're getting an enhanced plan, it's actually fairly hard to figure out what the enhancement is and why one amount of enhancement is better than another amount of enhancement.

And why not have some kind of actuarial value label so we could tell that -- you know, people can call their plans bronze or silver, but it doesn't have any meaning. And maybe we can try to create some meaning, whether we go as far as we did with Medigap or less.

Obviously, there are basic plans that are

actuarially equivalent, and that's most of the market actually, and then trying to figure out even what the differences are there.

And then this whole question of sort of what you choose on, I think, is very interesting.

The Plan Finder -- this goes to some of what Herb said and, ultimately, to some of what Jon said. You know, the Plan Finder does a lot of really useful things, but it still tends to make the premium sort of the first thing you see or the total out-of-pocket cost given the current assumptions.

And we do know that people tend to sort of overrate -- and I think Kate mentioned this earlier -- overrate premiums as a feature over some of the other kinds of things.

You know, there's been this push now with these preferred pharmacy networks in Part D. It actually be fairly hard to get that right. You're asked now to put in the pharmacy you use, but that doesn't give you a provision to say, well, would I save money if I switched pharmacies?

And so that -- you know, that's there.

And then when you try to put this in the MA

context, how you capture in the Plan Finder as you see it up here isn't going to tell you anything about the fact that the network in Kaiser is going to be different than the network in MedStar and this kind of situation.

Then I think we really need to think more about how to build, whether it's pharmacy networks which is relatively minor, or MA networks which could be huge, for what people care about, and then also, other aspects of sort of a benefit design and the insurance protection aspects.

I think we could really think a lot about how to work off the Plan Finder platform, which is a great start, but to try to build more of these features in it.

And if you layer that with some of the standardizing kinds of things and maybe this notion of providing somebody a default, you could maybe create a choice environment that's a lot easier to work with.

If people still want to stay with their BlueCross, you know, that's fine. They're going to do that. But we can make it possible for those who do want to be price-sensitive, would like to save the $20 or $1,000 a year, whatever, to have an easier time doing that.

MS. UCCELLO: Well, most of what I was going to

say has been said, but I will again echo that notwithstanding Jon's, I think, really compelling arguments, I think we're still worried that people may be undervaluing certain aspects of this. You know, not really understanding enough to pay attention to the out-of-pocket costs as compared to the premium -- I think that's a really big deal.

And, in terms of actuarial values, since Jack brought it up, I know that's such an understandable concept. But just kind of reminding ourselves that actuarial value is good on an average level, but it's not really good for any particular person to pick what plan is best for them. So that's just something to remind ourselves of.

Going back to what Glenn said about whether we have enough to have a good market, to discipline the market, I'm kind of thinking about what exactly do we mean by market discipline. Even with that, one thing would be, are they managing costs well? But more of that is, are our networks adequate; are they quality kinds of issues?

I'm just really thinking off the top of my head here. But, is there a way to marry kind of what we think and we desire for what we want market discipline to be with kind of helping us think about the kinds of things we want

beneficiaries to be considering?

MR. HACKBARTH: Okay. Any others?

Julie, go ahead.

DR. LEE: Just very briefly, given the discussions, I think one way to think about today's presentation is the different types of costs that beneficiaries have in their decision-making. There are some direct costs that are like premiums or out-of-pocket spending that we tend to focus on because there are some data on that. But, on indirect costs, there's a time cost that people have to invest in making that choice.

But, as Jon pointed out, there's also the convenience or inconvenience or it's an unpleasant experience. So there's this utility that comes from that.

But I think there's a final type of costs -- that we use heuristics or rules of thumb in narrowing our choices down, but the literature shows that there are certain biases in those heuristics that we use.

So, to the extent that information conveyed can mitigate some of those biases, I think that also can lower some of these indirect costs associated with their decision-making.

MR. HACKBARTH: Any other questions or comments?

[No response.]

MR. HACKBARTH: Okay. Thank you very much. This was thought-provoking.

Okay. Next is measuring challenges in measuring the effects of medication adherence.

MS. SUZUKI: Good morning.

Medication adherence is viewed as an important component in treatment of many medical conditions. In this session, we will report on findings from our analysis that explores the complexity involved in measuring the effects of medication adherence on medical spending for the Medicare population.

So there has been much interest in policy interventions to improve medication adherence because adherence to appropriate therapies has the potential to improve health outcomes and reduce the use of other health care services.

Studies that focus on certain chronic conditions have found that evidence-based medication therapy reduces the incidence of hospitalizations and emergency room visits.

Recently, the Congressional Budget Office

announced its plans to include medical spending offsets for future policies that increases the use of prescription drug coverage under the Part D, while they also continue to review new evidence.

The literature suggests that there are still gaps in our understanding, and as I'll discuss shortly, our previous analysis suggested that measuring the effects of improved adherence using administrative data is complicated.

In addition, because adherence to most medication therapies decay over time, typically within 1 year, the long-term effects of policies that improve medication adherence is uncertain at best. This issue is also important because medications could have negative effects on health outcomes if not used appropriately. For example, studies have shown that heavy use of medications, particularly in the elderly who are most likely to have multiple chronic conditions, increases the risk of having adverse drug reactions and drug-drug interactions. So policymakers must use care in crafting policy intervention, so that they do not inadvertently harm the beneficiaries.

So this is the overview of this presentation. First, I'll summarize some of the key findings from our

previous analysis that we presented to you last March. Next, I'll discuss methodological issues we explored in our current analysis. In the results section, we will highlight some of the key findings and summarize them at the end.

Our previous analysis found that the effects of better adherence to medication therapies vary across conditions, medication regimens, and low-income subsidy status. The variability in our findings suggested that the results are not generalizable.

Some of our findings suggested that the estimated effects may be confounded with factors that affect beneficiaries' health that are unrelated to their medication-taking behavior. For example, contrary to what we expected, we found that the observed spending effects were often unrelated to the condition being treated. We also found that a greater improvement in adherence did not necessarily result in a larger reductions in spending compared with a more modest improvement in adherence.

Finally, we also found that across all condition cohorts we examined, that adherence to medications decay over a fairly short period of time.

In our discussion with you last spring, and in

particular, Kate, you had raised concerns about the method we used to select and define the study cohort. So we have taken a look at this issue again to think about the implications of the decisions that are made in choosing a study cohort. I'll focus on the few main issues we considered. A more detailed discussion of this is included in the paper.

For our previous analysis, we used both diagnoses on medical claims and actual prescriptions for the study medications to identify the study cohort. This ensured that only those prescribed one of the study medications were included in the study.

However, as Kate pointed out, relying on drug claims also means that we would exclude individuals who were prescribed one of the study medications but did not fill the prescription; that is, we would be excluding the least adherent individuals.

One alternative is to rely only on medical claims. This has the advantage of including the least adherent individuals, but we may also capture those who were screened for but did not actually have a condition.

Another issue we considered is how to adjust for

the severity of the condition, particularly for diseases that are progressive in nature. This is likely to be true for many conditions, regardless of whether you use both medical and drug claims or rely only on medical claims. The concern here is the difference in the severity of the disease may affect how adherent an individual is.

For this study, we focused on beneficiaries with congestive heart failure, mainly because many of the drugs used to treat this condition has been shown to be effective, and this is one of the conditions where we might see the benefit of adhering to the medication therapy.

After several attempts at controlling for the severity, we decided instead to limit our analysis to those who are newly diagnosed with CHF. We did this by identifying medical claims with a CHF diagnosis for an individual who had no CHF claim in any setting for the past 3 years. We refer to this as a CHF event.

Our thinking was that, with this method, we are more likely to capture individuals at a similar stage of the disease and are also more likely to be identifying individuals who are candidates for starting on CHF medications.

We further restricted our initial study cohort to those who were not on CHF medications before the CHF event to limit the confounding effects of preexisting health conditions, such as hypertension or other precursors to CHF, and we also limited our cohort to those who received their initial CHF diagnosis in an inpatient setting to limit the possibility that a CHF diagnosis on claims reflected screening or other diagnostic events rather than an actual diagnosis for CHF. In our sensitivity analysis, we plan to examine the effects of relaxing these assumptions.

We assigned the initial study cohort into three groups based on the level of adherence. Adherence in this study is defined as possessing any of the study medications. This method allows for those whose treatment regimen is switched during the study period to continue to be treated as adherent.

Beneficiaries starting on any of the CHF medications within 3 months after the CHF event and continuing on for at least 6 months were assigned to a high adherence group.

Those who started on CHF medications within 3 months after the CHF event but discontinued within 6 months

were assigned to a low adherence group.

And finally, those who either did not start on CHF medications after the event or started on CHF medications after more than 3 months had passed since the CHF event were classified as non-adherent. About 90 percent in this last group did not start on CHF medications.

For this analysis, we used an OLS regression model to estimate the effects of medication adherence on Medicare's Parts A and B spending. We looked at two outcome periods, the first 6 months after the CHF event and the subsequent 6 months after the CHF event.

Spending effects for adherent groups are relative to the non-adherent group.

The initial cohort is the restricted group that I just discussed, those who had CHF event in an inpatient setting with no prior CHF medication use.

Using this initial cohort, we examined how different model specifications and different populations affect the estimated spending effects. We also plan to do some sensitivity analysis using different cohort selection criteria.

So beneficiaries in non-adherent group differed

from those in the adherent groups in other ways than how adherent they were to CHF medications. There is more detailed discussion of the differences in the paper, but I'll just mention a few.

Beneficiaries in the non-adherent group tended to be older, have more medical conditions, and had higher health care use and spending prior to the CHF event.

The mortality within the first 6 months of a CHF event was much higher among beneficiaries in the non-adherent group, about 18 percent compared with 7 percent for those with high adherence and 3 percent for those with low adherence. We are not entirely sure why the mortality among people with high adherence is higher in the short term compared to those with low adherence, but that relationship is reversed by the end of the first year.

Over the longer run, the difference in mortality rates between the adherent groups and the non-adherent group becomes smaller, but it is still somewhat higher, particularly compared to those with high adherence.

The mortality is measured after the CHF event, so it is not clear whether the higher mortality among those in the non-adherent group reflects the effect of not taking CHF

medications or differences in health status that existed prior to the CHF event.

This table shows the regression results. As you move down from specification 1 to specification 6, you can see the incremental changes in the covariates that were added to the model. The amounts shown are the estimated effects of better adherence, either high or low, on average medical spending per beneficiary per month.

The first specification only included an indicator for adherence groups. You can see that there were pretty large spending effects during the first 6 months for both high and low adherence groups, but the effects are much smaller for months 7 to 12, $800 compared to over $5,000 for those with high adherence. For those with low adherence, the effects are reversed, meaning that their spending per month was higher by about $300 on average, compared with those who did not take CHF medications.

Specifications 2 and 3 adds socio-demographic characteristics with and with race, and as you can see, the results did not change very much from specification 1.

In specifications 4, 5, and 6, we start to add health and health care use variables, and you do start to

see some changes in the estimates. But the biggest changes, largest changes were from the addition of survival status in specification 6. The effects during the first 6 months are about half of the estimates obtained from the other estimates. And those in the high adherence group, the estimated effect for months 7 to 12 is much smaller and no longer statistically significant.

This finding doesn't prove that mortality is capturing the health status differences -- I'm sorry. I should go back. This finding doesn't prove that mortality is capturing the health status differences that are not explained by the other health status variables in the model, but it does raise questions about the estimated effects and potential confounding by prior health status, as Rita and others suggested at the last meeting.

We conducted two subgroup analyses using specification 6 that includes the full set of covariates.

Bill Hall, during the last session, you mentioned that the effects might be very different for older people, particularly if they have other conditions. So in the first subgroup analysis, we stratified the beneficiaries into

those who were 80 or younger and those who were over 80 to assess the estimated effects of medication use by age.

In the second subgroup analysis, we stratified the beneficiaries by their LIS status to assess whether the estimated effects differed between LIS and non-LIS beneficiaries. We found that spending effects were larger for those over 80 compared to those 80 or younger. We also found that effects were larger for LIS beneficiaries compared with non-LIS beneficiaries. We again found that spending effects during the second 6 months were much smaller and not statistically significant in most cases.

The exceptions were older beneficiaries with low adherence and LIS beneficiaries with low adherence. For both of these groups, we found that taking CHF medications did not reduce spending during the second 6 months. These findings again raise questions about the estimated effects.

So to summarize, our primary finding is that better adherence to evidence-based CHF medications is associated with lower medical spending among Medicare beneficiaries in the short term. We only looked at this one condition, but in our previous analysis, we found that the effects vary across conditions. So our findings are not

generalizable to other conditions. Our subgroup analysis shows that the effects vary by age and by LIS status, and likely by other characteristics as well.

We find that estimated effects are sensitive to model specifications, although adding socio-demographic factors had negligible effect. Other factors, particularly those related to health status and health care use did seem to have an effect.

We changed the way we identify the study cohort from the last time, and that has had a significant effect on the estimated effects, and we are continuing to look at this issue and will be conducting additional sensitivity analysis.

We found the largest effects from adding survival status to our regression model. Including the survival indicator reduced the estimated savings by nearly half during the first 6 months after the event. It is reasonable to think that one's overall health status affects the ability to adhere to or start a new medication therapy, and because Medicare beneficiaries are more likely to suffer from multiple chronic conditions compared to the general population, this issue may be more of an issue for Medicare

beneficiaries.

Finally, the results consistently showed that the effects of medication adherence diminished over time. The effects in the second 6 months were much smaller compared to the first 6 months, and for some groups, the effects during the second 6 months turned into a small cost.

So to conclude, our study demonstrates that there are many questions that need to be answered: how effects of medication adherence vary by condition, the model used, the population studied, and how the study cohorts are selected; how one's health status affects adherence to medication therapy and
vice versa; and why adherence decays over time and why the estimated spending effects also decay over time.

That concludes my presentation.

MR. HACKBARTH: Thank you, Shinobu.

You took great care to emphasize that this was just a study of CHF. As a layman, it seems to me -- and I guess this is a question for the clinicians in the group -- that it matters a lot what the condition and the drug are. In some cases, the benefits of adherence to the drug may come very quickly. In other types of chronic illnesses, the

benefits may only accrue over a long time frame, and so to generalize about the benefits of adherence seems really complicated as a result of that.

Given that, one of the most interesting things to me was how quickly adherence declined. Now, if that reflects something about human nature that's true across different drugs and different illnesses, that is really important.

Did that make any questions?

MS. SUZUKI: So we found this with other conditions that we looked at last time. We looked at COPD and depression, and in both cases, the adherence did decline fairly quickly.

MR. HACKBARTH: Yeah, yeah.

Okay. Clarifying questions? Peter, then Rita, Jack, go down the row. Okay, go ahead, Rita.

DR. REDBERG: Just because you said clinicians, but, I mean, you are absolutely right. I think CHF is a good example, because obviously it's a common disease among Medicare beneficiaries, and it is very commonly treated with medications. And it would certainly differ depending on like preventive medications, like the osteoporosis drugs.

You wouldn't expect to see any kind of effect right away or perhaps ever.

[Laughter.]

DR. REDBERG: But I think it is also true, and we talked about this a little last time, that people that take their drugs are inherently different than people that don't, and that's irrespective of their illness as well, so there are a lot of different variables.

And I would just also note that there is a difference in the levels of evidence for different drugs, and so some drugs, clearly, you would expect to see very significant beneficial effects, and some drugs are on the market based on surrogate outcomes and really have never been shown to have clinical effects. So it is very hard to generalize, because of all the different patient factors and drug factors.

That's all.

MR. BUTLER: So not on your slides but in the chapter, you display differences in high versus low versos non-adherent in table 2. I found it interesting that the physician visits per beneficiary are 3.9 for highly adhering and 4.7 for non-adhering, which is again -- but then if you

look at inpatient admissions per thousand, you see 213 for the high adherent and 366 for -- so a really big gap there, suggesting a lot of the spending differences in hospitalizations.

Now, what I am zeroing in on is that the fact that we are spending so much energy around 30-day readmission rates in CHS, you don't have that specific rate shown here, but if you show that most of these were readmissions within 30 days, then you'd sit there and say, "Oh, my God, now the hospitals really ought to focus tremendous energy on making sure they are taking their drugs when they get home." And I know now I am tripping into round two in a way, but I can do whatever I want now, right, Glenn?

[Laughter.]

MR. BUTLER: And while I'm at it, I've got three more things to say.

DR. MARK MILLER: Can we shut the mic off?

[Laughter.]

MR. BUTLER: This is where I go rogue.

But you understand, I am trying to get the practical connection of this data down to readmission rates that say, "Hey, if you really do this, you can make a

difference on hospitalizations."

MS. SUZUKI: The one thing I would say, so the table 2 demographics, health care use, that is a baseline. So this is prior to the initial CHF event. So it's not the number of admissions after that initial inpatient admissions that have the diagnosis. Presumably, they were not prescribed the CHF medications when this use was measured.

DR. BAICKER: Just a clarifying question on that table 2 and the readings or I think table 10 showing the different models in the slides. The mortality rate is the only thing that you're controlling for that is an ex-post thing; is that correct? Everything else is measured at baseline. Obviously, you don't use mortality at baseline, because you have to be alive to get in the sample. But then the mortality is potentially endogenous. Nothing else is.

MS. SUZUKI: Correct.

DR. HOADLEY: And I just wanted to make sure I am correctly reading your left-hand side variable. The total spending is total A/B spending, not D spending?

MS. SUZUKI: Just A/B spending.

DR. HOADLEY: And obviously, then it's total A/B spending, regardless of what it's being spent on. So is

there any real way to attribute how much of the A and B spending is for CHF-related things? I mean, that strikes me as it would be hard to do, even if it was the right thing to do.

MS. SUZUKI: So we did not look at the CHF-related spending this time around, but last time we did.

DR. HOADLEY: Okay.

MS. SUZUKI: And we actually found that for some cohorts that it was maybe a quarter of the spending effects were attributed to CHF. It varied across cohorts, but it was not the majority of the spending effect.

DR. HOADLEY: Okay, thank you.

DR. MARK MILLER: And that was one of the things the last time that was a little bit confusion, that that's kind of where you expect the first effect, and it wasn't consistently showing up, and it kind of threw us off a bit.

MR. HACKBARTH: Other clarifying questions from this side?

Jon.

DR. CHRISTIANSON: So when you put in the health -- the status, survival status, is the implicit assumption there that the amount of money that you spend does not

affect survival? You have got money spent as a function of whether you died or not, but whether you died or not might also in that time period be a function of how much money was spent on your care. So is that kind of addressed in the econometrics here?

DR. SOKOLOVSKY: I am not exactly sure what you are asking, but we didn't stretch the amount of money across the whole period.

DR. CHRISTIANSON: No, no, no.

DR. SOKOLOVSKY: So if it's not about that, a lot of what we could be seeing is the rise in spending in the last 6 months.

DR. CHRISTIANSON: I am just wondering whether survival status is exogenous, so you can enter on the right-hand side or whether you correct it for that in econometrics. Maybe it is endogenous.

MS. SUZUKI: It could be endogenous. We put the survival status in the right-hand side. We did control for some of the higher spending that are likely to occur at the end of life, so we control for that too.

We don't say whether the causality goes the other way, and we do not control for that.

DR. MARK MILLER: Right. So there is no instrumental variable, no two-stage or anything like that, if that is what you are asking, Jon.

DR. CHRISTIANSON: Yeah. I was asking whether --

MR. HACKBARTH: You have to use your microphone.

DR. CHRISTIANSON: So that got a big drop, obviously, for reasons we probably understand when you're near end of life. The medical care system throws a lot of money at you, but there is also this interpretation that it could be something that you need to adjust through in this variables approach or something like that, since it has such a huge effect.

But if you are willing to just assume that the amount of money that gets spent on your is not going to affect your survival, then fine. Then it is exogenous.

DR. BAICKER: And my concern in asking about the mortality was not so much that mortality affects spending, because if mortality affects spending, surely mortality does correlate with spending, but it won't affect the coefficient on adherence unless it also is related to adherence. But if you think that part of what adhering to your drugs is supposed to do is keep you from dying, then the adherence is

affecting the mortality, and both are related to spending. And then you get the bias, and there is no available instrument for the mortality.

So we can dig in, in the next round, but I think the two-part test of the problem is, is mortality correlated with spending and is mortality correlated with adherence, and I think there's reason to think that both are true. And that's when you get the bias.

DR. CHERNEW: But there is an instrument for the adherence.

DR. MARK MILLER: Right, but the thing that we wanted to be sure that we do -- because if we had rolled in here with instrumental variables, we would have been dismantled, as you well know, and so we wanted to start out with OLS, have you guys make these comments, and then we would figure out how to instrument past it, because the instrumental stuff really gets hairy, and a lot of judgment comes into play there.

MR. HACKBARTH: Herb looks like he has a question about instrumental variables.

MR. KUHN: I feel like when Glenn says to look at these papers and if I read them, I wouldn't understand them,

so I think I'll stick with Glenn on that one.

MR. HACKBARTH: Dave.

DR. NERENZ: Just to clarify in the definition of non-adherence -- and I am prompted by some of Peter's comments here -- these are higher-cost folks at baseline, more admissions, more visits. Part of the definition of non-adherence is they just got no medications at all after the event, but in the dataset, we don't know if they were prescribed medications. Is that correct?

MS. SUZUKI: That is correct, and that is why we try to limit the initial cohort to people who had a CHF event in an inpatient setting, so that they are more likely to have been candidates for CHF medication.

DR. NERENZ: Okay. Well, I guess in round two, maybe perhaps Rita and others can talk about whether there's something about the sickness at baseline that may have contraindicated the medications, and that's sort of what's pushing a lot of what we see later, but that's a round two --

MR. GEORGE MILLER: Yeah. Thank you for this. This is fascinating reading.

I wanted to go to what Dave just said about the

definition of non-adherent, and do we understand why there was non-adherence? Are there issues that may affect the non-adherence, and did you take into consideration the impact of poverty on why they may be non-adherent, if that is the factor, if those are the factors?

MS. SUZUKI: I don't think we saw a lot of difference in terms of demographics. There are some differences that we discussed a little bit. You know, maybe they are a little bit older. I didn't see a huge difference in, say, LIS status.

I guess we don't' have a theory of why they were not adherent, but we did see that they were less healthy at baseline, so we do speculate that maybe that had something to do with why they were not adherent.

MR. GEORGE MILLER: And then a second round one question for sure is, when you mention about the health status and the conclusion affects adherence and vice versa, did mental health status have any impact from your perspective in your study, particularly dementia or other --

MS. SUZUKI: I can get back to you on that, but I am trying to remember. We did look at various --

MR. GEORGE MILLER: I won't be here.

[Laughter.]

MS. SUZUKI: -- comorbidities.

MR. GEORGE MILLER: Me and Peter have gone rogue.

[Laughter.]

DR. MARK MILLER: [Off microphone.]

MS. SUZUKI: I don't remember seeing that as a huge difference between the different groups.

MR. GEORGE MILLER: Okay. Thank you.

DR. CHERNEW: I have a question about Slide 10, and I think I just somehow fundamentally don't understand. So the low-adherence group were defined as people that stopped taking their meds within the first six months. So in the last column, in the low-adherence group in the last column, months 7 to 12, none of those people could have been taking any meds in those months by definition because you've defined that group as people that aren't taking their medications after six months, right?

MS. SUZUKI: So they were the group that started taking medication within three months and then stopped taking medications within six months. So you have up to nine months --

DR. CHERNEW: Oh, so six months after the three

months?

MS. SUZUKI: I think so. I can get back to you on that, but my understanding is we measured --

DR. CHERNEW: Right, but I'll come just for this. You should come to the seminar, actually. I think that's the thing, if you feel real comfortable with seminar format. But, yeah, so I think the reason I was confused is because if they weren't taking medications after six months, I couldn't understand what the last column was going on there, because by definition -- but I think what you're saying is some people are taking their medications in the very beginning of that window, because you measured six months after when they started as opposed to six months from the CHF event that started them.

MS. SUZUKI: Yes, that's my understanding. I can get back to you on that if it's not that.

DR. CHERNEW: Because I take -- I guess I would just say one interpretation of what's going on in the higher spending in that last column is it isn't that adherence is actually causing you to spend more money; it's the fact that those people are people that were dropping off and then bad things are happening in various ways.

MS. SUZUKI: But so these are relative to people who almost never took any CHF medications. So their spending -- so the costs, recurring costs, is a spending above what the non-adherent people are spending.

DR. CHERNEW: Right, but it's a strange -- yeah, okay. It's just a strange group because they're people that, by definition, mostly weren't taking their medications and then in some months, some of them might have been.

DR. SAMITT: But it's the cost implications in that period for these cohorts. So it really doesn't matter, right, when the medication's stopped. It's a comparative of cost for the care for those patients. And in the bottom, in the footnote, it does talk about the fact that it's 7 to 12 months after the qualifying event. So it doesn't look as if it's after the medication is --

DR. CHERNEW: Yes, this is a deeper Round 1 question. It's not worth asking. But it's not clear what -- the adherence variable I think is monthly, if I remember, and it's like did you take it -- or at least did you have it on hand that month? Right. So it's just a question of the comparison results, which is what all of these questions have been about, because it becomes complicated in some of

these different groups, because they're also defined based on their adherence.

MR. HACKBARTH: Okay. Let's move to Round 2. David, you said you had a Round 2, but you wanted Rita for that or do you want to wait until --

DR. NERENZ: Yes, it was essentially a question about whether in a subset of these folks who are particularly sick at baseline, are there clinical contraindications to the CHF drug, so that what's really going on, at least in that group, is that, A, they don't get prescribed the drugs, which means, B, they don't have them; and the costs run higher later just because they were going to run higher later anyway. But that requires some clinical input. I don't know that contraindication part.

MR. HACKBARTH: Bill, Rita, do you want to comment on that [off microphone]?

DR. HALL: I think Rita's probably the expert on this. So I think this is a really scholarly piece of work. I think this ought to be published somewhere. I really was excited about t his. And in trying to figure out why some of these kind of paradoxes occurred, I have sort of one scenario here.

One is we're learning a lot, as Peter mentioned, on hospital readmissions within 30 days. And, of course, one of the cardinal diagnoses that's being studied is congestive heart failure, understandably. So if you take all the people in the last two years that have been admitted with a primary diagnosis of congestive heart failure and then follow them 30 days post admission, somewhere around 15 to 20 percent of those people will be readmitted. And of the readmissions, less than half will have a diagnosis of congestive heart failure, so they're admitted with other things, like confusion, delirium, sometimes some pressure sores, infection, a whole panoply of things.

But about 10 percent of that category of other things is the recognition of an adverse drug event that occurs to a medication that was started during the hospitalization. So one might argue that at least a subset of non-adherents who have less costs are paradoxically there because they had a reaction to a drug and it was stopped so that the people taking the drug would have a much more likely chance of being readmitted. And I'm flipping around concepts with facts here.

But this is a very real phenomenon that we're just

beginning to understand because of the interest in readmissions, obviously because hospitals are taking a hit if they readmit.

So sometimes it's much better to actually not be on drugs than to be on drugs if you're 80 years old and you're taking 12 or 13 medications, because the whole scenario of your life changes once you leave the hospital. So I think we're starting to get a handle on it, but it's an important issue when we talk about adherence, non-adherence, and do we penalize a hospital because of "non-adherence," when, in fact, they may be doing exactly the right thing? And I don't want to overemphasize that, but I think that's part of the complexity of this.

DR. NAYLOR: I want to build on Bill's thread. First of all, I totally agree this should be published. This is really gorgeous work and highlights the complexity from the very beginning on the definition of "adherence." So the limitations, as you knowledge, using claims data, which says adherence, we have to be guided by possessing somebody who went -- got a prescription, went and got it, but we all know that even having all of them in closets does not mean that we have adherence. So that's a really, really

big challenge. And to Dave's point, we also know that to get to be non-adherent, you have to have a prescription that follows and so on, and there are good clinical reasons why people are not -- you didn't have CHF as the primary discharge diagnosis. It had to be, as I understand it, in the bundle of diagnoses at discharge that you were looking at it as a new claim.

So anyway, that all said, to your questions, I think if -- it's almost similar to the conversation we were having before. If we can look at the most vulnerable among these groups of people, and here people who are older adults, who are on 10 or 15 or 20 medications, are typically not adherent because they typically feel terrible, and so maybe, you know, as you think about how effects vary by -- I would say let's look at the most complex and let's look at people who have, as you've done, multiple chronic conditions rather than one condition. Heart failure never exists by itself. It's always with, as you saw, COPD, diabetes, often complicated, about 40 percent, by depression. So let's look at these people and see. If we can uncover what the challenges are for adherence for that group, and there is -- to your second point, how does health status affect, and

which way is it causal? Does having terrible health status say, "I'm stopping this stuff"? Or does having all this stuff lead to terrible health status?

So I think those are two really vitally important components that I would pursue. If we can unbundle any of this, I think we have a real chance at getting to the healthy, on-one-medication kind of thing. So congratulations.

MR. HACKBARTH: So does anybody want to build on these comments about the clinical complexity here? Jack, is it in this area, or do you want to go in a new direction.

DR. HOADLEY: Generally in this area [off microphone]. I guess one question I have is -- and you may have done this in the previous work. Did you look at the number of medications somebody had? I don't think I see it in this paper, but it seems like I remember it, maybe, because that goes partly to Mary's question.

MS. SUZUKI: We did and, you know, I don't remember the results exactly. But I also did not think that had a huge effect in the regression model.

DR. HOADLEY: Okay.

MS. SUZUKI: And we actually did control for it a

little bit here, too, having three or more chronic medications, that was part of the regression model. It had some of that, but not a big effect.

DR. HOADLEY: And it does seem like there's -- I mean, I really liked the depth of this analysis and the way we're digging into a lot of the questions. And one aspect of that that you may have in here again, but I didn't pick it up, is how -- you know, when we're looking at this dropoff from the long term to the short term, is trying to parse out how much of this is changes in the adherence, how much of this is in the changes in the costs where the adherence is the same. I don't know if you've been able to tease that out in any way beyond what's sort of shown here.

MS. SUZUKI: We have not, but we have -- let's see. So we measure the adherence for each of the groups, and for the high-adherence group, it's about 80 percent, so 80 percent of the time they have medications, compared to low-adherence groups where it was roughly 40 percent adherence. So we can sort of estimate where the dropoff happens.

Having said that, the effects in the first six months are both fairly large, and the high-adherence group

seems to have continuation of drugs for an extended period of time, but they do see a similar dropoff in the second six months.

DR. HOADLEY: I mean, it's the complexity of these patients that creates the challenge, and I guess one of the things is trying to think about, you know, going back to the question of how is this particular category of patients different from others and the degree to which we could repeat this -- and I know these are not small analyses, but repeat this for some different classes. Obviously you did some of that at the first level in what you presented the last time.

One aspect that obviously is not ideal in this case is that these CHF drugs are actually also hypertension drugs, and so, you know, that seemed like a complicating factor. And probably for any class of disease or class of drugs you look at, we'd have some aspect that's complicating. And so, you know, if we look at a bunch of classes, on the one hand, we're just seeing are there different circumstances in different diseases, some where, like Rita says, we might not expect short-term effects or might not expect any effects, but each one also has special

complications that lead us. But, you know, I think if we could -- to the extent that we could do more of these kinds of -- in a couple of different classes and begin to sort of see how much -- and you did some of that before, and it's sort of working out more of the details. So it's a really helpful analysis.

MS. SUZUKI: And one thing that we did see in CMS' evaluation of MTMs under Part D, and I think they also found for many conditions that the effects disappear within a fairly short period of time, and that included diabetes.

DR. BAICKER: So thank you for this analysis and for trying all the different things. I think it conveys a lot of information about, first, how hard it is to do in an observational context, you know, any sort of causal inference. Just because of all of these factors, it's very hard to know whether it's the adherence that's causing the differences in spending, and the documentation of the differences at baseline between those who never have a prescription filled, who have a prescription filled but desist, and then have a prescription filled and seem to keep filling it. They're different in lots of other ways at baseline before the CHF event occurred, and so that makes us

wonder about whether this is really a causal effect.

I find it somewhat reassuring that adding in the comorbidities and the drug use at baseline going from Model 3 to Model 4 doesn't change things as much as I thought it might have. So in some ways that suggests the pattern is a little bit robust.

The fact that it drops off significantly at Model 6 when you add the one thing that is clearly endogenous suggests to me that we probably don't want to add that thing in or that my preferred model wouldn't be including that endogenous outcome on the right. If we had an instrument for adherence, that would be great. And I don't know if you have ideas for that. I suspect it's just a bridge too far. And what we have documented here is the evidence of how difficult it is to cleanly define a cohort where we think adherence is -- you know, everybody's comorbidities are equally appropriate for being indicated for the drugs in the first place. All of those difficulties are going to be pretty hard to solve generally. But these patterns should suggest to us the importance of looking across silos and, in my mind, reinforce the idea that the drug spending is likely to be quite intertwined with the spending on the other

things, and that understanding those is really important. The methodology of us being the ones to figure out the causal effect is probably not likely, given our resource constraints and the many other things that are on people's plate.

So I took this as a very intriguing fact pattern, but not one that should reassure us that we know the causal effect.

DR. CHERNEW: So I think there's two things that are sort of going on here that sometimes get confounded, besides the actual research but relate to this sort of clinical discussion we're having. The first one is the notion that physicians might be prescribing drugs they shouldn't. That's the notion that there's too many drugs being prescribed, polypharmacy and whole bunch of things like that. And I think in that case, the general view is that the world would be better if people weren't taking that entire vast complex mix of drugs, and, in fact, you could have bad outcomes associated with taking drugs, and there's potential solutions to that that you see in a lot of the policy things we talk about, like, you know, bundled payment quality measures, a whole series of things.

And then there's some notion which is patients not taking the drugs that the doctors prescribed, and if you got rid of the first problem and they were only prescribed drugs that they should have, I think there's a broad consensus -- and by that I mean the people that I hand out with -- that people should take drugs as prescribed, particularly when the doctor should be prescribing those drugs. And I think there's a vast literature and I think the CBO does a reasonable job of suggesting that the drugs can be an incredibly, incredibly valuable portion, part, of managing chronic disease if prescribed, you know, correctly or effectively one way or another. And I think congestive heart failure, from what I understand, is an area where people generally would think that drug treatment is really amongst the most high-value things you can do, again, if you get rid of all the polypharmacy and all the other sort of things.

So I think the question in the end becomes how do we, A, make sure that the physicians are prescribing the drugs that they should and only those drugs, and how do we make sure that patients are taking the drugs that they should take. The latter I think pushes us towards aspects

of benefit design, and I think the type of instruments and things I would look at -- in fact, if you look at the CBO -- and I know you did because it's cited, and I know you know it well. A lot of the studies that the CBO cites in their offset-type work, which I think is also really useful, is look at variation across policy options where people were given incentives to do things or not do things, and then look to see what the outcomes were. And I think you still run the risk in those cases of, if you encourage people to take drugs, you're encouraging them to take the ones they really should, but also maybe too many. But there is some balance there, and I really like the idea broadly going forward of connecting aspects of it -- the intellectual exercise of adherence on outcomes is useful, and I think that -- and I applaud the notion of looking at that. But more important is the connection between the policy options we talk about, working through adherence, and then the outcomes that we care about, which is spending and easily as much health.

MR. HACKBARTH: So I confess to be confused by all of this. Before we started looking at this, you know, I was generally familiar with some articles saying that, oh, this

is sort of the prototypical value-based insurance design thing. Sometimes we want people -- we want to lower co-pays so people will take their drugs and that will produce both health benefits and lower costs.

Based on the two sessions we've had on this, it seems way more complicated than that, and almost like I don't know how anybody can reach that conclusion so definitively.

And then just in the same vein, CBO, which is always so cautious about, you know, giving credit for different types of interventions, for them to have said, oh, we think that this is where we're going to give scoring credit, given all this I can't make it all add up. I'm more confused than when we started. Anybody want to --

MR. GEORGE MILLER: Yeah, well, let me add to your confusion.

[Laughter.]

MR. GEORGE MILLER: Yesterday we had an it study that said -- particularly talking about primary care physicians, that the average beneficiary uses two -- sees two physicians. So my question would be, to add to the confusion, that probably adds to the complexity because if

they're not coordinating care, we could have two different physicians ordering two different medicines or taking two different prescriptions for congestive heart failure --

MR. HACKBARTH: Which was what Mike [off microphone] --

MR. GEORGE MILLER: Which is what Mike was speaking about, and that would even add to the confusion.

DR. CHERNEW: What I would say -- and I don't -- you know, we don't have to have a broad discussion of all the CBO work. But there is, in my opinion, a vast and strong body of research that the CBO, others review, much of which is cited by you as well, that suggests the broad premise that if you encourage the use of taking drugs, that there is some offset on the AB spending. And we could debate that literature in a sort of broader, different venue, and that doesn't mean that you save money overall, but at least there's some savings associated with that. And most of that literature takes the flavor of looking at places where people were encouraged to take drugs by lowering co-pays or some other thing, and then looking at offsets, such as Neuhaus has a study, John Gruber has a study, we have a study. There is a lot -- I'll defer to --

but I think the literature actually on that basic point was at least in the view of the CBO, sufficiently strong to justify their assumption. And, again, I haven't been involved with work at the CBO, but I have to tell you at least one guy personally, I think that's a very reasonable outcome that they came to based on my read of the literature.

DR. MARK MILLER: The only other thing I would add, just to say, you know, again, we're kind of making statements about what CBO said or would do. I think there's more caution attached to that sentence than probably, you know, the policy process is going to generally pick up on, because I think the way CBO would think about this issue is drug by drug, policy by policy, and I think part of what we're trying to say here is, yeah, you probably want to be careful about how you apply it. And I think they would.

And so I think in the policy process these kinds of things get elevated to a single bumper stick that I don't -- and not among you, but I think part of what we're trying to show here is you have to move through this carefully.

DR. REDBERG: So as we have been discussing, I think it is a very complex area. You know, all drugs are

not created equal. They go through various kinds of rigor in their development, in their approval process, and that's part of it. So some of them were shown certainly to decrease costs and save lives or decrease hospitalizations, but some are not, and that there is, I think, an increasing move in the FDA to approve drugs based on surrogate outcomes and markers. And so we're going to see more and more disconnects because those have not been shown to actually be beneficial on clinical effects. For example, a lot of the diabetes drugs are evaluated on HbA1c, instead of -- which it may or may not. You know, it turned out that in the Accord study, going for a lower HbA1c, which is to measure glucose, it turned out to be having adverse effects and was causing more problems. And so it's not an assumption that if you're taking more drugs you're going to have lower medical costs. It really is a lot more complex.

And then there's all the other patient issues because we know that the patients that are generally studied in the trials are not like our Medicare beneficiaries. They tend to be younger, healthier, and have many less comorbidities. So I think you really addressed all of that very well in the chapter, that, you know, these patients,

their health status at baseline makes a big difference.

And just a last point, as it is very hard, I think, for a beneficiary confronted with, you know, ten different medications, and most people don't want to take ten drugs, don't feel good taking ten drugs, a beneficiary is not in a good position on their own to know which of these medicines they should continue to take, which of them they shouldn't. So I do think considering all of that in our design and how we can go forward would be very helpful, because there just is marginal value to additional medications, and we certainly know that Medicare beneficiaries are taking way more medicines now than they were 10 years ago. And that's not necessarily in their interest or in the program's interest.

DR. BAICKER: So just synthesizing that, because I think that that's a point that's very well taken, there's likely to be huge heterogeneity variability in the effect of different drugs for different conditions on downstream spending, and some are really good for health and avert other downstream spending, and some are overused and may generate worse outcomes. On net the outside literature suggests to me that that heterogeneity is surely through,

but on average, increasing adherence promotes better outcomes and potentially lower spending on other things. And I take that as the synthesis of all of those studies that have different little clever strategies for teasing out the causal effects, be it co-payment changes or rolling over beneficiaries -- enrollees from one plan to another plan, whole cloth. There are different ways of getting around that, and each of them, I think, has produced a different small piece of evidence that the cumulative effect is pretty persuasive that increasing adherence would on average generate improvements in outcomes with some huge and important exceptions that should be taken into account. And I take that more from reading of the literature than from this particular set of tables, which is a really interesting documentation of what's going on, but not that methodological causality.

DR. HALL: Well, I think one of the -- in terms of policy implications, to the extent that there's some unexplained variances here and some surprises, we talked a lot about teams yesterday, and another emerging member of the team is clinical pharmacologists, who are available in most hospitals now, but have not entirely found their place

in the sun. So there might be some policy implications here that there needs to be more scrutiny of drug management, particularly at that critical point when people leave the hospital. And it might be something that we can explore.

And I can't help but -- I may have said this before, but the most famous quote about drugs was by William Osler, who's considered to be the Father of Internal Medicine, who in the Victorian era said, "If all the medicines we use were thrown into the sea, it would be to the benefit of humanity and the detriment of the fishes." So we should keep that in mind as we go forward.

DR. MARK MILLER: [off microphone].

[Laughter.]

MR. KUHN: You know, one of the things that I would be interested in, you know, if we have future conversations on this issue -- and maybe Jack can help me out on this one a little bit -- is the role of the various interventions and the effectiveness of the interventions, particularly from PBMs. And what I've read and heard from different PBMs is that many of them now have very, very sophisticated predictive modeling for beneficiaries to assess risk and adherence. And so as a result, a lot of

that deals with how they package the drugs that they send the beneficiaries. So some, for example, will just come in a straight bottle, and they feel pretty good about that adherence. Some will need to come in blister packs with dates on them because they understand the profile of that particular beneficiary and that will help the adherence. And they go all the way up to the point where they even have alarms in the top of the caps that will go off every 8 or 12 hours to drive adherence, because the alarm won't shut off until someone actually opens that pill bottle, to the point where even some have telemetry where they can know by phone if someone has opened a pill bottle to do that. So there's different things out there.

So, you know, obviously, I think as Kate said, there's some observational context here, but it would be really interesting to understand those that are really steeped in this and they're spending that time and doing that predictive modeling and the various interventions. What's their level of adherence and what are they seeing as that science continues to develop as well.

DR. NERENZ: This may be just an extension of Herb's comment, but I was thinking about this before he

started on this. If we float all the way up to the policy context for which this whole discussion is happening, the issue that was framed in the chapter in terms of trying to understand better the effect of policy options to promote adherence, and when that phrase is used, the example is cost sharing. But I became curious. What other examples are there? Because presumably our domain is policy. All the things that Herb mentioned are interesting, but generally these are not things that we talk about. We don't do them. We don't control them. We don't advise so much.

So what are, other than beneficiary cost sharing, the policies that promote adherence that are under our purview?

DR. SOKOLOVSKY: Well, in Part D the main thing that is supposed to promote appropriate drug use, including adherence, is the medication therapy management programs. I think the best we can say so far is that the results have not been very impressive. It has been very hard to get beneficiaries to agree to participate. Those who participate don't necessarily get the full range of interventions that one might think would be likely to work.

There is no connection for a stand-alone PDP with

the providers, and so some providers may pay attention and others -- and we've heard this in focus groups -- throw out papers that they get from them. And even beyond that, for those where it seems to be working, all they can determine is short-term working, and they and CMS' analysis have found the same decay in adherence over time for the participants.

MR. HACKBARTH: Even with the medication therapy management programs, they are run by the Part D plan. So CMS can require them and write rules about what they need to do, but how well they are run and how they engage with the beneficiaries is delegated to private parties, so it sort of an indirect policy variable there.

DR. REDBERG: Does CMS get any report on how well they are run from the private parties?

DR. SOKOLOVSKY: At first, they did very little of that, because it was a brand-new program, a new idea without any standards, so they wanted the plans to innovate in different ways. But in the past year, they have gotten Commission evaluations, and what I was talking about was from the evaluation.

And the places -- and I don't think this will surprise anybody on the Commission. The places where it

seems to work best are the integrated health care systems, and they are probably doing other things as well in terms of adherence and connections.

DR. NERENZ: So just then to extend that example, is it now a requirement of Part D plans to have medication therapy management programs?

DR. SOKOLOVSKY: Yes.

DR. NERENZ: Okay. So that would be an example of a policy that could be strengthened, weakened, added, subtracted. Okay. I just was looking for what this domain looks like.

DR. MARK MILLER: And it's actually a bit in play, because there's some proposed rule that says, well, you should expand the population that your MTM touches.

We have our doubts in the sense of, well, if we're not showing particularly in the unintegrated environment that it's doing much, why do more of it? So while that is kind of the vehicle, there's some real questions there.

In answer to your question, I think there is the cost sharing. There's measurement. You could say, okay, I'm going to develop quality metrics that would track to adherence if someone could conceive of them and be confident

in them, and then there is the regulatory road, which generally here we don't -- or in the past, you have not wanted to walk down unless there's very clear evidence that you do this thing. Then you can put a requirement in place, and I think in a very sweeping way, that is sort of the tools that you can think about.

DR. NERENZ: Thanks. That's exactly what I was looking for.

DR. MARK MILLER: That's what I thought.

MR. HACKBARTH: Just to go back to the medication therapy management programs for a second, remember when we talked about team-based care yesterday. We said, conceptually, this is a good thing. What are the policy levers to promote it? Is it to say, well, everybody has got to do team-based care, defined what it is, and what regulations, or is it to create an environment that makes it worthwhile to do team-based care? And I think the same sort of reasoning applies here.

I don't have anything against medication therapy management programs. I doubt you get there effectively by writing regulations and requirements. It is much better to create an environment where, oh, this is a good thing to do

because it helps me succeed as an organization.

Craig.

DR. MARK MILLER: Just before you jump, did you want to -- David had that question for Rita. Do you recall this?

MR. HACKBARTH: Well --

DR. NERENZ: Well, actually, we needed --

DR. MARK MILLER: You got it dealt --

DR. NERENZ: Well, Bill spoke to it a bit, and any of the clinicians, I think I was asking just are there contraindications to the CHF meds for people with certain high levels of illness at baseline, and I think Bill spoke to that a bit, and so it may have been taken care of.

DR. MARK MILLER: All right. Sorry, Craig.

DR. SAMITT: So just like Mark stole Glenn's thunder yesterday, I think Glenn has stolen my thunder in the remarks. Given it's inherently forbidden to use the expression in the real world, I won't use that expression.

But my point is that there are organizations out there that are very much focusing on adherence. As an organization that cares for nearly 300,000 MA patients, you know, this is -- despite what the literature and the

research has shown here, we very much focus on adherence, because we know that it works. And so it goes back to Glenn's point. Let's look at the models that are integrated and accountable and see exactly what they are doing.

I think that beyond the fact that I am a believer in that model and we should be shifting more patients to an accountable setting and more providers to an accountable setting, I think that when we look at what those types of organizations do to achieve greater adherence, there may be some policies that we can learn from that.

So we very much focus at the clinician level on polypharmacy and strategies to use pharmacists to achieve medication adherence. Let's study organizations that already do this very well and see if there are nay policy opportunities that can stem from that.

DR. CHERNEW: Rita said something which I agree with, which is beneficiaries are taking a lot more medications, although I think our phrasing has to be careful if what we really mean is beneficiaries are taking a lot more medications or physicians are prescribing a lot more medications, because in the end, the beneficiaries are taking more medications, but is that sort of a beneficiary

demand-driven problem that we think about sort of that kind of approach or is it physicians are prescribing more, and we have to think about it through that sort of lens? So I think it makes a difference which actor you want to focus on.

My view is, in addition to some things that are directly targeted to adherence, like the MTM programs -- and I agree with Glenn's characterization -- the biggest way to deal with this in a broad sense is aspects of accountability in some of the payment things, and there are very specific issues like the role of Part D plans in ACOs, for example, and how that differs in MA-PDs, which I think we do -- you know, who captures the savings, so the PD plans don't have the same incentives as an MA-PD plan would because of the connection.

ACOs might want to reduce use, but they actually don't control the Part D plan or anything like that, that the beneficiary might have chosen, so they can't do the same type of stuff often that Craig was talking about.

So knowing which set of actors, is it the person and it's a benefit design issue, is it the physician or the organization, I think ends up being important when we move

towards the policy levers.

DR. HOADLEY: So, yeah, I think Dave has put us on a good track here talking about what are the policy levers, and some of these points are being made. I mean, performance measurement is clearly a potential. I mean, I am not always thrilled by what I see in terms of the performance measures either that are out there or how well they are used or measured but can certainly think about more ways -- and I am thinking particularly now about the standalone PDPs where we don't have some of the advantages of the integrated system of tracking more on the side of adherence, again, measures that we're going to have to think about, which ones, is high always better, and all that kind of stuff, but it is something we could do as a policy lever.

I think this whole MTM discussion -- Glenn, you make the point that we should ask the people to do them and then look for it to create a good environment. Part of the issue is that we have seen, okay, the law created them, but then nobody really did anything. So that's a push towards being a little bit more prescriptive. The last round of regulations sort of pushed for more breadth, get more people involved. Maybe the right answer was more depth, push to do

the smaller set of patients better rather than expand. This notion particularly on the polypharmacy angle that patients should really have that kind of comprehensive medication review where they sit down with presumably their primary care doctor but at least some doctor and say let's talk about all the drugs you're taking and are there four that we should be taking you off of and then three that you really should be adhering to more consistently, having that kind of review. And there's a lot of suggestion that those aren't really happening, even thought that seems to a core part of the MTM.

And then to this last point about again the ACOs and that Mike started to raise, there is the question out there right now: Should the standalone PDPs be brought into the ACO environment? I think one of the CMS requests for information put up that question.

There's some complexities there. Obviously, there's financial. It has its own bucket and all that stuff, but that's certainly something, again, a policy lever we can think of where is the right way to do that, should it be done; if so, how.

Then the last comment I'll make sort of goes back

to Herb's question, and I think you're right. PBMs are doing a lot of really interesting stuff. My sense -- and I don't know this for sure -- is a lot of what they are doing in some of these devices and technologies and things you talk about are probably more to the younger population that's taking just one or two drugs, has a simpler situation. And they are not maybe doing as much -- and I am only being speculative here; I don't know this for -- about the complicated patients that are taking 6, 8, 10, 12 medications and where it's not just a matter of, yeah, make sure you take every pill in the bottle, but back to that question of which bottle should you not be getting, and PBM may not be paying as much to that but could. Again, that points to the policy side.

MR. ARMSTRONG: So first, I just want to acknowledge I really admire the economist and clinician's ability to not only understand that graph up there but to have such an in-depth debate about what it means.

I find myself wondering how I could contribute to this and feeling a little like Glenn did, and yet I think the one point I could make is that, first of all, I think there's a difference between policies and presuming that

evidence is being driven in clinical decisions about the use of medications. Those really are two different issues. They are both real issues, but I tend to separate them.

But the way I think about this is that adherence, assuming it's adherence to something we value, is just a specific example of a broader set of policy goals to advance quality, and that regardless of our debate, I will continue to live with my delusion or belief that better quality leads to better health leads to lower costs. And that is a policy position that we apply to a lot of decisions elsewhere in our payment policy world. It just seems to me adherence is just one more example of that, and to the degree that offers some perspective or value to this whole thing, I just would add that.

MS. UCCELLO: So we've talked a lot about adherence and policy levers around adherence, but I'm getting the sense that -- and you can tell me if I'm wrong here, but there is still some uncertainty whether some of these drugs are worth prescribing and to whom. So do we also need to think about in the scope of this of the comparative effectiveness type of analyses and whether they are broad enough to examine this kind of broad population of

are analyses done on people that have other prescription needs? Their ages, their cognitive abilities, those kinds of things is a broad enough range of population being tested on these different drugs to see who they are best prescribed to.

DR. REDBERG: Just to respond to Cori's point, it was very astute, and I think absolutely that is the role for comparative effectiveness.

Currently, I saw a recent report from the Center for American Progress -- because we thought PCORI would be providing a lot of comparative effectiveness and hasn't to date actually been its emphasis, but that would be very useful even in heart failure, which is certainly one of the conditions that we think medications are most useful for. There comes a point of diminishing returns, and when patients are already on a lot of good medications, what is the value of a new medication? That is where comparative effectiveness, particularly using observational data -- and that is where I think it is an advantage over randomized trials, because we get what actually happens when we use additional drugs.

So I think seeing more comparative effectiveness

research would be really helpful for our beneficiaries.

MR. HACKBARTH: Remind me what we know about the differences in prescribing patterns between MA-PDs and what happens in the freestanding PDs. The reason Cori's comment triggered this question is that, presumably, in an MA-PD, you've got things better aligned. Not only do you have the drug costs and the A and B costs in a single entity, you also -- and vary greatly across MA plans, that clinicians presumably have some incentive not to overprescribe. That doesn't exist if they're in traditional Medicare coupled with freestanding drug plan. That's not something they have to worry about. Plus, at least the more integrated MA plans also I think spend a fair amount of time working on what appropriate prescribing patterns are for their clinicians.

So if all of that is true, you would think that there would be evidence of significantly different prescribing patterns in MA-PD as opposed to -- and traditional Medicare plus a freestanding drug plan. Do the facts support that?

MS. SUZUKI: So I don't think we actually have data on prescribing patterns in either MA-PDs or PDPs. What we have is observation that someone filled the prescription,

and one of the problems with identifying even who is prescribed is that we don't get that data in the claims. Comparing PDPs to MA-PDs, we have seen that on average, people use less medication under MA-PDs. This is aggregate level. It is not clear how much of it is health status-related versus prescribing pattern-related.

MR. HACKBARTH: Okay. Let's see. I have Kate and Jack. Anybody else wanting to get in here? Peter.

DR. BAICKER: SO just to put a finer point on this distinction that I think is really important people are making, there is potentially over-prescription of things that are not so useful and patients taking too many things and polypharmacy creates downstream problems, and that is an issue of provider choices and interacting with the patients. And then there is patients adhering to what they are actually prescribed. That adherence is better when the prescription quality is better, but conditional on the stuff you've been prescribing, I don't think there is any evidence that patients are selectively non-adhering to the stuff that they shouldn't have been prescribed in the first place. I think the non-adherence is fairly random and not likely to be correlated with an improvement in the medication basket

the patient is taking. They don't know which of the five things they've been prescribed is the really important one, which two interact with each other and shouldn't both be taken.

So I'm comfortable taking imperfect adherence as a sign of low-quality outcomes for the patient, even if some of those things shouldn't have been prescribed in the first place.

And then the problem is that what we're observing here and what a lot of datasets observe is not actual adherence to what was prescribed but possession of medications, which may or may not translate to adherence, and you don't know what things were prescribed and never filled, and you don't know what things were filled but never taken. So this imperfectly captures that second piece, but conceptually, I think it's clear that we want adherence to be higher. Yes, we want prescribing quality to be as high as possible but conditional on the basket of stuff you are supposed to be getting according to your physician. We want tools, whatever those tools may be, to make you take more of them.

DR. HOADLEY: I'll just say quickly on that last

point, which I agree with, to the extent that there is evidence from the studies on things like caps on number of prescriptions, the ones people choose not to take are more likely related to symptoms, what makes them stop feeling better kind of things than on anything more about really the ones that will help them the most.

And the other observation simply is just reminding all of us that when we're looking at this kind of analysis, we're all in the PDP world because, of course, we don't have claims data to look at this on the MA side. We talk about these things as if they're all in Medicare, but we have to remember these are only on the fee-for-service side.

MR. BUTLER: I'm not sure this will be helpful, but I would like to frame things, as you know.

It strikes me, we spend so much energy on policies and payments, trying to get the providers and those providing the services to do the right thing, and this morning, we have been talking more about how we engage the beneficiary themselves through their lens.

I don't know how we do this better, but there are probably five or six things, and as you become a Medicare beneficiary and age of the years that you're worried about,

one is picking the plan. And it's left to how it is all structured now. I think we're saying the beneficiary struggles and won't always make the right choices, and we need to make it easier for them. So whether it's picking the plan or staying in fee-for-service, whether a next event, you start getting sick, you start taking a range of drugs, and we're saying it's not also the right range. And that's another important thing.

Then you have an event that requires a procedure or an intervention, and again, we're not sure that we -- we have errors of omission and commission, and we don't make the guidance for the beneficiary. As they go through this, it's not all that clear. Yesterday, we said, well, we really ought to need more home care. Well, how do we engage the beneficiary in that decision? And then you get to palliative and hospice care, and we don't do very well as well at kind of engaging all of these things from the beneficiary's perspective that says we've got a set of tools here that is going to make easier for you to look to Medicare as the trusted agent to help guide you thought. I don't know whether there is a chapter on -- we have had shared decision-making. We have kind of skirted around what

it's like to navigate through the system through these issues, but I don't know if we have quite framed it a way that the average beneficiary would say, "Now, that made it easier for me to be engaged in the choices."

We too often just come from the provider's side and incentivizing them to do the right things. So I told you, I don't know what you do with that other than remind us that in the end, MedPAC, among other things, ought to say, "Well, they made it easier for me to make the right choices when I needed to make them.

MR. HACKBARTH: Other comments? Questions?

[No response.]

MR. HACKBARTH: Okay. Thank you very much, Shinobu, Joan.

We will now have our public comment period.

[Pause.]

MR. HACKBARTH: Seeing nobody go to the microphone, thank you all very much, and thank you for your service, George and Mike and Peter. And the rest of you, see you in September -- in July.

[Whereupon, at 11:10 a.m., the meeting was adjourned.]