

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C.

Thursday, March 7, 2013
11:19 a.m.

COMMISSIONERS PRESENT:
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1 P R O C E E D I N G S [11:19 a.m.]

2 MR. HACKBARTH: Okay. Good morning. Let me begin
3 with an apology to people in the audience. Sorry for the
4 delay in the beginning of the meeting. We had to redo the
5 schedule yesterday based on the snowfall that never came,
6 and for a while we were really concerned about getting
7 Commissioners here for the meeting in time for the early
8 start, and that is why we moved it back. But in the event,
9 it proved unnecessary.

10 Our first item today -- oh, and by the way, we
11 have no recommendations that we'll be considering today, no
12 draft recommendations. We have made our final
13 recommendations for this cycle. The next step in our
14 process is the June report. But there will be no
15 recommendations in that report on which we have not yet
16 voted.

17 So the first item for today's meeting is refining
18 the hospital readmissions program, and who is leading the
19 way? Jeff, take it away.

20 DR. STENSLAND: All right. So last September we
21 talked about the new hospital readmission reduction program,
22 and today we'll discuss the status of that program and three

1 refinements that could possibly improve the program.

2 First, a bit of history. The Commission
3 recommended a hospital readmission reduction policy in 2008,
4 and that recommendation came out of a discussion of trying
5 to increase providers' incentives to work across silos to
6 improve quality and cost. And it was actually part of a
7 package of recommendations, and this included a gain-sharing
8 recommendation for physicians to work with hospitals, also a
9 recommendation to test the concept of bundling where there
10 would also be joint responsibility for the full cost of the
11 30-day episode, and the other part was this readmission
12 penalty.

13 In the end, all three recommendations push
14 hospitals to look beyond their doors and coordinate care
15 with other providers.

16 A key motivation for the readmission penalty is
17 that readmissions are a poor outcome for patients.

18 The second motivation is that they result in
19 substantial amounts of unnecessary Medicare spending. A 10
20 percent reduction in readmission rates would save over \$1
21 billion a year. And while it is feasible to reduce
22 readmissions, there was little progress prior to 2008. And

1 hospital executives told us that everyone wants lower
2 readmission rates, but it was difficult to place a priority
3 on funding readmission reduction programs when there are
4 competing needs for that money for other programs that could
5 actually generate revenue rather than reduce your revenue.
6 So the incentive was not there to direct funds toward
7 reducing readmissions, and the new penalty has changed that.

8 Finally, before I get into the details of the
9 readmission penalty, I want to point out that it can be
10 complementary with other policies that exist out there. For
11 example, imagine if you had an ACO run by a group practice.
12 I would have an incentive to reduce readmissions, but it
13 would want some cooperation from the hospital that is not
14 necessarily in the ACO. Now this aligns their incentive
15 because the hospital also has an incentive to commit
16 resources to reducing readmissions.

17 And there is another Commission recommendation out
18 there to have a penalty to reduce readmissions for the SNF,
19 when a patient goes to a SNF and then is readmitted to the
20 hospital. And if you have that penalty in effect, too, then
21 you would have an alignment of all the incentives. The SNF
22 would have an incentive, the hospital would have an

1 incentive, the physician group practice and the ACO
2 incentive, and they could all be aligned to create better
3 care for the patient and avoid those readmissions, which
4 patients have clearly shown that they consider a poor
5 outcome.

6 Now for some of the details of the policy. The
7 current readmission reduction policy was enacted in 2010, so
8 hospitals knew that their readmissions in 2010 and 2011
9 could result in penalties when the penalties started in
10 2013.

11 The penalty is initially based on three
12 conditions: AMI, heart failure, and pneumonia. The policy
13 will add at least four more conditions in 2015, including
14 COPD, CABG, PTCA, and other vascular procedures. The
15 Secretary, however, can add more conditions in 2015 if he or
16 she thinks it's appropriate.

17 In 2013 -- that is, this year -- the average
18 penalty is 0.3 percent of base inpatient hospital payments
19 or roughly \$125,000 on average for each hospital facing a
20 penalty. The magnitude of the penalty is capped at 1
21 percent of operating payments in 2013, 2 percent in 2014,
22 and 3 percent in 2015 and after.

1 The magnitude of the penalty has been large enough
2 to capture the attention of hospitals. And hospitals have
3 reported taking a broad number of initiatives to reduce
4 readmissions.

5 For example, they're reducing complications that
6 occur in hospitals, such as hospital-acquired infections

7 Second, they've identified patients at most risk
8 for readmission and have targeted their efforts on that
9 population, including patients who have been frequently
10 readmitted in the past.

11 For these targeted patients, there are several
12 efforts to reduce readmissions. There are transitional care
13 models, Project RED, Project BOOST, for example. They all
14 can provide patient education (such as teach-back) and self
15 management; some schedule follow-up visits and medication
16 reconciliation before discharge; others make follow-up calls
17 or visits with the patients after discharge in their home.
18 They can all lead to better communication between the
19 physicians, post-acute providers, and the hospital.

20 The policy appears to be having some effect.
21 Recall that hospitals had an incentive to reduce 2010 and
22 2011 readmissions after the policy was enacted. We examined

1 changes in risk-adjusted readmission rates from 2008 to 2011
2 using a 3M measure. We found a 0.7 percentage point drop in
3 readmission rates by 2011. And last week, CMS reported that
4 readmission rates fell further from 2011 to 2012 by a
5 similar amount.

6 These declines coincide with a flurry of activity
7 and anecdotal reports we hear from hospitals that they are
8 able to reduce readmissions. Now, it may not be easy and
9 the changes might not be dramatic, but it appears that they
10 have started.

11 While the current program appears to be having an
12 effect and should continue, there are some refinements that
13 could make the program more equitable across hospitals.
14 Specifically, we discuss refinements to address these four
15 long-term issues with the current policy that I listed on
16 this slide. The objective is to increase the incentive to
17 reduce readmissions, continue the downward trajectory of
18 readmission rates, and fix the computation of the penalty to
19 be more equitable across hospitals and more equitable for
20 the industry as a whole.

21 Now we will go through those four issues.

22 The first issue is random variation. The concern

1 is that small hospitals may be more subject to penalties due
2 to having greater random variation. Currently, to address
3 this problem, CMS shrinks the reported values toward the
4 national mean, as we discussed in your mailing. The problem
5 with this solution is that it reduces the incentive to
6 improve performance and can distort values that are
7 presented to the public.

8 One possible solution is to use an all-condition
9 measure. This would expand the number of observations and
10 reduce random variation.

11 We could continue to use three years of data.

12 And, finally, if some hospitals are still
13 concerned about receiving a penalty due to random variation,
14 we could allow the hospitals to report individually, but to
15 combine their performance within a system of hospitals for
16 purposes of computing the penalty. This would reduce random
17 variation and would also create peer pressure and create an
18 incentive to share best practices within their group which
19 is collectively generating a penalty or avoiding the
20 penalty.

21 This slide shows the increase in the numbers of
22 observations if we switched to an all-condition measure.

1 I suggest you look at the first row. This is the
2 10th percentile of PPS hospitals. They have 60 heart
3 failure patients and 60 pneumonia patients on average over
4 the three-year period. For hospitals with 60 cases, the
5 expected number of readmissions is only about 10. So if
6 random variation caused just two additional readmissions,
7 this would shift the readmission rate by 20 percent, and
8 this is just too much random variation. What CMS currently
9 does to deal with this issue is a process of blending the
10 hospital's actual readmission rate with the national
11 average. This is also called "shrinking the score to the
12 mean."

13 The problem with the current method is that for a
14 small hospital, the vast majority of their score is based on
15 the national mean, not their own performance. And any
16 change they actually make in their readmission rates will
17 not have a large effect on their score. So the danger is
18 hospitals may start to think their own performance does not
19 have much of an effect on their publicly reported
20 readmission rate or their penalty, and that may lead to them
21 being less willing to expend financial resources to reduce
22 their readmissions.

1 A better solution than just adjusting everyone's
2 score toward the mean is to use more observations. In this
3 slide, we show that if we move to an all-condition measure
4 with three years of data, the numbers of observations even
5 at the 10th percentile would increase from roughly 60 heart
6 failure cases to 1,170 discharges in the all-condition
7 measure.

8 While two random readmissions could make a 20
9 percent difference in the rate when a hospital just has 60
10 admissions, it would only make a 1 percent shift in their
11 readmission rate when we're looking at the full 1,170
12 readmissions.

13 So the first refinement we've talked about is
14 moving to an all-condition measure with data collected over
15 three years. This largely eliminates the small numbers
16 problem, and the benefit is this reduces the need to shrink
17 all values toward the mean that is currently done.

18 The second issue we'll talk about that could also
19 be helped by moving to an all-condition measure is dealing
20 with something called "the penalty multiplier," and Craig
21 will now talk about that.

22 MR. LISK: Moving on to our second issue, the

1 computation of the readmission penalty, in this graphic we
2 have algebraically simplified the penalty payment formula
3 that appears in the law. The penalty is a function of two
4 pieces shown in the boxes above.

5 The first box is the estimated cost of excess
6 readmissions. For example, if you were expected to have 10
7 readmissions and you had 12, you have two extra readmissions
8 on a risk-adjusted basis. If the base operating payment for
9 that DRG at your hospital is \$10,000, your excess cost of
10 two excess readmissions is \$20,000.

11 The second box is the penalty multiplier. This is
12 set equal to one divided by the national readmission rate
13 for the condition. For example, if the readmission rate is
14 20 percent, the multiplier is five. A multiplier greater
15 than one makes the penalty larger than the revenue generated
16 from the readmissions, creating a strong incentive to avoid
17 readmissions. So in our example here, we said they have
18 \$20,000 in excess readmissions; their penalty would be
19 \$100,000.

20 Some would argue that a strong incentive is needed
21 because the penalty only applies to three conditions. To
22 get institutional change from a penalty that only applies to

1 a limited number of cases, the incentive will have to be
2 large. The readmission penalty as currently constructed,
3 though, creates two problems.

4 The first problem is that the penalty remains
5 constant as the industry readmission rates improve.

6 Second, the penalty multiplier differs for each
7 condition. If the national readmission rate for a condition
8 is 5 percent for one condition and 25 percent for another,
9 the penalty will be five times as great for the condition
10 with a 5 percent readmission rate. The multiplier will be
11 20 in that case.

12 Third, under the current policy, over half of all
13 hospitals are always going to be penalized for each
14 condition covered under the policy, as the penalty is
15 calculated on a hospital's performance relative to the
16 average. And that continues to change over time.

17 So what are some possible improvements to the
18 policy to address these issues?

19 First, you can set a fixed readmission target that
20 is set below the historical average readmission rate. You
21 could set it at the 40th percentile of the current
22 readmission rate distribution, for example. In this way

1 hospitals have a goal that, if they achieve it, they can
2 avoid receiving a readmission penalty.

3 Second, you can set the penalty equal to
4 Medicare's costs of excess readmissions over the target.
5 This effectively is like setting the penalty multiplier to
6 one for all excess readmissions across all -- for all types
7 of conditions. So we don't have that differential between
8 the different conditions anymore.

9 So let me demonstrate the problem with the current
10 readmission penalty. In this chart we show hospitals sorted
11 into readmission deciles bases on 3M's potentially
12 preventable readmission measure, which is the first column
13 in this chart.

14 In the second column we show the average
15 readmission penalty for hospitals under the current
16 readmission policy, and as you can see, the average penalty
17 is 0.31 percent of base PPS operating payments.

18 As you can see, the penalty also increases with
19 each readmission decile, increasing from 0.02 percent in the
20 first decile up to 0.73 percent in the 10th decile.

21 So what happens now, though, if all hospitals
22 reduce their readmissions for the three conditions covered

1 by the readmission policy by 10 percent? Well, as you can
2 see in the third column, even though all hospitals reduced
3 their readmissions by 10 percent, they will continue to
4 receive a penalty of roughly the same magnitude in aggregate
5 -- 0.31 percent before the reduction and 0.30 percent after
6 -- and this relationship holds across all the readmission
7 deciles.

8 So now let's turn to see what happens under our
9 potential refinement where we, as Jeff talked about, use an
10 all-condition readmission measure. In this example, we are
11 using 3M's potentially preventable readmission measure.

12 Two, sets a prospective target at the 40th
13 percentile of the potentially preventable readmission rate,
14 which is 12.2 percent. That's noted by the arrow in the
15 chart.

16 And, three, sets the penalty equal to the average
17 base operating payments for potentially preventable
18 readmissions that occur over the target.

19 What we see when we do this is that hospitals in
20 the 1st through 4th deciles, looking at the second column,
21 receive no penalty as their readmission rates are below the
22 prospective target. Hospitals in the 5th through 10th

1 deciles will receive a penalty because their readmission
2 rates are above the target. And the average penalty across
3 all hospitals with a 1 percent penalty cap will be 0.48
4 percent.

5 But what happens, though, if readmission rates
6 drop by 10 percent across all hospitals? This is what we
7 show in the third column. If the readmissions decline by 10
8 percent, what you will see is that the average penalty falls
9 to 0.21 percent. Hospitals in the 1st through 6th deciles
10 now receive no penalty, and the penalty is now lower for
11 hospitals in the 7th through 9th deciles. So with a
12 prospective readmission target, penalties decline when
13 readmission rates improve.

14 The principal objective of this refinement is to
15 encourage hospitals to reduce readmissions so they can avoid
16 receiving a readmission penalty.

17 In the last column, we show that the savings from
18 reducing readmissions can result in larger savings than what
19 is achieved through the penalty, 1.15 percent of base
20 operating payments on average with a 10 percent decline in
21 potentially preventable readmissions across all hospitals.

22 Moving on to our third issue, the third issue is

1 that hospitals serving poor patients tend to have higher
2 readmission rates. This could be due to poor patients
3 having fewer resources outside the hospital. To bring these
4 readmission rates down, hospitals may have to expend more
5 resources on these low-income patients.

6 Outcomes for minorities also differ. But the
7 story is less clear. African Americans tend to have higher
8 readmission rates, but also have lower mortality rates. The
9 effect for other minority groups, however, can go in
10 different directions. However, if we control for income,
11 the effect of race on readmission rates is smaller.

12 Because we have this relationship between
13 readmission rates and income, we find that the penalties
14 under the current policy are higher for hospitals treating
15 more low-income patients. There are two possible
16 refinements to address this issue in the readmission policy.

17 First, you could add SES to the risk adjustment
18 models used for determining readmissions. However, NQF, the
19 Yale team that has worked on readmissions, and CMS have
20 concluded that including SES status in the risk adjustment
21 would end up hiding disparities in performance in the risk-
22 adjusted values, which is not desirable.

1 A second option would be to leave SES out of the
2 risk adjustment models, but in computing the penalties,
3 compare hospitals to peer hospitals based on their level of
4 SES. So in this refinement we are considering, we set the
5 target readmission rate for each hospital equal to the 40th
6 percentile for hospitals in their peer group, in this case
7 based on its SSI deciles. We're using Supplemental Security
8 Income deciles for Medicare patients.

9 No hospital that meets the peer group prospective
10 target would get a penalty in this case, and the average
11 penalty within each peer group would be approximately equal.

12 If this approach were adopted, you would still
13 report hospital readmission rates without adjusting for
14 socioeconomic status.

15 So what happens if we make this refinement?

16 The first column of this chart groups hospitals
17 into deciles based on their share of Medicare beneficiaries
18 on SSI. The actual SSI patient shares is shown here.

19 The second column shows the average readmission
20 penalty by decile under the current readmission policy. You
21 will note that the average penalty rises steadily as SSI
22 patient share increases, starting in the lower 20 -- 0.2

1 percent range up to 0.4 percent range at the top for
2 patients with over 18 percent SSI share.

3 When we move to a system that compares hospitals
4 against their peers, we show that the average penalty is
5 close to average across the distribution, 0.49 percent at
6 the bottom decile, from 0 to 3 percent readmission rate, up
7 to 0.54 percent in the top decile -- all close to 0.5 across
8 all the deciles. You can see it's very even there.

9 Now, if the readmissions decline by 10 percent, we
10 see that the penalties within peer groups will also go down.
11 Remember that under the current readmission policy, the
12 average penalties really will not change with a reduction in
13 readmissions.

14 So, with that, David will continue on to talk
15 about mortality.

16 MR. GLASS: Thank you, Craig.

17 The fourth issue is that mortality and
18 readmissions can be related, and an inverse relation raises
19 concern that if readmissions are reduced, perhaps mortality
20 goes up, although, of course, correlation does not imply
21 causation.

22 There are two hypotheses on how an inverse

1 relation might happen.

2 Hypothesis 1 is that some hospitals may keep very
3 ill patients alive, but after discharges those same patients
4 tend to be readmitted more often. And there is the converse
5 of that argument, that very high mortality leaves very few
6 patients to be readmitted, but the positive form is the one
7 usually suggested.

8 Hypothesis 2 is that some hospitals may just have
9 more liberal admissions policies and they tend to admit more
10 patients and readmit more patients and, because they admit
11 less ill patients, have lower mortality.

12 This slide shows a simple example of each of those
13 hypotheses.

14 At the top we compare a low-mortality and high-
15 mortality hospital. They each see 100 patients and admit
16 10. In the first hospital only one patient dies; in the
17 second two die. Hence, the lower mortality rate of 10
18 percent in the first and 20 percent in the second. However,
19 perhaps that one patient who Hospital 1 saved is then
20 readmitted. Then the first hospital has two readmissions
21 and the second hospital has one with the resulting
22 readmission rates. As the first hospital's mortality rate

1 goes down, its readmission rate goes up and there is an
2 inverse relationship.

3 Under the competing hypothesis in the bottom
4 example, the high admitting hospital admits 12 patients
5 instead of 10 and readmits three instead of two. The same
6 number die. The result is the high admitting hospital has a
7 lower mortality rate and a higher readmission rate, again,
8 an inverse relation. And we think as we look at the data we
9 see some support for the second hypothesis.

10 The finding that has caused concern is that the
11 CMS heart failure mortality measure has a high negative
12 correlation with all three readmission measures used in the
13 policy, which are CHF, AMI, and pneumonia. We find this,
14 Yale found this, and other studies find this. The data are
15 shown on page 24 of your mailing, and there is a
16 statistically significant negative correlation of about 0.2
17 across the board.

18 The other two mortality measure, CHF and
19 pneumonia, have either non-significant or much lower
20 correlations with readmissions.

21 CMS heart failure mortality also has a significant
22 negative correlation -- we found minus .25 -- with the 3M

1 readmission measure we have been using earlier. One
2 explanation of this would be the second hypothesis we
3 discussed: that CHF admissions may be more subjective and
4 some hospitals simply admit more CHF cases, which drops
5 their mortality rate, and then readmit them more often as
6 well. AMI we expect would be less subjective, and it shows
7 no significant correlation. And perhaps some of the
8 clinicians could tell us about how subjective pneumonia
9 might be; it has significant correlation with AMI and CHF
10 readmissions but not with the all-condition measure.

11 So this topic clearly deserves more study and
12 perhaps the development of a joint measure of mortality and
13 readmissions. However, for our purpose today, we point out
14 that when using a more inclusive mortality measure -- an
15 AHRQ measure of mortality for five conditions, and the all-
16 condition readmission measure -- the correlation diminishes
17 and is no longer significant.

18 In other words, the penalty would not be targeted
19 to low-mortality hospitals. This is another reason we think
20 moving to an all-condition measure may be a useful
21 refinement to the policy.

22 In summary, we find that the hospital readmission

1 reduction program which started last October appears to be
2 working. It is creating some incentive to reduce
3 readmissions which is better for beneficiaries and will save
4 money for Medicare. As such it represents a major
5 improvement.

6 However, we also find that there are four major
7 issues in the current readmission policy that will need to
8 be addressed in the longer term, and we have presented some
9 refinements to address these issues.

10 Moving to an all-condition measure helps with the
11 small numbers problem and makes it more possible to evaluate
12 hospitals on their individual performance.

13 Decreasing penalties as the hospital industry as a
14 whole reduces readmissions creates a better incentive for
15 hospitals to work together to reduce readmissions and thus
16 could result in greater program savings.

17 Creating peer groups based on low-income share and
18 judging performance within those groups makes penalties
19 similar across hospitals serving different SES groups and
20 does not penalize hospitals that serve low-income patients
21 disproportionately. And using an all-condition measure also
22 limits issues regarding interactions between readmissions

1 and mortality.

2 Finally, remember the goal is to reduce
3 readmissions. These refinements increase the incentives for
4 individual hospitals and the industry as a whole to reduce
5 readmissions. And the savings from reducing readmissions to
6 the program may be much larger than any penalty if the
7 incentives created are strong enough to get real action to
8 reduce readmissions from a large number of hospitals.

9 First, we note that almost all of the policy
10 refinements discussed will require a change in law rather
11 than an administrative action by CMS.

12 In your discussion, we would like you to consider
13 if the refinements we have discussed are moving in the right
14 direction.

15 Should the policy move to an all-condition
16 measure? We have illustrated using the 3M potentially
17 preventable measure, which is used by several states and
18 private payers. Yale has developed an all-condition measure
19 for CMS.

20 Is setting a target in advance a good idea? We
21 have illustrated setting a target of having readmissions at
22 the 40th percentile of the previous year's readmission rate

1 distribution.

2 Is it reasonable to compare hospitals to their
3 peer group rather than to all hospitals? We have
4 illustrated peer groups based on the percentage of Medicare
5 patients who receive SSI payments as a proxy for low-income,
6 low SES patient share.

7 We look forward to your discussion and would be
8 happy to answer any questions.

9 MR. HACKBARTH: Okay. Thank you. And thank you,
10 Jeff, for your introductory comments, putting this
11 discussion in the context of past MedPAC recommendations,
12 including the initial recommendation to have a link between
13 payment and readmission rates.

14 As I have watched the debate on this unfold,
15 initially it seemed like a lot of the debate was how good
16 are readmissions as a measure of hospital quality, and that
17 was one of our reasons for being interested in this. As
18 Jeff indicated in his comments, this is a bad result from a
19 patient perspective.

20 But the other part of the rationale was to begin
21 breaking down the silo of accountability, and the thinking
22 that, "Oh, I'm only accountable for what happens within my

1 four walls," and actually get people to think about, "Oh,
2 what happens when the patient leaves my institution?" That
3 was a major goal of ours that at least was lost initially in
4 some of the debate about this. I have seen it more
5 prominently mentioned now in some of the more recent
6 literature, and that is a good thing.

7 I had a clarifying question about the all-
8 condition approach. My hunch would be that the likelihood
9 of readmission varies by condition, that it is not evenly
10 spread across all conditions. If that is true and we're
11 using an all-condition measure, then a hospital's
12 readmission rate will be influenced in part by their mix of
13 cases. So that's just a reaction. Tell me what you think
14 about that.

15 MR. LISK: The all-condition measures adjust for
16 that, so you're already adjusting for the fact that the
17 expected rate for someone with heart failure is 24 percent
18 versus someone who has a hip or knee replacement is 10
19 percent, and the expected is relative to those. So it's all
20 adjusted for within that.

21 MR. HACKBARTH: George, do you want to lead off
22 with clarifying questions?

1 MR. GEORGE MILLER: Sure. Thank you.

2 The chapter was very well done. I really enjoyed
3 the reading, and it certainly provided a good beginning for
4 conversation, so I certainly want to applaud you on the
5 work. And I think -- well, let me do a clarifying question
6 first. I think we're going to in the right direction. I
7 will say that.

8 I'm just wondering if in doing the analysis, did
9 you go down in comparing and use the term "liberal hospital
10 admission policies," did you look at different times of day,
11 different times of the week for why some were readmitted?
12 And did you look at the difference between hospitals if they
13 employed the ER physicians versus if it was contracted? And
14 then taking a little granular, at least at my place we know
15 by the admissions who the ER physician was. So I don't know
16 if you took that into consideration in doing some of the
17 analysis, or did you just take a broad brush?

18 DR. STENSLAND: We haven't done that detailed
19 analysis. We'll have to think about whether we can do it.

20 MR. GEORGE MILLER: Yes. Just curious. I'll come
21 back for round two.

22 DR. NERENZ: Thank you. I definitely think this

1 is moving in the right direction. I commend you for the
2 steps. We'll get to that later in the second round.

3 Two clarifying questions.

4 First of all, in Slide 15, I was quite surprised
5 in comparing the second and third column. It seemed like in
6 spirit this issue of comparing to peer groups is designed to
7 relieve what Column 2 seems to indicate is, I'll call it, an
8 unfair burden on hospitals serving high proportion. But my
9 interpretation, if I'm correct, is that everybody's worse
10 off in the adjusted model. All those Column 3 numbers are
11 higher than the corresponding Column 2 numbers. How can
12 that be?

13 MR. LISK: We didn't set it in terms of being
14 absolutely budget neutral here in terms of -- we just picked
15 off 40th percentile and what would happen here. We could
16 adjust it to be the same amount, but what we did here is
17 just set it at the 40th percentile, as an example. So we
18 could have done some other maturations to get it to be the
19 same, but the principle of that number in the middle, if we
20 lowered it down to where the average penalty was 0.31, it
21 would be similar to that.

22 But, remember, the penalties -- it's actually

1 going to end up expanding, the cost is going to end up
2 expanding, too. So --

3 MR. GLASS: There are two competing things going
4 on. Since we're doing all conditions, that raises the
5 penalty. The other lever you can pull is do you go with 40
6 percent, 50 percent, 60 percent? If you change that, then
7 you can make the average whatever you want, in other words.

8 DR. NERENZ: Okay, that --

9 MR. GLASS: So you can change -- this is just
10 illustrative.

11 DR. NERENZ: Okay. That helps. Because, clearly,
12 the point that seems to be what this was designed to do is
13 to have those numbers in Column 3 be very much alike. I
14 appreciate that.

15 MR. LISK: Yes.

16 MR. GLASS: Yes.

17 DR. NERENZ: The fact that they're all higher than
18 number 2 surprised me a great deal.

19 MR. GLASS: Right, that's because we're doing all
20 conditions, and we set it at the 40th percentile rather than
21 the 50th percentile.

22 DR. NERENZ: Fine. Okay. So that would not

1 necessarily be --

2 DR. MARK MILLER: Just one more pass at this for
3 you and for also the public. What David was saying there
4 and Craig was saying there at the end is the calibration
5 here can be set to whatever you need to hit. So if it's
6 budget neutral, you can make the bottom-line numbers equal.
7 This was just all-condition and 40 percent.

8 DR. STENSLAND: And I think when CBO would go to
9 score something like this, they would have a baseline, and
10 their baseline would say, What do we expect readmissions to
11 do over the next 10 years? And if they expect readmissions
12 to go down, say, by 10 percent over the next 10 years, then
13 we're in the last column by the time it's 10 -- and then we
14 have a lower penalty. If they expect readmissions to be
15 just flat, then we'd actually have a higher penalty under
16 this. But I suspect they would expect some decline in
17 readmissions since we've already seen some decline. And the
18 way this is set up now, I wouldn't be surprised if that 40th
19 percentile target would be about budget neutral, because
20 it's basically saying, well, if things stay constant, you
21 would pay a little more; if things actually get better,
22 you're going to pay less; and we're not sure how much

1 they're going to get better. So actual expected penalty is
2 probably somewhere between the third column and the fourth
3 column. It's not just the third column. Does that make
4 sense?

5 DR. NERENZ: Okay. Thank you. That helps.

6 The second question. This would now go to Slides
7 4 and 5. On Slide 4 you've listed a number of things that
8 hospitals are doing, and actually on page 4 in the chapter,
9 you've got a few more. All of these things cost money.
10 They take time, they take resources. And as I understand
11 the program, there are no new resources built into this, so
12 these are resources taken from somewhere else. The question
13 is: Do we know anything now about the costs of these
14 activities? And then as I extend into Slide 5, this does
15 report some smallish positive effect, but I'm wondering if
16 there is now the ability to compare cost and benefit, and
17 particularly to do some comparative analysis to see whether
18 is this the best possible use of the resources that are
19 being devoted to this as opposed to, for example, pressure
20 ulcer prevention, sepsis prevention, and other kinds of
21 things, because, you know, it's kind of zero sum in terms of
22 time and budget available within the hospital. Do we know

1 any of this?

2 MR. GLASS: Well, reducing the complication is one
3 of the things we listed, I think, which would be the --

4 DR. NERENZ: Well, then another question. Do we
5 know how much variance in the readmission rate comes through
6 that pathway?

7 MR. GLASS: No, I don't think so. No.

8 DR. STENSLAND: I think that's a good thing for us
9 to look into, what is the cost, and the cost isn't directly
10 paid for in any way directly. But that cost is computed
11 into the overall hospital cost, and so when the payment
12 adequacy discussion comes up every year, that could be
13 factored into that discussion, because it will affect the
14 overall cost and the overall margins.

15 DR. NERENZ: Yeah, I think I'm a little more
16 interested just in what the tradeoffs are within the
17 hospital. I'm just curious what we know about that.

18 MR. HACKBARTH: And, Dave, I think you're raising
19 an important question on this issue. This is one of the
20 reasons why I hope the ultimate estimation here is to move
21 to bundling of payments. And there what you've done is you
22 now have a larger pool of resources that can be reallocated

1 and used to high-priority, high-value purposes as opposed to
2 this more narrow approach. And, again, that goes back to
3 the context that Jeff mentioned at the outset.

4 When we first looked at this, we looked at
5 bundling and said, you know, that has a lot of appeal to it,
6 but it's not going to happen overnight, and it's going to
7 take some time to work out how to best design it. And what
8 can we do in the shorter term that will help address the
9 issue of readmissions, but ultimately could be supplanted by
10 bundling and a more flexible approach?

11 DR. NAYLOR: Just building a little bit on Dave's
12 comment, you know, this program does co-exist with multiple
13 investments, huge investments being made in care
14 transitions, in hospital innovations and health care
15 innovations. And so you can never disentangle how much the
16 effects of the policy changes are from the multiplier of
17 programs relative to this. I think contextually that's
18 important to comment on because once those resources go
19 away, it'll be really important to monitor what we're
20 seeing.

21 But the two questions I have are around the
22 relationship between mortality and readmissions, and I

1 understood the recent work showing weak associations between
2 mortality and readmissions, certainly for AMI and pneumonia,
3 and only a weak association between heart failure. And so
4 that's -- it's a paper you cited, Krumholz in JAMA, and so
5 I'm wondering, because whether or not other possible
6 measures that seem to be connected with readmissions -- and,
7 obviously, you're highlighting one of them, SES, but
8 symptoms and functional status were considered as possible -
9 - so I guess my first question is, you know, Is the evidence
10 really clear about this association between readmissions and
11 mortality given the most recent data?

12 MR. GLASS: We think it is for CHF, for heart
13 failure. On page 24 of the mailing materials, we have a
14 little table showing it.

15 DR. NAYLOR: So does it depend on the measure? I
16 mean --

17 MR. GLASS: Well, yeah, I mean, there does seem to
18 be something there for that one particular thing, and, you
19 know, if the clinicians could tell us, is that somehow more
20 subjective? Is there more leeway in deciding on --

21 DR. MARK MILLER: Dave, this is the way I would
22 say it. When this first relationship hit the literature and

1 kind of people started talking about it, it was, I think,
2 exclusively predicated on what was observed for CHF. And so
3 then there was sort of this prevailing view: readmissions
4 and mortality move in a different direction.

5 When you look at other conditions, as you're
6 zeroing right in on, it doesn't hold.

7 And then the last thing I would say is we've
8 raised some questions -- and maybe some other folks, but I
9 know internally we've been talking about this. Is this a
10 mortality readmission tradeoff or are both of these results
11 kind of governed by an admission pattern? And that --

12 DR. NAYLOR: Right. I mean, Krumholz's work shows
13 that there's this group of people for whom there is poor
14 performance on mortality and poor performance on
15 readmissions. So I was just wondering whether or not the
16 science has evolved to really challenge us, those
17 associations.

18 Lastly, frailty. Did you consider beyond SES
19 given the real challenges of people that are coming in with
20 heart failure plus cognitive impairment plus functional
21 deficits who are high utilizers, whether or not that, as we
22 think about refinement, should be also a consideration?

1 MR. LISK: I mean, to the extent that within the -
2 - both all-condition readmission measures there are CCs that
3 kind of get at people with a couple co-morbid -- multiple
4 co-morbid conditions or a higher level of patient severity
5 which would probably take those into account. So in the 3M,
6 it's four levels of severity so those patients would be in a
7 higher category with a higher expected readmission rate, for
8 example, because of those factors. So the risk adjustment
9 kind of tries to get at those issues. Whether it gets at it
10 perfectly or not, you know, that's debatable.

11 DR. MARK MILLER: But the very direct, if I
12 understood your question, is what about things like
13 functional status.

14 DR. NAYLOR: Exactly. I mean, I think Joan Teno's
15 recent piece about frailty distinct from multiple chronic
16 co-morbid conditions and the kind of way -- and functional
17 status is -- I mean, I think it's a two to three times
18 higher readmission rate for those with frailty relatives.

19 DR. MARK MILLER: And what I wanted to answer very
20 directly is I don't think those have entered into the
21 adjustment factors in what we're talking about here, and I
22 want to be a little bit careful about this comment. I think

1 in the bundling discussions, we are working on some stuff in
2 that direction.

3 MR. LISK: We are.

4 DR. MARK MILLER: So we may have something to say
5 about that down the road.

6 DR. NAYLOR: Okay. Thank you.

7 MR. HACKBARTH: Let me just pick up on Mary's
8 question. I think this is important. And just to be clear,
9 I'm sympathetic to the idea of using a comparison group
10 based on SES. Certainly the goal here is not to handicap,
11 harm institutions that care for a disproportionate number of
12 low-income people. But it really isn't what we're trying to
13 adjust for. We don't think the meaningful factor is income.
14 We think that's correlated with other things that may affect
15 readmission rates. And is this the best correlate to use?

16 So another might be geography, you know, even down
17 to the zip code level, that might signify the sort of
18 community resources that exist.

19 Mary is going in still another direction, you
20 know, patient-specific characteristics that may contribute
21 to readmissions.

22 Could you just talk a little bit about why this

1 correlate and why not some other correlates, or even more
2 direct measures of things associated with readmissions?

3 MR. LISK: Well, frailty, for instance, we don't
4 have any measure for every patient that comes out of the
5 hospital. So the only thing we have, if you want to take
6 that type of information, is from -- if they went to a post-
7 acute care provider, you might be able to capture something
8 there, but we don't have it for every patient who leaves the
9 hospital. So that's a major reason for not being able to
10 deal with that one.

11 In terms of the geography thing, that's another
12 approach that's different than what we've done with using
13 the SSI. But we do see a pretty strong relationship with
14 the SSI as a measure, and that is measuring the poorer
15 folks. And in terms of the resources for those folks -- and
16 a lot of other studies have talked about what difficulties
17 poorer folks have in communities. But you're right about in
18 terms of certain community resources. So some communities
19 may have Meals on Wheels that help make sure that those
20 patients have good food and nutrition; whereas, in other
21 places they may not have it, and those patients may suffer
22 and not have good food and are more likely to get

1 readmitted, for instance. So some of that is those
2 community resources that differ.

3 DR. MARK MILLER: You have to be careful there too
4 because if you just take geography, depending on what level,
5 you can be capturing practice patterns which may be higher
6 readmission rates, and then in turn you'd be adjusting them
7 downward for those reasons. And so all of these get pretty
8 messy pretty quickly.

9 MR. GRADISON: I've got a couple of technical
10 questions. I'll reserve some policy questions for later.

11 First, an observation. I think this is kind of
12 curious. My understanding is that a readmission counts as
13 an admission and, therefore, that in the computation of the
14 readmission rate, the more readmissions you have, the lower
15 rate you're looking at next year. Is that -- it's minor,
16 but I just want to make sure I understand that correctly.

17 MR. LISK: It depends upon the readmission measure
18 you're using, and I -- it depends upon the readmission
19 measure you're using here. In terms of the current --

20 MR. GRADISON: Well, the current policy.

21 MR. LISK: In terms of the current policy, in
22 terms of how the formula actually works, the readmissions do

1 count towards the count of cases, but it doesn't reduce your
2 readmission rate because the readmissions are not counted in
3 the readmission rate. So it's initial admissions without a
4 readmission that are considered in calculating the
5 readmission rate.

6 MR. GRADISON: Okay. Thank you.

7 One other point. This goes to -- on page 5,
8 towards the bottom, we're talking about the importance of
9 the readmission penalty having to be larger than the sum of
10 the marginal profit the hospital gets from additional
11 Medicare readmissions. That's true. But I think there's
12 another element that goes into this, and that's, in effect,
13 the incremental costs incurred by the hospital in trying to
14 reduce its readmission rate, and I think you might want to
15 take a look at that, because my sense of how this would
16 actually work over time is that the incremental cost of the
17 reduction or trying to reduce readmission rates would
18 steadily rise over time in the sense that you do the easier
19 things first, and the least expensive things. And I'll come
20 back to that later from a policy point of view.

21 I do want to ask a question, and it comes to
22 points made on page 10 about the VA hospitals and the

1 critical access hospitals. Do you have any information on
2 readmission experience in those two groups of hospitals that
3 are otherwise excluded here?

4 DR. STENSLAND: So the critical access hospitals
5 are excluded in two different ways. The one way is they're
6 not subject to the penalty, and their readmission rates are
7 roughly similar -- you know, some studies say a little
8 below, some studies say a little above, but it's on average
9 about similar.

10 The other thing that is a little bit of a quirk in
11 the policy and we're not quite sure why it is in there is if
12 someone is at a PPS hospital, say in the big city, they get
13 discharged and go back to their home in their small town,
14 and then they get readmitted to the critical access
15 hospital, that readmission to the critical access hospital
16 doesn't count against the PPS hospital's readmission rate.

17 MR. GRADISON: And, by the way, how about the
18 reverse? What if the -- I couldn't figure that out from the
19 paper.

20 DR. STENSLAND: If they go from the --

21 MR. GRADISON: Critical access hospital to a PPS
22 hospital.

1 DR. STENSLAND: It would count as a readmission
2 for the critical access hospital, but the critical access
3 hospital doesn't suffer any penalty. There's no penalty
4 there for it.

5 MR. GRADISON: Okay. So the second admitting
6 hospital isn't dinged for it.

7 DR. STENSLAND: Right. It would be publicly
8 reported, but --

9 MR. GRADISON: And how about numbers on the VA?
10 Do we have any information on readmissions?

11 DR. STENSLAND: No. It might be out there. I'm
12 not aware of it.

13 MR. GRADISON: Okay. Thank you.

14 DR. MARK MILLER: Jeff, when you answered the CAH
15 question, those are readmission rates without the shrinkage
16 adjuster in there or with, when you were saying they were
17 about average?

18 DR. STENSLAND: They're about average without the
19 shrinking.

20 MR. GRADISON: This is a policy issue, not a
21 number issue, but I would think there would be ways to bring
22 the critical access hospitals under this, even though

1 they're not paid in the same way. Okay. We can do that
2 later. Thank you.

3 MR. KUHN: On Slide 14 you made the observation
4 that both CMS and Yale indicate that the SES risk adjustment
5 model might hide disparities, and I'd like to kind of
6 understand that a little bit more. And the reason I'm
7 curious about that is I guess in the last couple of days,
8 the New England Journal of Medicine published a perspective
9 piece that talked about the readmission policy. And one of
10 the observations the authors made is that there is growing
11 evidence that those safety net as well as large teaching
12 hospitals tend to be more highly penalized than other
13 hospitals, and they reflect on that that it's probably
14 because they have a larger proportion of complex patients as
15 well as the SES issues as a result of that.

16 So if the evidence is showing us this kind of
17 directionally, give me a little understanding kind of on
18 their policy rationale why they discounted this.

19 DR. STENSLAND: Why they would discount it [off
20 microphone]?

21 MR. KUHN: Right.

22 DR. STENSLAND: Well, there would be a concern

1 that what if there is, say, different resources in the poor
2 communities or different resources in communities with high
3 shares of African American populations, and those different
4 resources are really adversely affecting the care people
5 receive and they are resulting in higher readmission rates.
6 If we put those variables into the regression model, the
7 regression model would come out with results showing, oh,
8 the readmission rates are equal, and people wouldn't even
9 know that there are these differences that are associated
10 with these disparities maybe in income or community
11 resources. And so this approach would say, well, let's
12 leave those, at least those income variables out of the
13 model and run the model so we're aware that there are these
14 differences maybe in resources and the effective readmission
15 rates; but then not take away the money from these places
16 that happen just to have high readmission rates just because
17 they treat a lot of poor folks by adjusting the penalty
18 formula. So you can kind of do it in two different ways:
19 either adjust it up front, and then it's kind of adjusted
20 deep inside the black box and you never know really what's
21 happening with those poor communities; or let's take a look
22 at what's happening with the poor communities, but not

1 penalize them more than the wealthier communities if they
2 have the higher readmission rates.

3 MR. GLASS: So from the beneficiary perspective,
4 the beneficiary might like to know that Hospital A has a
5 much higher readmission rate than Hospital B. Whatever the
6 reason, they might like to know that when they're choosing a
7 hospital. So you don't necessarily want to hide it.

8 And also, there's this feeling that you're kind of
9 just tolerating higher readmission rates for poor patients
10 if you put it in the risk adjustment --

11 MR. KUHN: Yeah, and of course, that makes that
12 the assumption that all these communities are homogeneous,
13 but I understand that argument as part of that.

14 MR. HACKBARTH: Yeah, so, Herb, the piece you're
15 referring to is the joint and jaw piece that appeared this
16 week --

17 MR. KUHN: Yeah.

18 MR. HACKBARTH: When I read that, it wasn't clear
19 to me how they might react to this approach as opposed to
20 putting it in the formula using a comparison group approach.
21 Do you have any insight on it?

22 DR. STENSLAND: I think they would be open to this

1 approach as being a reasonable way to address that problem,
2 because in that article they specifically showed our tables
3 using these SES deciles. So their illustration of this
4 problem uses our approach of the 10 SSI deciles.

5 MR. KUHN: Yeah, and the real key here is, you
6 know, how do you make sure that you have equity in the
7 system and then make sure you're not pulling resources out
8 of these communities that desperately need them, because
9 then it becomes a self-fulfilling prophecy. You just get
10 worse as part of the process. And I think that's an
11 observation you made earlier, Glenn, as well.

12 MR. HACKBARTH: Yeah, and the way I interpret this
13 approach is that what we're trying to do is achieve that
14 policy goal while also not depriving the patient potentially
15 of information that he or she might find useful. So it's
16 agree with the goal, but just take a little different tack
17 on it.

18 MR. KUHN: And one other quick question. Also in
19 their piece, they made the observation that the number of
20 hospitals penalized are much higher than the original models
21 predicted. Do you know why they made that particular
22 statement? Or are we seeing data that supports that? They

1 just kind of made that statement, but I just wasn't aware
2 where it came from.

3 DR. MARK MILLER: I read that this morning, too,
4 and I got to tell you, I mean, I read through it, and most
5 everything that I read I followed. That point was a little
6 confusing to me because they refer to this 5 percent outlier
7 number. And what I would suggest here is let us look at it
8 before we pop off in public on what we think they might have
9 meant. But I remember hitting that point in the article and
10 going, "I don't understand why this is being said." So if
11 we could, unless somebody's got it wired, I would suggest we
12 come back on it.

13 DR. COOMBS: So thank you very much, Herb. I was
14 thinking along the same lines, especially dealing with the
15 fact that, you know, the disproportionate hospitals may have
16 a greater challenge in terms of being able to meet certain
17 fiscal benchmarks, and then there's the burden of the excess
18 penalty that is superimposed on that.

19 One of the questions I had was, is there any kind
20 of analysis on the number of beds per -- hospital beds per
21 given area, correlating that with penalty? Because I think
22 that's another issue, because if you look at the table on

1 Page 13, Table 3, and you're looking for consistency, and I
2 noticed you guys had some -- grasp with the correlation was
3 very weak.

4 I'm wondering if there's another confounding
5 variable that lends itself to a better understanding with
6 the readmission rates in the sense that if you're in an
7 area, you might not necessarily be in a rural area. You
8 might be in an area where the density of hospital beds are
9 much lower and it's not necessarily rural, but it may -- you
10 know, like in inner New York there's a lot of crowding of
11 hospitals in a small amount of area, and if that's been
12 shown to have an impact on readmission rates.

13 MR. GLASS: I think there is something on
14 occupancy, isn't there, Jeff, some relation? I notice that
15 there's a lot of hospital beds available. I think that
16 admissions rate and readmission rate goes up.

17 DR. MARK MILLER: The table you're referring to is
18 in the paper?

19 DR. COOMBS: Yes, I'm sorry.

20 DR. MARK MILLER: Okay. No, I just want to make
21 sure what we're looking at. So it's Table 4 in the paper?

22 DR. COOMBS: Page 13, Table 3.

1 MR. GLASS: Probably hospital group, the table by
2 hospital group.

3 DR. STENSLAND: We can look at that, but there is
4 some literature showing areas with high admission rates,
5 initial admission rates also have higher readmission rates,
6 suggesting there's some practice patterns, and you see that,
7 that certain cities tend to have higher readmission rates
8 than other cities. People out west tend to have lower
9 readmission rates where they generally tend to admit less,
10 and sometimes out east in some other cities where they tend
11 to admit more have higher admission rates and readmission
12 rates.

13 DR. COOMBS: And one last question and that was,
14 we haven't talked about this and maybe it's something that's
15 obvious, just the piece about Visiting Nurse Association
16 support. Are there any phases where someone had brushed
17 with an intermediate care facility with some of these
18 readmissions? So say, for instance, if someone has a short
19 stint leaving the hospital and then they bounce back, say
20 two weeks after being at home.

21 DR. STENSLAND: I didn't.

22 DR. MARK MILLER: Give us another pass at it. I

1 think --

2 DR. COOMBS: I was just speaking of a patient that
3 we had in the ICU. Someone goes home immediately from the
4 hospital or maybe they go to a short-term rehab facility,
5 and then they go home. You know, the pressure is for length
6 of stay to be squashed considerably, and the natural
7 inclination would be that maybe there's some of those
8 patients that fall through the crack because we're pressured
9 to actually get to this optimal length of stay, and those
10 patients may have a short stint at an intermediate care
11 facility as well.

12 And so, that those numbers may result in a
13 readmission in a short period of time, and I'm wondering if
14 that's something that has been teased out. Or if, maybe,
15 less of those patients who are being readmitted actually go
16 straight home and they're not quite necessarily ready to be
17 at home. And if they're bouncing back for reasons that
18 could have been actually handled at home.

19 DR. MARK MILLER: So I'm taking your question as
20 do you see any variation in readmission rates depending on
21 what the first site of care is following the hospital?
22 That's your question? Okay. Now, I don't recall us looking

1 at it that way, but...

2 DR. STENSLAND: No, we didn't. And if that's the
3 question, we don't have any information. If your question
4 is, is there a connection between length of stay and
5 readmission rates?

6 DR. COOMBS: Not only that, but is there an
7 intermediary help system for that patient? Because that's
8 really huge, isn't it, in terms of revision?

9 DR. STENSLAND: I don't think -- Mary could
10 probably discuss the intermediary help system much better
11 than we could and how that reduces readmission rates, so
12 maybe I'll wait for her to go around.

13 DR. COOMBS: Well, see, my question was, if we
14 actually looked at that, if that's one of the pieces that we
15 actually looked at.

16 DR. STENSLAND: Just through the literature which
17 often does show some benefit, and a lot of those programs
18 we've discussed have some system. Mary's system, other
19 people's systems of either getting that initial visit as
20 soon as they leave the hospital, someone going actually out
21 to their home to help coordinate their care and smooth the
22 transitions.

1 There is a fair number of studies that have some
2 moderate success with that, and I'm already feeling like I'm
3 stretching too far into Mary's territory, so I'm just going
4 to be quiet.

5 DR. HOADLEY: Yeah, I had two questions. One is,
6 do observation stays count either when you're looking at
7 admissions or at readmissions?

8 MR. LISK: No.

9 DR. HOADLEY: And is there any -- been any look at
10 whether there's anything going on that could be greater use
11 of observation stays in order to avoid a readmission or
12 anything like that?

13 MR. LISK: I mean, there is an incentive here in
14 the policy to use observation stays to potentially avoid an
15 initial admission that potentially could end up with a
16 readmission, or as -- if the person's admitted, to use it to
17 avoid the readmission when the person comes back to the
18 hospital.

19 DR. HOADLEY: Right.

20 MR. LISK: So there is an incentive in here, but
21 that's not part of the policy as it currently stands.

22 DR. HOADLEY: Is there any way to look at that

1 analytically?

2 MR. LISK: Yeah. We have not directly looked at
3 that, but that is actually something that could be examined.
4 It's a little more complicated because then we have to go
5 from Part A to Part B bills and stuff like that.

6 DR. HOADLEY: And my second question, the use of
7 three years of data. I assume that was done, you know, to a
8 great extent to get more into the mix. If you go to the
9 all-condition measure, first of all, is there any concern
10 that three years kind of mutes the ability to see the
11 response, and if you go to the all-condition measure, is
12 there any ability -- does it seem reasonable to reduce that
13 amount of time, or is that a dynamic that's worth thinking
14 about?

15 DR. STENSLAND: I think that's kind of a judgment
16 call. When you look at, okay, you know, what is the
17 variation with these different numbers of observations? I
18 really think you need the three years. Some other people
19 would think no, maybe we can take more variation and just do
20 one year. I think in some of the Yale work on the new all-
21 cause measure they've had, they've just used one year, but
22 then they continue to use that round of effects model which

1 shrinks everything to the middle which has some issues. So
2 there's some various trade-offs there.

3 One possibility, if people really -- the incentive
4 is really, I think, the same because you know that if you
5 reduce your readmissions in 2013, you know you're going to
6 have a lower penalty or no penalty for three straight years.
7 So you still have that same incentive. Some people would
8 like it to be closer so that if you get -- things change
9 now, it affects your results right away. That is a trade-
10 off.

11 Maybe if you wanted to get more complex, you could
12 have a more complex policy where you said, for smaller
13 hospitals, you need three years. If you're really big and
14 you have 10,000 admissions per year, maybe you can have one
15 year of data.

16 DR. HOADLEY: One way of looking at that trade-off
17 is, do you want to shrink towards your hospital's mean over
18 three years or do you want to shrink toward the national
19 mean over one?

20 DR. SAMITT: Great job on the chapters. Thank
21 you. Two quick questions. Page 15. What struck me was the
22 last column on the right, and even under the new system with

1 the 10 percent reduction, there's this phenomenon for the
2 share of beneficiaries all the way in the lower right.

3 So what's going on there? It looks like there is
4 a much greater increase in penalty, even with these
5 modifications, when the SES is significantly higher.

6 MR. LISK: I think that may be a function of that
7 distribution where you have the over 18, and even the 13 to
8 18 is a highly skewed distribution. So we're looking to the
9 average within that distribution because of the skewness. I
10 think that may be part of what's going on.

11 You know, we've done it by deciles. You probably
12 could have some sort of continuous adjustment instead of the
13 deciles or something like that that might mitigate that
14 some. But like this decile group, because then you have a
15 clearer picture of where you stand, but I think it may be
16 that skewness of the distribution that's contributing to
17 that.

18 DR. SAMITT: Because ideally a solution would
19 solve that as well so that there isn't inequity there.

20 MR. LISK: It's -- it's substantially reduced in
21 terms of the difference from what is under current policy.

22 DR. SAMITT: Okay. My second issue is about the

1 all-condition readmissions. I certainly understand why it's
2 being recommended where we're trying to solve a couple
3 problems. I guess my question is, does it cause new
4 problems when we shift to an all-conditions measure? You
5 know, the current policy using three conditions is a much
6 more typical common admission, a more typical condition.

7 If we move to all conditions, would we see a
8 greater skew that creates greater penalty for academic
9 medical centers or organizations that would attract higher
10 complexity illness for less common conditions that would
11 face readmission? So I don't know if you've looked at that.
12 I just wouldn't want us to come back and say, All right, we
13 solved some problems by doing this, but we've created new
14 ones.

15 MR. GLASS: Well, I guess it's a question of
16 whether the risk adjustment picks it up or not, and that's
17 hard to determine.

18 DR. SAMITT: Okay.

19 MR. GLASS: Presumably if it's risk adjusted, if
20 you have the much more risky patients to begin with, that is
21 taken into account. But whether it completely does that or
22 not, I'm not sure.

1 MR. HACKBARTH: Mike.

2 DR. CHERNEW: So that leads into my first question
3 which is, in the materials you mention that the risk
4 adjuster is based on HCC categories. Do they do that
5 separately for the three conditions? Are those three
6 separate risk adjustment models that they're running? And
7 do we think when we move to the all-cause measure, or even
8 with the ones that we have, that the risk adjuster will be
9 good enough to address what we'd like it to address?

10 MR. GLASS: Which one? There are two models?

11 MR. LISK: Well, actually, the current -- yes, the
12 current models are separate for pneumonia, heart failure,
13 and AMI.

14 DR. CHERNEW: But when you move to the all-cause,
15 you're not going to run them separately for all cause, I
16 assume?

17 MR. LISK: No, actually in terms of -- we can get
18 down to the details of what Yale does versus 3M. I don't
19 know if we want to get to it here, but they do do some --
20 they define it in for, let's say, for Yale into five
21 categories; for 3M, we're looking within DRG specific.

22 DR. CHERNEW: The real question was whether we're

1 comfortable with the risk adjuster as we move to a broader
2 set of conditions. And I see some basic nods, so that's a
3 yes, for the record.

4 DR. STENSLAND: I think we're basically
5 comfortable, but that's not to say it couldn't be improved.

6 DR. CHERNEW: I think understanding where we think
7 the errors in the risk adjustment might be could be
8 important, like academic medical centers and things.

9 The second question just simply is, is the
10 mortality a 30-day mortality rate?

11 MR. GLASS: Yes.

12 MR. LISK: Yes.

13 DR. BAICKER: My questions follow up on the ones
14 that Herb and Craig brought up about using the SES or SSI-
15 based cohorts as a benchmark for evaluating, and I
16 understand the motivation to not want to punish facilities
17 that are serving more complicated, more expensive patients
18 that happens to be correlated with income and race.

19 You mentioned in the slides that controlling for
20 SES or controlling for income still leaves a race residual.
21 First question is, does controlling for SSI still leave a
22 race residual? Is SSI just a better measure of income than

1 income? Or do the same issues persist there?

2 MR. LISK: We're using SSI as our measure of
3 income.

4 DR. BAICKER: As income, okay.

5 MR. LISK: It's our measure of income.

6 DR. BAICKER: So it's not that you have a
7 continuous measure and you're using a poverty binary.

8 MR. LISK: And really, for the highest -- that
9 looks like the highest decile of hospitals treating African-
10 Americans, that's where we still see an affect. But if you
11 look at it without SES, you see kind of a continuous affect.
12 When you control for SSI --

13 DR. BAICKER: By SES, you mean SSI?

14 MR. LISK: SSI, yes. It flattens out, but you
15 still have a spike up for the highest, the hospitals with
16 the highest share of African-Americans. So that's hospitals
17 with over a 30 percent share, for instance.

18 DR. BAICKER: So part of my motivation in asking
19 that question was that I understood the dueling concerns
20 about not wanting to punish providers that were treating
21 more complicated patients or more expensive patients with
22 higher readmissions, et cetera. And on the other hand, not

1 wanting to say that it's okay if those groups have worse
2 outcomes.

3 I wonder if this control -- comparing within SSI
4 deciles, to me, seems like it has all the same problems,
5 just slightly obscured in that comparing within SSI, deciles
6 is really just a different functional form from throwing in
7 SSI as a control, and maybe it works better as a functional
8 form or maybe it works worse, but it has the same issues
9 embedded in terms of that.

10 Is it okay for these SSI -- you know, higher SSI
11 deciles to have worse outcomes -- we're just not penalizing
12 them for it -- versus saying, we want to be sure that we're
13 not masking this to the public.

14 So I'm trying to understand whether you think
15 conceptually there's any difference between looking at SSI
16 deciles versus controlling in some flexible, functional form
17 for SSI, and whether the same solutions in terms of one set
18 of reporting to people that doesn't mask this versus another
19 set of calculations for penalties might apply to more
20 flexible, functional forms for controls as opposed to just
21 the deciles. That was a complicated question.

22 DR. MARK MILLER: No, no, but I followed it, and

1 what I would say is that, you know, for the first half of
2 your question -- and what I'm going to do is, there's a
3 measurement in the methods question, and then there's a
4 policy question. I would say what has been put together
5 here is decidedly a different policy.

6 On the methods sense, I could interpret what
7 you're saying as, Look, you can either methodologically
8 adjust it as part of your risk adjustment, or you can do
9 these cohorts, but either way you're sort of giving them a
10 buy. And up to that point, I completely agree, and I think
11 we all agree. A nod would be appreciated.

12 But the second part of it that I would say is --
13 and, you know, there's the hiding thing which you were
14 tracking on, so I know you're all over that. But what I
15 think is important about the cohort approach is, when you
16 put it in a cohort, what you will find is that there are
17 some people with lots of poor folks who don't have high
18 readmission rates, and you're saying you're going to be
19 judged against those.

20 So from a policy perspective, there's still some
21 force on that hospital to say, I need to clean up my act if
22 I'm way out on the right-hand tail of this group.

1 DR. BAICKER: Wouldn't the exact same statement be
2 true if you were controlling for SSI? I just am trying to -
3 -

4 DR. MARK MILLER: I think you end up without a
5 penalty.

6 DR. BAICKER: It's a different functional form.

7 DR. CHERNEW: Exactly. I think the question is
8 what your penalty is relative versus what you're being
9 reported as, and the cohort approach --

10 DR. MARK MILLER: Take it over, Mike.

11 DR. CHERNEW: No, I'm just going to get it wrong.
12 I think the cohort approach was designed to have the
13 penalties reflective of the SES, but not mask your admission
14 rate when you report it to the public. So if you were to
15 adjust it and report an adjusted admission rate, the
16 reporting number to the public would be adjusted.

17 But if you don't adjust for it and just -- we're
18 trying to do just the -- I would say, they're trying to
19 adjust the penalty, but not the actual adjusted number, if
20 that makes sense.

21 DR. BAICKER: So then just to -- I want to make
22 sure that I understand the methodological niceties. It

1 seems like what you're trying to achieve is having two
2 different things reportable, two different outputs, one that
3 does not, you know, mask these differences for reporting to
4 the public, and the other that takes them into account when
5 doing the penalty calculation.

6 I understand that distinction. I would think you
7 could make that distinction in lots of different functional
8 forms that you're using and that there's nothing magic about
9 this cohort method as opposed to other controls where you
10 could report partially adjusted outcomes with or without
11 that adjuster taken into account.

12 So that it's not -- it's just a functional form
13 difference. We're not changing anything fundamental.

14 DR. MARK MILLER: I understand, but if you put a
15 functional form into, you know, the regression work that
16 ultimately goes into the reported readmission rate, I still
17 think what you would be saying is, Here's your full
18 unadjusted readmission rate. I put some functional form in.
19 Here's your adjusted one. And that would be less than --
20 otherwise it has no effect -- what your raw readmission --
21 and, of course, none of it is raw, it's risk-adjusted --

22 DR. BAICKER: Sure, sure.

1 DR. MARK MILLER: -- but not for income. And it
2 would still kind of bring that number down and, in a sense,
3 say, Some of this difference is going to not be reported.

4 DR. BAICKER: I think we're saying the same thing.
5 I just want to be clear that in reporting those two
6 different numbers or in using those two different numbers,
7 one that adjusts and one that doesn't, that's the way we're
8 handling this sticky-wicket of differences by SES, whether
9 it's measured by SSI or any other variable. It's that
10 difference in reporting that's the way we're handling it,
11 not the fact that we're looking in cohorts, because looking
12 in cohorts versus putting in controls, it's all the same.

13 DR. STENSLAND: I think there is a difference
14 because you can do it two different ways. You're saying,
15 Well, let's just put it in there and run two different
16 regressions, basically.

17 DR. BAICKER: Or run one regression, but report
18 results that are either partially -- that are either fully
19 adjusted for the model or only adjusted for the parts we
20 want.

21 DR. STENSLAND: Yeah, but you're basically then,
22 because we want to publicly report the one that doesn't have

1 the SES adjustment in there, that would be one review models
2 of outcomes. The other model is when it's in there, you'd
3 have a different outcome. So I think that is one
4 difference.

5 The way we're doing it, there's really only one
6 number out there, because we're coming up with, this is your
7 readmission rate and you're compared to this cohort of
8 people, but you only have one number. So I think if we ran
9 two different models or a model with and without SES, then
10 you have two different numbers floating out there which
11 could create some --

12 DR. BAICKER: Although the two different numbers
13 are really just the one number and the difference between
14 that and your cohort, in essence. So there's still two
15 things going on. There's you and there's your cohort that
16 adjusts for everything within that bin.

17 I just don't want it -- I just don't want us to be
18 misled about -- not misled. But what I want is to be clear
19 on what it is that we're doing in terms of whether we think
20 it's okay to take these variables into account or not.

21 DR. MARK MILLER: And with some real license in
22 going through the detail here, I think I agree with you that

1 you adjust inside the model, you do this cohort thing up to
2 that point. Yeah, that's the same thing. You're sort of
3 giving consideration to a hospital that has a bunch of poor
4 folks. Up to that point, I completely agree with you.

5 I think that the two places where we feel that
6 it's different -- and for the record, our policy is magic.
7 I want to be clear on that point.

8 DR. BAICKER: Excellent. Withdraw my question.

9 DR. MARK MILLER: Yeah, right, because that's all
10 I've got at this point.

11 [Laughter.]

12 DR. MARK MILLER: -- is the transparency of the
13 number and, you know, whether it's one or two, whatever the
14 case, and the continued pressure to change if you end up --
15 you know, the penalty of somebody with very few poor people
16 may be bigger than the penalty for hospitals that have a lot
17 of poor people. But within here, we still think there's
18 some pressure to change their behavior. That, we think, is
19 fundamentally different about the policy, not the measure.

20 DR. BAICKER: And that's where I feel -- and I'll
21 stop with this iteration and we can talk about it more off-
22 line. But I'm with you on the first part, that it may be

1 easier to interpret this way and to have the one number
2 where there's this difference in going on sort of in the
3 background from the cohort, rather than two numbers might be
4 more transparent. I'm with you there.

5 But then the second part of your statement made it
6 sound like there was a more substantive difference in terms
7 of the pressure that was exerted, and there's where I don't
8 see the difference. But I would think that there's -- if
9 you're taking your SSI share into account in a regression
10 framework as opposed to in these cohorts, you're still
11 competing against others who have the same SSI share. It's
12 holding SSI share constant. That's the whole point of
13 putting it in the regression.

14 So I would think that the fiscal pressures would
15 be similar, but that -- I have no problem with this in terms
16 of transparency and if it's an easier way to report it and
17 calculate it, great. But let's not think that we're adding
18 extra pressure throughout the distribution. Then we would
19 be with an equivalent adjustment model.

20 DR. CHERNEW: Right. Can I just say, I think
21 there are probably other ways to try and accomplish the same
22 goals that are worth discussing. I think the cohort

1 approach is a simple way to try and accomplish things that
2 don't get accomplished by the simple functional forms they
3 use.

4 So when you open up the set of things you could
5 do, we probably could address it in other ways. There are
6 other problems with the cohort approach. You create seam
7 effects and other types of things that go on. So it's worth
8 discussing, but if you compare it to the existing way of
9 just sticking to the model linearly, then you don't have the
10 right functional form that we were trying to address.

11 MR. HACKBARTH: Peter.

12 MR. BUTLER: I'm not that anxious. This kind of
13 broadly fits into the pay-for-performance category except
14 it's don't pay for poor performance, as opposed to pay for
15 performance. I do get a little bit of a headache thinking
16 we have value-based purchasing blossoming, we have a
17 hospital-acquired condition, we have meaningful use turning
18 from carrots to sticks, all of which, by the way, are likely
19 to have some of these same kinds of explanatory variables
20 that we're going to want to address if there are unintended
21 consequences of where the money is flowing. Okay, that's my
22 only editorial comment.

1 My question is quite a different one. There's a
2 cap on individual institutions of 1 percent going to 2
3 percent going to 3 percent. I'm a little unclear if we
4 recommend or say, you know, let's make sure that the
5 improvement is credited, so to speak. What is
6 Congressionally required to be changed versus what is within
7 the discretion of CMS to grab hold of some of these thoughts
8 and execute them? Because the nature of what we might want
9 to lay out could be significantly different depending on
10 whether we're dependent on Congress voting on this versus
11 the Secretary.

12 MR. GLASS: Almost everything is in law. The
13 formula is in law.

14 MR. BUTLER: The amount that needs to be taken out
15 would automatically be the higher level unless they take
16 some action and say no. Right now it's .3 percent, for
17 example, in one year. Is there a -- what is the
18 Congressionally mandated amount of dollars?

19 MR. GLASS: Oh, no, I don't think -- the formula
20 is in law. The formula for computing the penalty is in the
21 law, not the -- there's not a target, I don't think, for how
22 much money comes out.

1 MR. LISK: The only thing that's in there related
2 to that is the 1 percent cap for the first year, 2 percent
3 next year, and then 3 percent afterwards, so 3 percent of
4 base operating payments, and then the expansion of the
5 policy to the four other conditions is what is in law that
6 the Secretary must do. But the formula is very prescriptive
7 in terms of what is -- how it's calculated and stuff.

8 MR. BUTLER: Okay. So I'm still a little lost
9 then on the formula in the sense that, let's say, all the
10 readmission rates went down to 10 percent nationally. Would
11 we potentially be in a position where it wouldn't have any
12 penalties at all then?

13 MR. LISK: No.

14 MR. BUTLER: Or the formula automatically
15 generates additional penalties?

16 MR. LISK: The formula continues to address --
17 it's penalties, and in fact, for certain types of
18 institutions, if you're -- if you have no chance of getting
19 there, if you're already really high on readmissions, you
20 have probably no incentive to reduce your readmissions
21 because you're going to be like spinning your wheels in the
22 process.

1 MR. BUTLER: That's good. Because then my only
2 point -- and I'll forego Round 2 which we may not have
3 anyway -- is to make it clear the distinction between what
4 automatically happens by law versus what the Secretary might
5 be able to do with reformulating the methodology.

6 MR. HACKBARTH: Late start or the snow day
7 phenomenon. Boy, we're a gabby group today.

8 [Laughter.]

9 MS. UCCELLO: We are going to have round two,
10 right, or not? Okay. Well --

11 MR. HACKBARTH: Scheduled for 8:30 tonight, at
12 this rate.

13 [Laughter.]

14 MS. UCCELLO: I had the same questions that Kate
15 had, although I think she put them much better than I would
16 have. So this comes under the "be careful what you wish
17 for" request, but if there are additional conversations
18 about this, I would like to be kept in the loop.

19 DR. HALL: I'll be brief. David and Mary and
20 Glenn alluded to the fact that there may be other things
21 going on in the health care system that might be alleviating
22 the problem of excessive readmissions, mainly bundling,

1 moving to Accountable Care Organizations, et cetera. And
2 your own data suggests that there's some inexplicable drop
3 there that hasn't been explained necessarily by legislation.

4 What do we know about some of the pioneer
5 Accountable Care Organizations where there are some data?
6 Are we seeing a difference in 30-day readmissions that might
7 inform us a bit?

8 DR. STENSLAND: I don't remember readmissions, but
9 the overall number of admissions, there wasn't much of a
10 movement.

11 DR. HALL: That might be worth looking at, I
12 think.

13 DR. REDBERG: So I came in with two, but now that
14 it's gone all around, I have a few more, but I'll just stick
15 with these two for now.

16 So one is on Slide 16, you know, on the
17 hypotheses. I just want to suggest, and it's related to the
18 question, another hypothesis which is kind of the opposition
19 of Hypothesis 1 is that the reason there's no relation --
20 it's inversely related is because patients that take very --
21 hospitals that don't -- that take poor care of their
22 patients, they die, so they have low readmissions but a high

1 mortality rate.

2 So related to that, though, what is -- and you can
3 answer this offline, too -- is in the risk adjustment,
4 because right now, I only know that SES or some things are
5 not. But I'm not clear on what is in the risk adjustment.
6 But it does argue, certainly, for going toward a more
7 bundled measure of readmissions and mortality, at least for
8 heart failure, where it does seem to be -- of course, I
9 guess if we go to the all condition measure, we'd have to
10 look at whether that was overall true or not true for all
11 condition.

12 MR. GLASS: That is -- on page 24 of your mailing
13 material there, it shows that when you go to the all
14 condition measure and the more inclusive mortality measure,
15 the effect goes away. It's no longer a statistically
16 significant.

17 DR. REDBERG: Even for heart failure? I couldn't
18 --

19 MR. GLASS: Oh, no, no, not for heart failure, but
20 for -- as a --

21 DR. REDBERG: Oh, okay.

22 MR. GLASS: -- if you go to the total mortality

1 total, then that goes away.

2 DR. REDBERG: Okay. You can answer it some other
3 time about what is the risk adjustment.

4 And the other question I had, of course, is on
5 page 13 in the mailing materials, do you have some feeling
6 for why major teaching hospitals were in the high penalty
7 area? Do you think -- was it related to the kind of
8 patients they take care of or the kind of care or --

9 MR. LISK: They are high -- they, on average,
10 treat more -- they have a higher SSI patient share, which is
11 consistent with what we show here, and so more low-income
12 patients could be one factor. There could be other factors,
13 probably, too, but --

14 DR. REDBERG: They would be higher than government
15 hospitals, because that had the lowest penalty.

16 MR. LISK: The reason here is this is also
17 adjusted -- this is actually the actual payment effect.

18 DR. REDBERG: Oh.

19 MR. LISK: So those hospitals are already
20 receiving high DSH payments --

21 DR. REDBERG: Oh.

22 MR. LISK: -- so a lot of the numbers we presented

1 to you today are just base operating payments, so we don't
2 show the effect of DSH payments or IME payments on what the
3 penalty would be. So these numbers here on Table 13 are
4 showing that effect. So the government is lower, in part,
5 because they get a lot of DSH money.

6 DR. REDBERG: I see. Thank you.

7 MR. HACKBARTH: Okay. We'll do a quick round two,
8 he says, hopefully.

9 [Laughter.]

10 MR. HACKBARTH: A question based on Dave's round
11 one question about the resources that go into this. One of
12 the ideas that you laid out for dealing with the small
13 numbers problem was giving hospitals the option of pooling
14 and being evaluated as part of a pool. And Dave's comment
15 struck me as, well, maybe some of the necessary resources to
16 deal with transitional issues and the like could be handled
17 more efficiently on a pooled basis than an individual
18 hospital basis. So why not give all hospitals an
19 opportunity to say, we want to be evaluated as a pool?

20 DR. STENSLAND: Makes sense.

21 MR. GEORGE MILLER: [Off microphone.] -- system,
22 and if you're not part of a system, the small hospital, you

1 don't have that opportunity, so your point is very well
2 taken.

3 MR. HACKBARTH: George, round two.

4 MR. GEORGE MILLER: Just quick for round two. I
5 want to say I like the idea of eliminating the penalty, but
6 the question would be, what would be the national rate that
7 we'd use, so I'll just put that out there, expressing a
8 concern.

9 And to Herb's point about the JAMA study and what
10 the CMS and the Yale measures, aren't there planned
11 readmissions and are they included? I think the JAMA
12 excluded them, but the CMS/Yale did, and if I remember
13 correctly, 43 percent of the JAMA said they did not come
14 through the ED, but the Yale/CMS model had nine percent,
15 which led me to believe that the different models had a
16 different planned readmissions than the other. And so the
17 CMS/Yale model used the lower. So I would think that would
18 change the data and change the impact.

19 And then back to Kate's question, why not use dual
20 eligibles instead of SSI in your formulary?

21 MR. LISK: On the planned --

22 MR. GEORGE MILLER: Yes.

1 MR. LISK: The different models treat planned,
2 potentially preventable, differently. The current
3 readmission measures used right now basically include all
4 cause readmissions, so even planned readmissions are
5 included in most cases, except for a few exceptions in AMI.
6 But the new Yale/CMS all condition measure does eliminate a
7 selected set of planned readmissions.

8 MR. GEORGE MILLER: Why?

9 MR. LISK: Because they are planned, so they're
10 going to be readmissions that are going to be -- so it's
11 someone who has --

12 MR. GEORGE MILLER: But there may be a good reason
13 for --

14 MR. LISK: -- for surgical. So, no, they're not
15 going to be counted as a readmission.

16 MR. GEORGE MILLER: Oh, you're not counting them?

17 MR. LISK: No. When you have the planned --

18 MR. GEORGE MILLER: Okay.

19 MR. LISK: So the readmission measure is -- so the
20 title readmission measure is for unplanned readmissions,
21 okay? So planned readmissions are excluded.

22 DR. MARK MILLER: This is a really important point

1 worth repeating for the public, just not so much George at
2 this point. We're trying to be really careful to say two
3 things. All conditions, avoidable or preventable, whatever
4 your word is, we're thinking it's really important that
5 hospitals, that there should be some effort when you
6 construct the measure to remove those readmissions that are
7 expected to occur or not really open to being prevented.

8 And I just say this very carefully because the
9 word "all cause" gets thrown around and that generally is
10 put it all in there, and we're saying, don't put it all in
11 there.

12 DR. NERENZ: Okay. Let me just repeat my "yes"
13 answer to your question to us about is this going in the
14 right direction. Yes. I am most significantly focused on
15 the question of the social demographic, socio-economic
16 adjustors and the fact that we are proposing a way to do
17 that, I think is a very, very important and good thing. I
18 would -- so, yes, I like that.

19 There may be additional things even beyond this
20 just to keep in mind as this continues to go forward. I'm
21 thinking this may tie into Kate's earlier comment about the
22 factors that are most directly in a causal path, so to

1 speak, about why a readmission occurs. I draw your
2 attention to low literacy, limited English proficiency just
3 as two examples. I know that you don't go there first
4 because we have limited data at the individual patient
5 level, but on those factors or other similar, we have data
6 at the community level.

7 So now tying back to Glenn's comment, if we are
8 willing to consider the concept of building some adjustment
9 or cohort identification based on community-level factors,
10 then I think some other opportunities open up and I would
11 suggest that you look at those. I think that might take us
12 even farther down the road.

13 DR. NAYLOR: So a 2008 recommendation that results
14 in a policy and now leads to refinement, kudos. And this
15 paper and your presentation, for someone who actually knows
16 a little bit about this, just highlights the complexity of
17 the issues. You did a fantastic job of making that clear.

18 So on the recommendations for refinement, I think
19 pursuing all condition preventable is really a very
20 important target, not just from the capacity to increase the
21 observations, but because we're seeking policies that get us
22 to all system redesign and not just focused on specific

1 conditions, but we know people come back with heart failure
2 50 to 60 percent of the time for something else. So I
3 really like that.

4 I also, in my comments, I think SES is a very
5 important -- and the way that you're attempting to model
6 that, but building on Dave's comments and my earlier
7 questions, whether or not we can continue to work on the
8 refinements about what it is that helps us to understand
9 who's complex and where other adjustments might be made.

10 And on the issue of mortality, I have lots of
11 questions and concerns about that, but hope that we will
12 think about quality, other quality measures rather than
13 mortality. They are measured differently, mortality, zero
14 hospital admission to 30 days and readmissions discharge.
15 And so I think that there are other options there. Thank
16 you.

17 MR. GRADISON: I want to raise a question about
18 one of the objectives that's listed on page 14. I have
19 serious questions about starting off, at least, with the
20 idea that it should generate savings that are equal to or
21 budget neutral. We don't generally do that. Remember our
22 hospital recommendations the other day actually talked about

1 an increase, which would not be budget neutral because we
2 felt the hospitals had been dinged enough already towards
3 the end of last year. And I'll tell you, I really think
4 that this would be counterproductive to start off with this
5 objective.

6 The point has already been made, and I want to
7 repeat it because I think it's very important, so long as --
8 unless you assume that all hospitals eventually get to zero
9 in terms of potentially preventable readmissions, there are
10 going to be some above the mean and some below the mean, or
11 average, whichever way we do it. That means that for some
12 group of hospitals, it's not going to make any sense
13 financially for them to incur incremental costs to try to
14 reduce the rate of readmissions because they're not going to
15 have a chance to reduce the penalty. And I think that's a
16 very -- I mean, I think that's sort of self-defeating.

17 I mean, the more direct way to do this, if we are
18 able, if we are actually able to identify potential
19 situations where readmission can be avoided, then I think
20 the straightforward thing is that the penalty ought to be
21 basically we won't pay you for the readmission, period, and
22 everybody gets dinged to the extent that they fall within

1 that category. The response may be, well, we're not that
2 sure and it's judgment, but the judgment enters into anyway
3 in terms of the numbers of whether an admission is actually
4 potentially preventable. So we may come to a point of
5 wanting to be budget neutral, but I wouldn't start that way.

6 And I think it would be helpful as we move forward
7 on this to know a little bit more about how the scoring was
8 done under the ACA. My hunch is -- let me put it this way.
9 It's possible that this was written in order to obtain a
10 score, whereas other methods of doing it might not have been
11 as sure to be scored in that manner, and I'd like to know
12 more about the history of this because I think it sheds some
13 light on how Congress actually got to writing it the way
14 that they did. Thank you.

15 DR. MARK MILLER: Just to follow up on at least a
16 couple things that you said, and I'm going to say this, but
17 I may have misunderstood what you're saying, so just heads
18 up.

19 One of the things, and this is back in the day
20 when we were talking about this a few years back, we were
21 very focused on the notion of calculating a rate for the
22 hospital, because there can be some play, and there is some

1 judgment on an admission by admission basis and not applying
2 the policy for a specific admission, and then the notion of
3 how the penalty affected -- you didn't lose your entire
4 payment, necessarily. Your rate had to be fairly out of
5 line with the entire distribution.

6 I thought I heard you saying, and this is where I
7 want to be clear, if a given readmission is determined to be
8 avoidable, don't pay, and I think that's --

9 MR. GRADISON: Fair enough. Yes, I did say that,
10 although it could say you pay 50 percent. I think that
11 something less than the full amount that they would
12 otherwise get. We're limiting this to prospectively paid
13 hospitals, at least that's the current practice, so there is
14 a number that one could take a look at and say, well, we'll
15 pay you less.

16 DR. MARK MILLER: And that was the second point I
17 wanted to definitely get to, and I realize that we may have
18 set this up in a confusing way, certainly unintentionally.
19 When we're using budget neutral in this context, we're
20 saying that the Congress took an action that actually
21 results in savings. They executed a penalty, and we're
22 saying we're not going to eliminate those savings. In a

1 sense, we're saying, we're not trying to over-achieve more
2 savings or under-achieve those savings. We're trying to
3 remain consistent with what the Congress has already put in
4 place.

5 MR. GRADISON: My objective here, and this is
6 something that's been bothering me for many, many years
7 about Medicare policy in my old life, and that is budget --
8 generally speaking, my experience is that budget policy
9 drives health policy and not always in a very wise
10 direction, and that's really where I'm coming from and why
11 I'm raising the question. We may in the end want it to be
12 budget neutral. But to state at the outset that this is one
13 of our four criteria, four principles that inform these
14 refinements should be, I'm not prepared to do that yet.

15 MR. KUHN: Also answering your question, Glenn,
16 does this move us in the right positive direction, I think
17 it does, so I would agree with that.

18 And I'm really pleased that we are looking at
19 refinements only on the heels of this policy being
20 implemented, which began last October. Historically, when a
21 lot of folks review Medicare policy, it's four, five, six
22 years after it's been implemented. So the fact that we're

1 almost going concurrently to begin raising these issues, I
2 think, is helpful and useful to the program and those that
3 provide services through the program, principally hospitals
4 here.

5 I would just say that, as the conversation has
6 gone before, that I think the SES issue is a critical issue
7 and I like the recommendations that we have here. I do
8 think that SES presents a significant explanatory power in
9 terms of readmissions, and I think to have an unadjusted
10 rate, I think sends all the wrong signals to those
11 institutions that are serving a very difficult population
12 that's out there.

13 And so I think what we have here is a good
14 recommendation, but what I'd like us to see, maybe as we
15 move forward with this paper, if we could add some ideas or
16 thoughts based on some of the conversations we've had here
17 and perhaps others that there might be some other SES-
18 enriched models that we could look at into the future and
19 maybe give a little bit of lean towards this is one way to
20 do it, but there might be more refinements down the road,
21 and see if we can continue that conversation or at least
22 encourage others to continue that conversation down the

1 road.

2 DR. COOMBS: Thank you very much for the work
3 you've done. I appreciate the detail.

4 I think that this moves us in the right direction,
5 and I have some reservations about just the amount of data
6 that we have at our fingertips. And one of the things I
7 would like to see is for us to actually investigate this
8 whole notion of what happens when the patient leaves the
9 hospital. I think it's really important. It may be that we
10 discover that there's some really best practices that
11 hospitals will probably be motivated to pursue in avoidance
12 of any kind of penalty. And I think that's where we want to
13 be, not just to implement penalties without some kind of
14 change in the culture. And changing the culture means we
15 have all the data at our fingertips to say, this is like a
16 best practice.

17 I am concerned that, you know, you look at the
18 data and many of the charts and there's not a consistent
19 correlation with whether or not they're rural -- I mean,
20 there seems to be some propensity for rural, for academics
21 because of more of the SES penetration there, but it's not a
22 consistent for-profit, nonprofit, pattern there. And I

1 would be interested if there's something that we're kind of
2 missing that might lend itself to us changing the
3 environment for the beneficiaries.

4 So the data that I would recommend is looking at
5 the number of beds in general areas in terms of readmission.
6 And I think it's really true, because what happens at the
7 microscopic level in terms of in the emergency room does
8 matter in terms of the threshold to fill beds in terms of
9 occupancy, and those kind of things, I think, become very
10 important, that you might not want to incentivize in certain
11 areas. So there's another opportunity to make a difference
12 in terms of cost and quality for patients.

13 DR. HOADLEY: Thank you. This is really a good
14 chapter on some pretty complicated stuff, so thanks.

15 I do, as others have said, I think we are going in
16 the right direction on this.

17 I think one thing that might -- you know, a lot of
18 people here have been talking about what are the ways that
19 hospitals are responding to this policy and maybe this is an
20 area where a little more qualitative look at some of what
21 hospitals, in fact, have been doing and interacting with
22 some of the factors that we're putting up here. So would a

1 fixed known target be something that would encourage a
2 response in a different way than the way it's currently
3 structured, or the all condition measure versus the specific
4 areas. You know, is a hospital more likely to do that kind
5 of broad culture change that somebody mentioned versus, say,
6 oh, we've got a problem here with our cardiac patients and
7 we ought to go and do something specifically in that area,
8 or maybe it's all of the above. It might be some discussion
9 with some hospitals around the country in just terms of how
10 they are responding, how they would respond to some of these
11 alternatives.

12 And the only other thing I'd put up there, there
13 was a little bit of concern on the all condition measure.
14 Maybe it was Craig that mentioned it. If some of the larger
15 teaching hospitals, more complicated hospitals, by picking
16 up all the measures, there may be putting them at some
17 disadvantage, and whether there's any kind of a role for a
18 "most conditions" measure as opposed to an "all conditions"
19 measure, where you would take sort of all of the different
20 kinds of common things that kind of are broadly used across
21 all hospitals and aggregate them, but not necessarily
22 absolutely everything. So I don't really know what that

1 means, but I sort of throw it out there as something that
2 might be worth a little thinking.

3 DR. SAMITT: I think this is definitely going in
4 the right direction and I support all the recommendations,
5 actually.

6 My only concern is, while it's heading in the
7 right direction, I'm just not sure it's going far enough. I
8 have to admit, I'm underwhelmed by the progress to date in
9 reducing readmissions. It makes me wonder whether there are
10 reasons we're not seeing more progress. I'd echo some of
11 the questions raised earlier. You know, if the costs to
12 implement interventions that would reduce the readmissions
13 are greater than the reduction in the penalty, maybe
14 institutions won't do it as readily.

15 There was also some comment about if you start
16 with an ACO, then the physicians are already aligned around
17 the need to reduce readmissions and then now hospitals in
18 partnership because of this. I'd ask the other way around.
19 So if hospitals are now responsible for readmissions but
20 they're not in partnership with a physician group that's
21 aligned and there isn't an ACO, does that really hamstring
22 the hospital from really doing all the things they need to

1 do to reduce readmissions?

2 So I'm just worried about the lack of progress.
3 And while this solves the inequities of the penalty, I'm
4 just worried that it doesn't enhance the imperative to solve
5 this big problem, and maybe we just need to wait longer to
6 see if we see more progress over the course of the next few
7 years because it's still young. But I'm a bit impatient and
8 I'm thinking that we should probably do more.

9 DR. CHERNEW: So, first in response to that, I do
10 think the ACO is automatically aligned in some sense,
11 because they're responsible for the readmission even if it's
12 not at all related to them. But I think the broader point
13 is that in the spirit of what David said earlier, hospitals
14 are doing a lot of things and we sometimes talk about this
15 like this is the only activity that they should then focus
16 on.

17 And I think while I'm supportive of encouraging
18 reductions in readmissions, continued monitoring of its
19 impact on overall quality, along with monitoring overall
20 quality because of payment reform and a bunch of other
21 reasons, becomes crucially important.

22 And as long as we can maintain the recognition

1 that this is a small part of quality of care that now has a
2 separate system, but it's not the totality of care quality,
3 then I'm basically supportive of this. And I do think some
4 attention to the cohorts and the issues of the seam affects
5 and exactly what we're doing will require some more
6 discussion. But basically, I'm supportive.

7 MR. ARMSTRONG: Yeah, I too support the general
8 direction we are heading in and the principles that we're
9 using to evaluate the analysis that we're doing. I would
10 just add, I share Craig's point of view that while I think
11 it's very impressive right on the heels of implementing a
12 policy change where evaluating the impact of it and asking,
13 you know, how can we improve on that, we just have to
14 remember, this is -- readmission rates are a symptom of a
15 system that's not working very well.

16 And it's costing us and it's costing our patient
17 or beneficiaries in pretty severe ways. This is one more
18 example where the frustration of trying to deal with payment
19 policy tweaks on one small component of a system feels very
20 un-gratifying. That's our job and so we're going to do
21 that, but to the degree we can, you know, keep pushing this
22 forward of trying things and not over-analyze this and then

1 adjust, I think it's kind of an attitude I hope we try to
2 lean a little bit more toward, rather than worrying that we
3 need to get this perfect and do endless analysis until we
4 have exactly the right answer because we never will. We
5 just never will.

6 And then remember other payment reforms really, I
7 think, ultimately are going to be the better answer to
8 solving this problem.

9 MR. HACKBARTH: Scott, do you know your
10 readmission rate for Medicare patients?

11 MR. ARMSTRONG: I know my overall readmission
12 rate. And I know that I've taken it down by 30 percent over
13 the last three years.

14 MR. HACKBARTH: It might be -- you know, I think
15 there really are issues about focusing in on one particular
16 thing and trying to create the incentives versus the broader
17 approaches and I'm a fan of the broader approaches. We
18 embarked on this path as an opportunity to get started while
19 broader things developed and were put into place.

20 But there is this issue of how you make the
21 transitions. You don't want to apply all of your resources
22 into the narrow thing to the point they become a distraction

1 from the broader thing. That's an important strategic
2 question.

3 MR. ARMSTRONG: Just one additional point. I know
4 Mary's made this and others have as well. A very few of our
5 interventions to reduce readmission rates had anything to do
6 with the patient's care in the hospital. So, I mean, I
7 think that's part of the issue that we're dealing with.

8 MR. BUTLER: Said a little differently about the
9 importance, it's hard to believe June 2008 is when the
10 chapter was created that put this in motion. I'm not sure
11 it would have happened and PPACA without it. I mean, it
12 certainly was a helpful thing and people shouldn't forget
13 that some of these statements made at a certain time do have
14 a big impact.

15 For that reason alone, I think it's our obligation
16 to continue to try to get this right, because we've got to
17 set it in motion, and what's laid out there in this chapter
18 really does directionally help further refine. So I think
19 as a principle and how we've processed things, this is one
20 that we not only -- we have a responsibility, almost, to
21 stay after it to try to get it right.

22 MR. HACKBARTH: I certainly feel that. I'm sure

1 the staff feel it even more intensely, that to some extent
2 people see this as, Oh, this is a MedPAC idea. Don't you
3 dare, just to say -- walk away, say oh, never mind. So I
4 think that's a really important point.

5 On the other hand, we also have to keep in mind
6 that this wasn't the end goal. It's not a goal of itself.
7 It was part of a planned start the system moving and these
8 transitions, when you go from one approach to another are
9 really important ones.

10 My general feeling is that, you know, to use this
11 as an example, I want to create pressure here. I think it
12 is a problem. It's detrimental to beneficiaries. Let's use
13 this easier focus mechanism to draw attention to it. But
14 then let's start opening other doors that are broader
15 payment options that create more flexibility for
16 institutions.

17 You don't have to necessarily ever repeal this.
18 People will volunteer to say, Oh, this alternative is a
19 better approach than being accountable just for
20 readmissions. I want to be accountable more broadly. Cori.

21 MS. UCCELLO: So I am supportive of the direction
22 we're going in terms of the all-condition measure and

1 setting the target. I'm less comfortable with how we're
2 dealing with SES. I could be convinced that this peer group
3 way might be better, but I'm still concerned.

4 I'm especially concerned about talk of including
5 more SES-type measures into this process. Our goal here
6 isn't to explain readmission rates. It's not to predict
7 readmission rates. The goal of this is to improve patient
8 care, and allowing hospitals who treat certain patients to
9 have higher readmission rates I don't think gets at that
10 goal.

11 You know, one of our implicit, maybe not explicit,
12 goals here is to reduce disparities, and, you know, maybe in
13 this peer group way that can, I mean, maybe potentially get
14 at that if you're still applying pressure. But I'm
15 wondering if a way to do that better is to rather than
16 reducing penalties, is if these patients are more costly,
17 need more resources to care for, that we need to be thinking
18 more about how to address this from the up-front payment
19 side, rather than the readmission side.

20 DR. MARK MILLER: Now I just got a clarification
21 that I wasn't following earlier. So when we were having
22 this exchange, I was thinking you were saying you were

1 agreeing that maybe we should consider putting it in the
2 formula with some of the -- the concept. I don't know. And
3 you're saying no, and so that's a clarification in my
4 thinking about where you were.

5 And one of the things I wanted to remind you of is
6 the Commission did make a recommendation a couple of years
7 back -- I've forgotten now -- about how to target the QIO
8 money and say it should be going to hospitals that are
9 struggling with -- it could be viewed as saying hospitals
10 like this, to give them the resources to try and turn their
11 situation around, enough, not enough. You know, for the
12 moment, I'll be agnostic, but there is some thought in the -
13 -

14 MS. UCCELLO: And I completely agree with that and
15 maybe we need to reiterate that, you know, in this
16 discussion. And yeah, my initial reaction to this peer
17 group may or may not be this kind of the same kind of
18 ultimate thought that Kate was having, but it's like, well,
19 this just seems like a different way to risk adjust to me.
20 I'm not comfortable with risk adjusting so I'm not
21 comfortable with this different way of doing it.

22 DR. HALL: I think our discussion and what you've

1 done has been very informative and I think we're all saying
2 that we should look at readmission rates as a marker of
3 something. It may be a marker of good care sometimes
4 clinically, or may be a marker of bad care. It's like the
5 speech that every first-year medical student gets when the
6 professor gets up and says, 50 percent of what we teach you
7 is going to be wrong, but we don't know which 50 percent.

8 But we have to find markers to get to that 50
9 percent if we're going to reach this triple bottom line of
10 quality care, safe care, and cost effective care. So I
11 think we're doing the right stuff here. As long as we don't
12 think that it's an end in and of itself. I guess four or
13 five or six -- maybe we've all said that. Thank you.

14 DR. REDBERG: So, I wanted to say, overall I think
15 the policy has clearly, you know, moved us in the right
16 direction, in the right direction being better patient care,
17 because I think that is our goal. In terms of the
18 refinements, it does seem to me like an all-condition
19 measure would be better.

20 I wasn't here in 2008, but, you know, there is --
21 it seems -- especially because the correlations with the
22 reduction in readmission really correlated better with

1 potentially preventable readmission that might be a better
2 measure than all, because readmission -- and I have to say
3 that this penalty multiplier and the idea of adjusting,
4 although I understood the reason for it, I'm not sure that
5 that was overall a good thing, especially the penalty
6 multiplier which really -- you know, because if you have a
7 lower readmission rate, you get a huge multiplier and it
8 doesn't seem like what you want to be rewarding.

9 I mean, you always have the absolute and the
10 relative, which is why I don't think setting a target in
11 advance would necessarily be good, because like the example
12 you gave, if your readmissions were really high, you'd never
13 have an incentive to go lower because you're just not going
14 to get there.

15 And so, at some point, you know, we should
16 probably also look at, you know, have there been an increase
17 in observation stays at the hospitals at lower readmission
18 or an increase in readmissions that started on day 31 and
19 after.

20 But the other thing I have a comment on, on the
21 socioeconomic, again I think it's very tough. I mean, I
22 understand when I read the reason for not including the

1 adjuster was not to give hospitals a buy for not reducing
2 readmissions in low SES patients and that makes sense. But
3 I think the issue is, you know, kind of as Scott pointed
4 out, in his hospital, they reduced readmissions. It really
5 had nothing to do with what was happening in the hospital.

6 And I think a lot of, particularly in low SES
7 areas, it's not even in the health care system what's
8 causing readmissions. We're talking about huge social
9 problems, housing, education. Those aren't things that is
10 any -- no matter how great the health care system can try to
11 be, they're not going to address those other issues and
12 they're going to be penalized for it. So I think we need to
13 consider that.

14 MR. HACKBARTH: Okay. Good discussion and thanks
15 for the great work on this. And so, we will reconvene at --
16 sorry, sorry. I'm hungry. We'll have our public comment
17 period in just a second. My goal here is, we're
18 substantially behind, obviously, and so my goal here will be
19 to be back and started again by 2:15. With that in mind, we
20 will have a -- thank you, Mark. You're so sweet.

21 DR. MARK MILLER: Everyone says that.

22 MR. HACKBARTH: We will have a brief public

1 comment period, and help me get to real lunch, please, by
2 being brief.

3 MR. LIND: Very brief. Keith Lind, AARP. I just
4 wanted to address a comment that's sort of floating over the
5 discussion but hasn't really been nailed. I think we don't
6 really know where the lowest level of readmissions can go.
7 I think the point over here about we don't know which 50
8 percent is not the right 50 percent.

9 As you push down readmissions, at some point you
10 may see an increase in mortality. I think the Krumholz JAMA
11 article was reassuring. There's almost no relationship
12 between readmissions at this point. But as you drive it
13 down, somebody needs to be monitoring mortality rates, not
14 just quality. Quality absolutely, but mortality rates, too.
15 That should be a big, visible measure.

16 Thank you.

17 MR. HACKBARTH: Thank you all for not standing
18 between me and my lunch.

19 [Laughter.]

20 MR. HACKBARTH: So we will reconvene at 2:15.

21 [Whereupon, at 1:17 p.m., the meeting was
22 recessed, to reconvene at 2:15 p.m., this same day.]

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AFTERNOON SESSION

[2:16 p.m.]

MR. HACKBARTH: Okay. It is time to begin our afternoon session and first up is competitively-determined plan contributions.

MS. LEE: Good afternoon. The Commission has been considering reforming the traditional Medicare benefit to complement our ongoing work to improve the payment system and the health care delivery system. Last fall, we presented an overview of the concept we call competitively-determined plan contributions and today we continue our discussion on CPCs.

So let's begin with a very brief review of the two previous presentations on the topic. In September, we defined what we mean by CPCs, which refer to Federal contributions toward the coverage of the Medicare benefit based on the cost of competing options for the coverage. Also in September, we discussed some of the key policy issues that the Commission would need to consider under a CPC approach, such as should the benefit package be standardized and how should the Federal contribution be calculated? We won't go over them in the presentation today, but they are included in your mailing materials.

1 In November, Jeff and Carlos discussed the
2 relationship between provider prices and the cost of private
3 Medicare plans relative to fee-for-service Medicare.
4 Because a CPC approach first relies on competing options for
5 the Medicare coverage from private plans, the factors
6 affecting their costs are important.

7 Today's presentation is in two parts. First,
8 we'll quickly go over the conceptual framework of a CPC
9 model, and second, we'll present a preliminary analysis of
10 private plan bids and availability using current MA bids as
11 a starting point of the analysis. We want to emphasize that
12 we made many simplifying assumptions that may be unrealistic
13 if the design of a CPC model diverges from the current MA
14 system. We'll discuss them in more detail later in the
15 presentation.

16 Before we get to the analysis, let's briefly
17 review what happens in a CPC model and the context in which
18 we need to look at what these plans do.

19 There are three main actors in a CPC model. One,
20 the Medicare program designs the model and makes the rules
21 for determining the CPC contributions and plan payments.
22 The program's goal is to design a system so that private

1 plans have the incentive to lower their cost and to bid
2 close to their true cost and the beneficiaries have the
3 incentive to make cost-conscious choices. Additionally,
4 Medicare will continue to manage and set fee-for-service
5 payment rates.

6 Now, given these rules, private plans make their
7 business decisions, such as whether to enter or exit a
8 market, and if they decide to enter, then how much to bid
9 and what benefit designs or products to offer.

10 And finally, given the options for the Medicare
11 benefit at the prices offered by the plans, beneficiary
12 choose how they will get their Medicare coverage. Because
13 their individual premiums depend on their choice under a CPC
14 model, they will have to trade off the benefit and cost of
15 what they wish to buy.

16 Our analysis today focuses on the second actor,
17 private plans, and tries to understand where private plans
18 might be available and what their bids might be. As a proxy
19 for plan bids and availability under a CPC model, we used
20 the data from MA plan bids for 2013 and we organized those
21 bids at the level of payment areas to best approximate the
22 insurance markets served by private plans.

1 The definition of payment areas are based on the
2 Commission's recommendation from 2005. I will return to a
3 more detailed discussion of payment areas in the next slide.

4 As we mentioned at the beginning of the
5 presentation, we also made several simplifying assumptions
6 in our analysis. First, we assumed the same plans would
7 participate at their current bids. In other words, we
8 haven't adjusted for potential new entry and exit and
9 different bidding strategies if the CPC rules were different
10 from the current MA rules. We also assumed that plans have
11 the capacity to serve the payment area.

12 So let's go back to the definition of payment
13 areas used in our analysis. Under current law, MA plans
14 choose the counties that make up their service areas. In
15 2005, the Commission recommended combining counties into
16 larger payment areas consisting of MSAs and Health Service
17 Areas outside the MSAs. Health Service Areas are defined by
18 where beneficiaries receive most of their short-term
19 hospital care.

20 The goal of the recommendation was to define
21 payment areas that reflect more accurately the insurance
22 markets served by private plans. This definition of payment

1 areas means that, for our analysis, we need to convert
2 current MA bids, which are at the level of service areas,
3 into recalculated bids at the level of the payment areas.
4 This process involves quite a few steps, and now Scott will
5 describe exactly what they are.

6 DR. HARRISON: As Julie described, calculating
7 plan bids at the payment area presents complications and
8 requires that we make a few big assumptions. Remember that
9 plans currently submit bids for service areas made up of one
10 or more counties that each plan chooses for itself. Those
11 service areas can be smaller than one payment area or could
12 span many payment areas, so our task is to attribute the
13 bids for the service areas to the new payment areas that
14 Julie defined.

15 First, we assume that the bids the plans submit
16 are constant over their entire self-selected service area,
17 meaning that the plans are making the same bid for each of
18 the payment areas within their service area.

19 Then we eliminate some bids for some payment areas
20 because we assume that the bid doesn't really reflect the
21 plan's true cost for the average beneficiary in the area.
22 Generally, we excluded bids from plans that are not

1 available to all types of beneficiaries, such as employer-
2 sponsored plans and special needs plans. These plans enroll
3 only certain subgroups of beneficiaries and, therefore,
4 would only reflect the cost of those subgroups. We also
5 excluded bids from plans who did not demonstrate they could
6 offer enough capacity in the payment area. Thus, we
7 excluded bids from plans that did not project significant
8 enrollment in the area, and also, we only accepted bids from
9 plans for areas where the plan was available to the majority
10 of the beneficiaries in the area. There is more detail on
11 the methodology in the paper and I can give more details on
12 question.

13 This slide summarizes the payment areas in the
14 plan bids that result from our assumptions. We end up with
15 1,229 payment areas and fee-for-service spending averages
16 \$784 per month. Looking at the second column on the table,
17 most payment areas have average fee-for-service spending
18 between \$690 and \$825 per member per month. And looking at
19 the lower right of the table, 61 percent of the
20 beneficiaries live in payment areas that average more than
21 \$750 in monthly fee-for-service spending.

22 As for bids, our final sample included 1,550

1 independent bids. Most bids span more than one payment
2 area, and after the exclusions, there is an average of four-
3 and-a-half bids per payment area.

4 However, our data leaves us with 167 payment areas
5 containing about two percent of all beneficiaries where
6 there are no bids. This result is somewhat different from
7 the current state of play, where less than half-a-percent of
8 beneficiaries do not have a plan available.

9 Here, we have displayed the average bid, as well
10 as the tenth and 90th percentile bids, for groups of payment
11 areas that we described. We see that, as expected, the
12 average bid rises as fee-for-service spending in the area
13 increases. The lowest group of payment areas, those with
14 average fee-for-service spending under \$645, have average
15 bids of \$701 per month. And those areas with spending over
16 \$900 have bids that average \$762. So while the bids do tend
17 to rise, they do not rise as fast as fee-for-service
18 spending.

19 Now, as I showed you on the last slide, bids rise
20 as fee-for-service spending rises, but you can see clearer
21 here that the ratio of the bid to fee-for-service declines
22 as fee-for-service spending rises.

1 The three groups of payment areas shown on the
2 left with fee-for-service spending under \$750 have average
3 bids that exceed local fee-for-service spending, illustrated
4 by the average ratios over one that go from 1.14 down to
5 1.01, which are the yellow numbers. The three groups of
6 areas over \$750, as shown on the right, have average bids
7 below fee-for-service, shown by average ratios below one and
8 as low as 0.79 for the highest fee-for-service spending
9 group. The main lesson from the chart is that plans often
10 bid considerably less than fee-for-service in areas where
11 fee-for-service is relatively high, but tend to bid higher
12 than fee-for-service in low-spending areas.

13 So we took the bid data that I've just described
14 and used it to determine the Federal contribution under a
15 couple of illustrative scenarios. We also looked at the
16 results from setting the contribution at 100 percent of fee-
17 for-service spending in the local payment areas as a base of
18 comparison. Local fee-for-service spending ranges from \$543
19 to \$1,335, averaging \$784 per month. And, of course, fee-
20 for-service always has a ratio of one with itself, so those
21 next three numbers are all one. And our data have 86
22 percent of beneficiaries living in payment areas where at

1 least one private plan is bidding below fee-for-service, but
2 availability will vary geographically.

3 I should note that, currently, virtually all
4 beneficiaries have plans available, but in some areas, plans
5 are bidding above fee-for-service and the program is
6 subsidizing them by contributing more than fee-for-service,
7 so that's why currently we have more than 86 percent of
8 beneficiaries with plans available.

9 Under the next scenario, we consider local fee-
10 for-service as a plan bid, calculate the average plan bid,
11 including fee-for-service, and set the Federal contribution
12 to that average. The average contribution under this
13 scenario would be \$763, which is about 98 percent of fee-
14 for-service. Because plan bids can be above or below fee-
15 for-service, the contribution set by combining the plan bids
16 and fee-for-service can result in the Federal contribution
17 being above or below one, as you can see from the ratios.
18 Because the contribution can be above fee-for-service, we
19 see an increase in the number of beneficiaries living in an
20 area where at least one private plan is bidding at or below
21 the Federal contribution.

22 Under the last scenario, the Federal contribution

1 would be set at the lesser of the average plan bid in the
2 payment area or the average fee-for-service spending in the
3 area. Here, fee-for-service is not included in the average
4 bid. The average contribution would be \$727, or about 93
5 percent of fee-for-service. Here, because under this
6 scenario the contribution is not allowed to go above fee-
7 for-service, the ratio to fee-for-service never goes above
8 one. Even though the Federal contribution is seven percent
9 less than the 100 percent fee-for-service scenario, the same
10 percentage of beneficiaries, 86, live in an area where a
11 private plan bids at or below the contribution.

12 Now, let's look at how these scenarios might
13 affect the beneficiaries. As with the plan bids, we are
14 showing static effects. We did not model any beneficiary
15 behavioral responses to new premiums. It is very likely
16 that beneficiaries would move to less expensive plans if
17 they were available. The results here, however, assume that
18 beneficiaries stay in fee-for-service or whatever plan that
19 they are currently in. We also assume that any change in
20 the Federal contribution would be fully offset by a change
21 in the premiums paid by the beneficiary. We show the
22 changes separately for beneficiaries in and remaining in

1 fee-for-service and for plan enrollees who are assumed to
2 remain in their current plan.

3 Looking at the first line, enrollees in fee-for-
4 service Medicare would not see any changes in premiums if
5 the contribution were set at local fee-for-service spending.
6 However, as plan bids are below fee-for-service, on average,
7 many plan enrollees would get premium rebates, which would
8 average \$56 per month in the absence of any enrollment
9 changes. Some plan enrollees would get much larger rebates,
10 but enrollees in some plans would see premium increases.

11 Under the scenario where fee-for-service is
12 considered a plan bid, fee-for-service beneficiaries would
13 see an average premium increase of \$10 per month, but
14 beneficiaries in some areas would get rebates. Plan
15 enrollees under this scenario would see an average rebate of
16 \$35, but some enrollees would have to pay additional
17 premiums, assuming they did not switch plans.

18 The last scenario, which lowers the Federal
19 contribution the most, would raise premiums the most, by \$53
20 per month, on average, for fee-for-service beneficiaries.
21 Ten percent of fee-for-service beneficiaries would see
22 premium increases of \$154 per month, assuming they remain in

1 fee-for-service.

2 Now, looking at the plan enrollees, while some
3 would receive premium rebates, the average premium for
4 enrollees would rise by \$17, and ten percent would see their
5 premiums rise by at least 97 percent, assuming they did not
6 switch plans.

7 DR. MARK MILLER: [Off microphone.]

8 DR. HARRISON: Ninety-seven dollars. Sorry.

9 MR. HACKBARTH: You said percent.

10 DR. HARRISON: Dollars. Sorry.

11 Well, that is our presentation for today.

12 [Laughter.]

13 DR. HARRISON: Next month, staff will present on
14 issues related to low-income beneficiaries, and now we are
15 happy to take your questions and comments on the methodology
16 and simulation findings, and you may wish to discuss
17 principles for determining the Federal contribution under
18 CPC.

19 MR. HACKBARTH: Okay. Good job.

20 Before we turn to questions about CPC, let me just
21 do a little housekeeping here.

22 In order to -- my goal is going to be to finish at

1 6 o'clock, so for anybody who needs to tell dinner parties
2 their time of arrival, we're going to be finished at 6
3 o'clock. In order to do that, I'm going to do two things.
4 One is pare down the time a little bit for each of the
5 sessions on the schedule. And the second thing is that I'm
6 going to propose to speed up the process, and instead of
7 going around one by one for Round 1 clarifying questions,
8 I'm just going to open the floor for a few minutes to the
9 group at large, and raise your hand if you have a clarifying
10 question about a particular slide. And then -- not yet,
11 Cori. Boy, you're eager.

12 [Laughter.]

13 DR. CHERNEW: Cori has a question.

14 MR. HACKBARTH: So that's what we're going to do
15 on the schedule, and I'm sure we'll finish by 6:00.

16 Before we go to Cori, just one additional comment
17 for the audience, for people who haven't been following
18 MedPAC's discussions of this topic. We're using this phrase
19 "competitively priced contributions," and for some of you in
20 the audience, you may be saying to yourself, "Boy, this
21 sounds a lot like premium support" or some other legislative
22 proposal out there.

1 The reason that we're using this term,
2 "competitively priced contributions," is to avoid
3 terminology that already is closely associated with existing
4 proposals. We are not in the process of evaluating any
5 particular proposal but, rather, certain principles and
6 concepts that may or may not be appropriate for the Medicare
7 program. So we want to abstract ourselves from all of the
8 sometimes heated discussion that has existed about premium
9 support or vouchers or defined contribution and try to look
10 at this strictly from an analytic perspective in the first
11 instance. So that's where this name comes from.

12 Now we are ready to have clarifying questions, and
13 Cori is going to lead off.

14 MS. UCCELLO: So Slide 11, all of this is going to
15 take a little while to sink in for me, but the one question
16 I have here is, on the first row, the last column on the
17 right, that 86 percent, tell me again why that's not higher.

18 DR. HARRISON: Okay. What this says is that 86
19 percent of beneficiaries live in a payment area where at
20 least one plan is bidding at or below the contribution, one
21 private plan, so fee-for-service doesn't count.

22 MS. UCCELLO: Okay. That was --

1 DR. HARRISON: But, you know, there are -- that
2 number is currently higher, but a lot of the reason it's
3 higher is because there are areas where plans are bidding
4 above fee-for-service, but the current payment rates are
5 above fee-for-service.

6 MS. UCCELLO: So this last column is reflecting
7 private plans.

8 DR. HARRISON: Yes.

9 MS. UCCELLO: Okay. Thank you.

10 MR. HACKBARTH: I am too a little uncertain about
11 this. So this last row, Medicare fee-for-service isn't
12 counted in the calculation? I had thought that it was.

13 DR. HARRISON: Instead, it's the lower of the
14 average bid without fee for -- the row above we include fee-
15 for-service in the bid calculation.

16 MR. HACKBARTH: And in the last row it's fee --

17 DR. HARRISON: In the last row, it's the lower of
18 fee-for-service or the bids -- the bids without -- right?

19 MR. HACKBARTH: So the average is not calculated
20 with the private bids.

21 DR. HARRISON: It's the average of the private
22 bids and fee-for-service -- not the average. The lesser of.

1 MR. HACKBARTH: Yeah. You know, you could do it
2 the other way where fee-for-service is always calculated in
3 the average, but there's a cap. We never pay more than the
4 fee-for-service level. That's what I had thought initially
5 the last row was. But it sounds like you -- you've taken
6 the fee-for-service out of the calculation at the average.

7 DR. HARRISON: And just used it -- right.

8 MR. HACKBARTH: And just used it as an upper
9 limit.

10 DR. HARRISON: Yeah.

11 MR. HACKBARTH: Okay. Other clarifying questions?

12 DR. SAMITT: So I'm on page 12, and I'm trying to
13 understand how the percentiles compare from the current fee-
14 for-service beneficiary box to the current plan enrollee
15 box. And so if the presumption is that I as a beneficiary
16 can choose fee-for-service or choose a plan, can I -- is it
17 fair to say that I'm comparing percentiles against each
18 other? So as I look at this and I analyze these boxes, I
19 would say for the most part, assuming the percentiles align
20 in each of those boxes, if I have a choice, I'm going to
21 choose a plan, not fee-for-service, in every scenario other
22 than if I'm in the 90th percentile in the fee-for-service

1 area today, so 100 percent local fee-for-service and average
2 bid. So I think I'm having a hard time understanding that
3 as a beneficiary, knowing that I have a choice, how would I
4 use this information to make decisions?

5 DR. HARRISON: This doesn't set up choices for --
6 this assumes that everybody stays where they are.

7 DR. SAMITT: Okay.

8 DR. HARRISON: And so living in different areas,
9 you're going to have different possibilities.

10 DR. SAMITT: Okay.

11 DR. HARRISON: In all areas --

12 DR. MARK MILLER: It's also true that the 90th and
13 the 10th percentile are not particularly comparable because
14 the people who make those up in each of the two different
15 boxes --

16 DR. SAMITT: Are different.

17 DR. MARK MILLER: -- maybe living in different
18 places.

19 DR. HARRISON: Right. Now --

20 DR. SAMITT: And that's what I was getting at.
21 They're not comparable.

22 DR. HARRISON: Right. Now, one thing to think of

1 is in all these scenarios, everybody in the country would be
2 able to get something, either fee-for-service or a plan, for
3 no additional premium. It just depends where you live what
4 it is you would be able to get.

5 DR. SAMITT: I see.

6 DR. HOADLEY: When you're calculating the plan bid
7 amounts, I assume you're not counting the drug expenses,
8 Part D?

9 DR. HARRISON: Correct. Yeah, just A-B.

10 DR. HOADLEY: And for the plan bid, are you making
11 any kind of adjustment for extra benefits added by the plan?

12 DR. HARRISON: No.

13 DR. HOADLEY: So everything's included.

14 DR. HARRISON: No, because when they submit a bid,
15 there's a piece of it that says this is for A-B.

16 DR. HOADLEY: Okay. So it's only the A-B part of
17 it.

18 DR. HARRISON: Right.

19 DR. HOADLEY: Okay. And then when you're making
20 the comparisons on, say, Slide 12, the fact that some
21 beneficiaries may have a rebated Part B premium, how is that
22 figured in?

1 DR. HARRISON: Yeah, that's not figured in. This
2 is really just a difference in premiums.

3 DR. HOADLEY: So they would just kind of --

4 DR. HARRISON: Whatever they had before, they
5 would sort of carry through.

6 DR. HOADLEY: It wouldn't be a negative premium to
7 pick up the fact that they also are getting some of their
8 Part B --

9 DR. HARRISON: Right, that's not figured in.

10 DR. HOADLEY: Okay.

11 MR. ARMSTRONG: This is a little bit off the
12 specific topic but related. Over the course of time, this
13 spread between the high-cost fee-for-service markets and the
14 low-cost fee-for-service markets, has that spread been
15 relatively constant? Or is it getting wider or is it
16 getting narrower?

17 DR. HARRISON: I think when -- the first time we
18 saw this in the late 1990s, I kind of thought there was like
19 a 3:1 or 4:1 spread between the high and the low county. So
20 maybe it's gotten a little bit better.

21 Go to the slide before. So now we're at -- no,
22 the other one, the 543, the min and the max. Well, it was

1 543 to 13 something. So I guess that's slightly better than
2 it used to be.

3 MR. ARMSTRONG: I mean, I'm just asking -- and
4 correct me if the way I'm thinking about this is wrong.
5 We're basing policy and pricing for these prospective
6 products on the basis of average fee-for-service cost in
7 different markets. And it just kind of presumes that -- it
8 is what it is. I know that. But it kind of ignores the
9 fact that that's a pretty spectacular range, and it in and
10 of itself implies there's something wrong. But I don't know
11 if maybe it's getting better or worse over time. Anyway,
12 like I said, it may not be relevant to this particular
13 topic, except for the fact that it is a basis upon which
14 we're thinking about how we might structure the benefit.

15 MR. HACKBARTH: Just to be clear, put up one of
16 the tables that you had up with the different approaches for
17 calculating the contribution. If you use the calculation in
18 the first row, then basically you're sort of locking in this
19 wide distribution. As you move to the second row, then you
20 would be starting to compress the government contributions.
21 So you're putting your finger on something which is one of
22 the central policy choices here. It's a big issue.

1 MR. ARMSTRONG: Yeah, and I think I'm tipping my
2 hand to my bias around this, obviously, but --

3 MR. HACKBARTH: Let me guess.

4 [Laughter.]

5 MR. ARMSTRONG: Yeah, but I guess it's a
6 completely different issue. You know, what are we doing to
7 confront the fact that there is this huge variation in the
8 average fee-for-service cost in different markets?

9 MR. HACKBARTH: Yeah, and, you know, a little
10 digression here I think is useful. So the huge variation
11 has been a topic for a long time, and one of the things that
12 the Congress tried to do with Medicare Advantage by creating
13 the system of benchmarks was to have less variation in the
14 payments to Medicare Advantage plans than existed in fee-
15 for-service. And as a result, in some areas of the country,
16 including, I think, Seattle, we were paying Medicare
17 Advantage plans significantly more than the underlying
18 Medicare fee-for-service costs. And so they tried to use
19 Medicare Advantage as a redistributive mechanism to address
20 perceived inequities in Medicare fee-for-service payments.

21 The problem is that doesn't work. What you end up
22 is you pay really high amounts under Medicare Advantage in

1 some markets of the country, including Bend, Oregon, and
2 private plans get paid a lot of money and Medicare
3 beneficiaries get a lot of benefits for doing nothing, for -
4 -you know, even private fee-for-service plans.

5 So trying to redress the imbalance in regional
6 payments through Medicare Advantage alone while Medicare
7 itself is on the side doesn't work. It creates a whole
8 different set of problems.

9 These pricing schemes, like the second row, would
10 say, well, if you really want to redress regional imbalances
11 in Medicare, you have to include Medicare fee-for-service in
12 the bidding. And then you have a structure where you can
13 start to say, oh, this huge range is going to be reduced.
14 And there are a lot of different ways that you can do it.
15 You could use blends of local and national average bids and
16 gradually move towards equalization or a lot of different
17 variations. But it is one of the central policy questions
18 here. Are we going to try to use this as a mechanism to
19 redress regional differences in payments?

20 DR. HOADLEY: A quick follow-up on that point [off
21 microphone]. If you did the second -- so the first or the
22 second row on the mins and maxes goes to just the point

1 you're talking about. So fee-for-service today ranges from
2 543 to 1335. But the second row is the average of bids plus
3 fee-for-service, so I assume there's a fair amount of fee-
4 for-service, those are weighted averages. Do you know what
5 the second row would look like if it was only the average of
6 bids or approximately what it would look like? Because that
7 would sort of go to how much range of variation is there
8 just on the MA side?

9 DR. MARK MILLER: [off microphone].

10 DR. HOADLEY: Is that -- okay.

11 DR. HARRISON: That shows you the range of bids.

12 DR. HOADLEY: Okay. So from six something at the
13 min end -- or that's actually the 10th percentile, but --

14 DR. HARRISON: Yeah.

15 DR. HOADLEY: So it's not quite, but -- okay.

16 Thank you.

17 DR. MARK MILLER: But as a matter of just to bring
18 a line of sight, we can tell you the variation on the bids
19 and the variation on fee-for-service, put it in a table, and
20 put it in the paper. Okay? So that's certainly one
21 takeaway from this.

22 MR. HACKBARTH: Okay. Other clarifying questions?

1 [No response.]

2 MR. HACKBARTH: Okay. Hearing none, we'll move
3 now to Round 2, and, Rita, do you want to lead off?

4 DR. REDBERG: Sure, and just thank you for all of
5 this. I'm still trying to digest it. But what would be
6 helpful, besides looking at the difference in bids, is if we
7 had any data on outcomes and how the private plans do
8 compared to fee-for-service, so that we kind of can get some
9 feeling for the value for the spend. What kind of outcomes?

10 DR. HARRISON: Got any suggestions on how to
11 measure that?

12 DR. REDBERG: Well, I mean --

13 DR. HARRISON: In our quality discussions, we've
14 tried.

15 DR. REDBERG: -- you could either do mortality or
16 condition specific, you know, I think --

17 DR. HARRISON: But you're thinking quality kind of
18 measures?

19 DR. REDBERG: Yes. Well, like, how are patients
20 doing. Yeah, so quality outcome kind of measures, not
21 process, like not how many tests they're getting but how --
22 you know, are they having less hospitalizations, less

1 readmissions, dying less, less MI, less stroke, things like
2 that.

3 DR. HARRISON: Craig usually starts with this
4 question, but the encounter data from -- we don't have any
5 encounter data from plans yet, so we don't know what goes on
6 inside. We expect that we may get some in a few months.

7 DR. REDBERG: Right.

8 DR. HARRISON: They started collecting it at the
9 beginning of 2012, so hopefully we will have something in
10 the not too distant future that we can look at.

11 DR. REDBERG: Great.

12 DR. HARRISON: But it is unlikely before --

13 DR. REDBERG: The next meeting?

14 DR. HARRISON: The next meeting, yeah.

15 DR. REDBERG: Thanks.

16 MS. UCCELLO: I'm still processing this myself,
17 but in future steps, is there a thought that that's going to
18 move beyond the static analysis and incorporate any kinds of
19 switching? Or is this really just to show, all right, this
20 is what people would face if they just stayed where they
21 were?

22 DR. MARK MILLER: All right. The way to see

1 what's going on right now in the short term is we're
2 building a chapter for June, so we have all the stuff from
3 the fall and we did this analysis and that analysis, and
4 this would be another step in that. And for the purposes of
5 June, the answer would be no.

6 Also, even going forward, it's very complicated
7 and very open to -- and I know you know this --
8 interpretation as to how you make those assumptions. We can
9 take it under advisement, and Glenn is probably going to say
10 something in a minute. But this gets a lot harder when you
11 start making those kinds of --

12 MS. UCCELLO: Or is there another way to maybe
13 display the choices that people face other than if you stay
14 -- I mean, these are just averages of, well, if people stay,
15 the range in saving this or spending more of that, is there
16 another way to kind of look at the range of choices
17 incorporating both sides of this.

18 DR. BAICKER: Sorry to jump in, but to follow up
19 on that, I had wondered whether you might be able to display
20 in the static framework something like the distribution of
21 savings available to people were they to switch. Without
22 saying how many people were going to switch, you could say

1 here's how many people could have their payments lower,
2 here's how many people could save \$100 or here's how many
3 people could save \$200 without making a judgment about
4 whether they would. And then a complement to that would be
5 to add to that a row to the table that said what if instead
6 of pricing at -- you know, the contribution being at the
7 average of the bids, what if it was at the 25th percentile
8 or some other amount, which would be another way of showing
9 the range of savings to people available without making a
10 judgment?

11 MR. HACKBARTH: Let me pick up on Kate's point. I
12 think making a prediction about how people will respond will
13 be very difficult. But I like the idea of saying are there
14 ways that we can more clearly array what the choices would
15 be to people. So if we could pursue that, that would be
16 helpful.

17 One of the concerns that I have had about a static
18 analysis like this is that sometimes it produces commentary
19 that says, well, you know, people are going to have to pay
20 this amount for this option. And at one level that's true.
21 I'm not saying that's inaccurate or dishonest.

22 But, on the other hand, to some extent that's the

1 point of the policy, is that you create options, give people
2 choices with different financial implications. If they
3 choose higher-cost options, then they ought to pay for that.
4 That's the design. That's not an unintended consequence.
5 That's the design.

6 Now, people can and will debate whether that's a
7 good principle to apply to the Medicare population. But I
8 think any way that we can enhance sort of understanding here
9 are the choices that people will have, here are the
10 opportunities they may have, enriches the debate without
11 making predictions on exactly how they'll respond.

12 MS. UCCELLO: Right. And I think when this is
13 written up, if it kind of highlights that caveat of the --
14 you know, here's where they stayed, but they don't have to
15 do that. So it lessens the ability to take some of these
16 results out of context.

17 MR. ARMSTRONG: I just want to affirm that, you
18 know, the way in which we pay for this kind of a plan is --
19 I don't know what the right answer is, but the way the
20 analysis is being organized, I think you're asking all the
21 right questions. So I think the directions are great.

22 DR. CHERNEW: So I think three things are

1 important. The first one relates to this issue that was
2 raised about how behavior is going to change. But I don't
3 want to let it go by without noting that it's not just the
4 question of how consumers would change in response to the
5 incentives, but it's also how plans would change in response
6 to the bids, and that matters a lot.

7 The second point is this isn't happening in a
8 vacuum, and thinking about how this would work and how it
9 would be synchronized with ACOs becomes very important. And
10 the ACOs are paid a particular way, and the plans are paid a
11 particular way, and it's not exactly congruent. For
12 example, the plans here are paid based on the service area,
13 which you discussed, where the ACOs are paid based on sort
14 of their own organization's historic spending, if I follow
15 correctly. And, in fact, there's some organizations that
16 could choose between being an ACO or a plan, depending on
17 their size, and so there's a lot of synchronization that I
18 think is important to think about when you think about how
19 this payment is going forward.

20 The third thing that I think is important is we've
21 built an elaborate policy relating to the rebates that
22 happen so these are all A-B with no supplemental coverage,

1 and we've built an elaborate set o rules for what happens
2 when the plans bid below the benchmark and it goes back to
3 beneficiaries and there's a series of things that happen,
4 which is important.

5 Right now we're kind of silent on what we say
6 would happen to those rules, which might be fine, but I do
7 think it's worth thinking about, at least a little bit, in
8 this context -- if the plans would be forced to give the
9 whole difference back, if they'd be able to give it back
10 with a tax, if you will, you know, some portion of it back
11 based on their star rating, what happens if they bid above.
12 And so there are some nuances about that which I think in
13 the broad scheme of the policy are important.

14 All of that said, I think this is exceptionally
15 illustrative of where we are right now, and I think that's
16 really important for people to understand because doing all
17 these behavioral things is going to be very, very difficult.
18 And any sense of what the status quo would look like if
19 there weren't big changes I think is helpful to let people
20 see this wide range of possible outcomes.

21 DR. SAMITT: I think I'm where Michael is on this.
22 It's hard for me to get my head around the scenario in a

1 static circumstance, because it's not static. So in many
2 respects, I think to understand it, we need to see a
3 simulation of sorts to say, you know, if these various
4 alternatives were put in place, what would the beneficiaries
5 do and what would the plans do in response, and how does
6 that begin to change and shift the scenarios? Because if we
7 play that out several times, it may highlight much more
8 clearly the best alternatives. So I don't know if I
9 articulated that well, but it's hard to understand it just
10 from a purely static perspective.

11 MR. HACKBARTH: Any follow-up? Scott or Julie, do
12 you understand what Craig is seeking?

13 DR. MARK MILLER: I mean, the way I--

14 DR. SAMITT: I may not be understanding what I'm
15 seeking.

16 DR. MARK MILLER: No, no, no. I think I
17 understand what you're saying, but it doesn't remove the
18 inherent tension here. I think what you're saying is your
19 mind, and, you know, any person's mind, might be able to
20 absorb better if this is the starting point, assuming
21 behavioral changes, this is -- you know, ten plans would
22 participate, or nine, and, you know, seven beneficiaries

1 would pay more and three would pay less. And you would say,
2 okay, now I understand how this works.

3 This definitely goes back to this very difficult
4 problem of what do you assume in a world that nobody has
5 observed yet and you're working with data from a world that
6 doesn't operate that way. And the secondary follow-up on
7 that, when you say, well, I made a guess and here it is, and
8 people jump all over you for your guess. First point.

9 But to Kate's point and some of what I think was
10 happening around the table here with Glenn is maybe some of
11 that can be gotten across by showing the distributions and
12 saying more clearly if a portion of these people -- we might
13 be able to get to some motion in this data to serve your
14 question.

15 MR. HACKBARTH: You know, trying to figure out how
16 you might do this in a quantifiable way is way beyond my
17 skills. But it occurs to me that a scenario sort of
18 approach, a qualitative approach may have some value, and
19 let me focus on one particular scenario.

20 Let's assume a market where traditional Medicare
21 is one of the more expensive options or the most expensive
22 option, and we're in a contribution scheme where

1 beneficiaries who wish to stay in traditional Medicare have
2 to pay significant sums out of pocket to do that. And
3 assume as a result of that there's significant disenrollment
4 from traditional Medicare over time, people shift to private
5 plans. What are the implications of that happening?

6 You'll recall that -- I think it was in November
7 when we talked about this -- we talked about the effect of
8 Medicare fee-for-service rates on the dynamics in health
9 care markets, and there are some indications that having
10 Medicare there with its market power and its rates actually
11 has a disciplining effect on what happens in the
12 negotiations between private plans and providers. So in a
13 scenario when traditional Medicare withers and maybe can't
14 command those same low rates anymore, how does that then
15 affect the dynamics in the private marketplace, including
16 the negotiations between private plans and providers? So
17 even if we can't sort of have a predictive model, here's how
18 people are going to react, there may be some particular
19 scenarios that we want to think through in a conceptual way
20 to see if it leads to important policy implications.

21 DR. SAMITT: I think that would work. I mean, it
22 would give us a clearer sense of how this could play out.

1 DR. HOADLEY: I had one sort of smaller question
2 that I want to come back to on this topic of static and sort
3 of how you deal with it. The smaller question, I guess,
4 came up with Slide 8 in terms of the number of areas, and,
5 you know, I know that there was the previous recommendation
6 that sort of going from the current system that, you know,
7 counties was too small. But is it clear that the right way
8 to envision this is something that would have 1,229 areas
9 across the country as opposed to, you know, the exchanges,
10 which there will be one per state, or even the regional PPO
11 or Part D market, which were designed to be even less than
12 one per state? And it seems like that makes the world look
13 a lot different in terms of how -- so I don't know if that
14 has been thought about, or it just seems like something we
15 ought to think about at some point.

16 MR. HACKBARTH: So the design of these areas is
17 something that we have thought about.

18 DR. HOADLEY: Right.

19 MR. HACKBARTH: And this approach to defining the
20 areas was something that MedPAC recommended. How long ago,
21 Scott? Five years? Something like that.

22 DR. HARRISON: 2005.

1 MR. HACKBARTH: 2005. And, you know, we didn't
2 like the counties because of, you know, the cliffs and all
3 sorts of specific issues. So we tried to come up with an
4 alternative configuration that would make sense for Medicare
5 Advantage where you would have reasonably homogeneous areas,
6 minimize the cliff, have stable numbers, you know, sort of
7 optimizing among multiple considerations, and came up --

8 DR. HARRISON: And small enough so an HMO could
9 cover the whole thing without --

10 MR. HACKBARTH: Yeah. Now, that was all done
11 within the confines of Medicare Advantage without looking
12 at, you know, all these other areas that are now in other
13 parts of Medicare and ACA. And so, you know, it may make
14 sense to reconsider. But that's where this particular set
15 came from.

16 DR. HOADLEY: And I don't necessarily think the
17 other is better. I mean, the idea of HMOs that have limited
18 ability to have a service area certainly has got to be
19 thought about in that. But, you know, we should just be
20 careful about locking this in as we move forward in this.

21 I guess as we think about all these issues of how
22 to get beyond a static model, I think a couple of

1 considerations I would throw out. One is we really do have
2 to make sure we're thinking about dynamic decisions both at
3 the beneficiary level and at the plan level, and it's the
4 kind of things that Mike was talking about, but it's also
5 just, you know, a plan that's planning to go in an existing
6 Medicare Advantage market and put these bids up, is thinking
7 about the dynamic that exists in that market where they are
8 playing -- potentially looking for a small market share,
9 doing certain things, in or out of the market depending on
10 the current Medicare Advantage rules. And so I think we
11 need to be careful about assuming the kinds of bids that
12 exist in that world, you know, could be radically different
13 from bids that might exist in another world. I don't know
14 how you deal with that, but I think it's just worth --

15 DR. MARK MILLER: Would you tell Craig that? He's
16 the one that wants --

17 [Laughter.]

18 DR. HOADLEY: And then I think on the beneficiary
19 side, you know, I agree with sort of the solution in the
20 short term is, you know, thinking about some scenarios and
21 trying to picture just what we have, but as we go further
22 down on this, I mean, there just seems -- I can just start

1 to list the complications in terms of thinking about how
2 beneficiaries respond to this. Some of it goes back to some
3 of the design issues that we didn't talk about today, like
4 how much standardization you do, what are the rules around
5 supplemental coverage, is supplemental coverage -- you know,
6 do you have, as in Part D where there has to be a standard
7 option and can be an enhanced option, or might enhanced
8 versions be the only thing? You know, then the basic issue
9 of the stickiness of beneficiaries in wanting to -- being
10 reluctant often to change choices. You know, would this be
11 rolled out as a sort of one-shot new thing where this is
12 kind of like, okay, this is a new system, you're making a
13 sort of first-time choice? Or is it more blended in where
14 people's default is sort of to stay where they are? And so
15 the ability to think about people switching and, therefore,
16 the plan response, the premium response is to those
17 assumptions matters a lot.

18 So, I mean, obviously that's not stuff we can do
19 in any kind of a short run, but I just wanted to talk about
20 those a little bit.

21 MR. HACKBARTH: You're mentioning benefits and,
22 you know, what are the rules of the game around benefits.

1 It just reminds me to say that, you know, what we're trying
2 to do is explore this really complicated topic in sort of
3 bite-sized pieces. And so there are lots of issues like are
4 the benefits standardized, how much variation is permitted,
5 that are really important policy questions, and the fact
6 that they haven't been mentioned to this point doesn't mean
7 that, oh, we're oblivious to that or that we won't talk
8 about them later. We're just trying to do it, you know,
9 sort of a step at a time in a way that can fit into an hour
10 and a half or an hour and 15 minutes.

11 DR. COOMBS: Thank you. I think the algorithm or
12 some kind of flow or scenario that actually puts
13 beneficiaries in the system and walks us through this whole
14 process might be helpful, as you mentioned.

15 I was just thinking about some of the things that
16 are kind of similar with exchanges in terms of some of the
17 issues because it's kind of comparable in terms of, you
18 know, that there's this paternalistic impact that you might
19 have on helping patients and beneficiaries navigate the
20 system. So I think it's important in that respect.

21 MR. GRADISON: I continue to try to figure out the
22 relationship of what we're talking about to the experience

1 that individuals would have who acquire their insurance
2 through the exchanges. And so this question for another day
3 is related to that. Do we have or can you find for us any
4 data that relates to the income of beneficiaries to the
5 choices that they make among MA plans?

6 DR. HARRISON: Meaning which types of designs they
7 go into within MA?

8 MR. GRADISON: Yes, or whether they choose MA as
9 against traditional Medicare.

10 DR. HARRISON: We might have some ways of getting
11 at that, like MCBS may have some data on that.

12 MR. GRADISON: If you don't mind, take a look.
13 That's all I'm asking now.

14 DR. HARRISON: Yeah, the income stuff is hard to
15 find.

16 MR. GRADISON: I understand that. Thank you.

17 DR. MARK MILLER: Scott, and, Carlos, if I need
18 you, would you please be read? We have looked at some of
19 this in the past. Have we not?

20 DR. HARRISON: I think we've reviewed other
21 documents. Dan may have done something.

22 DR. MARK MILLER: All right. Fine. Bill, I'll

1 get t his.

2 DR. ZABINSKI: [off microphone].

3 DR. MARK MILLER: All right. We'll sort this out.

4 I do think we have some of this.

5 MR. ZARABOZO: Next month we'll have it [off

6 microphone].

7 MR. HACKBARTH: Bill, this has, in fact, been an
8 issue in the Medicare Advantage debate, and AHIP and others
9 as well have said that their analysis suggests that lower-
10 income beneficiaries are more likely to enroll in Medicare
11 Advantage. And so there has been a fair amount of
12 conversation about that and about the analysis that they
13 did, and then I'll let Mark and the staff handle the rest of
14 that.

15 But it also reminds me of another issue, in the
16 spirit of what I said to Jack. You know, a whole other
17 question here is if Medicare were to go to a CPC type
18 system, what would you do for low-income beneficiaries? You
19 could within the system build in, you know, special
20 protections and what-not for low-income people in a very
21 targeted way, you know, protections on premiums and stuff
22 like that.

1 DR. NERENZ: Do you think the examples that you
2 have to work with, the current plan bids, are based largely
3 or even perhaps exclusively on fee-for-service payment from
4 plan to provider? Would that be fair? The vast majority of
5 them?

6 DR. HARRISON: That's not something we -- we
7 haven't looked at how the providers are paid.

8 DR. NERENZ: Okay. Well, I'm not suggesting that
9 that change a whole lot here, but I'm just observing -- this
10 is actually, I think, prompted by a comment Scott made a
11 while ago -- that there are clearly some plans, particularly
12 those in organizations like he and Craig have, where the
13 payment from plan to provider could be structured
14 differently, the nature of the benefits, the packaging and
15 things could be done differently, and, therefore, the bid
16 price might be different. And I don't think you're in a
17 position where you can simulate that whole range now, but
18 just as a tangential thing around the edge of this, you
19 might just acknowledge that those possibilities are out
20 there so that there could be plans that would bid
21 differently because of the way they would be able to pay
22 providers differently.

1 DR. MARK MILLER: The only think I want to pick up
2 in that is -- and, again, I don't see Jeff, but I do see
3 Carlos.

4 [Laughter.]

5 MR. HACKBARTH: He's trying to hide.

6 DR. MARK MILLER: Yeah. I mean, I thought some of
7 our analysis from the fall suggested that, by and large, the
8 prices are closer to fee-for-service among the managed care
9 plans -- not plan by plan --

10 DR. HOADLEY: Provider [off microphone]?

11 DR. MARK MILLER: Yeah, that's what I'm -- I'm
12 sorry. I'm not being clear. That, you know, the provider
13 payment rate are closer to fee-for-service in the MA plans.
14 Right?

15 DR. LEE: So the overall relationship, yes, they
16 tend to follow the level of benchmark, which comes from fee-
17 for-service. Now, as to what is happening between plans and
18 providers and what kind of arrangements they have to get the
19 negotiated rates, we do not know. We only looked at overall
20 area level averages.

21 DR. MARK MILLER: And I was going to say obviously
22 I'm sure it varies and you can find plans all over the

1 place. But the thing I wanted to loop back with Scott's
2 comment, just in case there was enough time -- and I'm sure
3 there isn't -- is while there is vast variation in fee-for-
4 service -- and that's a very disturbing and unhappy
5 situation that we have to face -- keep in mind also that
6 when you look at private sector pricing payments among
7 providers, there is extreme variation across the country.
8 And so that also you have to keep in mind.

9 Do I want to introduce this variation in fee-for-
10 service that's making me crazy? But if you bring in the
11 variation in private sector prices, you have huge variation
12 out there as well. So you have a couple of difficult pulls
13 to navigate between.

14 DR. SAMITT: So can I add a supplemental request
15 to my usual request, which is that I would love to see a
16 correlation between the manner by which private plans
17 incent and pay providers versus the quality of outcomes in
18 those institutions once we get MA information. That
19 correlation will be very important for us to see, I think.

20 MR. HACKBARTH: Although the MA information, even
21 when we get it, will be encounter data and will not
22 characterize the method of payment used by the MA plan to

1 providers. They'll just say this many visits, this many
2 hospital days. I don't know what the level of granularity
3 is. But it doesn't relate to the contractual relationship
4 between --

5 DR. HOADLEY: Or quantity, not price [off
6 microphone].

7 MR. HACKBARTH: Yes. I think that's right.
8 Correct me if I'm wrong, Scott.

9 DR. HARRISON: I don't know, but it's possible
10 that the encounter data will have some sort of pricing on
11 it.

12 MR. HACKBARTH: Price level --

13 DR. HARRISON: Yeah, but --

14 MR. HACKBARTH: -- as opposed to --

15 DR. MARK MILLER: I'll take any money on that.

16 [Laughter.]

17 MR. HACKBARTH: If we ask for that, that will be,
18 let's see, 2024 that it arrives.

19 DR. BAICKER: It will be any day now [off
20 microphone].

21 MR. HACKBARTH: Right, right.

22 [Laughter.]

1 DR. HOADLEY: And tomorrow never comes

2 MR. GEORGE MILLER: Yeah, just briefly. In the
3 reading it mentioned that 64 percent of the beneficiaries
4 live in an area below the bid, and then correspondingly, 35
5 percent live above. Do we map that out? Do we know where
6 that is -- it was in the reading material, Mark, not on the
7 slides.

8 DR. MARK MILLER: Well, there's some of it right
9 there on that slide.

10 MR. GEORGE MILLER: No, where they lived in the
11 country.

12 MR. HACKBARTH: Yeah, so George is looking for --

13 MR. GEORGE MILLER: Geographically.

14 MR. HACKBARTH: -- a geographical distribution.

15 MR. GEORGE MILLER: Geographically where they live
16 in the country. Yeah, I agree with the slide, but I'm just
17 curious if there is something unique about the area of the
18 country that's below the bid amount. Is there something to
19 learn from that? I'm just wondering if there's anything to
20 learn, and those that are above, like those above, is that
21 in Miami-Dade County?

22 DR. MARK MILLER: Bids below fee-for-service, just

1 to use your example, in Miami-Dade bids are well below fee-
2 for-service on average because fee-for-service is very high
3 in Miami, bids here.

4 MR. GEORGE MILLER: Got it.

5 DR. MARK MILLER: Then you go out to some low fee-
6 for-service area, bids are higher. We could give you some
7 sense of the -- you know, when you go across the --

8 MR. GEORGE MILLER: I don't know if there's
9 anything to learn from it. I'm just curious.

10 DR. MARK MILLER: But we're happy to give you some
11 sense as you look across that, you know, who might be in one
12 group versus another, just to give you a sense.

13 MR. HACKBARTH: Yeah, so you've seen the Dartmouth
14 Atlas with the variation.

15 MR. GEORGE MILLER: Yes.

16 MR. HACKBARTH: It would be sort of the --

17 MR. GEORGE MILLER: So are we consistent with --

18 MR. HACKBARTH: Yeah. You know, generally
19 speaking, that's the pattern. Where Medicare fee-for-
20 service is very high, the private plans are able to bid
21 lower. Where Medicare fee-for-service is really low, like
22 in Oregon, private plans tend to bid higher. So it's sort

1 of -- that's the pattern.

2 MR. GEORGE MILLER: Okay. Thank you.

3 MR. HACKBARTH: Would you put up Slide 11 for just
4 a second, Scott? So the rows here represent three different
5 ways of calculating the bids. Another way that has been
6 discussed is to, you know, calculate an average Medicare
7 cost per beneficiary in year one and then index that number
8 by some inflator. And so that's another approach that isn't
9 modeled here. That would not really fit under the heading
10 of competitively priced contributions. That would be, you
11 know, sort of more a defined contribution sort of model.
12 But I just wanted to point out that there is another
13 approach.

14 The other thing I want to emphasize about this is,
15 you know, none of these approaches is sort of right versus
16 wrong. They each have different characteristics. And for
17 me, one of the most important questions in working down this
18 path is what is your objective here. If your primary
19 objective is to produce scorable CBO savings, then what you
20 may want to do is use the approach I just described. Let's
21 calculate the average Medicare expenditure in year one and
22 then index it by a low number that's likely to be lower than

1 the increase in Medicare fee-for-service costs and you'll
2 tart to get CBO pictures that show a growing wedge and a big
3 budget savings for the program.

4 For me at least, that would not be the principal
5 objective or the desirable way to go. I'm not saying it
6 doesn't have merits, but for me, the worry would be that
7 we're creating another SGR sort of mechanism where we have a
8 government formula that may be increasingly disconnected
9 from the real-world health care delivery and insurance
10 marketplace.

11 For me, the principal objective here is not to
12 produce a CBO score, but it would be, if Medicare were to go
13 down this path, to change the dynamics in the health care
14 marketplace. And so that's the test for me. Can this be
15 done in a way that would enhance our efforts to encourage,
16 stimulate reform of the health care delivery system, change
17 how health care is delivered in the country? That would be
18 the objective.

19 Now, I think it's still, in my mind at least, very
20 much an open question whether, in fact, it would be a useful
21 tool for that. But that's the target that my eye is on, not
22 can we ring up a big CBO score.

1 The reason that I think that, despite all the
2 complications and difficulty of this that it's at least
3 worth thinking through, is that, you know, as I look at the
4 health care system, one of the things that continues to
5 strike me is the very large variation in performance among
6 health care providers, even within the same market. And
7 when you have that sort of variation, applying the tools
8 that we now have in our Medicare arsenal, you know, sort of
9 across-the-board hospital payment systems, physician
10 payments systems, those are really weak tools for dealing
11 with this variation in performance. What you need are tools
12 that discriminate more among individual providers and their
13 performance and move volume of patients to the high
14 performers and, conversely, volume away from the low
15 performers. And I think that's really sort of difficult to
16 do with traditional Medicare.

17 And so for me, the question is: Would this be a
18 tool that would create that sort of dynamic forcing
19 improvement at the level of health care delivery? And as I
20 say, I don't know the answer to that in my own mind yet, let
21 alone for the whole Commission. But that's why I think this
22 is worth trudging through some pretty complicated issues to

1 try to sort it out.

2 So on that note, we will end -- thank you, Julie
3 and Scott -- and move on to our next session. We're almost
4 on -- actually a little bit ahead of my revised schedule
5 here. So the next one is on effects of adherents to Part D-
6 covered drugs on Parts A and B spending.

7 [Pause.]

8 MS. SUZUKI: Good afternoon. Medication adherence
9 is viewed as an important component in the treatment of many
10 medical conditions. In this session, we'll report on
11 preliminary findings for analysis of the Medicare data to
12 see how the use of Part D drugs affects spending on medical
13 services covered under Parts A and B of Medicare.

14 We're pursuing this research because we'd like to
15 understand the relationship between medication adherence and
16 health care spending for the Medicare population. That will
17 help us better understand how the Part D benefits affect
18 Parts A and B spending. It could also help us inform our
19 thinking on the LIS cost-sharing policy that we recommended
20 last year.

21 Finally, this research may help us understand the
22 relationship between medication adherence and inappropriate

1 use, including overuse and underuse, in the Medicare
2 population. There are many studies that looks at the impact
3 of medication adherence on medical service use and costs.
4 Because these studies generally focus on younger populations
5 with less complex medical conditions compared to the
6 Medicare population, findings from past studies may have
7 limited applicability to Medicare beneficiaries.

8 Our study asks two questions: First, what is the
9 relationship between medication adherence and medical
10 service use for the Medicare population? Second, does that
11 relationship between medication adherence and medical
12 service use vary by condition and/or medication regimen?

13 We selected three conditions for this study.
14 We chose CHF and COPD because these are high-cost conditions
15 that are likely to benefit the most from appropriate
16 medication therapy that prevents or reduce the incidence of
17 costly complications.

18 We subdivided the CHF cohort into non-severe and
19 severe cohort because effects may be different depending on
20 the degree of severity. An individual was classified as
21 having severe CHF based on clinical markers such as having a
22 pacemaker implanted. For COPD, we looked at people with

1 severe COPD, defined as having diagnosis for COPD and
2 requiring the use of supplemental oxygen.

3 Finally, we chose depression as the third
4 condition because there is no clear literature regarding the
5 effects of medication adherence on medical spending for
6 antidepressants. For CHF and COPD, we further divided the
7 condition cohort by the specific drug regimens shown on this
8 slide. In total, we examined 10 condition-drug regimen
9 cohorts.

10 Our analysis consisted of three time periods. In
11 the first period, the selection period that span roughly 18
12 months, from January 2008 to June 2009, we identified study
13 cohorts based on diagnostic codes on Parts A and B claims
14 and the use of designated drug therapies based on Part D
15 claims.

16 In the second period, the observation period which
17 spanned six months, from July 2009 to December 2009, we
18 identified the level of adherence to the study medications
19 based on Part D claims data. In the third period, the
20 outcome period, which is the entire 12 months in 2010, we
21 measured our outcomes of interest, which is annual Medicare
22 spending for Parts A and B services.

1 Beneficiaries in each condition-drug cohort were
2 classified into four groups based on the level of adherence
3 to study medications measured during the observation period.
4 Medication adherence was measured using the proportion of
5 days covered metric, which is defined as the number of days
6 covered by a prescription for a given drug divided by the
7 total number of days in a measurement period.

8 Beneficiaries with PDC at or below .3 was
9 classified as the least adherent, and beneficiaries with PDC
10 above .8 was classified as the most adherent. Although PDC
11 metric is an imperfect measure of medication adherence, we
12 have no other data sources to measure adherence and we
13 expect a fairly high correlation between the fills observed
14 in Part D claims and the level of actual adherence.

15 We used regression analysis to estimate the
16 effects of improved adherence on medical spending for each
17 condition-drug cohort, with separate models for LIS and non-
18 LIS beneficiaries. Our outcome variables were Medicare
19 Parts A and B spending in 2010, and Medicare spending in
20 2010 by service category, such as inpatient hospital,
21 outpatient hospital, and home health.

22 Effects of the improved adherence is the

1 difference between the predicted spending at the highest
2 level of adherence and the predicted spending at a lower
3 level of adherence, such as those in the category with PDC
4 less than .3. That is, we are measuring what the potential
5 change in spending would be if people who were not adherent
6 became adherent. We make two pretty big assumptions.

7 One, that it's possible to change people's
8 behavior to take their medications as directed. Two, that
9 when people become more adherent, the health outcomes and
10 spending will look more like those who are currently
11 adherent.

12 In reality, making people more adherent may be
13 difficult. Even if better health outcomes and lower
14 spending were achievable through improved adherence, those
15 effects may take time before they are fully realized. The
16 net effect of an improved adherence is the sum of the
17 effects on Parts A and B spending and the increase in drug
18 costs from becoming adherent.

19 The increase in drug costs of improved adherence
20 was estimated by taking the difference in average gross
21 spending for beneficiaries with the highest level of
22 adherence and gross spending for beneficiaries with a lower

1 level of adherence.

2 The costs of becoming adherent, in this analysis,
3 do not reflect other potential costs of increasing adherence
4 to medications, such as lowering copays.

5 In the next few slides, I'll go through some of
6 the preliminary findings from our analysis. The first few
7 will present our findings on the level of medication
8 adherence across cohorts and over time. The next few will
9 show selected estimates of the effects of improved adherence
10 on Medicare spending. And finally, I'll have a few slides
11 to show the relationship between medication adherence and
12 Medicare spending we observed for our study cohorts.

13 This table shows the number of beneficiaries in
14 each condition cohort, shares of beneficiaries who received
15 Part D's low-income subsidy in 2010, and the level of
16 adherence to study medications, as measured by the PDC
17 metric. As you can see, the share of beneficiaries
18 receiving the low-income subsidy ranged from 41 percent
19 among beneficiaries in the severe CHF cohort to 66 percent
20 among those in the depression cohort.

21 Comparing the first two columns, you'll see that
22 the distribution across the four PDC categories are nearly

1 identical for beneficiaries in the severe and non-severe CHF
2 cohort, with slightly less than three-quarters of the
3 beneficiaries in the category with PDC above .8. Adherence
4 was much lower for severe COPD cohort, shown in the third
5 column. And the last column shows that 78 percent of
6 beneficiaries in the depression cohort were in the category
7 with PDC greater than .8, which was the highest among the
8 four conditions.

9 Adherence rates were higher among LIS
10 beneficiaries for those in COPD and depression cohorts, but
11 not for those in the two CHF cohorts. Although not shown on
12 the slide, among the CHF and COPD cohorts, those on
13 combination regimen had lower mean PDC compared to those on
14 single regimen.

15 This chart shows how the rate of adherence to
16 study medications declined for all condition-drug cohorts
17 over time. The decrease between 2009 and the end of 2010
18 ranged from about 7 percentage points for the depression
19 cohort to about 14 percentage points for beneficiaries in
20 one of the severe COPD cohort.

21 For many cohorts, the rate of decline were similar
22 for both LIS and non-LIS beneficiaries like the trends for

1 the CHF cohort shown in orange and yellow lines at the top.
2 For COPD cohorts, divergence between LIS and non-LIS tended
3 to be large, as you can see in the blue lines at the bottom.
4 In 2010, most non-LIS beneficiaries faced 100 percent of the
5 cost of the drugs filled in the coverage gap. And even
6 during the initial benefit phase, cost sharing tends to be
7 higher for higher cost medications.

8 LIS beneficiaries, on the other hand, has no cost
9 sharing or a nominal cost sharing because the subsidy picks
10 up most of their cost sharing. This difference in cost
11 sharing may have contributed to the divergence in the drop
12 in adherence rates between LIS and non-LIS.

13 This table shows the estimated change in Medicare
14 spending from improved adherence to study medications from
15 the lowest adherence category to the highest adherence
16 category for selected cohorts. The column on the right
17 shows the effects of improved adherence on Parts A and B
18 spending.

19 As expected, we found reductions in Parts A and B
20 spending for many of the CHF and COPD cohorts. There were
21 some exceptions. For example, improved adherence resulted
22 in higher A/B spending among LIS beneficiaries with severe

1 CHF treated with beta-blockers. For the depression cohort,
2 the reduction was very small or positive, indicating a
3 higher expected spending with better adherence.

4 The second column shows the drug costs to Medicare
5 of improved adherence, and the last column shows the overall
6 effects on Medicare spending after accounting for the
7 increase in Part D spending. As you can see, the net
8 effects on spending varied across cohorts and by LIS status.
9 As I noted earlier, the medications used to treat COPD are
10 high compared to other treatment regimens that we examined,
11 so that even though we found reductions in A/B spending for
12 many COPD cohort, the effects on overall Medicare spending
13 tended to be small and not statistically significant or a
14 net increase for many of the COPD cohorts.

15 For a subset of cohorts with severe CHF, we found
16 that over 60 percent of the effects resulting from improved
17 adherence were attributable to CHF-related conditions. But
18 one of the surprising findings was that in other cohorts,
19 the effects on condition-specific costs accounted for
20 relatively small portions of those effects.

21 For example, we found that CHF-specific costs
22 accounted for less than a quarter of the effects on Parts A

1 and B spending for many non-severe CHF cohort. And among
2 the COPD cohorts where we found significant reductions in
3 Parts A and B spending, COPD-specific costs accounted for
4 less than a third of the effects on medical spending.

5 The effects of improved adherence on spending
6 differed across health care settings. As expected, we found
7 that for most cohorts where better adherence resulted in a
8 significant reduction in A/B spending, the largest effects
9 were typically for inpatient hospital spending.

10 Better adherence often resulted in lower spending
11 for physician services and services provided in emergency
12 room settings, but magnitudes were much smaller and not as
13 consistent. And we found mixed results for other health
14 care settings.

15 For drug therapies that do tend to improve health
16 outcomes and reduce the use of other medical services, we
17 had expected that there would be a larger reduction in
18 spending from individuals who were the least adherent
19 compared with those who were more adherent. And I'll
20 explain this using a hypothetical example shown on this
21 chart.

22 The vertical axis shows the effects of improved

1 adherence on medical spending. The left bar represents
2 beneficiaries with the lowest adherence, the next one in the
3 middle representing those with moderately low adherence, and
4 the bar on the right represents those who are nearly
5 adherent.

6 Our expectation was that the effects of improved
7 adherence on spending would be largest for those with the
8 lowest adherence, and smallest for those who were nearly
9 adherent, and that's what this chart is showing. Largest
10 reduction on the left, and the smaller reduction as you move
11 to the right.

12 This chart shows our findings on the effects of
13 improved adherence on Parts A and B spending for
14 beneficiaries in the severe CHF cohort. The chart on the
15 top shows the effects on spending for non-LIS beneficiaries.
16 Again, the lightest green represents those with the lowest
17 PDC and the darkest green representing those who are nearly
18 adherent. The chart on the bottom shows the effects for LIS
19 beneficiaries.

20 As you can see, it looks very different from the
21 previous chart. In general, the effects were not
22 proportional to the magnitude of the improvement in

1 adherence as we had expected. This may be because there are
2 unobserved characteristics that differ between the adherent
3 and less adherent beneficiaries that are not captured by our
4 model that rely on observational data.

5 So to summarize, we found that adherence to study
6 medications varied across conditions and drug regimen.
7 Adherence declined over time for all cohorts. Effects of
8 improved adherence on Medicare spending varied by condition,
9 medication regimen, and by LIS status.

10 Reduction in spending were typically largest for
11 inpatient hospital, but we found mixed results for other
12 services. Effects on condition-specific cost varied across
13 conditions, and a greater improvement in adherence did not
14 always result in larger reduction in spending.

15 I'd like to point out some of the limitations of
16 our study as you consider the future direction for this
17 research. The analysis was limited to specific conditions
18 and drug regimens. The variability in their findings across
19 conditions and within conditions, depending on the
20 medication regimen, raises some questions, but it does
21 confirm that a relationship found for a given condition or
22 drug regimen are not generalizable to other conditions and

1 drug classes.

2 Our estimates of the net effects of improved
3 adherence likely overstates the effects on spending, first
4 because we assumed that you can move people into the highest
5 adherence category. In reality, particularly for some
6 regimen, that may not be possible. And the fact that
7 adherence fell over time for all cohorts raises questions
8 about sustainability of high adherence, even if it were
9 achieved.

10 Second, we ignored the costs of making people more
11 adherent. As I mentioned earlier, we cannot measure
12 people's adherence directly with administrative data. The
13 PDC metric is an imperfect measure, and there may be cases
14 where the PDC metric is not a good proxy.

15 Finally, the study period was not long enough to
16 observe the longer-term effects of greater adherence. Given
17 that adherence decline over time for all conditions, we may
18 want to examine longer time periods to determine whether the
19 effects on spending are sustained beyond the 12-month
20 period.

21 In the next phase of this study, we intend to
22 analyze other conditions and observe longer time periods to

1 see effects during the first -- effects to see if the
2 effects are sustained beyond the first year.

3 That concludes my presentation.

4 MR. HACKBARTH: Okay, thank you, Shinobu.

5 So let me ask for clarifying questions. Kate?

6 Ooh, they woke up.

7 [Laughter.]

8 DR. CHERNEW: No one on this side.

9 MR. HACKBARTH: Kate first, and we'll just go down
10 this row and then over here.

11 DR. BAICKER: So just limiting to strictly
12 clarifying questions, the definition of PDC, I wasn't clear
13 whether being on a drug to begin with was sort of a
14 requisite index event or just having the diagnosis. In
15 other words, could you -- do you measure it among people who
16 are diagnosed with, you know, CHF and thus should be on a
17 drug, and if they have zero, that's a zero, or are they only
18 in if they first have a drug?

19 MS. SUZUKI: So we had three periods, and in the
20 observation period, we looked at people's adherence, and we
21 actually require that people had the drug at the beginning
22 of the observation period.

1 DR. BAICKER: So that's an "and" not an "or."

2 MS. SUZUKI: Mm-hmm.

3 DR. BAICKER: So then that seems to me to build in
4 that mechanical reason that you would see declines over
5 time, because to be in the cohort where you are looking at
6 adherence you have to first be in the possession of the
7 drug. There's some necessary mean reversion built in where
8 I would think you'd almost have to see some decline over
9 time, because people can't get more adherent than they were
10 in the starting period where you're measuring them as being
11 in full possession. An alternative way would be to look at
12 people who ought to have a drug based on their diagnosis and
13 have that be the index event, regardless of whether they
14 have an initial prescription, and then they could -- then I
15 wouldn't expect that mechanical thing. But I just wanted to
16 make sure I understood that it was an "and," not an "or,"
17 and how that builds that in.

18 MS. SUZUKI: So maybe I'm -- I'll just clarify how
19 we measure this. The six-month period, observation period,
20 we measured -- we require that people had the drug. We
21 measure the adherence for that six-month period. And then
22 we were looking at 2010 quarterly to see what their PDC was.

1 And I understand that since we required the possession, that
2 would necessarily be the case.

3 MR. BUTLER: Line 12. The chapter was a little
4 clearer than the slide to me. So I'm not -- this is the
5 estimated impact on spending, but the title says -- are
6 these people that have moved from low compliance to high
7 compliance? Tell me again what --

8 MS. SUZUKI: So this is assuming -- right. So
9 we're looking at what happens when people's adherence
10 changed from the lowest category to the highest category.

11 MR. BUTLER: So these people were at the bottom
12 end and now they're at the top end, and that's the impact on
13 Medicare spending for --

14 DR. MARK MILLER: Just to put this a little bit
15 differently, you measure their adherence.

16 MR. BUTLER: Yeah.

17 DR. MARK MILLER: You measure you're a and B and
18 then you say, knowing how A and B behave for people who are
19 highly adherent, if the low adherents moved to that, how
20 much A would be. So it's an imputation as opposed to --

21 MR. BUTLER: Oh. It didn't say that's what would
22 happen. That's what would happen if they moved to high

1 adherence.

2 DR. CHERNEW: Can I -- there aren't people that
3 are moving from low to high. You look at low people, high
4 people --

5 MR. BUTLER: No, I've got it. I've got it.

6 MS. SUZUKI: Right.

7 MS. UCCELLO: So, to clarify, the outcomes are
8 looking at Medicare spending, A and B. Is that gross
9 Medicare spending or does it net out the out-of-pocket?

10 MS. SUZUKI: On the A and B is the Medicare
11 payments, so program spending. So not the out-of-pocket --

12 MS. UCCELLO: Would including that make any
13 difference, I mean, because we care about out-of-pocket
14 spending, too, on this stuff. I mean, maybe the results
15 would be the same, but --

16 And this is probably obvious, but the people who -
17 - the reduction in adherence over time, presumably, that's
18 more because people are just dropping out of adherence as
19 opposed to kind of moving down gradually?

20 MS. SUZUKI: We don't know the answer to that
21 question, but we can definitely look into this.

22 MS. UCCELLO: And for one of these or more, you

1 looked at when the cost changed, what costs were the
2 condition-specific versus those that were not. Did you do
3 this for the depression? I know there really wasn't
4 savings, but I'm just wondering how their spending differed
5 by depression-related versus non.

6 MS. SUZUKI: So identifying condition-specific
7 costs are sort of an imperfect science, and for CHF and
8 COPD, we were able to figure out the diagnoses that are
9 associated with the condition and fairly reliably identify
10 those that look like they were related.

11 For depression, we were not sure if depression
12 ever even became the primary reason for, say, admission or
13 visits, so we couldn't reliably identify related conditions
14 for depression.

15 DR. HALL: Shinobu, I was interested in Table 1 in
16 the reading material. The depression population seems quite
17 a bit different. They're much younger. Almost half are not
18 age 65 yet. Just note that. I'm not sure that means
19 anything.

20 But my question was, would it be possible to make
21 any breakdown looking at the older age cohorts there? The
22 numbers may get very small, but within the Medicare age

1 range, I would predict that the older population might have
2 very different drug effects on concomitant chronic disease
3 than the younger --

4 MS. SUZUKI: I think that would be interesting to
5 look at.

6 MR. HACKBARTH: [Off microphone.] Rita, did you
7 have anything?

8 DR. REDBERG: Yes. Just to clarify, when you were
9 doing this analysis, there was no intervention to make
10 people more adherent, because, you know, when it says
11 improvement in adherence, it makes it sound like you're
12 doing something to help them improve adherence. And the
13 reason I ask is because it's very different. You know, we
14 know that people that take their medicines are very
15 different than people that don't take their medicines, and
16 their health status is kind of independent in some cases of
17 their medicines. It's like people that show up for their
18 doctors' appointments are, in general, a healthier group.
19 People that sign up for randomized trials are a healthier
20 group.

21 And so this wasn't an intervention study. So I
22 think we have to be careful not to say "improvements,"

1 because this is really different groups of people that take
2 their medicines and don't. And, in general for medicines,
3 people do stop taking them over time. So it's hard to look
4 at.

5 I mean, I think -- this is not a clarifying
6 question, so I could save it. I just had a comment.

7 MR. HACKBARTH: [Off microphone.]

8 DR. MARK MILLER: She already, like, violated the
9 rule, so --

10 [Laughter.]

11 DR. MARK MILLER: -- so I'm not going to violate
12 the rule is what I was going to say.

13 MR. HACKBARTH: Right.

14 DR. REDBERG: You are exemplary, Mark --

15 [Laughter.]

16 DR. MARK MILLER: No, the thing I want to follow
17 up on that is, first of all -- and I'm sorry to interrupt --
18 but first of all, on the vocabulary, you're right, and we
19 will -- you know, it's a draft and we will work to get this
20 right in the chapter. And it is difficult, because the line
21 of questioning here is you sort of impute a change. So we
22 will try and get that straight.

1 But your point, I also think is one that's really
2 important to track on. You can statistically say, if this
3 person moved from here to here, here is what you might
4 expect. But a real question is, what do you have to do to
5 get that person to move? And so the notion of as adherence
6 changes, you get these savings, or you don't, whichever way
7 the case may be, but there may be also a cost involved in
8 getting the person to move, and I think that's what's got to
9 also be kind of understood in this. And I think that's your
10 most underlying point, if I followed it. No, it's not?

11 DR. REDBERG: I thank you.

12 DR. SOKOLOVSKY: I think that one thing Shinobu
13 said that we're very interested in is exactly what I thought
14 you were saying, that maybe these people are different in
15 ways we can't measure, and if you have some idea about how
16 we could measure it, that would be great.

17 DR. REDBERG: Well, just in some of the things I
18 said, because I think people that take their medicines more
19 they are different, I mean, and the different -- their
20 taking their medicines is just one way that they are
21 different. I mean, in general, like I said, people that show
22 behaviors where they're actively taking an interest in their

1 health have a lot of different behaviors. They tend to have
2 a lot more healthier habits. Those are the ones who show up
3 for their doctors' appointments. Those are the ones who
4 watch their diet more. They tend to smoke less, you know,
5 eat healthier diets. So they have a lot of different
6 characteristics besides taking their medicines.

7 DR. CHERNEW: [Off microphone.]

8 DR. REDBERG: Then just on a technical point, but
9 now we maybe could discuss offline, because I think it's
10 hard to define severe heart failure and non-severe heart
11 failure, but I'm not sure just using an ICD pacemaker
12 definition would be the -- you know, we could talk about
13 that.

14 DR. CHERNEW: There is literature that uses a
15 different approach that looks at interventions when people -
16 - particularly around Part D -- when people were taking
17 their meds more because they were getting better coverage.
18 What happened to the offsets, and the Congressional Budget
19 Office has a bit of a literature review on this in their
20 memo that they put out when they changed their assumption
21 which is useful, I think, to think about, because they're
22 all intended to try and figure out how to solve this case

1 mix difference that Rita is raising, which I think is a
2 really important one.

3 DR. REDBERG: And again, it depends -- last
4 clarifying comment -- it's kind of that healthy user
5 hypothesis. I mean, there are medicines and there are
6 medicines, so it depends what you are taking. But, you
7 know, like the healthy user is probably why a lot of the
8 estrogen studies, the famous example, but the vitamin
9 supplement studies. I mean, people that tend to take those,
10 they tend to be healthier anyway, so it really depends on
11 what we're looking at. Are they taking a life-saving
12 medicine? Are they taking a medicine that doesn't really
13 matter if they take it or not? Or are they taking a
14 medicine that actually might be harmful for them, and that's
15 very nuanced.

16 MR. HACKBARTH: [Off microphone.] Other
17 clarifying questions?

18 DR. SAMITT: I guess the purpose of my clarifying
19 question is to really -- I would imagine we're looking at
20 this to determine what's actionable to improve adherence and
21 reduce medical costs. So my clarifying question is, does
22 the study enable us to look at other potential correlates

1 with adherence?

2 So, for example, I'm interested in knowing whether
3 we can determine whether there's polypharmacy going on with
4 these patients and that polypharmacy is driving non-
5 adherence, or whether there's a way to get at patient
6 satisfaction levels with their providers as a correlate with
7 adherence, because there are other studies that would
8 suggest that, you know, what we want to do -- if we presume
9 that adherence drives a reduction in medical costs, then
10 what we really want to know is what do we do to improve
11 adherence that is under our control, as opposed to what's
12 not under our control, which is the patients are just
13 different.

14 So I don't know whether the analysis enables us to
15 do those correlates. With the assumption that there is a
16 correlation between adherence and reduction in cost, we then
17 want to know -- we want to go sort of further upstream to
18 know what we can do about adherence.

19 DR. HOADLEY: I will stick to my purely technical
20 question. When you're measuring -- you have it on Slide 6,
21 but when you're measuring adherence, you're just doing a
22 straight measure within that, I think it's six-month period,

1 of how many fills, how many units they filled in that period
2 --

3 MS. SUZUKI: They supply --

4 DR. HOADLEY: -- divided by days?

5 MS. SUZUKI: Mm-hmm.

6 DR. HOADLEY: And have you done any looking at
7 sort of the boundary issues of if people are doing a 90-day
8 supply in December or right before the period starts, any of
9 that kind of stuff?

10 MS. SUZUKI: We have not -- well, we haven't, but
11 we can check with our analysts and --

12 DR. HOADLEY: I think especially given that this
13 is just a six-month period to test, we should take a good
14 look at the literature and see if there's any other
15 suggestions for refining that.

16 MS. SUZUKI: Okay.

17 MR. KUHN: Unlike Craig, I am interested in the
18 other potential correlates, but I think it's fascinating
19 that we're having this conversation, where we started the
20 day talking about readmissions, which hopefully will help
21 lead to compliance, and we'll finish tomorrow with shared
22 decision making, which will help. So I think it's nice that

1 this is sandwiched in between those two conversations.

2 But I'll define mine as technical. But I'm just
3 curious, on Slide 11, the one on COPD --

4 DR. HOADLEY: [Off microphone.]

5 MR. KUHN: Yeah. I'm on Rita's list, too. We're
6 both on the watch list.

7 I'm just fascinated. Maybe some of the clinicians
8 can answer this question, as well, in the room, but the
9 COPD, I'm just fascinated that the adherence drops so
10 steeply for so many others, but this one in particular just
11 fascinates me with the potential breathing problems these
12 patients would have and you would see compliance drop
13 dramatically here. Does anybody, I mean, any kind of
14 speculation why this one -- we would see this, particularly
15 with the one that says severe COPD? I was just fascinated
16 by that.

17 DR. COOMBS: I was going to comment on round two
18 about COPD specifically because the six-month trial for
19 adherence for COPD is really short, and there's so many
20 other mitigating factors, and you look at the Part A and B,
21 which is considerably increased. And so the COPDs have less
22 under control when you compare them to CHF in the sense that

1 an infection throws them off, and smoking, and those are two
2 of the compounding things that you have no control over.

3 So, in a sense, the COPD is a very hard disease to
4 get your arms around in terms of looking at the impact of
5 subsidy or no subsidy and the impact of adherence versus
6 non-adherence because you have exacerbation of COPD and
7 increasing costs.

8 And then the other piece of it is that a lot of
9 the drugs that are used in COPD are not on formulary, and
10 then so there's maybe some other issues in terms of copays
11 and things of that nature, especially for some of the long-
12 acting beta agonists, whereas CHF has a lot of drugs that
13 are pretty much -- they've become benchmark drugs in terms
14 of where you follow the algorithm. So I think COPD lends
15 itself clinically to a lot more variation in the type of
16 drugs that you use, and hence the generic name under COPD as
17 long-acting. They didn't specifically do ARBs versus ACE
18 inhibitors.

19 So I think that's part of the piece of the puzzle,
20 because you're not really comparing two diseases that are
21 comparable, and the time frame for COPD, I don't think, is a
22 realistic measure of being able to say that adherence is

1 going to make a big difference in their money spent, either,
2 because of the other factors that enter in.

3 DR. REDBERG: I also wondered about that when I
4 saw this slide, because you have to think, if the medicine
5 was making you feel better, you wouldn't stop taking it. So
6 it does make you wonder. People don't -- it's a lot harder
7 to get people to keep taking medicines when they don't feel
8 the effects of it, but COPD is something you would have
9 expected to -- actually, it's treating symptoms, so it does
10 make you wonder about the efficacy of the treatment.

11 DR. HALL: Just very briefly, COPD is notoriously
12 [indiscernible] by the season of the year in which you study
13 it. So it really depends when flu is around. This year,
14 that was 2009, flu was around December, January, February,
15 which confirm to my bias. On the other hand, if flu came in
16 the fall, I wouldn't expect that to happen, but it's a very
17 iffy thing to follow seasonally.

18 MR. GEORGE MILLER: Yeah, I think most of this has
19 been covered by Herb and Rita, but just for a clarifying
20 question of the -- in this context, what do we define as
21 adherence, and if the other socio-economic factors are a
22 part of that equation as we look at this going forward.

1 Particularly, I'm wondering if the effects of disparity have
2 any impact on adherence, as well, and how do we handle that
3 going forward and what recommendations we made. But most of
4 mine track what already Rita has said.

5 MR. HACKBARTH: Okay. So we have already sort of
6 gone partially into round two, but we will now officially go
7 into round two. Rita, we'll start with you.

8 DR. REDBERG: Really, I was -- I kind of alluded
9 to it in the last comments --

10 MR. HACKBARTH: Yes.

11 DR. REDBERG: -- it's just that there are
12 different kinds of medications, and if we really -- and I'm
13 sure you tried to pick the ones that are in the life-saving
14 categories, but, I mean, as Craig alluded to, it does depend
15 a lot on how many medicines you're on and also what kind
16 there are, because, I mean, as we saw in the Garfinkle study
17 that you mentioned last time, not all medicines are
18 necessary or even beneficial and so it's important that we
19 kind of try to make that distinction: The ones that are
20 life-saving or certainly beneficial in outcomes, the ones
21 that maybe don't make a difference one way or another, and
22 the ones that you probably would be better off not taking,

1 and looking at the adherence.

2 Presumably, CHF and COPD, most of them were in the
3 beneficial on outcomes category. But, the problem is they
4 might have been on other drugs, too, and then we know the
5 more drugs people are on, the less likely they are to take
6 them, in general, because they get a lot more side effects,
7 particularly in the Medicare age group. You know, the
8 interactions just are synergistic with number of
9 medications, particularly once they're up to three to five,
10 and so many beneficiaries are over that number at this time.

11 MR. BUTLER: So a little bit along those lines,
12 this is, first, really -- I think it's really good, but it
13 would -- I suspect there's many problems. If you look at
14 all the elderly that had more than X number of drugs, you'd
15 see more damage done by that than the opportunity that there
16 is by adhering to ones that can make an impact. So it would
17 be another way to look at the lens of what's going on.

18 DR. BAICKER: Yeah. I'm really supportive of this
19 kind of analysis because I think if we don't look at costs
20 across silos, we'll never be able to think about aligning
21 payment. So I'm really a big fan of the question.

22 And the part that makes me most concerned is the

1 attribution of the causality, and I think this is part of
2 what Rita was getting at and what I was gesturing at Mark
3 about, is that to me, the issue of how much it costs to get
4 somebody from low adherence to high adherence is second
5 order relative to would we really expect to see somebody who
6 looks non-adherent now to look like somebody who looks
7 adherent now if we just made them adherent or are there
8 fundamental differences in these patients that are coming
9 from lots of other things. When I take my meds, I also diet
10 or I also do other things that my doctor is recommending to
11 control my diabetes and it's not just taking the meds per
12 se. It's a constellation of behaviors, whereas if you could
13 change the med taking behavior, you still might not realize
14 the better outcomes of the more adherent patient.

15 And so the fact you're looking at this highly
16 relevant population is a big advantage over some previous
17 literature, but some previous literature has some advantages
18 in identification strategies in using other mechanisms to
19 try to get at really causal effects of changing adherence.
20 and until we feel as though -- I think documenting the
21 variation in adherence is a really important first step, but
22 until we're able to really pin down a causal story more

1 persuasively, using words like "results" and "effect" make
2 me a little nervous. I don't think that we're there yet and
3 I want to see, though, that set of accumulated facts
4 documented nonetheless. Even if we can't get at the causal
5 story, I still think there's a lot of value here, but we
6 need to be really careful with that causal language.

7 DR. CHERNEW: So, first, my main point is I agree
8 with Kate, and my follow-up points are --

9 DR. BAICKER: [Off microphone.]

10 [Laughter.]

11 DR. CHERNEW: Well, no, I was just going to say it
12 again.

13 DR. MARK MILLER: [Off microphone.] Do you want
14 to change your --

15 DR. CHERNEW: Most importantly, I think it's a
16 huge step forward just generally to recognize the connection
17 between Part D and Part A-B. It moves us away from silos,
18 and anything in that direction, I think, is really
19 important.

20 I'll say that it's important to recognize -- and
21 this didn't come up -- that you're measuring adherence,
22 which is what you set out to measure, which I think is fine,

1 but that's different than measuring use. So there's people
2 that weren't using at all that may start using and they are
3 basically not included in here. So you're not measuring
4 that thing.

5 More broadly, there's clinical questions and
6 there's policy questions, and in some ways, this is designed
7 to answer a clinical question, "If you take your drugs, what
8 will happen," of which there is work on. But it's important
9 to recognize that when we do that, we have to be aware that
10 that's not the same as actually the policy question, "What
11 would happen if we were to make changes in the Part D
12 coverage gap" or anything of that nature. And so that
13 disconnect becomes important in what we infer from this
14 work. But, nevertheless, I think understanding this stuff
15 is really important.

16 The last thing that I'll say, which, again,
17 follows, I think, on where Rita was, and she was exactly
18 right, that there's a lot of heterogeneity. There's good
19 things that we want to spend a lot of time encouraging,
20 whether it saves money or not, but we care about the
21 quality. And then there's all kinds of other issues,
22 unintended consequences of polypharmacy and situations where

1 there's not a lot of value for taking the drugs, or when
2 you're purchasing them, inefficiency, a whole lot of things
3 you might not want to do.

4 And so understanding the connection between the
5 policies that we're thinking about and how detailed they are
6 at addressing the specific clinical things matter, because
7 some policies we look at quality measurement is sometimes
8 relatively clinically specific. We are thinking about this
9 type of adherence as a quality measure for various types of
10 plans. Other times, changing copays and the Part D coverage
11 gap, tend not to be particularly nuanced. They tend to be a
12 very broad stroke, where you're lowering copays on good,
13 wonderful, high-value drugs and maybe some that aren't so
14 much.

15 So the more we can recognize the analysis and how
16 it's going to be used in the context of policy, I think, the
17 more we can add to what I believe is still a very useful
18 exercise of recognizing the connection between Part D and
19 the rest of the Medicare program.

20 DR. SAMITT: So, I'm admittedly struggling with
21 this. I think that it's valuable to look at adherence, but
22 I think that there are so many organizations like our own

1 and pharmaceutical companies and others that really struggle
2 with changing behavior and enhancing adherence, and I would
3 want us to spend our time on the things that we can truly
4 control and influence.

5 So I hate to sound like a broken record, but in
6 high-performing organizations, so Pioneers or ACOs or
7 Medicare Advantage-type plans, I'd be interesting in
8 knowing, you know, let's step away from adherence, knowing
9 which organizations have very effectively been able to
10 control the costs of severe CHF or non-severe CHF or COPD,
11 and what are the specific interventions that they've put in
12 place to influence quality and cost, and maybe adherence is
13 not where they spend their time and effort because it's not
14 something that they can do a whole lot about. You know,
15 maybe, as we think about policy, the levers we should pull
16 are different ones.

17 So I think what I struggle with is the degree to
18 which adherence is a lever that we concentrate on, because
19 at the end of the day, how much would we really be able to
20 move that versus other potential interventions.

21 DR. HOADLEY: So, I'm really glad to see this
22 analysis, and I think part of what we've been talking about,

1 but some of also what you've talked about for future
2 directions, is what'll help make this more valuable. So
3 trying to think about what are the measures that influence
4 adherence is certainly a part of what needs to go into this,
5 and in the Commission's recommendation of last year on
6 changing the copay policy for the LIS population, part of
7 that was to increase generic use, and there are studies that
8 suggest increased generic use is associated with increased
9 adherence. So there are some policy levers we can think
10 about how these pieces start to go together, and I think
11 that's part of it.

12 We've also -- you've also done a lot of work on
13 the medication therapy management, and we don't know a lot
14 about what plans are doing. Maybe we will soon. But that's
15 obviously aimed at doing various things, part of which would
16 be increasing adherence. And so thinking about the
17 correlates of adherence, as Craig was talking about, would
18 be part of getting into that.

19 I think as you think about a longer time period
20 over this, there may be some of the measurement issues that
21 we're struggling with that might straighten out a bit with
22 more time period.

1 A few other things that I want to just mention. I
2 mean, there's definitely a literature out there about
3 declining adherence over time. So some of it may be the
4 statistical property of starting with the adherers and that
5 assumption. But there's also literature that suggests that
6 people get tired of taking their drugs and these sorts of
7 things, regardless of where they start. So, I mean, you
8 clearly want to take a look at that, if you haven't already,
9 and think about where that fits in and whether that -- even
10 things about things that you want to do as adjustments to
11 looking at some of the modeling of this.

12 And I wonder if it's possible to look at -- I
13 mean, you have, with a period of time, the clarification.
14 You said you were doing a modeling process to look at what
15 would low adherers look like if they became high adherers,
16 but you all do have some in the population who do move from
17 one adherence category to another, and maybe separately to
18 look at that group, see if there are some things associated
19 with that that might give us some further clues and get us a
20 tiny bit closer towards that causality, cause and effect
21 kind of thing. It won't get us there, but it might help.

22 I'm generally not surprised by the kind of

1 condition-specific variation, but it's also something, and
2 we've already had some discussion around this, that we'd
3 want to keep challenging. You know, what are the clinical
4 expectations for these different conditions? Where are ones
5 where we might think you'd get a result? Where are ones --
6 you picked depression because there wasn't an obvious
7 argument whether we should see a difference, and that's a
8 useful starting point. You didn't see a difference, so
9 maybe that's as expected.

10 Others, and as you begin to look at more
11 conditions, having a good preexisting sense of where
12 clinical expectations are, both for what you'd expect in
13 impact on spending, but also whether that impact is purely
14 on the spending for that condition. In some cases, if
15 people are healthier, it's not always going to show up in
16 the spending related to that condition. It could show up in
17 a broader set of spending, because, obviously, health
18 conditions are interrelated. But I think it can be a good
19 sense of expectations going into the different conditions we
20 look at, would be helpful, both before going into it but
21 also as you try to explain it.

22 And the last comment, I'll link back to something

1 Mike said about the CBO memo of last fall where they do have
2 some literature, and obviously you know about that, but
3 there are some subtle differences there because they were
4 looking specifically at volume of drug use as opposed to
5 adherence, and as we talk about this, trying to tease out,
6 you know, where there's just more drug use in their case as
7 associated with lower overall A and B spending, and if at
8 some point we can understand the difference between volume
9 effects and adherence effects, that would obviously be
10 useful going forward.

11 So I can elaborate on these at another time, if
12 that's helpful, but I wanted to throw a bunch of things out.

13 DR. COOMBS: So there's lots of studies out there
14 on adherence, and I think Ira Wilson has done a great job
15 looking at some models of adherence.

16 I think your questions are spot on, first of all,
17 and I think where you're going with this is important. And
18 I'd like to remind everyone that we're actually looking at a
19 movie and we're just looking at a position in time. Where
20 we're talking about medical homes, we're talking about going
21 to ACOs and the like, it's possible, and I'm sure there are
22 some best practices out there, to get to adherence that

1 looks much better than this. We're not there yet, so I
2 think it behooves us to really kind of pay attention to this
3 corridor right now and what we're dealing with in terms of
4 moving to the next meter of making sure that adherence is
5 important.

6 I do believe that the adherence is a key factor in
7 terms of hospitalizations for some diseases. I'm not sure
8 that's avoidable in many of the cases of COPD, as Bill and I
9 have mentioned already in terms of what moves COPD into
10 hospitals and exacerbation of illness.

11 So I think you're spot on. I think it's going to
12 be a lot more than six months that's necessary to get some
13 real, true information. Thank you.

14 MR. GRADISON: You mentioned that you might take a
15 look at other conditions, and with apologies to the
16 clinicians, I'm going to suggest one, which is atrial
17 fibrillation and the use of anticoagulants. I had occasion
18 to spend quite a bit of time focusing on this recently in
19 preparation for a couple of days with a think tank. And
20 here, we're talking in the conditions that you have already
21 listed of potentially serious effects, like stroke, in this
22 instance.

1 But one of the special features here is that
2 there's some novel agents that have come along as options to
3 coumadin. Coumadin has to be monitored very closely. It
4 can have some pretty bad reactions to it in some instances.
5 and it is a periodic -- staying on it isn't easy because of
6 the periodic testing, which is, as I understand it, not as
7 required -- the frequency is not as required, or it's not as
8 often as for these new agents.

9 So I think you might get some interesting, a
10 different window looking at this, because as I think about
11 this, and I know this is very subjective, but watching the
12 decline, I do -- a couple of questions come to my mind, but
13 one of them is the question of side effects, which I
14 appreciate that's a very difficult thing to quantify. But
15 perhaps as you're looking at different conditions and
16 particularly different drugs that just by their history have
17 significantly higher levels of potentially serious or
18 uncomfortable side effects, that might be an interesting
19 window into this, as well. Thank you.

20 DR. NAYLOR: So I'm really delighted you're
21 pursuing this. I think this is such a central system issue
22 for which policy responses might be important, and there are

1 three paths that you're already focused on, but I would
2 encourage if we can continue to look at it.

3 One already mentioned is the whole notion of
4 polypharmacy, and your data already suggests that fewer
5 prescribers and medications lead, and there is a pretty good
6 body of literature suggesting for older adults, polypharmacy
7 is a major factor that inhibits adherence.

8 The second is one which might test some hypotheses
9 with which I think people have a sense that we know the
10 causal path, and that's the group of people who have high
11 rates of hospitalizations and heart failure. And there's
12 always the sense that they're not adherent. Therefore,
13 they're going into the ED and using acute care resources and
14 coming back again. And I'm wondering -- I don't know
15 whether or not there's an opportunity here to look at what
16 might be the path here. Is it because they have these acute
17 episodes of illness that make them feel really awful that
18 contribute to poor adherence, et cetera? I don't know
19 whether or not.

20 And the third thing is interesting here in
21 diabetes. Diabetes has been a focal point of patient-
22 centered medical homes and huge investments in diabetes

1 educators and so on. And here you have for a -- in the LIS
2 group -- a very, much higher rate of diabetes as comorbid.
3 So wondering whether or not that presents an opportunity to
4 avenue for you to look at is that kind of investment
5 beginning to pay off in focused education for that problem.

6 DR. NERENZ: Yeah. I'm just trying to think ahead
7 to some of the Medicare payment implications of this whole
8 body of analysis, and I'm going to observe that even if a
9 causal relationship between shifting patients from low to
10 high adherence produces the effect on savings that Kate was
11 concerned about, let's just imagine that that can happen,
12 it's real, illustrated, for example, on Slide 12.

13 My next observation, though, is that the entities
14 incurring the costs of producing that improvement in
15 adherence will not be the entities realizing the savings
16 unless you're in Medicare Advantage, and only in a partial
17 sense if you're in an ACO.

18 So even as this line of thought keeps going
19 forward, I think we have to say, if these relationships are
20 real, and if they are causal, and if we can improve it here,
21 and we can generate savings, how are we going to move the
22 money to actually make those actions occur?

1 DR. HOADLEY: No, I think Dave raises a really
2 important point, and it's almost worse because a Part D
3 plan's costs go up if adherence goes up, because they're on
4 the hook for those costs. And thinking about how to do
5 that, even if we don't think about ways to move money
6 around, thinking about how to create incentives to the Part
7 D plans to take measures to encourage adherence is something
8 that's not obvious and not simple, and I think that as we
9 think about the policy side of this, we really do want to
10 think about that, those points.

11 MR. HACKBARTH: Agreed. Good points.

12 Thank you, Shinobu and Joan. Nice work.

13 And we're on to our final session for today, and
14 this is addressing differences in Medicare payment rates
15 across settings.

16 [Pause.]

17 MR. WINTER: Ready? Okay. In this session, we'll
18 be continuing our exploration of payment differences across
19 settings for ambulatory services, and I want to begin by
20 thanking Jeff Stensland, Kevin Hayes, Julie Somers, and Zack
21 Gaumer for their help with this work.

22 First, we'll explain the importance of addressing

1 payment differences across settings. We will then review
2 the Commission's principles for how Medicare should pay for
3 similar services provided in multiple sites of care. Next,
4 we'll consider different types of services for which it may
5 be appropriate to align payment rates across settings, based
6 on our principles. And for each of these groups of
7 services, we have modeled the impact of alignment payment
8 rates on Medicare spending, beneficiary cost sharing, and
9 different categories of hospitals. And we will also
10 describe ways to mitigate the impact of these changes on
11 hospitals that serve many low-income patients.

12 So, let's start by talking about why it's
13 important to address this issue. There has been rapid
14 growth in hospital employment of physicians, which has
15 contributed to the migration of ambulatory services from
16 free-standing offices to outpatient departments. According
17 to the AHA's Annual Hospital Survey, the number of
18 physicians employed by hospitals increased by 55 percent
19 from 2003 to 2011. And according to a survey by the
20 American College of Cardiology, the share of cardiologists
21 employed by hospitals grew from 11 percent to 35 percent
22 from 2007 to 2012.

1 As more physicians become employed by hospitals,
2 the billing of services in Medicare is shifting from
3 freestanding offices to OPDs. As shown on this slide, the
4 number of evaluation and management visits per beneficiary
5 grew by eight percent in OPDs from 2010 to 2011 compared
6 with a small decline in offices. The number of
7 echocardiograms increased rapidly in OPDs while declining in
8 offices. And the trend is similar for nuclear cardiology
9 studies.

10 Because payment rates for most services are higher
11 in OPDs than in offices, the result of services shifting to
12 OPDs is higher program spending and beneficiary cost
13 sharing. Meanwhile, there may be no significant changes in
14 patient care.

15 We projected how much more Medicare would spend
16 per year if the migration of E&M visits and cardiac tests to
17 outpatient departments were to continue at the same rate
18 over the next ten years. We estimate that by 2021, Medicare
19 spending on E&M visits would be over \$1 billion higher
20 annually due to the shift to OPDs, and beneficiary cost
21 sharing would be about \$300 million higher. Medicare
22 spending and cost sharing for echocardiograms and nuclear

1 cardiology studies would also be higher by similar amounts.

2 The Commission has developed key principles to
3 guide Medicare in paying for similar services in multiple
4 settings. First, patients should have access to settings
5 that provide the appropriate level of care. But if the same
6 service can be safely provided in different sectors, it may
7 be undesirable for a prudent purchaser to pay more for that
8 service in one setting than another. Therefore, Medicare
9 should base its payment rates on the resources needed to
10 treat patients in the lowest-cost clinically appropriate
11 setting.

12 But there are reasons why it may make sense for
13 Medicare to pay more for certain services in a hospital
14 outpatient department than in other settings. First,
15 hospitals incur costs to maintain stand-by capacity for
16 handling emergencies and to comply with additional
17 regulatory requirements. Second, patients treated in OPDs
18 may be more medically complex than patients treated in
19 offices and it might be more costly to treat sicker
20 patients. And, third, the hospital Outpatient Prospective
21 Payment System is more likely than the Physician Fee
22 Schedule to combine the cost of a primary service with

1 ancillary services into a single payment, a concept known as
2 packaging.

3 In our March 2012 report, the Commission made a
4 recommendation to equalize payment rates for non-emergency
5 E&M visits across settings, and the rationale for this
6 recommendation is described on the slide. We also
7 recommended that this change be phased in over three years
8 and that there should be a stop-loss policy for hospitals
9 with a high share of low-income patients. This
10 recommendation would result in lower payment rates for E&M
11 visits in OPDs, producing annual total savings of \$820
12 million and cost sharing savings for beneficiaries of \$190
13 million.

14 Since we made our recommendation on E&M visits, we
15 have been exploring other services that meet the
16 Commission's principles for aligning payment rates across
17 settings. For the purpose of this analysis, we combined
18 services into Ambulatory Payment Classification Groups, or
19 APCs, which is the unit of payment in the Outpatient PPS.
20 And based on a careful analysis of how our different
21 services stack up with our criteria, we identify three
22 groups of APCs.

1 Groups one and two include 66 APCs for which
2 payment rates could either be equalized between OPDs and
3 offices or the differences could be narrowed, and we
4 discussed these two groups at the October and November
5 meetings. We also focused -- since then, we have focused on
6 three cardiac imaging APCs that appear in groups one and
7 two. And, finally, we have identified 12 APCs that are
8 commonly done in ambulatory surgical centers and for which
9 payment rates could be equalized between OPDs and ASCs.

10 So this slide talks about groups one and two.
11 Group one includes APCs for which payment rates could be
12 equal across settings, and group two includes APCs for which
13 the OPD rate could be higher than the office rate, but the
14 differences in the payments could be reduced or narrowed
15 from the current level.

16 At the November meeting, we described the
17 selection criteria for each group. The key difference
18 between the criteria for groups one and two is the extent of
19 packaging. Services in group two have a significantly
20 higher level of packaging in the OPD, and we factor in these
21 costs when we calculate the revised OPD payment rates. As a
22 result, the OPD payment rates are still higher than the

1 office rate, but the gap is narrower.

2 Since the November meeting, we have had a lot of
3 discussion with hospital industry groups about the criteria
4 that we used to identify these services. As a result of
5 their comments, we changed how we measure the frequency with
6 which an APC is provided with an emergency department visit,
7 which is the third criteria shown on the slide, in both
8 boxes. As a result of this change, we ended up dropping
9 five APCs from groups one and two. So it went from 71
10 altogether to 66 APCs in both groups. And I'd be happy to
11 take questions about this during the discussion period.

12 Next, Dan will explain the impact of changing
13 payment rates for APCs in groups one and two.

14 DR. ZABINSKI: So we evaluated the national level
15 financial effects of the payments adjustments for groups one
16 and two that Ariel just covered and we find that combined
17 program spending and beneficiary cost sharing would decline
18 by about \$900 million per year.

19 In your meeting paper, we mention the amounts by
20 which beneficiary cost sharing would decline depends on the
21 method used to determine the copayments for each OPC, and
22 the specifics are in your paper, but the cost sharing would

1 decline from in a range of \$140 million to \$380 million per
2 year. Also, the more beneficiaries save in cost sharing,
3 the lower the program savings are by the same amount.

4 And we also estimated that these payment
5 adjustments in groups one and two would reduce hospitals'
6 overall Medicare revenue by 0.6 percent and their Medicare
7 OPD revenue by 2.7 percent.

8 We also evaluated the effect on hospital
9 categories, including urban and rural; nonprofit, for
10 profit, and government-owned; and major teaching, other
11 teaching, and non-teaching. And the effect of these payment
12 adjustments for groups one and two is similar to the overall
13 average of 0.6 percent for each of these hospital
14 categories, except for rural, which would have their
15 Medicare revenue decline by 0.9 percent.

16 Finally, we evaluated the effects of combining the
17 payment adjustments for groups one and two with equal
18 payments across OPDs and freestanding offices for E&M visits
19 the Commission recommended in the March 2012 report. We
20 found that this combined policy would reduce hospitals'
21 overall Medicare revenue by 1.2 percent and Medicare OPD
22 revenue by 5.4 percent. And this combined policy would have

1 a disproportionately large impact on rural, major teaching,
2 and government-owned hospitals.

3 A concern that many have expressed about aligning
4 payments between OPDs and freestanding offices is that
5 access to ambulatory services among low-income patients may
6 be adversely affected. In response, we have considered
7 methods to mitigate the impact on hospitals serving low-
8 income patients. Ideally, we would like to target hospitals
9 that serve a lot of low-income Medicare patients in their
10 OPDs, but currently, no measure represents that. In
11 response, we have decided to use hospitals' disproportionate
12 share, or DSH, percentages as a proxy. And the DSH is based
13 on the number of inpatient days for low-income Medicare and
14 Medicaid patients. But a better measure would be focused
15 strictly on care provided to low-income Medicare patients in
16 OPDs.

17 Another issue to consider is whether the policy
18 should be a stop-loss protection or a set pool of dollars.
19 A stop-loss has the advantage of providing assistance to all
20 hospitals that meet a certain set of criteria for being
21 deserving of assistance. But the amount of revenue returned
22 to hospitals would not be known ahead of time and may exceed

1 the amount anticipated.

2 A pre-set pool has the advantage that the amount
3 returned to hospitals is known ahead of time, but it has the
4 disadvantage in that it may result in some hospitals that
5 may be deserving of assistance not getting as much as they
6 need to remain viable.

7 For the purpose of this presentation, we use the
8 following illustrative example of a stop-loss, where losses
9 would be limited to two percent of hospitals' overall
10 Medicare revenue if their disproportionate share percentage
11 is above the median of 25.6 percent. The Commission
12 recommended the same policy in the March 2012 report, along
13 with equal payments across settings for E&M visits.

14 And we have collected the hospitals in our
15 analysis into the categories listed on the left margin of
16 this table. The first column of numbers in the table
17 represents the effects of the payment adjustments for groups
18 one and two on each of the hospital categories. Column one
19 indicates these payment adjustments have quite similar
20 effects across the hospital categories, except that rural
21 hospitals are disproportionately affected, which we
22 mentioned earlier.

1 The second column of numbers represents the
2 effects of the payment adjustments for groups one and two
3 plus the stop-loss that we just defined. We find that the
4 stop-loss would return about \$10 million, and this results
5 in virtually no difference between the first and second
6 columns, which indicates the stop-loss has a nearly trivial
7 effect in this situation.

8 The third column represents the effects of
9 combining the payment adjustments for groups one and two
10 along with payment adjustments for the E&M policy that the
11 Commission recommended in the March 2012 report, and we
12 simply refer to this as the combined policy. And you can
13 see that some categories lose much more than others under
14 these combined categories, with rural, major teaching, and
15 government-owned hospitals losing more than the average.

16 And the fourth column is the effects of the
17 combined policy coupled with the stop-loss. In this case,
18 the stop-loss would return \$210 million to the qualifying
19 hospitals and narrow some of the differences among the
20 hospitals, and particularly reduces the losses for
21 government-owned and major teaching hospitals.

22 So that completes our analysis of the 66 APCs in

1 groups one and two.

2 Based on Commissioner comments at the meeting last
3 October, we also did a similar analysis that focuses on
4 three cardiac imaging APCs in groups one and two. These
5 APCs have shown unusually rapid migration from office to
6 OPDs, which reflects the increase in hospital employment of
7 cardiologists. Also, payment rates are substantially higher
8 in OPDs than in freestanding offices for these services, and
9 they comprise over half of the savings from groups one and
10 two. Following the same payment adjustments for these APCs
11 that we did for them in our analysis of groups one and two
12 would reduce combined program spending and beneficiary cost
13 sharing by about \$500 million per year, with beneficiaries'
14 cost sharing going down by about \$100 million.

15 And this slide has the same structure as the one
16 presented two slides ago, but we've replaced the payment
17 adjustments for groups one and two with the payment
18 adjustments for the three cardiac imaging APCs.

19 Column one indicates these payment adjustments
20 have a similar effect in all hospital categories, except
21 that rural loses a bit more than the other categories.

22 Column two indicates that adding the stop-loss to

1 hospitals that serve low-income patients has little effect
2 on the payment adjustments for the three cardiac imaging
3 APCs.

4 And column three, we combine the payment
5 adjustments for the cardiac imaging APCs with the E&M policy
6 from the March 2012 report. And as you can see, some
7 hospital categories are affected more than others, with
8 rural, major teaching, and government losing more than
9 average.

10 And column four, the stop-loss returns \$140
11 million to qualifying hospitals under this combined policy.
12 It narrows the differences between the hospital categories
13 and provides the most assistance to government-owned and
14 major teaching hospitals.

15 And we also identified 100 hospitals that would be
16 most affected by the payment adjustments for the three
17 cardiac imaging APCs without any stop-loss or the effects of
18 equal payments across settings for E&M visits. Compared to
19 all other hospitals, these 100 most affected hospitals are
20 more likely to be rural or nonprofit, less likely to be
21 major teaching or for-profit, have about one-third the
22 number of beds, on average, and they have a similar DSH

1 percentage, and only six of them are specialty hospitals.

2 So far, we've focused on payment rate differences
3 between OPDs and freestanding physician offices. At a
4 previous meeting, Commissioners suggested that we also
5 investigate aligning payment rates between OPDs and
6 ambulatory surgical centers, or ASCs. For all services,
7 payment rates are higher in OPDs than in ASCs, with most
8 services being 78 percent higher in OPDs.

9 We have identified three criteria that should be
10 met for a service to have equal payment rates in ASCs and
11 OPDs. They should be performed more than 50 percent of the
12 time at ASCs, infrequently provided with an ED visit when
13 done in an OPD, and patient severity should be no greater in
14 OPDs than ASCs.

15 And we identified 12 APCs that meet these three
16 criteria. Reducing OPD rates to the level for ASCs in these
17 12 APCs would reduce combined program spending and
18 beneficiary cost sharing by about \$590 million per year,
19 with beneficiary cost sharing declining between \$40 million
20 and \$220 million per year, depending on how copayments are
21 determined.

22 And this is the third time you've seen the version

1 of this slide. In the first column, you can see that the
2 equal payment rates between OPDs and ASCs for the 12 APCs
3 reduces revenue in most hospital categories by close to the
4 0.4 percent for all hospitals. Rural hospitals are an
5 exception and lose 0.7 percent.

6 In the second column, we add the stop-loss that we
7 discussed earlier, and it would return \$10 million to the
8 qualifying hospitals, and its effect is largely minimal in
9 terms of the differences between the first and second
10 column.

11 The third column shows the effect of combining the
12 equal payments across settings for the 12 APCs with equal
13 payment rates in OPDs and freestanding offices for E&M
14 visits. This combined policy would vary across hospital
15 categories, with rural, government-owned, and major teaching
16 hospitals being disproportionately affected.

17 And the fourth column shows the effects of adding
18 the stop-loss we defined earlier to the third column. In
19 this situation, the stop-loss would return \$160 million to
20 the qualifying hospitals and has important effects for
21 reducing the impacts on government-owned and major teaching
22 hospitals.

1 And once again, we identify the 100 hospitals that
2 would be most affected by the equal payment rates across
3 OPDs and ASCs for these 12 APCs. This excludes the effects
4 of the stop-loss and equal payments across settings for E&M
5 visits. Compared to all other hospitals, the 100 most
6 affected hospitals are more likely to be rural or for
7 profit. They have one-sixth the number of beds of all other
8 hospitals, on average. They are less likely to be nonprofit
9 or major teaching. They tend to have a lower DSH
10 percentage. And 61 of them are specialty hospitals.

11 So the summary of our discussion today starts with
12 identifying 66 APCs where differences in payment rates
13 between OPDs and freestanding offices could be narrowed or
14 eliminated, and we define these as groups one and two. And
15 we evaluated the effects of these payment adjustments on
16 program spending and beneficiary cost sharing. We also
17 evaluated the spending and cost sharing effects of focusing
18 on three cardiac imaging APCs that are in groups one and
19 two. And, finally, we evaluated the spending and cost
20 sharing effects of equal payments in OPDs and ASCs for 12
21 APCs that are commonly done in ASCs.

22 On this table, the first column is a summary of

1 the effect on combined program spending and beneficiary cost
2 sharing of the policies that we discussed today.

3 Then adding the Commission's recommendation of
4 equal payment rates in OPDs and freestanding offices for E&M
5 visits would increase the effect of each policy by 0.6
6 percent, which is the second column on the table.

7 The third column shows that the three policies we
8 discussed today would substantially reduce annual Medicare
9 spending and beneficiary cost sharing.

10 And the fourth column indicates that the reduction
11 in beneficiary cost sharing would vary, with the level of
12 reduction depending on how beneficiaries' copayments are
13 determined in each APC.

14 Please note that there is overlap between the APCs
15 in groups one and two and the other two categories on the
16 slide. And because of that, the total impact on spending
17 and cost sharing from doing the changes in all three
18 categories would be much smaller than the amounts determined
19 by simply summing the columns on the table.

20 So to close, areas of discussion that would be
21 helpful for us today as we move forward on this issue
22 include questions about the analysis we presented,

1 discussions and additional services that meet the principles
2 of aligning payments across settings, and discussions of
3 ways to mitigate the impact on hospitals that serve low-
4 income patients or reduce beneficiary cost sharing, and we
5 turn things over to the Commission for discussion.

6 MR. HACKBARTH: Thank you.

7 So let me just say for the audience a little bit
8 more about the context of this discussion. This is a topic
9 that we've been talking about for a while now, and it's
10 become almost a regular feature of our meetings.

11 Much of the material in today's presentation is
12 addressing questions raised at our last discussion, whenever
13 that was, I guess in January or maybe it was in December
14 that we last discussed it.

15 DR. MARK MILLER: More like November, wasn't it?

16 MR. HACKBARTH: Okay, whenever. So we are trying
17 to respond to issues and ideas raised by Commissioners in
18 previous sessions. We have made a formal recommendation on
19 E&M services. We have no draft recommendation under
20 consideration right now, and plan no recommendation for our
21 June report. Based on the conversation today, we'll decide
22 what our future path is on this topic for the fall when we

1 reconvene again.

2 So with that, let's start Round 1, except I'm
3 amending the ground rules here. To be a qualifying Round 1
4 item, it has to be phrased as, "Please put up Slide blank,"
5 and then followed by, "What does blank mean?" Okay? In
6 order to qualify for Round 1, this is sort of like Jeopardy
7 where your answer has to be in the form of a question.
8 Round 1 has to fit --

9 DR. BAICKER: It has to be in the form of a
10 question.

11 MR. HACKBARTH: Yeah. This question, one of these
12 two questions. Okay? So Bill, you're going to be the --

13 MR. GRADISON: There are a lot of slides to have
14 the word rural on them. It's just a specific, very specific
15 question. When you use the category rural, does it include
16 critical access hospitals and solo community hospitals?
17 What's in rural?

18 DR. ZABINSKI: It excludes CAHs, the critical
19 access hospitals, and it includes solo community hospitals.

20 MR. GRADISON: Thank you.

21 DR. ZABINSKI: Basically it's all rural hospitals
22 that are under the inpatient prospective payment system.

1 MR. GRADISON: Thank you.

2 MR. KUHN: On Slide 23 -- excuse me -- please, on
3 Slide 23, I'm curious about the last column, beneficiary
4 savings, and you have ranges for the first two, but the
5 middle one is an absolute, you know, as close as you can
6 get. Because of the ranges, is that because of the formula-
7 driven overpayment, if that's what's driving that? What's
8 creating those ranges?

9 DR. ZABINSKI: What's going on with that one --
10 how to say -- I think you probably know about the way that
11 co-payments are determined once -- in the outpatient PPS,
12 once they reach the 20 percent level, they go up or down
13 with the payment rate. And in this case, all three of them
14 are at the 20 percent -- well, it's not all three of them --
15 two of them. But most of the money in there is at the 20
16 percent.

17 So we have three different methods for, you know,
18 estimating the effects on cost sharing, and since all three
19 of them are at that 20 percent level, then the three
20 different methods that we have produces essentially the same
21 \$100 million impact.

22 MR. KUHN: And so, that's why those are. And then

1 the others, because of the variation, some are above the 20
2 percent and that's why we've got that way. Thank you.

3 DR. COOMBS: Yes. Slide 13, please. So the third
4 bullet, in the writing you talked about -- in the paper you
5 talked about Medicaid, and I was wondering if that last
6 bullet was -- you were intending to put Medicaid, a Medicaid
7 benchmark there?

8 MR. WINTER: One of the questions is, it's more
9 about the second bullet, the second sub-bullet using DSH as
10 a proxy, because DSH includes share of inpatient days that
11 are for Medicaid patients as well as share of inpatient days
12 that are for Medicare patients on SSI. So the question is,
13 do you want to use a Medicaid measure as part of the measure
14 for determining hospitals that serve a large share of low-
15 income patients.

16 DR. COOMBS: Right. Right.

17 DR. ZABINSKI: Ideally -- I mean, I guess ideally,
18 we would like some measure.

19 DR. COOMBS: It was mentioned in the paper.
20 That's why I'm just bringing it up and I didn't see it up
21 there.

22 DR. ZABINSKI: Okay.

1 DR. MARK MILLER: Just to expand -- please, stay
2 on this Slide 13. Just to stay on this for just a second, I
3 think the conversation, if we end up talking about
4 mitigation policies, we'll engage in questions like, should
5 the measure be Medicare, say SSI/Medicare patients, should
6 it be Medicare plus Medicaid. But then another question has
7 come up is, what about inpatient versus outpatient?

8 I think what we're trying to do in a summary
9 fashion and in somewhat more detail in the paper, is put all
10 those questions in front of you. If you accept the Medicaid
11 point, and this conversation has occurred before, you are
12 kind of implicitly saying, Well, then we're going to include
13 a different payer in the measurement. And then there's the
14 inpatient and outpatient back and forth that we've had here
15 in other ones. Thank you.

16 DR. COOMBS: This is not a to-fro, but I do want
17 to say that I'm persuaded by the presence of Medicaid as
18 well. That's the only reason I asked the question.

19 DR. SAMITT: Slide 23, please. And this may be
20 more about -- less about this topic, but more of an
21 educational opportunity for me about Medigap. So in the
22 last column, the beneficiary savings, do these savings truly

1 accrue to the beneficiary or do they accrue to Medigap
2 plans, and do they then translate ultimately to the
3 beneficiary and reduce premiums?

4 MR. HACKBARTH: Let me try, Dan, and see if I've
5 got it right. I assume it's calculated just based on the
6 cost-sharing structure in Medicare. And so, to the extent
7 that a beneficiary is covered by a supplemental plan, it
8 would not flow directly into the beneficiary's pocket. If
9 the markets are at all competitive, it may ultimately flow
10 through to the premiums, but there's some reason to question
11 whether -- how competitive the supplemental markets are.

12 MR. ARMSTRONG: Could you please go back to Slide
13 13? And I just want -- the question I have is just to
14 remind me of why this is an issue. The concern about, you
15 know, applying our principles where we've applied them
16 everywhere else to those hospitals that have a higher
17 percentage of low-income patients, is our concern that those
18 hospitals rely on the cross-subsidization of Medicare
19 payments to pay for other payments -- patients? I just want
20 to be reminded why this is an issue for us.

21 MR. HACKBARTH: So our initial concern, the reason
22 why we put this in the recommendation we made on E&M

1 services was that in at least some communities, hospital
2 outpatient departments are really important providers of
3 these services. There aren't as many private physician
4 practices where people could go to receive the services.

5 So to the extent that we would compromise the
6 ability of those institutions to provide the services, it
7 could mean an access problem for Medicare beneficiaries.
8 And so, we wanted to err on the side of caution, take
9 special -- make special precautions not to hurt those
10 institutions unduly.

11 DR. MARK MILLER: And this is again with respect
12 to Alice's comment and still staying on this slide, is
13 that's the question. If it's about access for Medicare
14 beneficiaries in a particular community, your measure might
15 be different. And that's why we're trying to raise the
16 questions around the measurement.

17 MR. HACKBARTH: The other part of our
18 recommendation, as you probably recall, Scott, was to
19 recommend that the Secretary look further at this issue. If
20 the issue is protecting institutions that are important for
21 serving a particular community's low-income people, perhaps
22 the best way to do that is not through a subsidy run through

1 the Medicare program, but through another, a better targeted
2 approach. So this was sort of a stop-gap to create some
3 time for another approach to be examined.

4 MR. ARMSTRONG: It seems to me we've actually been
5 explicit about that principle in other conversations; that
6 that is not our responsibility. We're responsible to make
7 sure there's access for our Medicare beneficiaries, but for
8 cross subsidizing other programs that don't cover the costs,
9 that's not a criteria we should be applying.

10 MR. HACKBARTH: Clarifying questions.

11 MR. BUTLER: If it wouldn't be too much trouble,
12 please put up Slide 23. All right. So I'm curious on the
13 three cardiac imaging. You know, it's a whopping amount of
14 the total, as we've pointed out at earlier meetings. And I
15 think I asked you this privately before. Of all of the --
16 what do these three represent, though, of the totality of
17 the heart APCs? These happen to be the three that are the
18 big focus.

19 Is this, you know, like 90 percent of it, do you
20 think? I just don't know enough about the APCs to know if
21 there are a lot of other ones down the line beyond that that
22 are part of what would be addressed.

1 DR. ZABINSKI: I don't know how many, if you want
2 to call them, define them as cardiac APCs there are. You
3 know, just because these -- these three APCs have a lot of
4 volume in them and that's why there's such a big -- there's
5 such a big effect when you change the payment rates for
6 them.

7 So I would guess that they are a good chunk of the
8 total volume among all the current cardiac APCs that are in
9 the outpatient PPS, but I don't know that for certain. But
10 as far as how much, I, you know, I don't know.

11 DR. MARK MILLER: We could know that.

12 DR. ZABINSKI: Definitely could know that, yes.

13 DR. HALL: Please, 23. The assumption is that
14 there will be no net change in the number of procedures
15 done. Is that correct?

16 DR. ZABINSKI: That's correct, yeah.

17 DR. HALL: Okay. And we're sure of that?

18 DR. ZABINSKI: Well, basically the idea here is
19 get a sense of, you know, if you just paid hospitals at a
20 rate that aligns with another sector, how much would the,
21 you know, program spending and beneficiary cost-sharing be
22 affected. That's the idea here.

1 MR. WINTER: This is not meant to be -- this is a
2 basic model. We're not doing a very sophisticated analysis,
3 but we're considering behavioral responses such as CBO might
4 consider if they were doing an official score.

5 DR. HALL: Sure. We're in Round 2 already. I'm
6 sorry. I just wanted to clarify that one point.

7 MR. HACKBARTH: Round 1. Any further Round 1
8 clarifications? Rita.

9 DR. REDBERG: Please, we could stay on this slide
10 for -- I actually was looking at Slide 4 where you had the -
11 - so my question on Slide 4, and perhaps I missed this, but
12 you have the increase in growth in OPD, the decrease in
13 free-standing. But overall in that time period, was there
14 an increase or a decrease in overall imaging for these
15 services, the echo and the nuclear cardiology?

16 DR. ZABINSKI: I believe there was a small
17 increase overall. It was largely an offset, I believe, you
18 know. The decrease in the physician office and the increase
19 in the OPD largely offset each other.

20 DR. REDBERG: And then on Slide 23, please, did I
21 understand correctly that your assumption was that there
22 would be a decrease in Medicare spending because the volume

1 would stay the same despite the difference in reimbursement?

2 DR. ZABINSKI: Right.

3 DR. REDBERG: Just because, I mean, our experience
4 in SGR and other things, that hasn't been true.

5 DR. ZABINSKI: True. I'm not sure how much to
6 assume as far as a behavioral effect in this situation. One
7 can think that, okay, if they're not done, you know, you
8 could drop the rate in the OPD, you know. You could get
9 them done in a free-standing office, perhaps with no affect
10 on the volume. You know, it's hard to say what exactly the
11 behavioral impact would be.

12 DR. CHERNEW: We don't even know which direction
13 the behavioral impact might be.

14 DR. MARK MILLER: Like the CPC discussion that we
15 had earlier today, I mean, in a sense we're trying to go
16 through this in a static way to answer your questions that
17 you asked earlier and get to your sense of zeroing in on
18 things and then pick up from there and go further. But I
19 think Mike does make a good point. Which way you would
20 assume here if we got to that point, would be an interesting
21 question.

22 MR. HACKBARTH: No further Round 1 clarifying

1 questions? Okay. Let me kick off Round 2. Could you put
2 up Slide 14, please? So on various slides here for
3 different combinations, we have a column that says, you
4 know, here's the total revenue effect of combining these
5 policies. I just want to make a connection for people that
6 otherwise may be missed.

7 So certainly if you look at the far right column -
8 - and these are combined revenue loss numbers, right? And
9 so, these are revenue losses. All other things being equal,
10 what that would mean is that the overall Medicare margins
11 would decline by these numbers. And, of course, the other
12 place that we think about the overall level of Medicare
13 payments to institutions is during the update process.

14 So to the extent that the magnitude of the numbers
15 in that column, or any one of the columns in subsequent
16 slides, is an issue. Another opportunity to address revenue
17 loss is through the update process as opposed to the path of
18 thinking, Well, we ought not do this because it results in
19 the net revenue loss and the net decline in margins. There
20 are other payment variables at work here. And so, I just
21 wanted to highlight that for people, to get people to think
22 about that.

1 DR. MARK MILLER: And the only thing I would say
2 to that is, just a different way to think about that is, and
3 we do this all of the time when you think about when we go
4 through the payments systems. There's the level and then
5 there's the underlying equity of the -- and work ability of
6 the payment system. You can think of this as what's the
7 underlying workability of the payment system. And then if
8 there's more revenue to add, then the update part. I'm just
9 trying to state it a little bit different.

10 MR. HACKBARTH: So Dave, do you want to start on
11 Round 2?

12 DR. NERENZ: The first one would follow on some of
13 these other observations about behavioral change. I realize
14 it's hard to model that, but one of the questions, on some
15 of these examples, we've showed a fairly heavy effect on
16 rural hospitals, for example. It would be interesting to
17 know what alternatives to HOPD placement exists in those
18 places specifically. For example, would there be an
19 ambulatory/surgical site available as an alternative site,
20 even if you wanted to pay at that rate?

21 All those questions, I think, bear on the
22 speculation of what the behavioral changes really would be.

1 The one behavioral change actually that would probably leave
2 you with the same numbers would be if the procedures were
3 done overall at the same rate, but they just shifted in the
4 opposite direction, like from HOPD elsewhere. That wouldn't
5 change your projected payments. But enough change in
6 procedure volume would. So just observation.

7 The other thing -- you'll just cut me off if this
8 doesn't work. I noticed the figure that you have in the
9 chapter doesn't appear in the slides. And I did have a
10 question on that. I'm looking for the page where that is.
11 I'm sorry. This is the one, the scatter plot -- yeah, that
12 one. What page is it on?

13 MR. WINTER: Page 26.

14 DR. NERENZ: Page 26, sorry. I just, to repeat an
15 observation I think I made in November, that the -- what
16 seemed to me interesting in this when you first showed it,
17 and I make the point again, is the absence of relationship
18 here may actually be meaningful in that the way the thing is
19 arrayed, the points up near the top of this diagram are the
20 ones that have a lot of extra HOPD payment, if we call it
21 that way.

22 That effect, all else equal, would tend to push

1 those dots to the right, I think. The fact they are not
2 shifted to the right suggests that there's some sort of
3 corresponding efficiency effect. Now, it may be very small.
4 I understand that, you know, the contribution of these CNM
5 payments to this 30-day measure, this may not be so small.

6 But I guess the context here is that the absence
7 of relationship means there's nothing going on. My point
8 might be the absence of a relationship means that there
9 probably is something going on. It might be small, but it
10 might be something. I guess just to put a fine point on it,
11 you know, you talked about largely random r-squared .05. Is
12 there actually a statistically significant relationship in
13 here?

14 MR. WINTER: Yes, there is.

15 DR. NERENZ: But it's small.

16 MR. WINTER: Yeah. I mean, the .05, it's a
17 negative correlation and it's just not significant, but the
18 question is, is it a meaningful difference? So the
19 correlation is so small, you know, it doesn't seem to be
20 like a really meaningful correlation between how much from
21 revenue hospitals are getting from these services and their
22 scores on Medicare spending per beneficiary.

1 DR. NERENZ: But again, my starting point.

2 MR. WINTER: Right.

3 DR. NERENZ: The absence of a relationship may be
4 meaningful.

5 MR. WINTER: And so, the point I would make there,
6 as you alluded to, looking at 30-day -- spending for a 30-
7 day episode around admission, so most of the spending there
8 is going to be on the outpatient side and supposed to give
9 care. Much of it -- a very small portion is going to be
10 related to outpatient services like E&M clinic visits. So
11 yeah. And we did have the slide up at the November meeting,
12 so we didn't have enough time to put it back up again, but
13 thanks for raising the question.

14 MR. HACKBARTH: Just to go back to the November
15 discussion again, so even if you stipulate that there is
16 this small negative relationship, you're not finished with
17 your analysis. Then the next question is, is this the best
18 way to encourage effective management that reduces episode
19 costs or is this a not very well targeted approach?

20 DR. NERENZ: Agree 100 percent on that. I have no
21 problem with that at all. It's just exactly, how was this
22 presented in the written material.

1 DR. NAYLOR: Just with each iteration of this
2 work, I've become more and more convinced that this is the
3 right direction. And it's so aligned with the principles as
4 you described on Slide 6 and reiterated. The only issue,
5 and I guess I'm channeling Tom, is the impact on rural
6 hospitals.

7 But that said, I think all of the proposed
8 directions in terms of getting people who are clinically the
9 same, our program paying for the services, Medicare's
10 program paying for the services in the most efficient and
11 effective way is absolutely an important principle to
12 pursue.

13 MR. GRADISON: Maybe more on the same point. It
14 would seem to me that there may be some benefit in combining
15 our comments with regard to paying hospitals or other
16 entities the same for identical tests and other kinds of
17 services regardless of the site of service with the same
18 point that we've made about post-acute care. It's precisely
19 the same point.

20 And I realize we've had separate projects going
21 on, but it would seem to me they really ought to be combined
22 because it seems to me exactly the same issue, which is

1 paying equal pay for equal work, to go back to the old ERA
2 argument or something.

3 MR. KUHN: Dan and Ariel, thank you both for all
4 the work here and listening to the conversation from the
5 last meeting and including all the details you have here.
6 Like others, just point out the impact statements and tables
7 you've put up here. In particular the impacts on the rural
8 hospitals are a concern.

9 But the other issue, I just want to see if there
10 was a chance as we kind of carry forward this work into the
11 future, is really kind of thinking a little bit, after the
12 conversation this morning, about the readmission policy, and
13 the fact that there are things people are doing now in the
14 post-discharge environment, that would this interrupt that
15 feedback loop.

16 So are there some things now going on as a result
17 of the deal with readmissions that they are aligning
18 differently with the outpatient department, that these two
19 either might synch up or they might not. And does that kind
20 of create some issues there?

21 The other thing I would be real curious about, as
22 the care coordination efforts continue to get more robust

1 out there, particularly with the ACOs and maybe even the
2 Pioneer ACOs, does this -- would a policy like this
3 interrupt or would it support those kind of programs on a
4 go-forward basis? And so, as we continue to think about
5 that, I'd like to know how -- if there was a way that those
6 interactions could be looked at further.

7 DR. COOMBS: So as I looked and read the paper,
8 which was excellent -- I really appreciate the job that you
9 guys have done -- Table 3 and Table 4 actually deal with
10 what kind of adjustments would happen if we would make those
11 changes that we proposed. And one of the things that I was
12 very concerned with is, even the adjustment that's made is
13 still quite robust for different sites, same procedure,
14 different sites. And, you know, there's opportunity for
15 even greater savings there.

16 I don't know if we've actually, you know, thought
17 along those lines, because, you know, I'm looking at the OPD
18 for the Level III echo in terms of what goes to the hospital
19 and what goes to the physician who does it. And it's more
20 than you would account for in an office, considerably more.
21 And so, I think we've talked about stand-by capacity for
22 hospitals and how we cover them.

1 But I'm not sure that we've gotten to a place
2 that's actually even better in terms of our ability to kind
3 of justify what those charges are for and how we pay the
4 hospitals. Still, I think it's probably a little on the
5 heavier side compared to the same thing that actually
6 happens in the office for both the Level II and the Level
7 III.

8 And then I agree with what Glenn has said in terms
9 of that marker for what is a threatened access in the
10 community. We have a lot of hospitals that might fit into
11 that niche of being a safety net in terms of right being at
12 the border for the percentage of Medicare patients treated,
13 and the Medicaid penetration is probably a better proxy for
14 that hospital being under duress or stress in terms of just
15 the availability of resources in a given area.

16 So I think that's a real important thing to keep
17 in mind, not just as, Scott, you alluded to that we're --
18 Medicaid patients are not our charge, but many times that is
19 probably a more reflective marker of what kind of needs
20 exist in a community.

21 DR. HOADLEY: Yeah, thank you. As this has been -
22 - this issue has been articulated over the series of

1 meetings, and like Mary said, it seems to me it builds an
2 increasingly convincing case that this is a sensible route
3 to go. I think, you know, the refinements of it and the
4 sort of details, and obviously there's a few choices we can
5 make in terms of actually how to shape the details of a
6 recommendation at whatever point we do that, but I find this
7 very convincing, and especially in the context of so much of
8 this serve as shifting sectors already.

9 We're just saying, Okay, so if there's something
10 that's helping to move it from one place to the other, let's
11 try to level that playing field, in particular in this
12 situation.

13 DR. SAMITT: This is a great job. It keeps
14 getting better. I'm comfortable, absolutely comfortable
15 with where this is going. I think in the world of the ACO,
16 the ACOs themselves are seeking out these opportunities. So
17 in the world of bundled payment, we want to know all the
18 things, that actually we can achieve the same quality of
19 care or better in a lower acuity, lower cost setting.

20 And so, all of these things make total sense to
21 me. I'm equally concerned about the rural hospital problem.
22 You know, I think we've talked about things like this in

1 sort of similar settings, but is there a methodology that we
2 can use that says, you know, if a setting is available, so
3 if there is an ASC that is available in a rural area, then
4 the rate is paid at the lower rate. But if an ASC is not
5 available, for example, it's paid at a higher rate.

6 The concern about that is you want to incent the
7 creation of lower cost settings if that makes sense. But
8 maybe there's a methodology like that that can help float
9 rural.

10 And the last thing that I would say that I think
11 I've brought up before is, you know, thinking of the next
12 generation of these opportunities, I think the threshold of
13 looking at 50 percent being done in outpatient is too high.
14 I would imagine that there are some innovators where the
15 ratio is actually lower. So I'd be curious.

16 Even in some APCs that have a 25 percent
17 outpatient rate, who's doing those and is the quality in an
18 outpatient setting equal to an inpatient setting? It's the
19 innovators or those who are ACOs or what have you that are
20 exploring those. It may highlight the next generation of
21 APCs that we should be looking at next.

22 MR. HACKBARTH: Let me raise a question and invite

1 the rest of the commenters to react to it and then we can
2 also get people on this side a chance at the end as well.

3 So part of what we tried to accomplish with this
4 presentation is lay out different possible paths to do the
5 groups 1 and 2 with the criteria defined, focus on the
6 cardiac, add in the ASCs, and nobody has really addressed
7 the thoughts of which of those paths makes sense to them.
8 So that would be helpful. If you have thoughts about where
9 you might start, which of those paths makes sense, please
10 address that and then we'll go around here and give these
11 folks a chance.

12 DR. SAMITT: Do you want us to pick one?

13 MR. HACKBARTH: No. I'd just like to know what
14 people are thinking about that, because it will help give us
15 some guidance on how to shape the future.

16 DR. MARK MILLER: And the only other thing that's
17 unspoken and is, you know, transition, that type of thing.
18 You can either pick paths to say, I want to focus on these
19 things first, but you could also roll into a much broader
20 set more slowly. Those are also ideas.

21 DR. CHERNEW: To answer your question, I prefer
22 the broader sets of services to apply this to, but I want to

1 emphasize that in the spirit of what you said to start with,
2 my motivation is not at all to save money or to take money
3 away from sort of facilities. In fact, as again you alluded
4 to, I think in the end, we actually won't be saving as much
5 money as shows up on the slides because we're going to come
6 back in our update recommendations and have to deal with
7 updates in ways that reflect this.

8 So the concern that I have with the broader
9 approach, which I tend to recommend, is that there are
10 distributional consequences. So it's not true that if you
11 take a certain amount of money out and then put it back in,
12 that everyone is exactly the same. It's that you've taken
13 it out disproportionately from some versus others.

14 And so, I'm very supportive of the entire set of
15 analyses you've done about how to mitigate that, and I think
16 we have to keep thinking about that. But I think that
17 becomes important.

18 More broadly, what I'd like to at least get to say
19 on the record is that prices are not simply a mechanism for
20 funneling money to different provider types. They
21 inherently create incentives. And so, as we think through
22 the payment system here and wherever, an analysis which

1 simply tries to equate different amounts of money going to
2 different types of organizations is not the right way that I
3 would think about how to manage the system.

4 I would prefer to think about trying to get the
5 prices right -- relative prices right and then try and
6 adjust through some of the other tools that we have. And I
7 think this is a step in the right direction. So to the
8 extent that people think that you should not do something
9 because it's taking too much money out of a particular type
10 of organization, I would ask, well, let's worry about
11 getting the prices right.

12 And if we're causing some other problem with the
13 amount of money going one way or another, let's think of an
14 efficient way to get there. That principle, I think,
15 transcends just this discussion, but I think it's important
16 as we move forward.

17 MR. HACKBARTH: Could I just sort of amplify on
18 that, Scott? So if the relative prices are skewed and
19 sending distorting signals, we are influencing behavior and
20 we're seeing that real-time right now. The longer we stay
21 in this structure where we're paying dramatically rates for
22 the same service based on the location -- we've done that

1 test. We know people will respond to it. And so, getting
2 the relatives right is really important. This isn't an
3 academic exercise.

4 MR. ARMSTRONG: Well, I would start just by saying
5 I share that point of view that you just expressed, too,
6 Glenn. I think these payment principles are sound. We've
7 debated them for, it seems, at least a couple of years now.
8 I would take the broadest application of this, as defined by
9 the choices here.

10 I wouldn't apply the stop-loss kind of adjustments
11 that you've been talking about for some of the reason I've
12 mentioned before. Frankly, I would have extended the
13 application of these principles to these 61 or 66 APCs and
14 then the equalization of payments between the
15 ambulatory/surgery centers and the outpatient departments
16 back in March when we first made the payment policy changes
17 to the E&M codes. So if anything, I think we are too slow
18 and I would go much more quickly than we're talking about.

19 I think the last point I would make is that not
20 only is this a pricing structure that creates behavior
21 that's costing the Medicare program in ways that doesn't
22 create any value for the beneficiaries, the cost to health

1 care is far more than just the Medicare program. There are
2 a lot of payment structures in private plans that are
3 organized around the Medicare structure. I think that
4 there's tremendous waste as a result of this payment
5 structure. The sooner we change it, the better.

6 DR. BAICKER: I agree wholeheartedly with the
7 concept that the prices have to be right, and that involves
8 paying roughly the same amount for the same service
9 delivered to the same patient, and you want patients in the
10 right venues.

11 I have less of a problem with a stop-loss if it's
12 focused as you've outlined as one of the options on
13 preventing big sudden changes for vulnerable entities that
14 don't have as much of a smoothing capacity. So that implies
15 that it should be the two-part test of the -- a big drop and
16 only for targeted entities but, importantly, that it be
17 temporary, that this is just we don't want to pull the rug
18 out from under you.

19 The prices are wrong; we need the prices to be
20 right, but because we didn't announce it far enough ahead we
21 want to give you a little bit of time to adjust would be the
22 principle, I would think.

1 And I don't know how difficult it is to really
2 make something truly temporary instead of having it built in
3 forever.

4 And if the cost of having temporary smoothing is
5 that it's permanent smoothing, then I'd reconsider my stance
6 on that and look for alternative mechanisms. But if we
7 really had faith that it would be temporary, then I think
8 it's okay to have that transition smoothed out.

9 MR. BUTLER: So why am I not quite as enthusiastic
10 as the rest?

11 Getting the pricing is absolutely right,
12 especially if right now it's creating behaviors that
13 increase costs or increase movement from one to -- setting
14 to another because of price.

15 So I'm absolutely -- and Mike, I think,
16 articulated that well. And I think there is still some
17 movement going on because of that problem.

18 Of course, then there's a danger of cherry-
19 picking, and it's easy to say, well, this price is wrong,
20 and that price, but then you don't look at underpricing
21 elsewhere. So you just pick off the ones that are -- look
22 obvious.

1 But I'll now get to some other comments.

2 On the ASC, I'm less convinced. I agree with the
3 principle, but the -- you know, we're a little earlier on in
4 terms of suggesting which ones.

5 And unlike this -- unlike the E&M codes, there
6 still, I think, is movement from outpatient surgical --
7 outpatient surgery is still moving into the ASCs, not the
8 reverse. So it appears that the pricing isn't -- there's
9 anecdotally in the chapter, say, physician-owned surgery
10 centers that are closing up shop and moving into hospital
11 outpatient departments, but I think our data suggested that
12 there's actually more movement going the other way in the
13 aggregate.

14 So it's a little less obvious that, at least,
15 we're moving into more expensive settings because of the
16 prices.

17 So I wouldn't take it off the table. I'm just a
18 little less convinced by the data.

19 Now, Mark you also said what I do like. You've
20 told me publically and privately that I suggested heart was
21 a focus from the very beginning almost two years ago, and I
22 think it is. I think that's where I see this employment and

1 salaries being propped up by this mechanism. And I don't
2 know that it was necessarily the reason for employment, but
3 it certainly made it easier.

4 And so I really do appreciate kind of advancing
5 the heart ones especially and because I said, boy, if you
6 can figure it out for those three and then maybe a few
7 others, you know, you've got like half of the money almost,
8 something like that.

9 Or, said another way, if you can't do it for
10 heart, you know, you're going to have a hard time doing it
11 in a diverse set of the other APCs, I would think.

12 So that's my comment on the heart.

13 It still -- this is technically still not so
14 simple, I think as you know. How you actually set the
15 professional component and the facility component the way we
16 proposed, I'm not actually sure that that works well, but
17 we're not here to vote on a recommendation today. But I
18 would say that there's still more analytical or at least
19 thinking through how that might work.

20 I do get nervous about the fact that this is going
21 to be a chapter when we're not really done with kind of
22 firming up the specific recommendation. I understand the

1 need to advance it, but I do think that even though you have
2 the fiscal cliff hit on things like the coding and then the
3 2 percent this will just be viewed as, okay, here's another
4 one.

5 They can -- anybody can self-select what they want
6 from this menu and say, well, MedPAC has got it in their
7 report. Let's go forward with it. And it could be cherry-
8 picked along with some other things.

9 But I'm not saying we shouldn't publish the
10 chapter. I think we just have to be careful about the
11 messaging in the chapter itself as we put it out.

12 Now finally, go back to slide -- please -- 14. A
13 little bit on this impact issue -- and you know -- and Mark
14 knows what I'm going to say about inpatient versus
15 outpatient, but I have to say it because the chapter does
16 highlight the differences in the inpatient versus the
17 outpatient impact.

18 But if you look at these -- and Glenn rightfully
19 says we look at the aggregate Medicare margin when we look
20 at these things, not try to silo it.

21 But I do need to point out on the outpatient side,
22 for example, overall, it's 5.4 percent where it's 1 -- I'm

1 sorry.

2 Move to the third column over. So if you take the
3 Groups 1 and 2 in the E&--I just looked in the chapter --
4 it's 5.4 percent reduction on outpatient but 1.2 percent
5 overall.

6 And we express -- for the teaching -- major
7 teaching hospitals, it is 8.9 percent on the outpatient and
8 1.6 percent overall. The spread is a lot larger simply
9 because teaching hospitals have a smaller part of their
10 business in inpatient care.

11 And, for example, the rural hospital which looks
12 like it's identical to the major teaching hospital only is
13 6.2 percent reduction on the outpatient.

14 So, if you separate out, it's a very different --
15 this looks like everybody is kind of not too far from each
16 other.

17 And, Glenn, back to your point about you've got to
18 look at the overall, well, a major teaching hospital would
19 say we just got hit by a minimum of a 6 percent hit on NIH,
20 which is part of our overall economic enterprise. So, if
21 you really want to take the total impact as you have here on
22 the hospital side, you'd want to add in the rest of the

1 federal funding that is being impacted in academic medical
2 centers.

3 So I still have a little problem with that,
4 particularly because when I think people get to this
5 outpatient side -- and, Scott, this is a little to your
6 point. I understand the subsidy issue in looking at
7 Medicare alone, and Glenn articulated Medicare access in
8 certain communities may be dependent on these OPDs.

9 I look at it as a number of the OPDs as being the
10 only place for Medicaid and dual eligibles. These are the
11 open doors in some communities. And, believe me, there's
12 never been more of a frenzy for everybody chasing after the
13 insured dollars and beginning to say how can I avoid those
14 that can't pay. It's just, frankly, part of the equation.

15 So I think that those, as open doors, are going to
16 potentially close or be harder to get into. And yes, it's
17 not Medicare except dual eligibles do fit into that
18 category.

19 So these disruptions that don't look too bad when
20 you look at it at this level get to be double digit for some
21 institutions -- 251 major teaching hospitals that are
22 averaging the 8.9 percent decrease, so that the really major

1 ones are up in the double digit area.

2 So I've had a -- I felt I needed to say those
3 things even though the principle of getting the pricing
4 right, particularly for the heart, is -- you can't ignore
5 that. You really can't ignore something like that that I
6 think is something we need to address.

7 MR. HACKBARTH: Just two quick things. On the
8 messaging point that you made, Peter, about people will see
9 a chapter, you know, I do -- I agree we need to take care
10 when we write the chapter to frame it properly and make it
11 clear that we are not at the point of recommending any of
12 these.

13 I do think it's useful to publish a chapter
14 because that's a way that people have something to react to.
15 You know. They see the analysis, and then they can say:
16 You know, don't do this path; that path is better. Or, here
17 are the implications.

18 And so it's part of our transparency and eliciting
19 feedback.

20 MR. BUTLER: In fact, for that very reason I'm
21 very supportive of publishing it because I think there has
22 been concern so far, as Mark well knows, about, well, what

1 are these 66 APCs?

2 What are -- give us more so we can see what we're
3 actually looking at, and I think that the chapter will help
4 do that.

5 MR. HACKBARTH: Yeah. And then one other quick
6 observation on cardiac, which does stand out. You know, I
7 think it illustrates, you know, the web of different policy
8 and pricing decisions because I think one of the things that
9 caused the dramatic shift in cardiac was that on the
10 physician fee schedule side fees were significantly reduced
11 as we changed the relative values, not just on work but on
12 practice expense.

13 And so the cardiac area was one that went down
14 significantly in that redistribution, and that made
15 cardiologists more receptive to the hospital offer -- come
16 here and oh, by the way, we'll get these higher rates under
17 the OPD schedule.

18 So these things are amazingly interconnected with
19 one another.

20 DR. MARK MILLER: I would just reinforce that when
21 we publish the chapter all the stuff that you cited will be
22 in the chapter and that that was put in front of you.

1 As you can see those tables, they start to get
2 heavy when you do both ways, both with stop-gap and both
3 with combined, and it just becomes a sea of numbers. But
4 they will be published in the reports -- the statistics that
5 you went through.

6 MR. WINTER: Something quickly about what Peter
7 said about the migration between ASCs and OPDs of the
8 surgical procedures. It's true that between '06 and 2010 we
9 were seeing a migration from OPDs to ASCs of these
10 outpatient surgical procedures. But between 2010 and 2011
11 that appears to have stalled, and actually, we're seeing
12 faster growth in OPDs than in ASCs for these covered
13 surgical procedures, which suggests the migration that was
14 occurring has stalled or, if not, stopped.

15 MR. BUTLER: It's not much though yet, right?

16 MR. WINTER: One year. It's one year.

17 MR. BUTLER: No, but I remember we looked at it
18 when we looked at updates.

19 MR. WINTER: Yeah.

20 MR. BUTLER: So it wasn't much of -- anyway,
21 there's nothing like --

22 MR. WINTER: There was a slight difference --

1 MR. BUTLER: There's nothing as compelling as
2 what's here, but it's something to watch for sure.

3 MS. UCCELLO: So I agree with the direction of
4 this. I agree with the people who say, you know, we need to
5 get the prices right and to look at this as broadly as
6 possible -- seems to be the right way to go about it.

7 This is maybe more of a question than a comment,
8 but as I was -- with respect to the stop-loss issue. When
9 I'm reading the chapter, it made it seem like, well, these
10 DSH -- high DSH hospitals don't seem to be
11 disproportionately hit by these procedures perhaps as much
12 as they were for the E&M, and that seemed to imply that
13 maybe stop-loss wasn't needed for these.

14 But now kind of what I'm hearing more is that,
15 well, it's not necessarily that they're disproportionately
16 hit. It's that the hits that they're taking might matter
17 more to the people that they serve.

18 Is that --

19 DR. MARK MILLER: I would say two things. One was
20 the reason that we kept the stop-loss, you know, front and
21 center and presented the data, for example, this way and why
22 we had all of the permutations is you're absolutely right

1 that when you look at the new policies in isolation, at
2 least at the average, they don't do all that much. But when
3 they're combined with the E&M, which was also something that
4 you requested, we wanted to make sure it's like, okay, you
5 put E&M together and then the stop-loss comes back to
6 mattering again even at the averages.

7 And then, remember even if it doesn't move that
8 average around a lot there are some hospitals out of the
9 distribution where it could matter even in the new policies
10 although it doesn't have a big impact there.

11 You are correct in your interpretation of the
12 analysis.

13 MS. UCCELLO: So when we're thinking about this
14 now, we're not -- are we thinking of it more globally as
15 opposed to we're not -- if we do -- if this is taken up,
16 there wouldn't be a stop-loss just on the E&M, but it's a
17 stop-loss over whatever procedures are included in this
18 approach.

19 DR. MARK MILLER: [Off microphone.] Whatever
20 condition [inaudible].

21 DR. HALL: I think the more we've gotten into this
22 the more impressed I am with the granularity here. We know

1 a lot more about this than when we started, and I'm very
2 much in favor of the direction that we're going.

3 I guess one thing that I've been trying to do
4 since I became educated on this is to just in my local
5 environment ask a number of what-if questions, and it
6 largely has to do with who are these Medicare eligibles who
7 are coming to hospital OPD departments where in lieu -- they
8 used to come to offices.

9 And it's not all because of marketing. I mean, a
10 lot of them really, truly are there because they represent
11 this -- the real tsunami population. The population in the
12 United States reaching 65 has leveled off now. The next
13 tsunami, which has started, is the 75 to 85-year-old
14 population.

15 And many times bundling in a very concrete way,
16 not in the figurative way we use it in other ways -- it
17 makes sense for them to have the advantages of all the
18 ancillary services that are present at particularly a
19 teaching hospital and an OPD clinic.

20 So I think we've got to make sure that we're not
21 disenfranchising that population. They may not show up in a
22 disproportionate share. It's really saying a frailer, older

1 population who may need services that are much more suitable
2 in an institutional setting than in a private office in a
3 shopping mall.

4 DR. REDBERG: I certainly echo -- I think it was a
5 great chapter and that the payment principles that are
6 outlined I endorse and for applying them to broader sets of
7 services.

8 I would just add when we talk about getting the
9 payment right I think what we really want to be going for is
10 really value, not so much what we're paying, because the
11 other part of that is what are we getting for it. And some
12 of these services -- just like some of the drugs -- are very
13 valuable, and some of them are not. In fact, some of them
14 are leading to probably harm, and our beneficiaries would be
15 better off without them. And right now the payment rates
16 don't reflect any of that.

17 And so, you know, for example, looking at table 5,
18 page 20, although there certainly are a lot of cardiology
19 things, I notice that IMRT has a very large increase. Well,
20 IMRT has not been shown to be -- to lead any better outcomes
21 than much less expensive, you know, treatments for prostate
22 cancer, but we're paying a lot of money for it. So I would

1 say that's a very low value, you know, proposition unless
2 you can show that we're -- you know, that there's a reason
3 that it's priced so high when the outcomes have not been
4 shown to be better or even equal.

5 And the same with some of the imaging services --
6 again, you know, there's the whole choosing wisely and
7 professional society. Well, some of the imaging services on
8 this list have been nominated by the professional societies
9 as things we shouldn't be doing or should be doing a lot
10 less of.

11 So none of our payment structure currently
12 acknowledges any of that, and so certainly as we go forward
13 I think we really want to think about value more than just
14 cost and charges.

15 MR. HACKBARTH: I wanted to give people on this
16 side an opportunity to react to different paths that we
17 might take -- Groups 1 and 2, cardiac only, include ASCs,
18 not include ASCs. Any thoughts people want to offer?

19 DR. NAYLOR: I had written it down -- broadest
20 possible.

21 DR. HOADLEY: I agree on the broadest possible,
22 and I think the point that's been made that would get some

1 of the other options in the chapter means that we also show
2 people what other things would do, what lesser options would
3 do. So that's useful too.

4 MR. HACKBARTH: Okay. Thank you. Good job.

5 DR. COOMBS: Glenn, I just wanted to say I agree
6 with the stop-loss in order to ensure access.

7 And then I was thinking along the line of a phase
8 kind of approach more so because you can actually titrate or
9 study the impact of what you do, but I think that we're
10 going in the right direction.

11 MR. HACKBARTH: And when we did the E&M piece of
12 this, we had a three-year transition. So that's another
13 policy variable.

14 Oh, Craig.

15 DR. SAMITT: The only other thing I would add is
16 I'd echo Peter's observation that if we kind of need to pick
17 a path -- cardiology because it's the one that seems as if
18 it's been the most reaction following a prior action that
19 suggests that this is being propped up. And if we need a
20 pilot phase or what have you to really understand how this
21 transition will work, that may be the best place to start.

22 MR. HACKBARTH: Okay. Thank you, Ariel and Dan.

1 Great job.

2 We'll now have our public comment period, and let
3 me reiterate the ground rules. Please begin by introducing
4 yourself and your organization. And, as I always do, I'll
5 remind people this isn't your only, or even your best,
6 opportunity to provide input on MedPAC's work. When the
7 light comes back on, that signifies the end of your two-
8 minute period.

9 MS. CONROY: Thank you. I'm Joanne Conroy from
10 the AAMC, and we serve our nation's teaching hospitals and
11 medical schools.

12 We continue to be concerned about access issues.
13 We have undergone an analysis of those patients that
14 actually have been cared for in the HOPD versus physician
15 outpatient setting, and there are differences in the patient
16 population -- far greater number of dual eligible, complex
17 patients and certainly disabled patients. So, as you
18 continue deliberations, we certainly encourage you to
19 consider what this might do to access for these patients for
20 these services.

21 We will provide our research to you on an online
22 option.

1 Thank you.

2 MS. KIM: Hi. I'm Joanna Kim with the American
3 Hospital Association.

4 Perhaps, unsurprisingly, we're also very concerned
5 about the discussion that was undertaken here today.

6 The Commission has already recommended cuts to a
7 number of services of about a billion dollars as far as the
8 cut to the hospitals, and today we discussed another \$1.5
9 billion in cuts. That, as you said, would reduce outpatient
10 revenue by about 5.4 percent, and that's to a system that
11 already has a negative margin of 11 percent. And, as you
12 noted, the cuts continue to hammer the same types of
13 hospitals over and over -- teaching hospitals, safety net
14 hospitals, the public hospitals and rural hospitals.

15 And we're having a hard time seeing how those
16 discussions fit with the 1 percent update recommendations
17 that are going to be made in the March report.

18 The inpatient net update for fiscal year 2014 is,
19 right now, projected to be negative 0.6 percent and the
20 outpatient, about 1.8 percent. But that doesn't include the
21 sequester. It doesn't include the redistribution of DSH
22 payments. It doesn't include the increasing readmission

1 penalties, the HACs or meaningful use.

2 In addition, we have serious concerns about the
3 analysis that led to the list of APCs that was discussed
4 today. Last year, we worked with the MedPAC staff to
5 understand their analysis, and they were very generous in
6 their time, walking us through it and explaining all the
7 major points. But despite being on the same page as far as
8 all the major points of the analysis, when we did our own
9 analysis we were only able to replicate 33 of the then 71
10 APCs as meeting the criteria.

11 I think that speaks to the complexity of all the
12 payment systems that are being analyzed, but I think it also
13 speaks to the fact that small technical decisions in the
14 analysis are leading to really big results -- result
15 differences.

16 So that leads to questions in our mind of how that
17 policy is going to stand up over time. Are there going to
18 be APCs that float in and out of meeting the criteria year
19 after year, and how will those be considered?

20 In fact, one of the APCs that we could not
21 replicate as meeting the criteria was the cardiac one that
22 accounts for over a third of the savings. I believe it's

1 number 269. We didn't find that that met the ED criteria.

2 So, given the obvious complexity here and the
3 disproportionate impact that some very small technical
4 decisions are having on the results, we'd like to see an
5 increased level of transparency as far as the methodology
6 that was used before it's committed to a public chapter
7 because we absolutely think it will be used to support going
8 ahead with the cuts that you've discussed in the chapter.,
9 and we look forward to working with you on that.

10 Thank you.

11 MR. HACKBARTH: Okay, we are adjourned until 8:30
12 tomorrow morning.

13 [Whereupon, at 5:37 p.m., the meeting was
14 recessed, to reconvene at 8:30 a.m. on Friday, March 8,
15 2013.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 8, 2013
8:31 a.m.

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

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1 P R O C E E D I N G S [8:31 a.m.]

2 MR. HACKBARTH: Okay. It's time for us to get
3 started, and we have two topics for today: the payment
4 adjustment for health profession shortage areas is up first,
5 and then shared decisionmaking second.

6 So who is leading? Kevin? Go ahead.

7 DR. HAYES: Good morning. This session is about
8 Medicare's health professional shortage areas payment
9 adjustment.

10 Recall that during work on the mandated report
11 about the physician fee schedule's geographic practice cost
12 index for work -- the work GPCI -- the Commission adopted a
13 framework for evaluating policy options that address issues
14 of spending, access, quality, and advancing payment reform.

15 At the end of that process, there was discussion
16 of targeting payments toward beneficiary access problems and
17 using approaches other than the broad brush of, say,
18 establishing a floor for the work GPCI. The commitment then
19 was to come back for further discussion of payment
20 adjustments that are targeted.

21 The purpose of this session is to see if the HPSA
22 payment adjustment is an example of targeting payments

1 toward access problems. We anticipate that this session
2 will be the first in a series of conversations on this.

3 In this presentation, we will begin with the
4 rationale for reviewing the HPSA payment adjustment. From
5 there, we will describe the adjustment itself: the criteria
6 for designating HPSAs; who is eligible to receive the
7 adjustment; total adjustment dollars and how they are
8 distributed by physician specialty and type of service; and
9 how beneficiary use of services varies when HPSAs are
10 compared to other areas.

11 Next, we will list policy issues you might wish to
12 consider. And, lastly, we will outline possible next steps
13 for further work on this topic.

14 Just to recap a few points on the mandated report
15 on the work GPCI:

16 The Congress asked the Commission to consider
17 whether there should be a work GPCI.

18 To address this question and conduct its work on
19 two other mandated reports -- on outpatient therapy and
20 ambulance services -- you adopted an evaluation framework
21 structured according to issues of spending, access, quality,
22 and advancing payment reform.

1 Specific to the issue of access, the finding was
2 that the GPCI's impact is unclear.

3 While the supply of physicians and other health
4 professionals varies between high- and low-GPCI areas, we do
5 not see differences in service use across high- and low-GPCI
6 areas.

7 More broadly, you concluded that if access
8 problems are found, it's not advisable to implement broad-
9 scale policies through the GPICs, such as the floor.
10 Instead, the policies needed are ones that focus on
11 identifiable problems of beneficiary access and to do so in
12 a way that is targeted.

13 All of which brings us to the question of whether
14 Medicare's HPSA payment adjustment is an example of a
15 targeted approach.

16 The HPSA payment adjustment is paid for services
17 furnished in HPSAs. HPSAs are designated by the Health
18 Resources and Services Administration within the Department
19 of Health and Human Services.

20 HRSA's criteria for designating HPSAs focus on
21 supply. For example, in the case of a HPSA designated as a
22 primary care HPSA, an area must have a general population-

1 to-primary care physician ratio that is greater than or
2 equal to 3,500:1.

3 However, there are exceptions. For example, the
4 minimum is 3,000:1 if an area meets criteria of unusually
5 high need as measured by: births per 1,000 women, the
6 infant mortality rate, or the area's level of poverty. And
7 there are other ways an area can qualify, too, but the focus
8 remains on supply.

9 The HPSA designation is used to direct resources
10 under about 30 federal programs in addition to Medicare's
11 HPSA payment adjustment, programs such as the National
12 Health Service Corps.

13 Kate will have more to say about the HPSA
14 designations in a few minutes. But the point for now is
15 that the criteria for designating HPSAs focus on supply, and
16 the criteria are not specific to the Medicare population.

17 As to Medicare's payment adjustment, it is a 10
18 percent bonus for physician services furnished in a HPSA.
19 It's paid for physicians' professional services. It does
20 not apply to the technical component of imaging services.

21 It's paid for psychiatrists' services, whether
22 provided in a HPSA designated as a primary care HPSA or one

1 designated as a mental health HPSA based on the supply of
2 mental health professionals.

3 And the payment adjustment is paid for major
4 surgical procedures performed in HPSAs by general surgeons.

5 The adjustment is available to physicians only and
6 not to nurse practitioners, physician assistants, or
7 clinical nurse specialists who bill Medicare independently.

8 When billing for outpatient services, critical
9 access hospitals have the option of billing both facility
10 services and professional services if the physician or other
11 health professional reassigns his or her billing rights to
12 the hospital.

13 When billing under this option, the CAH is paid
14 for the professional services at 115 percent of the amount
15 otherwise paid under the physician fee schedule.

16 In addition, if the services are furnished in a
17 HPSA, there's the 10 percent adjustment on top of the 15
18 percent increase.

19 That's an overview of the HPSA payment adjustment.
20 Katelyn will continue with a graphic on HPSA locations
21 across the U.S.

22 MS. SMALLEY: In 2013, there were 1,329 geographic

1 primary care HPSA areas covering 29 million people. After
2 an area has been designated as a HPSA, the Medicare payment
3 adjustment in these areas is made automatically based on the
4 zip code on the claim.

5 HPSA bonus payments have nearly tripled in the
6 last 10 years, from about \$97 million in 2001 to \$274
7 million in 2011.

8 The large increases in payment that you see in
9 2004 and 2011 may be attributable in part to the inclusion
10 of mental health HPSAs in 2004 and the surgical bonuses
11 instituted in 2011.

12 We will now discuss how these payments are
13 allocated.

14 HPSAs are designated based on the ratio of primary
15 care physicians to the population, but Medicare's payment
16 adjustment is made to all physicians in the HPSA, regardless
17 of specialty. Based on 2011 claims, 31 percent of all HPSA
18 payments went to primary care physicians, including internal
19 medicine, family medicine, and geriatrics. About one-fifth
20 went to surgical specialties, including general surgery,
21 orthopedics, and ophthalmology. Cardiology accounted for 7
22 percent of payments, and 5 percent went to diagnostic

1 radiology.

2 Broken down by type of service, again, about one-
3 third of HPSA payments were made to primary care, and other
4 evaluation and management visits accounted for about one-
5 quarter of HPSA payments; 22 percent went to procedures, and
6 9 percent of HPSA payments were for imaging services.

7 Now Kate will talk about service use in HPSAs
8 compared to other areas.

9 MS. BLONJARZ: So we also looked at ambulatory
10 care service use across areas designated as HPSAs and those
11 that are not, and we did a similar analysis for the work
12 GPCI.

13 We see that the level of service use is quit
14 comparable across HPSA and non-HPSA areas -- 10.3 visits per
15 beneficiary on average in HPSA areas, and 10.0 visits per
16 beneficiary in non-HPSA areas.

17 While there is pronounced variation across the
18 country, the level and range of service use is similar. And
19 this is the same finding we showed in the work GPCI where we
20 did not see differences across high and low work GPCI areas
21 in terms of ambulatory care.

22 So to turn to some issues that we would raise for

1 your consideration, with respect to the HPSA designation
2 itself, first is the issue of the administrative process of
3 regions being designated and de-designated as HPSAs.
4 Regions become designated as HPSAs only if an entity
5 affirmatively applies. There is no uniform national process
6 to designate all areas meeting the HPSA standard. And areas
7 that get designated can sometimes retain their designation
8 years after they have been proposed for withdrawal.

9 Second, the HPSA measurement of population to
10 providers excludes some providers, notably, physician
11 assistants and advanced practice nurses. And the exclusion
12 of these providers could significantly affect the number of
13 regions designated as HPSAs and the depth of the shortage.

14 Turning to some issues with Medicare's use of the
15 HPSA designation to target a payment adjustment:

16 The HPSA was not designed for the Medicare
17 program. It was created to allocate slots for the National
18 Health Service Corps and is used in about 30 other federal
19 programs, mostly in the public health and workforce area.
20 The measurement, as Kevin mentioned, does not include
21 measures specific to Medicare beneficiaries.

22 And the payment adjustment does not apply to all

1 practitioners. In particular, it is not paid to advanced
2 practice nurses and physician assistants.

3 And finally are issues related more broadly to the
4 use of the HPSA payment adjustment as a potential mechanism
5 to improve access for Medicare beneficiaries.

6 The threshold for HPSA designation is set at a
7 fixed provider-to-population ratio established in the 1970s
8 and hasn't been updated since then. Using a fixed ratio
9 does not account for differences or changes in practice
10 style, productivity, or demand for health care.

11 And, finally, there is no or limited evidence to
12 support a relationship between the supply of ambulatory care
13 providers and access to quality care for Medicare
14 beneficiaries. This has been shown through surveys of
15 beneficiary access, quality measures, and ultimate outcomes
16 across high- and low- supply areas.

17 With there, there are a couple of potential next
18 steps for this work to take.

19 First is to do more work reviewing and assessing
20 the current HPSA payment adjustment.

21 The second option is to consider how a Medicare-
22 specific policy to improve access might be designed. How

1 should access to ambulatory care be measured, for example,
2 service use, beneficiary satisfaction, or quality? And how
3 would one target a potential policy?

4 Third, the Commission could also focus on pursuing
5 other payment mechanisms, such as an incentive payment for
6 primary care, or payments for patient-centered medical homes
7 or health centers that meet a set of criteria for improving
8 access to quality care.

9 So that concludes, and we're happy to take
10 questions and look forward to your discussion.

11 MR. HACKBARTH: Okay. Thank you. Good job.

12 What I suggest is that we use the modified Round 1
13 process from yesterday and just continue to experiment. So
14 Round 1 clarifying questions will be about, "What does that
15 slide mean?" "Row 3, Box 2." Please. So let me see hands
16 of people with clarifying questions. Mary, did you have
17 your hand up?

18 DR. NAYLOR: I have to find the slide first [off
19 microphone].

20 MR. HACKBARTH: Oh, okay. So we'll start with
21 Dave and just work down the row here.

22 DR. NERENZ: Thank you. Slide 5, the top bullet,

1 which is just basically the statement of the 10 percent
2 bonus, I wonder if you can tell us any more about exactly
3 what the mechanism is linking that bonus to access? For
4 example, is it designed to incent more professionals to come
5 into that area? Or is it designed to reward the providers
6 who are there for doing additional work, like being on call
7 more or having late-night hours more? Is it one or the
8 other or something different entirely? What is it supposed
9 to do?

10 DR. HAYES: I can tell you what the considerations
11 were when it was adopted back in the late '80s. The
12 original provision I believe was in the Budget
13 Reconciliation Act of 1987, and then there was a
14 modification in 1989. But in both instances, there was a
15 concern about supply, about availability of physicians in
16 areas, and disparities in just numbers.

17 So inferring from that, it would be more an
18 incentive to have a number of practitioners -- a desire to
19 have physicians in low-supply areas.

20 DR. NERENZ: Would it follow then that if this
21 program is successful, the HPSA designation should be time
22 limited? Because if this incentive brings people in, then

1 there's no longer a shortage. Would that follow?

2 DR. HAYES: It would follow, yes.

3 DR. NAYLOR: Slide 11, please. So HPSA does not
4 include certain providers that are recognized, and I'm
5 wondering, were you able to look at the HPSA service areas
6 and determine how many PAs or advanced practice nurses might
7 be available and how that would change?

8 MS. BLONIARZ: So what I can tell you is GAO did a
9 study almost more than a decade ago, and they looked at this
10 question. Specifically, if you included just advanced
11 practice nurses in the counts, you would change the level of
12 providers available in those areas by 22 percent. And so
13 many areas would probably lose designation if you did that,
14 and then the depth of the shortage would be quite different.
15 And that's over a decade ago. It is probably even higher,
16 significantly higher now.

17 DR. NAYLOR: And especially if you also add PAs to
18 that.

19 MS. BLONIARZ: That's right.

20 DR. NAYLOR: So on Slide 11, the general -- you're
21 talking about knowledge of problems a decade ago, and you
22 outlined in the report the barriers to act on those. But

1 I'm wondering if you could make that a little bit -- I mean,
2 the timelessness and the absence of a national process for
3 designation and when you get it, it never goes away. So can
4 you comment on what's getting in the way of changing a
5 methodology with the known flaws for such a period of time?

6 MS. BLONJARZ: So the two times that HRSA has
7 tried to do comprehensive rulemaking to change both the HPSA
8 -- or the HPSA and then also the medically underserved area
9 designation, you're talking about -- they were, you know,
10 considering processes that would really redistribute funds
11 across areas, and areas that would lose federal funding or
12 lose, you know, priority for federal funding, you know,
13 you're just talking about reallocating money across the
14 country, and a lot of groups and people were very upset
15 about that.

16 DR. NAYLOR: 700 or something?

17 MS. BLONJARZ: Yeah, exactly. Exactly. Both
18 times, you know, HRSA put out subsequent rules and said,
19 look, we've got so many comments on this, there are so many
20 concerns about the methodology, we just need to go back to
21 the drawing board. I think the provision in PPACA that was
22 established to create a consensus rulemaking process was

1 another attempt to try to say, okay, well, what if we get a
2 group of people together who represent different interests
3 and try to develop a new mechanism. That also failed. I
4 mean, I think it's just testament to how hard it is to
5 change formulas that are driving such a large share of
6 Federal dollars.

7 DR. NAYLOR: Thank you.

8 DR. MARK MILLER: And I think this was engaged in
9 there, but you have the geographic of moving money around,
10 but then -- and I know this will come as a surprise to you,
11 Mary. You also have, you know, the professionals sort of
12 deciding who gets counted and who doesn't get counted, and I
13 know that's a big surprise to you.

14 DR. NAYLOR: [off microphone].

15 MR. KUHN: Can I get Slide 10, please? I just
16 want to make sure I understand what we're looking at here.
17 So basically the service use is quite similar to HPSA and
18 non-HPSA areas. That's where we are.

19 So I was curious. Has there been any kind of
20 longitudinal data on the impact of these enhanced payments?
21 In particular, I'm thinking about the surgical incentive
22 payment that has just gone into place where you've got now a

1 20 percent bonus for those. Is there any evidence that that
2 has improved access yet? Or is it too soon to tell in terms
3 of where we are on that one?

4 MS. BLONJARZ: We haven't looked at it yet, I
5 think just because it has only been in place since 2011. I
6 think anytime you're thinking about doing a longitudinal
7 analysis, there are just so many other things affecting
8 access and service use over this -- you know, any time
9 period that we would be considering. Kevin and I were also
10 just talking. It's hard -- sometimes it's difficult to get
11 a list of areas that have been designated and then that have
12 either gained and lost designation longitudinally. So
13 that's another kind of wrinkle there.

14 MR. KUHN: So basically the best indicator we have
15 is kind of service use. It is going to be hard to do
16 longitudinal work in this to really kind of understand the
17 true impact of what these enhanced payments have done for
18 access.

19 MS. BLONJARZ: Yeah, that's right.

20 MR. KUHN: Okay. Thank you.

21 MR. HACKBARTH: Let me just follow up on Herb's
22 question. So you look at these numbers, and I can think of

1 at least two possible interpretations. One interpretation
2 is, "Oh, it works." The other interpretation is, "Oh, this
3 money's very poorly targeted." And we have no ability to
4 discriminate between those two possible interpretations.

5 PARTICIPANT: Okay.

6 [Laughter.]

7 MR. HACKBARTH: That's what I was afraid was the
8 answer.

9 DR. CHERNEW: That was clarifying, though.

10 DR. COOMBS: So I have two questions. One is
11 there is -- has there been anything that actually looks at
12 wait times? And the reason I'm asking that is because of
13 the skew of the population. Whereas, you might have an
14 average visit in an area, it may be some high utilizers who
15 skew that number off the scale, and I was wondering if there
16 was any kind of data that -- we talked about this, I think,
17 with the GPCI issue as well.

18 MS. BLONJARZ: So one study that we cited in the
19 paper is a study a couple years ago of Medicare
20 beneficiaries' perception of access across areas that have
21 high supply of ambulatory care providers and areas with low
22 supply. And they didn't find a difference in -- when

1 beneficiaries were asked, you know, do you have trouble
2 seeing a provider, do you have to wait a long time, are you
3 able to see one if you have, you know, a routine issue or an
4 illness or injury, and there just wasn't much difference
5 across low- and high-supply areas. There was variation, but
6 it wasn't correlated with how many providers there were in
7 the community.

8 DR. COOMBS: And have there been any studies that
9 look at pilots in terms of the pool mechanism within the
10 HPSAs, looking at pooling of the patients, the differentials
11 that might happen from geographic variations?

12 DR. MARK MILLER: What was [off microphone] --

13 DR. COOMBS: So if you look at aliquots of
14 patients, you might find a trend in high-risk patients in
15 given areas, and if there's some variables that kind of
16 correlate with that, so it would help you to predict, you
17 know, the utilization in some of the areas.

18 MS. BLONJARZ: I think this gets to just what the
19 Medicare -- like what a national program, you know, how well
20 it can identify access problems at very small geographic
21 areas or for certain populations. I think that's just a
22 problem that, you know, we're never going to be able to

1 identify at very granular levels, you know, based on
2 surveys. You're just not going to be able to get down to
3 that level of granularity that you might want. And I think
4 -- I'm not sure we would be able to do that.

5 DR. HOADLEY: On Slide 7, you show us the total
6 number of dollars represented by HPSA payments. Can you
7 indicate what's the share of Medicare's overall fee schedule
8 dollars both nationally and, if it's possible, within the
9 HPSA regions? In other words, how big a pot are we working
10 with?

11 DR. HAYES: Right, right, right. If you take the
12 \$274 million, I think we had a figure of -- it represented
13 about 0.4 percent of total fee schedule spending.

14 DR. HOADLEY: Nationally.

15 DR. HAYES: Yeah.

16 DR. HOADLEY: But obviously within these regions,
17 it would be a somewhat higher percentage.

18 DR. HAYES: Yes, that's true. Right.

19 DR. HOADLEY: That would be a useful number to
20 have as a context for its influence within those regions as
21 well as obviously the pot's pretty small overall.

22 DR. SAMITT: I have three hopefully quick

1 questions. If you could go to Slide 5, please. So what was
2 the motivation behind the introduction of the general
3 surgeon incentive program? So what motivated that change?

4 DR. HAYES: It was in the PPACA, and I'm not aware
5 of any research that was done ahead of time to show that
6 there was, you know, a difference in, say, the supply of
7 general surgeons, HPSAs versus non-HPSAs. It just kind of
8 appeared there.

9 MR. HACKBARTH: My recollection is the same as
10 Kevin's. I don't remember there being any research cited,
11 but it was a time when there were a lot of anecdotes about
12 problems with access to general surgery in rural areas in
13 certain parts of the country.

14 DR. SAMITT: No evidence of any kind?

15 MR. HACKBARTH: Not that I'm aware of.

16 DR. SAMITT: Okay.

17 DR. COOMBS: Glenn, I just want to say one thing.
18 I guess the surgical specialty had some issues around
19 training, and around that time they came out with a report
20 of about 1,000-plus residents being turned out, of which
21 300-some-odd residents were focused on general surgery. So
22 there was a perceived shortage long range of general

1 surgeons in the country.

2 DR. SAMITT: Okay. My second question is on Slide
3 7. When I first glanced at the recent dramatic increase, I
4 thought it was purely because of the surgical incentive
5 program, but that started in 2011. So do we know the makeup
6 of this change and what has increased and where from
7 essentially 2008 to 2011?

8 DR. HAYES: No. What we could do, if we -- we
9 don't know the answer to that question. I think one way to
10 start would be to look at distributional issues such as what
11 you see here represented on the pie charts to see where the
12 dollars are going.

13 DR. SAMITT: So we don't know if it's specialty
14 based or geographic based.

15 DR. HAYES: That's correct.

16 DR. SAMITT: But we potentially could do that
17 analysis.

18 DR. HAYES: Correct.

19 MR. HACKBARTH: Has there been a change, a
20 material change in the number of HPSAs?

21 DR. HAYES: We're not aware -- as Kate said -- we
22 don't know. As Kate said, we struggle with this question of

1 getting good data on how manly HPSAs there are.

2 MR. HACKBARTH: Okay.

3 DR. HAYES: But we could try if there -- to
4 decompose this.

5 DR. SAMITT: Great. Thank you. And then, lastly,
6 on Slide 11, please. The one thing that wasn't clear to me
7 in the report -- and I thought this was where Mary was going
8 -- is there have been some HPSAs that have been de-
9 designated, and yet they haven't been de-designated. So
10 what's the obstacle, once it's been decided to de-designate,
11 to actually make it happen?

12 MS. BLONIARZ: So the way the process works is
13 HRSA requests updated information on HPSAs that it hasn't
14 reviewed in three years from the states. If the states
15 provide information that either shows that it no longer
16 meets the criteria or that they don't provide any
17 information, it goes into kind of this bucket of proposed
18 for withdrawal. And at that point, the area -- you know,
19 outside groups could come in and say, okay, I have
20 additional information, I'd like to provide that. But it
21 doesn't become final until HRSA releases a list in the
22 Federal Register showing that it has been fully withdrawn.

1 I think we said in the paper it took about 10
2 years for that to happen. I don't know exactly why.

3 DR. CHERNEW: I have a question about Slide 6. I
4 think this is similar to Jack's basic notion. When I look
5 at this, I can't figure out, how close are the HPSAs to what
6 we saw is rural?

7 MS. BLONJARZ: So what I can tell you is of all
8 the primary care HPSAs, and this, again, there's geographic
9 ones, there's population-based ones, there's facility-based
10 HPSAs, but of all of those, about 60 percent are in non-
11 metropolitan areas and about 40 percent are in metropolitan
12 areas.

13 DR. CHERNEW: Of non-metropolitan areas, what
14 portion of that is in HPSA?

15 MS. BLONJARZ: I don't know, but we could find
16 out.

17 MR. BUTLER: On this slide, so two questions. One
18 is, so the total number of physicians that are participating
19 in HPSA is what, do you know? So you don't get -- is it,
20 like, ten percent, or -- you just don't know. We just know
21 it's \$275 million or something like that --

22 MS. BLONJARZ: It's knowable, but we just don't

1 have it right now.

2 MR. BUTLER: And then this is one of the few that
3 if Tom were here, he would say, hey, I've finally got some
4 dots in my State.

5 [Laughter.]

6 MR. BUTLER: At the same time, there's some
7 suspicious looking dots in part of the country where we also
8 find some heavy utilization. Do you have any sense of this
9 being representative of what you would expect versus skewed
10 in some disproportionate way towards various --

11 DR. MARK MILLER: One of the reasons that it's
12 hard to answer that question is, is we're all looking at
13 this and saying, what would we expect for Medicare? And so,
14 for example -- I think this is correct from our
15 conversations -- until very recently, McAllen, Texas, was
16 classified as a HPSA area.

17 MS. BLONJARZ: That's right.

18 DR. MARK MILLER: And so for utilization in
19 Medicare, around this table, you would go, McAllen? But
20 remember, just to try and get some balance, this stuff is
21 created for lots of other purposes. So when you say, does
22 this represent what you would expect, it's, I think,

1 whatever is up here, they're created for lots of different
2 reasons. So think about infant mortality driving some
3 classification of an area versus some other criteria,
4 because it kind of varies from area to area. It would be
5 kind of hard to answer -- for me to answer that question.
6 From a Medicare point of view, not so much.

7 MR. BUTLER: So just to make sure I understand the
8 process, every one of these dots is self -- I mean, it's
9 voluntary. You've got to come forward and ask for it.
10 There's no top-down, you know, have you thought about doing
11 one over here, right?

12 MS. SMALLEY: Right. That's another point that we
13 were going to make, is that it's an application process. So
14 you need to affirmatively say that my area should be covered
15 under this policy, and if a city or town doesn't have the
16 resources to do that or the State legislature doesn't --
17 isn't as actively affirming HPSAs, you may not get one.

18 MR. HACKBARTH: I just wanted to pick up on Mark's
19 point about McAllen. You know, that could be an
20 illustration of the difficulties in designation and removing
21 designation. But if you look at this map, you see swaths of
22 the country where we know Medicare utilization of services

1 is very high relative to the average and a lot of HPSA
2 designation. So at least there is not a very tight
3 relationship between designation as a shortage area and use
4 of services. Now, that's evident in your Slide 10, as well.
5 But in a way, this makes that even more graphic, that this
6 designation really isn't connected to utilization and access
7 in that sense.

8 MR. BUTLER: Yeah. I'm just trying to get a sense
9 of the elephant here, kind of. How many doctors, 274
10 million sprinkled across here? It sounds like it's really
11 not many dollars for most of the dots when all is said and
12 done, right?

13 MR. HACKBARTH: Yeah.

14 MR. BUTLER: At this point. But it's been
15 increasing rapidly.

16 MR. HACKBARTH: Yeah.

17 MR. BUTLER: Okay.

18 DR. MARK MILLER: I'm sorry. And that's a really
19 good thought to keep in mind, because there is always a lot
20 of concern about anybody messing, you know, out in the
21 general world, messing with these designations. But think
22 about the work that we did with ambulance where there were

1 add-ons being put out there on a very broad basis. And what
2 the Commission ended up suggesting is, if you had a tighter
3 designation, you could actually provide greater support in
4 the areas that meet that designation. This may be really
5 obvious given the statements that you just made, but I also
6 just want to make sure that the audience gets how you could
7 rethink that sprinkling of dollars.

8 MR. HACKBARTH: Cori.

9 MS. UCCELLO: So you didn't discuss this in your
10 presentation, but in the mailing materials, on page 20 -- so
11 I get a page number in there -- you talk about the Primary
12 Care Incentive Payment Program, and this was something that
13 is temporary. So I'm wondering more about why that's
14 temporary. Is it just a stop-gap until we get a better
15 balance between primary and specialty, or was it thought
16 that it just would be fixed, or is it a money issue, or --

17 DR. HAYES: That's one that could be interpreted
18 in a lot of different ways. When we think about the cost of
19 PPACA, maybe there was some consideration of just budgetary
20 impact and they wanted to be careful there. The other is
21 that, to your point, that there were other provisions in the
22 law about things like addressing the issue of misvalued

1 codes, and so maybe that was going to play itself out in
2 time and then there wouldn't be so much of a need for it, or
3 whatever it was. I just can't say. But there's a lot of
4 different ways, I would say, just to interpret what the
5 motivations were. But to answer your question directly, we
6 just don't know exactly what the thinking was.

7 DR. REDBERG: Please, on Slide 4, and also on page
8 seven in the mailing materials, I'm just trying to
9 understand who actually applies for the HPSA designation.

10 MS. BLONIARZ: So, technically, anyone can, any
11 individual or group or government, State, local, Federal --
12 or not Federal, but -- but in practice, it's generally the
13 States that are applying. The State Primary Care Office
14 would apply, but technically, anyone could apply to have an
15 area defined as a HPSA.

16 DR. REDBERG: And is it usually a county? When
17 you say an area --

18 MS. BLONIARZ: Yeah --

19 DR. REDBERG: -- how is the area defined?

20 MS. BLONIARZ: There are a lot of full-county
21 HPSAs, but then it can even be zip codes or census blocks.
22 One thing is that the applicant -- the application defines

1 the area to be considered as a HPSA. So, you know, someone
2 is kind of affirmatively saying, this is -- I'm asserting
3 that my area has a health professional shortage and I'm
4 drawing the boundary of what that is.

5 HRSA does say that areas outside can't have a
6 supply of providers that would be available to residents of
7 the HPSA. So it's not like you could draw the boundary so
8 tight that if they just traveled ten, 15 minutes, they could
9 have access to another set of providers. But it is kind of
10 created by whoever is applying for the designation.

11 DR. REDBERG: So I'm just still trying to
12 understand this better. How do they know who the doctors
13 are? What data sources are they using, and how do they --
14 and it's supposed to be primary care practitioners in
15 particular, right, so --

16 MS. BLONJARZ: I think, in practice, a lot of
17 applicants will use the AMA Master File. What I don't know
18 as well is what HRSA uses to kind of validate that. But,
19 yeah, that's all I'll say.

20 DR. REDBERG: And continuing, and maybe, I think,
21 you had that information on another slide, but once somebody
22 -- once the area, whatever it is, is designated as HPSA,

1 it's not just the primary care practitioners that are
2 getting the HPSA increases, then. It's all doctors in that
3 area, even if they weren't particularly in a shortage.

4 MS. BLONIARZ: Under the Medicare payment
5 adjustment, it's all physicians billing under the fee
6 schedule.

7 DR. REDBERG: And I'll make this the last
8 question. But is it Medicare money and is this all new
9 money, so however many doctors there are, everyone's just
10 going to get this increase, so there's no upper limit?

11 MS. BLONIARZ: Right. It's not subject to budget
12 neutrality or anything like that. It's new money.

13 DR. REDBERG: And then it's -- it's all services -

14 MS. BLONIARZ: And it's all services.

15 DR. REDBERG: -- not just underutilized or --

16 MS. BLONIARZ: That's right.

17 DR. REDBERG: Okay. Thank you.

18 MR. HACKBARTH: Could you put up 10 again for a
19 second. So the annual visits to physician office or
20 outpatient facility is included in this count, just M.D.
21 visits, or does this include other health professionals?

22 DR. HAYES: This would include the other health

1 professionals, also. So these are services -- for the
2 annual visits to physician offices, those would be office
3 visits billable under the fee schedule.

4 MR. HACKBARTH: Okay.

5 DR. HAYES: And then we've included also the
6 outpatient facility visits, as well.

7 MR. HACKBARTH: Okay. Well, for me, maybe --
8 there are a lot of interesting, important questions here,
9 but for me, this is sort of like the most basic one. Do
10 these numbers reflect that the program works or do they
11 reflect that it's just poorly targeted and we need to start
12 anew?

13 Okay. Round two. David.

14 DR. NERENZ: Well, you just said my main thought
15 on this. I think that is the fundamental question. I also
16 repeat my question about clarifying the intent of this.
17 Exactly through what mechanism should this address access?
18 But whatever path ultimately gets us to here, and then, as
19 you said, we can't really tell from these numbers whether
20 it's either working or unnecessary, and I don't know how to
21 move past that.

22 DR. NAYLOR: So, a great report, and I think that

1 it leans -- I am leaning toward thinking about how we would
2 move from lessons learned from this to targeted policies
3 that really promote optimal access of Medicare beneficiaries
4 to primary care to the availability of all workforce members
5 -- APNs, PAs, and physicians -- to access to all of the
6 system redesigns that promote and advance primary care, not
7 just a patient to provider. It sounds like there's been a
8 lot of effort already to try to tweak this, and in fact, you
9 have policies that are building on this with rural clinics
10 getting additional payments if they're in these HPSA
11 designated. So in some ways, we continue to extend maybe
12 what I would consider a flawed policy.

13 So my sense is that our best opportunity in terms
14 of this group and strategy is to think about what could its
15 replacement be rather than trying to spend a lot of time
16 changing something that people have been trying to change
17 for 15, 20 years and have not been successful.

18 MR. KUHN: In terms of your questions on your next
19 steps, I, too, kind of like Mary, I'm really interested in
20 the population-to-provider ratios, particularly with mid-
21 levels and their ability to operate at the top of their
22 license. But as we know, there's a great variation of State

1 licensure laws and I just don't know how we would manage
2 through that whole process. So if there could be some more
3 thinking about that one, I think that would be useful to
4 look at. But I think it could be very complicated, to be
5 sure.

6 The second issue I think you teed up here was the
7 issue of kind of Medicare-specific measures, looking both at
8 the quality and kind of access. Is it equitable out there?
9 And I think that just would probably be a much more accurate
10 forecaster of kind of the way to target, I think is the way
11 this was set up. So I'm kind of like Mary, as well. Rather
12 than trying to kind of fix a system that seems to be
13 intractable, it might be to look at a different way to kind
14 of do targeting for the Medicare dollars that are moving
15 here. It might be worth looking at, as well.

16 MR. HACKBARTH: So as we proceed through the rest
17 of this round, I invite comments on that, in particular.
18 Does it make sense to start clean or not? And for me, one
19 of the fundamental questions there is how do you measure
20 access? Is provider-to-population count a good measure?
21 For all the reasons we discussed in our rural report, I
22 don't think it is, and if that's the case, then that's an

1 argument in favor of the start clean path.

2 Alice.

3 DR. COOMBS: So I think what we have is HPSA. We
4 don't have a lot of other information. Because of that, I
5 think there are some opportunities for improvement with some
6 of the information we've gotten.

7 And I agree that the access issue is really
8 something that all of us are struggling with because we know
9 that utilization and access are two different things,
10 because you can have data that actually shows that there's
11 X-number of visits a year, but that does not correlate
12 necessarily with the comprehensive availability of access to
13 all parties within a given community. So I think that's one
14 of the questions that needs to be answered in terms of being
15 able to tease out some of the subsets within this area if
16 you were to look at this.

17 If I had a magic wand and I could actually drill
18 down into a community, I would want to know if there's,
19 like, a 25 percent driver for that utility in terms of the
20 visits that are seen in the office. And if there's a
21 preponderance of people in a population that say, "I can't
22 get in to see a doctor," I'm really interested in the wait

1 times for -- the average wait time for the general community
2 as being another proxy for access.

3 Well, you can't look at the ratios always, but I
4 can tell you one thing. If the ratio is really low, that
5 tells you right off the bat you have to travel 30 or 40
6 miles to get to a place, or if the doctor goes away on
7 vacation and it really kind of -- it cripples the system.

8 So all we have right now is the HPSA, and when
9 it's really low, it tells you that we're in a crisis
10 situation. When it's average or high, I don't know what
11 that means, either, because we've seen where, in some
12 regions, where some doctors are part-time equivalents and
13 there's a whole lot of other things that enter into the
14 equation for workforce.

15 But I think the most prevalent thing is there are
16 specific shortage areas, and this thing with surgery, the
17 American Surgical Society -- I passed it on to Craig so he
18 could see it -- there was 1,050 doctors being produced in
19 the training program, of which less than 500 were going out
20 to be general surgeons in the real world for 310 million
21 people.

22 So I think there are some struggles within the

1 workforce, and Health Affairs actually presented a couple of
2 -- had some great articles on nurse practitioners and P.A.s,
3 where they go and what they do. And I think there are some
4 lessons that we can learn from those two studies.

5 One of the things of interest is just the
6 specialties that are being pursued by -- and I work with
7 physician assistants and nurse practitioners every day in my
8 practice, and there's a propensity for them to leave out of
9 the primary care profession and migrate into the specialty
10 care. So there are some things that -- there's a moving
11 goalpost all around us in terms of what happens in the
12 community. So I think it's an issue.

13 MR. HACKBARTH: I agree, Alice, that the dynamics
14 here are really complicated, and if we were -- the task was
15 to do a biopsy, you know, do a research study on how good is
16 access in particular communities and what are the variables
17 that you'd look for, it'd probably be a long list of things
18 that you might do as part of that effort.

19 The issue here, I think, is a little bit
20 different. In order to run a payment adjustment, you can't
21 do biopsies of all communities and especially targeted
22 studies. You need to rely on readily available data that is

1 routinely collected and, hopefully, reliable. And so we
2 need to think about the payment adjustment task, not just
3 the research task.

4 DR. COOMBS: I guess what I'm saying is that HPSA
5 is one of the things that other benchmarks, I mean, use for
6 Public Health Service and all the other things that we use,
7 and I don't see that starting all over is any different from
8 you taking a pilot to prove that what's being reflected
9 there is actually robust enough for you to go on, and that
10 would be my contention right now, is that with that tweaking
11 and actually looking at some of these other issues as you go
12 along, it's probably going to be as important as starting
13 from ground zero and saying, let's create something new and
14 build it from the ground.

15 DR. HOADLEY: Yeah, I think it's a tough question
16 to figure out, starting new versus -- I mean, because any
17 time we start new, the idea that we could create something
18 that we could actually pass into law and implement could be
19 decades, or at least years. Fixing it, obviously, you know,
20 is not proved easy to get the things right.

21 I mean, one of the things that strikes me is on
22 the relationships that we were looking at on Slide 10 don't,

1 in a sense, speak directly to the question of whether
2 shortages are correlated with access. They focus on whether
3 HPSAs are correlated with access. And so part of what some
4 of the questions raise is whether HPSAs are actually
5 capturing access for a couple of reasons. One is the
6 definitional, the designation, the designation issues. One
7 is whether -- the underlying question of all these things
8 people have raised, you know, Medicare versus not Medicare,
9 primary care physicians and other kinds of professionals, et
10 cetera.

11 So I don't know whether -- and, as you said, there
12 may be some other literature or other studies we have done
13 that go more directly to the availability of practitioners
14 versus access kind of thing. So one thing would seem like
15 to make sure that we know what the literature overall says
16 about this question of shortages, relationship of shortages
17 to access, and you may already have most of that from other
18 things we have done.

19 The other thing that I don't know how much you can
20 do when you think about the map that you can show or the
21 other issues of designation, is how much could you go in and
22 measure how many of those HPSAs are correctly designated,

1 whether from their own criteria -- in other words, do you
2 have enough of a database of number of physicians, number of
3 primary care physicians and nurse practitioners and other
4 kinds of professionals to sort of go back and revisit those
5 measures, or is that, because of data limitations, far too
6 massive to be able to do, or is it something you could do
7 from the Medicare perspective, the number of providers that
8 are providing Medicare services in these areas. Is there a
9 way to look at that and figure out, maybe, how many of the
10 HPSAs from either of those kinds of measurement approaches
11 are incorrect today.

12 So is part of the problem that the designations
13 are so out of whack that, therefore, it's not working very
14 well, or the designations are actually close, although we
15 can pick out the flaws and the mistakes, and then that says,
16 at least, well, okay, what's there is there, whether it
17 works for Medicare or not.

18 So it seems like there's a bunch of things that
19 could be done to sort of figure out whether the HPSAs are
20 actually capturing shortage, actually capturing Medicare
21 shortage, actually capturing shortage in the rest of the
22 health system, but also the question of whether shortage is

1 related to access in any way. So there's those things I
2 would throw out.

3 DR. SAMITT: So my feeling on this is the concept
4 of HPSA is right, but to me, the methodology is clearly
5 wrong. I was frustrated reading this chapter -- it was very
6 well done, by the way -- because I wouldn't know where to
7 start. I mean, I have concerns about the designation, about
8 the de-designation, about the providers included, the
9 payment levels, and the payment methodology. I mean, I
10 think everything, to me, really seems flawed.

11 And so I don't know if we're allowed to ask for a
12 do-over, but I would clearly ask for a do-over. And I'd
13 start, I think, where others are on this. What's the
14 problem we're trying to solve and let's see if we can
15 measure that. And if we can come up with a good measurement
16 of the thing we're trying to solve and we apply it to the
17 current HPSA methodology, I think what we'll clearly see --
18 we'll get an answer to Glenn's question. I think we'll
19 clearly see that there isn't a correlation between the
20 problem we're trying to solve and the HPSA bonuses.

21 And once we've developed that new measurement
22 methodology, base a new and revised HPSA on a methodology

1 that does meet the underserved and deal with access
2 problems.

3 DR. CHERNEW: Yeah, so a few things. The first
4 thing is, it's sometimes hard to keep front and center, but
5 our motivation wasn't to do an evaluation of HPSA or even,
6 for that matter, to do an evaluation of the impact of HPSA
7 on Medicare. That said, it's hard to read this and not do
8 that.

9 And one of the things that jumps to mind, of
10 course, is for the places that, for example, are HPSA and
11 rural, then they're getting the HPSA and the rural floor,
12 because these programs -- I think they are, anyway -- and
13 these programs are often designed independently. So our
14 overlap issues are difficult and it might be worth looking
15 at, but it's not what we were doing now and I'm not sure how
16 much I'd recommend doing that.

17 I think -- I actually had a different main goal
18 than what Jack said, which was not to understand the
19 relationship between shortage and access, which I do think
20 matters a lot, but instead to understand the relationship
21 between payment and access, and shortage is sort of that
22 mediating thing, but I could think of a lot of models where

1 you pay people more but you don't solve the shortage.

2 And then, of course, we don't know the answer to
3 the question, if we pay them and get people to go there,
4 then we stop paying them, would they stay there, you know,
5 or do they leave? So there's a lot in our underlying model.

6 So since I have nothing of use to say about much
7 more of that --

8 [Laughter.]

9 DR. CHERNEW: But I would be remiss if I didn't
10 say something about research. I will say that one of the
11 things that strikes me is, like, if you look at Utah and
12 Nebraska, which strike me as relatively rural States -- and
13 beautiful -- that they don't have a lot of dots compared to
14 the number of dots that I would expect them to have, and it
15 might have something to do with the nature of people in Utah
16 and Nebraska --

17 MR. HACKBARTH: Put up the map for a second.

18 DR. CHERNEW: We should just have pictures of Utah
19 and Nebraska.

20 MR. HACKBARTH: Yeah, I know a little bit about
21 the geography, and the thing is that in a lot of those white
22 spaces in Utah, there's nobody. There aren't any people.

1 DR. CHERNEW: Right.

2 MR. HACKBARTH: It's desert. It's --

3 DR. CHERNEW: Yeah. So that might be the case,
4 but my comment would be, given the seemingly random aspect
5 of some of these designations, it strikes me that we could
6 find places that look a lot like HPSAs but aren't and work
7 on the Slide 10 comparison in a way that might be a little
8 more precise in the control group. So sort of almost a
9 matching.

10 It might not work, and I'm not saying we should
11 actually do it, but the ideal research -- longitudinal
12 stuff, which I think is what Herb was asking about, would
13 actually be my preferred thing to do. But in absence of
14 that, trying to find places that are matched as closely as
15 one can in the comparison as opposed to broadly HPSA, not
16 HPSA, or even HPSA in a county and not in a county, those
17 parts of the county might be very different or some version
18 of that. But it might be possible to do. Of course, it's
19 complicated since the organizations get to decide what the
20 unit of geography for a HPSA is, so you're not sure what the
21 right comparison is.

22 So I don't know if I have a really great answer

1 for that, but my gut feeling is if we wanted to understand
2 the impact of adding payment, we would try and do as close a
3 matching as we could do to see where this happened or -- in
4 absence of being able to do it longitudinally. And that
5 might be useful in answering the question I think is the
6 main question, which is when payment gets bumped up, does
7 access change a lot, and since we can't do that
8 longitudinally, trying to do a better cross-sectional thing
9 might be a way to go.

10 MR. ARMSTRONG: So I think I see this in very much
11 the same way Michael does, but I'll use many fewer words to
12 say that.

13 DR. CHERNEW: That's always true.

14 MR. ARMSTRONG: I think I share the frustration.
15 In particular, it does seem as if this is just one of
16 several policies within our overall payment scheme that's
17 trying to deal with the same issue and I just don't know how
18 they all relate to each other. Having said all of that,
19 this we spend \$275 million a year on? I would just stop
20 worrying about it. We have much bigger things to pay
21 attention to that are billions and billions of dollars.

22 Trying to unwind this and answer some of the

1 questions we're talking about, I just think aren't the
2 highest best use of our time.

3 DR. MARK MILLER: I'm sorry. I want to jump in
4 for just a second, because I think some things are being
5 said at this point that I do want to focus you on. So we do
6 -- we're talking about a dollar figure of whatever it is.
7 We're also talking about lots of time, you know, involved in
8 parsing or doing it, with all respect, you know, the cross-
9 sectional analysis.

10 And I agree with you that \$270 million is not a
11 lot of dollars and a lot of time, but remembering where the
12 conversation came from was, it's possible that as you look
13 across the country at a national level, you can generally
14 see that access for Medicare beneficiaries is good, but on a
15 spot basis or a market basis, you could have problems.

16 That, to me, I think, is the big question. So as
17 you think about where we devote our time -- and now I'm
18 speaking very selfishly for the staff -- do you really want
19 to parse through this? Because even if you could establish
20 information about the HPSA as one way or another, remember
21 the process and the purpose is probably going to always have
22 some tension relative to Medicare, because they're set up

1 for other reasons, too.

2 And Mike was correct, that we didn't start out to
3 make this a litigation of, you know, HPSA yes or no. It was
4 more -- somewhere along the line in history it got tied to
5 this wagon and then the question was, well, let's take a
6 look at this wagon.

7 If you parse it, no matter where it stands at this
8 point in time, there will always be this tension, that it's
9 up to other purposes, and we're sort of looking at access.
10 So where we devote our time, I would really get you to focus
11 on as I think you're starting to zero in on it.

12 MR. HACKBARTH: Kate.

13 DR. BAICKER: So I had a thought about how you
14 could try to disentangle whether this is a program that's
15 working, which we all seem a little skeptical about, or one
16 that's sort of randomly drawing money out. But now I feel
17 silly making that point after this, because I think the
18 bigger point is well taken, that this is clearly not the
19 vehicle for fixing any big problems, but I can't help it.

20 You could, in theory, even though you can't do the
21 longitudinal thing, look at an area that's designated as a
22 shortage area before its designation and at a comparable

1 area in the same time period, and then look after. And if,
2 as we all strongly suspect, the area that is designated as a
3 shortage area neither looks like a low access area before
4 nor after, then it's hard to make the case that the
5 designation as the shortage area was the thing that improved
6 access.

7 So I would think that that type of dip and dip
8 approach might help tease apart the causality. And maybe
9 there's a bigger point to make there about all of the
10 different payment tools that we're deploying sort of
11 haphazardly in an overlapping, uncoordinated way.
12 Collectively, if you look at all of those payments, is there
13 a way to figure out what the areas with real shortages are
14 and how much the collective payment change makes a
15 difference. And is there a way to harmonize all of those
16 different streams.

17 We've talked about that in lots of other contexts
18 from ambulances to what have you, that coordinating the
19 streams could really maximize the bang for the buck. And
20 so, in that sense, being able to say, This stream is not
21 doing anything on its own that we want it to do, is a --
22 helps one make the case for harmonizing across them.

1 MR. BUTLER: So we're all going to say the same
2 thing in little different ways. Several of us said, What
3 problem are we trying to solve, and the title of this
4 started with it's HPSA. That's what we're trying to solve.
5 And then as you weave your way through the chapter, you say,
6 Oh, by the way, we've got National Health Service Corps,
7 we've got FQHCs, we've got all these other things that are
8 part of the picture.

9 So by the end, you say, Wait a minute. The
10 problem is a different one than we started in the title.
11 And so, I do think -- and also the comment that says, you
12 know, it takes us a long time to get from here to there. I
13 do think we have a tremendous opportunity for an educational
14 role here in defining the overall -- half of the solution is
15 defining the problem correctly.

16 I think if we do present it as an overall access
17 thing, and as Kate says, show the range of mechanisms, the
18 tools currently being used, whether it's National Health
19 Service Corps or FQHCs or HPSA or whatever, there's a series
20 of tools that we could just lay out and say, These are how
21 we're trying to move physicians and providers around to let
22 -- whether it's synchronized. But just understanding that

1 portfolio is a great starting point.

2 You can still lead into HPSA and say, You know
3 what? Maybe there's a moratorium on additional ones at this
4 point in time, because this voluntary come get it if you
5 want it kind of thing is, you know, small dollars. It
6 doesn't seem like it's the right tool. Let's not keep using
7 it. That may be one of the kinds of outcomes.

8 But I would look at this in the longer term
9 because we're going to come back to this through various
10 other things that we're going to address one way or another.
11 So I think the overall access umbrella is going to be
12 increasingly important for us to kind of understand in a
13 more global sense.

14 DR. SAMITT: Can I tag onto that? Is it feasible
15 to see -- you know, one of the things we do in our own
16 organization when we try to get a handle on who's
17 benefitting from multiple different ways, especially in
18 terms of payment, is really sort of an exceptions grid that
19 essentially says, Where are all the exceptions to the
20 rurals?

21 So what I've never seen is really a single source
22 that says, What are all the different ways that rural areas

1 are actually potentially benefitting, or what are all the
2 exceptions? And are we potentially double counting? I
3 don't know if there's a way to really get that summary or
4 whether that itself is too complex, but I think it would be
5 useful to see and it may give some context to what Peter is
6 describing and asking.

7 DR. MARK MILLER: And I have a vague recollection,
8 Jeff, that when IOM started to look at some of its mandates
9 in the last two or three years, at least early on -- this is
10 the geographic variation broadly written. Early on, there
11 was some work where they tried to line up all of the, you
12 know, special adjustments for rural areas. So we'll start
13 there and see if we can get our hand on that list relatively
14 quickly, and then see if that starts to fit into what you're
15 saying.

16 MR. BUTLER: If Mitra were here, she'd say, Don't
17 just think about the rural areas. This is an access issue,
18 period, like FQHCs are -- a ton of those are sitting in
19 urban areas.

20 DR. MARK MILLER: And I knew that. So that list
21 was available so I was going to start there. Peter, I got
22 your point.

1 DR. HALL: Maybe just to drill down a little bit,
2 so I work in an area of the country where there are a number
3 of HPSAs and I've seen patients in these areas. So in
4 general, they do a very good job of -- we have a number of
5 rural ones. The whole Lake Ontario area of New York State,
6 you'll notice, is dotted with them. Those are primarily
7 serving migrant workers who come up to work in the crops in
8 the summer and then leave. Tremendous amount of health
9 problems. No health insurance.

10 Remember, this is not just a Medicare issue. This
11 is the whole access to care issue. And so, it's hard for me
12 to say that the money is wasted in those areas because there
13 really would be no access to care. And the fact that these
14 HPSAs have been initiated by local areas suggest a degree of
15 community engagement that is laudatory. It's not a hand-
16 out. They have to really do some work in order to get the
17 designation.

18 And then within our urban area, there are also a
19 few. Some are geographic. Mostly are ZIP code based.
20 Service of minority populations that really actually don't
21 get access to health care. Now, it seems to me that the
22 real issue for us in MedPAC is, that segment of the

1 population that are Medicare eligible are eligible for
2 benefits, period.

3 The real question is, do we have to pay an extra
4 10 or 15 percent? I think maybe that's really our issue,
5 not so much whether we're going to take on this entire
6 program around the country. I think that we could really
7 get lost in this very, very easily. So that's my point of
8 view on that.

9 DR. REDBERG: So I agree with a lot of what has
10 already been said. I will just -- about the concerns. It
11 seems the goal of this is to get more primary care services
12 to areas that need them, but it's very hard to look at that
13 money and say that this is what we're doing with this
14 program. And so, I think that's giving us a lot of concern.

15 You know, the National Health Service Corps, I
16 mean, it seems to me that it's not a lot of money, but it
17 does -- a fair amount of money and it could be used to
18 really more directly address the primary care issue. And
19 so, first of all, obviously as has been pointed out, primary
20 care practitioners are not restricted to doctors. There
21 are, you know, advance nurse practitioners and it's a shame
22 that they're not counted in this and that they're not

1 benefitting from it.

2 And also, when I think of National Health Service
3 Corps, I think, you know, more of the model of actually
4 using the money to directly bring primary care practitioners
5 to under-served areas and that seems like a much more direct
6 way to address it and then know that it's actually being
7 used. Because when I look at this and I see that only 31
8 percent of all the Medicare payments are actually going to
9 primary care, it makes me feel that even the money that
10 we're spending isn't really addressing the problem.

11 And then just in the bigger picture, it's very
12 frustrating. This program is already here, but if we were
13 certainly doing this today or thinking of new programs, it
14 really reminds us of how important it is to be able to
15 define what the problem is, to have a measure for it, and
16 not to start throwing money at it until we have a measure
17 and then we have a program and a plan to come back and re-
18 look at it and know whether we're actually addressing and
19 improving the problem, because otherwise, it's very -- we're
20 in this position where we have no idea if this money is
21 actually helping, although it certainly is hard to say that
22 it does help. So that's my kind of specific suggestions and

1 broader suggestions for future programs.

2 DR. CHERNEW: So I just wanted to say one thing in
3 response to what Scott said, just with more words, which is,
4 I agree that this is a small program, and in that sense, we
5 have a lot bigger things to think about.

6 But while this sort of poorly targeted aspect of
7 this is very troubling from a policy point of view, it may
8 be quite soothing from a research point of view if you could
9 think about the type of stuff that Kate was saying and the
10 sort of notion of how to get at this, because the question
11 in my mind isn't so much about HPSA or not HPSA or that,
12 it's about how the provider system and access responds to
13 payment.

14 And so, if you could do that well, and I'm not
15 sure you could, there's a whole range of questions that we
16 address that are much bigger than just HPSA about what we
17 think about payments in a bunch of ways. So if we knew the
18 general -- the answer to the general question, I think it
19 would help us leverage what we do in programs that are much
20 more consequential at large in the Medicare program.

21 MR. HACKBARTH: So, we got into this through our
22 work on the report on the floor on the GPCI work adjustment.

1 And in that conversation, we concluded that the floor was
2 probably not a very effective way of improving the access in
3 areas where there were problems with access. It might be
4 better to have a more targeted program. So now we're
5 looking at HPSA as an effort to target.

6 I tend to think about these things in the way I
7 might be asked questions in a Congressional hearing. So
8 MedPAC, like the GPCI floor. Is the HPSA bonus program
9 better than the GPCI floor? Does that do a better job? You
10 know, it's really hard to say based on the information that
11 we have, but if I had a choice between we're going to repeal
12 one of these two things, you know, the GPCI floor or the
13 HPSA bonus, which would you ask us to take away, I'd say,
14 take away the GPCI floor and keep the HPSA bonus.

15 For all of its problems, at least it's an effort
16 to try and identify where there are shortage issues. That's
17 not a very -- that's not very high praise, but compared to
18 that alternative, this is probably a better alternative.
19 But then the next question would be, Well, should the HPSA
20 bonus be enhanced, increased? And there, I think you'd have
21 to say, based on the evidence, no. It would be hard to make
22 the case that that would be a good use of scarce taxpayer

1 dollars.

2 The next point, to press still further, I would
3 say probably the thing to do is to take a broad look at all
4 of these various programs that are aimed at improving access
5 to care, not just Medicare payment adjustments, but the
6 National Service Corps, et cetera, and look at all of them
7 as a group at their effectiveness.

8 In fact, this was an issue, a point that we made
9 during our GME work back in 2010, that if you really want to
10 increase the number of physicians practicing in rural areas
11 where you want to change -- or even urban areas, under-
12 served urban areas -- you probably want to move upstream,
13 look at things like medical school, entrance policies,
14 recruitment.

15 And then a little further downstream National
16 Health Service Corps, Medicare payment adjustments or
17 Medicare GME funding adjustments are probably pretty weak
18 tools for dealing with distribution of physicians and
19 choices physicians make. So those would be sort of the
20 lessons that I take out of this for reasons that Scott and
21 others said. I'm not sure that it's a high value use of our
22 time to dig further into refinements of this. Let me stop

1 there and just invite reactions to that. Craig.

2 DR. SAMITT: You know, I would wholeheartedly
3 support a re-look of all of the things that could
4 potentially affect access, not today, but in the future. I
5 mean, I think even the discussion about the SGR fix and sort
6 of the need to re-distribute primary care is as much about
7 solving the future access problem as anything else; that if
8 we envision that there's going to be a deficit of certain
9 physician disciplines, whether it's the disciplines
10 themselves or the geography of the placement of those
11 physicians, I think someone should take a whole broad look
12 at where those barriers are and what policy recommendations
13 can be put in place to address them now and into the future.

14 MR. HACKBARTH: It's just sort of a technical
15 problem because a lot of them are in the Public Health
16 Service and outside of, you know, our jurisdiction. So
17 that's just an issue. I saw another hand. Jack.

18 DR. HOADLEY: I mean, I think I would answer that
19 first question you put up the same way you did, and one of
20 the reasons I would give for that is probably that the floor
21 is only a rural -- only addresses the rural issues.

22 MR. HACKBARTH: In fact, one of my objections to

1 it is, you know, Denver qualifies, San Antonio.

2 DR. HOADLEY: Or doesn't do it well.

3 MR. HACKBARTH: It doesn't really target.

4 DR. HOADLEY: And I think what the HPSA, at least
5 in concept, tried to do was figure out a way to address
6 urban issues. But the problem is the measuring -- all the
7 measurement tools. I mean, you can think of lots of places
8 that have plenty of providers in the geographic unit, but
9 they're not serving the population.

10 And, you know, we don't want to go back and redo
11 the rural analysis, you know. And maybe thinking about ways
12 we can try to focus on some of the urban areas is a way to
13 distinguish what we might do from what's already been done
14 on the rural side. It's harder, I mean, because the doctors
15 are often there physically in the community. They're just
16 not necessarily, you know -- they're dealing with other
17 income, higher income patients. So maybe it becomes more of
18 a low-income issue.

19 But anyway, that's -- it really goes back to the
20 importance of the urban issues.

21 DR. NAYLOR: So I really like also the idea of
22 framing or re-framing the problem, and even getting to

1 better clarification of principles to address this problem.
2 So the thing that I think has guided our work for the last -
3 - well, since I've been here is the set of principles and
4 that we can constantly go back to see.

5 Here it's not -- it's not just access of Medicare
6 beneficiaries. Here I think we want to really focus on
7 access of Medicare beneficiaries to primary care. And it
8 seems to me then we have a set of both payment tools and
9 newer delivery system tools that we need to be thinking
10 about as potential solutions and how payment can really
11 accelerate those tools, including workforce, but also system
12 redesign.

13 And then mapping the programs against meeting what
14 we hope will be the metrics, however broadly. We might not
15 need to define them. But I think I wouldn't have answered
16 that, based on reading this, that HPSA is accomplishing it.
17 I think it needs refinement, and if it becomes the way that
18 we continue to build and invest, and because so many -- 30
19 programs are feeding off this. So it seems to me it's not
20 just the \$270 million investment. It's a gargantuan
21 investment that's being made and building on this block.

22 So I would say if one of the opportunities here is

1 then what are the set of policy recommendations to refine
2 this to accomplish that goal, that's great. But I do think
3 we're at a point where we could take a look at our
4 principles, take a look and refine the problem, and that
5 would help us a great deal in evaluating existing options.

6 MR. BUTLER: So if we kind of go that direction
7 Mary is suggesting and do have the inventory of tools that
8 are currently being used, one way to highlight maybe our
9 priorities might be asterisking those ones that without
10 action something is going to happen. So SGR would be a good
11 one. You know, it's coming up again, or it could be that
12 the temporary add-ons that you mentioned, should we
13 recommend they continue or not.

14 So at least some of the things may require some
15 input because they're time sensitive and something is going
16 to happen to them one way or another, and our principles
17 might help guide how we would respond to at least those that
18 are in the pipeline that are going to require some action no
19 matter what.

20 MR. HACKBARTH: In fact, the reason I'm sort of
21 thinking about this in terms of questions that I'm hearing
22 is that I'm going to be testifying at a hearing next week

1 and I think this probably will come up. One of the things
2 they'll want to talk about is the extenders, including the
3 GPCI floor and our recommendations on that. So that's why
4 I'm very much in this mode and thinking about principles.

5 So I don't think the GPCI floor is well-targeted.
6 We'll elaborate more on that. HPSA bonus, you know, it's a
7 close call for me whether that is better than the floor.
8 I'd be inclined to say yes, it is, but with a critical
9 caveat, resorting to our principles. I don't think that
10 provider to population counts are a good measure of access,
11 and we laid out our case for that in the rural report.

12 So we have this built on what we think -- and
13 correct me if we don't think this -- that it's a weak
14 foundation, but it's probably better than just spreading the
15 money around to everybody that has a GPCI work value of less
16 than 1. Not a very high standard, but it's probably better
17 than that.

18 But if you want to add more money into the HPSA
19 bonus, I'd probably couldn't recommend that. And if you
20 really want to do something that's effective at improving
21 the distribution of clinicians, physicians, and others, you
22 really need to do a much broader look at the array of

1 programs that exist, many of which are in the Public Health
2 Service, that are a drag to that, do a careful evaluation as
3 appropriate restructuring. That would be my answer. Does
4 that sort of capture the spirit of this conversation?

5 DR. COOMBS: I just think one caveat, when you're
6 looking at the ratio, has got to be to reserve the notion
7 that when it's very extraordinarily low, I think the World
8 Health Organization, those several legitimizing bodies that
9 actually endorse this as a mean of a rubric to look at
10 sufficiency of workforce.

11 So I think when it's very low, it tells you
12 something very different than if it's normal or increased.
13 So I would just use that as one thing as an exception.

14 MS. UCCELO: My frustration in this entire
15 conversation is the -- how are we defining low-served areas?
16 And I don't think we -- we think we know what's not good,
17 but I'm not sure we've come up with something that we think
18 really does a good job of it.

19 MR. HACKBARTH: We certainly haven't come up with
20 a composite measure that, you know, we can say, Here's the
21 index and, you know, if you're more than 1.3 on the index,
22 you've got a problem. But I do think that we laid out a

1 rubric in the rural report for how you assess whether people
2 have access to needed services, and it's not just one thing.
3 It's a multi-variable sort of look, but it hasn't been
4 reduced into a payment formula and adjustment. Do you feel
5 comfortable with that? Okay. Craig, anybody else?

6 Okay, thank you. Good work, Kevin, Kate, and
7 Katelyn.

8 [Pause.]

9 MR. HACKBARTH: Okay. Our final topic is shared
10 decisionmaking.

11 DR. SOKOLOVSKY: Good morning. Lately the
12 Commission has been devoting an increasing amount of time to
13 beneficiary issues, including our work on benefit design.

14 A number of you have been asking for an update on
15 shared decisionmaking since we last looked at it in 2010.
16 Today we are going to summarize some recent developments.

17 Let me tell you what we're going to do today.
18 First, we're going to tell you about what we did to update
19 our past findings and get a better understanding of how
20 shared decisionmaking is currently working.

21 Next, we'll summarize our key findings. With few
22 exceptions these findings held across all the sites we

1 looked at. In the future, we hope to describe some of the
2 wide variety of other programs being developed.

3 One focus we had in the course of our work was to
4 examine whether shared decisionmaking had the potential to
5 reduce health care disparities. Today we're going to focus
6 on one particular program that seems to be making progress
7 on that issue.

8 I want to start by reminding you of what shared
9 decisionmaking is. It's a process that involves giving
10 patients personalized information about their condition,
11 possible treatment options, and the probabilities of
12 benefits and harms from these different treatments, and
13 allows the patients to communicate how they value the
14 relative benefits and harms so the patient can then
15 participate in decisions about their health care.

16 For example, breast cancer patients learn that, in
17 terms of average survival rates, there is no difference
18 between mastectomy and lumpectomy, but that there are other
19 tradeoffs with both procedures that they should consider.

20 Shared decisionmaking includes the use of patient
21 decision aides. They can be booklet, DVDs, online programs,
22 or other ways. They are basically tools that give patients

1 objective information about treatment options for a given
2 condition,

3 Shared decisionmaking is not appropriate for all
4 decisions. It mainly focuses on questions where the obvious
5 treatment option is not clear.

6 To update our past findings, staff conducted three
7 site visits. One was to Group Health, which has conducted
8 the largest demonstration of shared decisionmaking, testing
9 whether it could be incorporated in regular clinical
10 practice. Since 2009, they have distributed over 27,000
11 decision aids, mostly to patients considering elective
12 surgery.

13 Second, we visited Mercy Clinics in Iowa. While
14 Group Health started with specialists, Mercy focused on
15 primary care as part of their ongoing ACO.

16 Lastly, we visited the nurse practitioners at
17 FQHC, Public Health Management Corporation. Their clinics,
18 which service a largely Medicaid-eligible and public
19 housing-eligible population in Philadelphia, are organized
20 as medical homes, and they focus on primary care.

21 We conducted three focus groups with patients who
22 had taken part in shared decisionmaking, and we also

1 conducted about 20 structured interviews with individuals
2 implementing other programs, researchers, and companies that
3 are developing programs. This presentation focuses on our
4 site visits, including the focus groups.

5 As you suggested in 2010, increase in ACOs and
6 medical homes has led to an expansion of shared
7 decisionmaking programs. However, progress is slow.

8 Successful programs, although all unique, have
9 certain features in common: strong support from leadership
10 of the organization, provider champions, and often nurse
11 coaches. Physicians must support shared decisionmaking for
12 it to work, and for that to happen it can't interfere with
13 office work or add to the time that they have available to
14 see patients.

15 Compared to 2010, more demonstration projects are
16 incorporating shared decisionmaking in primary care but
17 challenges remain.

18 And, lastly, many believe that shared
19 decisionmaking has the potential to reduce health care
20 disparities, but empirical evidence is limited.

21 The International Cochrane Collaboration has
22 analyzed 86 randomized controlled trials of shared

1 decisionmaking with patient counseling and decision aids
2 relating to over 20 different medical decisions. Studies
3 have consistently shown that decision aids used with
4 counseling increase patients' knowledge, give them a more
5 realistic perception of treatment outcomes, increase the
6 proportion of patients who are active in decisionmaking, and
7 improve agreements between patients' values and the options
8 that they choose. In general, the studies also showed a
9 reduction in more invasive treatment options without adverse
10 effects on health outcomes.

11 Early results from Group Health focus on about
12 9,000 patients with osteoarthritis who were potential
13 candidates for knee or hip replacement surgery. Researchers
14 compared patients with these diagnoses during the six months
15 prior to the demonstration with those six months after the
16 demonstration began. This includes patients who did not get
17 the decision aids. Compared to patients in the early group,
18 the knee replacement surgery rate dropped 38 percent and the
19 hip replacement surgery rate fell 26 percent. Costs for
20 these patients also fell.

21 I want to just remind you that patients who don't
22 choose surgery still incur medical costs for alternative

1 treatments, for example, medication and physical therapy.
2 Physicians we spoke to said that even delayed surgery could
3 be better for patients because the new knees and hips can
4 wear out, and people who have surgery at a younger age may
5 need additional surgery later.

6 Shared decisionmaking at the three programs we
7 visited were characterized by leadership strongly supporting
8 the program. For example, at Group Health, when the project
9 got off to a slow start, leadership scheduled half-day
10 training sessions to explain the program and listen to
11 physician concerns, rearranging operating room schedules to
12 make sure that physicians could attend.

13 In all three sites, provider champions who
14 strongly supported the program in individual departments or
15 clinics were a key factor in encouraging others to try the
16 program. They were the ones who could explain that it
17 didn't increase the time they needed to spend with each
18 patient and that their patients were very enthusiastic.

19 At Mercy, shared decisionmaking depended on nurse
20 health coaches in each clinic. The nurses coordinate care,
21 provide patient education, and could also have
22 responsibility for distributing aids and explaining shared

1 decisionmaking.

2 In 2010, the Commissioners talked about the
3 difficulty implementing shared decisionmaking in primary
4 care. You suggested that the development of ACOs and
5 medical homes could provide the incentive and infrastructure
6 to make it more feasible. And to the extent that patients
7 choose less invasive procedures if they were less costly,
8 the ACO had the opportunity to realize savings.

9 CMS has developed CAHPS sections for medical homes
10 and ACOs within their patient experience modules that
11 reference exactly the activities associated with shared
12 decisionmaking. So we do see an increase happening but at a
13 very slow pace.

14 For example, CMMI, the Innovation Center, has
15 awarded three shared decisionmaking grants, and PCORI has
16 also awarded two grants. But when CMS recently conducted a
17 survey of their Comprehensive Primary Care Initiative, which
18 currently has 500 sites, only 2 percent of those sites
19 reported having shared decisionmaking programs.

20 We interviewed organizers from eight primary care
21 shared decisionmaking sites and found that they focused on
22 different conditions, used various methods of decision aid

1 distribution, and encountered a range of challenges. Some
2 made more progress than others. Mercy has been one of the
3 most successful of these sites and is expanding their
4 program beyond the demonstration. But they still face
5 challenges and report, in fact, that there were somewhat
6 fewer decision aids distributed in the second year of the
7 program than in the first year.

8 Some of the reasons we were given include: In the
9 first year, physicians were getting an incentive payment to
10 provide the decision aids. They're no longer getting that,
11 although they're still getting it in the P4P program.
12 Secondly, there are now over 30 aids, and that made it
13 harder for both the physicians and the coaches to remember
14 that there was an appropriate aid for a particular patient.

15 Finally, as the ACO has developed, health coaches
16 have increasing responsibilities, so it has been harder for
17 them to devote as much time to shared decisionmaking. Mercy
18 has responded to this problem by increasing the number of
19 coaches in each clinic.

20 We conducted two focus groups with Medicare
21 beneficiaries at Mercy who received decision aids. The
22 kinds of things patients said, and this is one quote that I

1 thought really captured the essence of what we heard:

2 "Overall, I feel that when my doctor comes in, I don't want
3 to bug him with petty questions. I think my questions are
4 just me being dumb so I don't ask them. But after seeing
5 these questions covered in the material, I realized they
6 aren't petty. And the doctor gave me straight answers to
7 the questions when I asked them in the office."

8 Another example: Sometimes people hearing about
9 shared decisionmaking and that people are more likely to
10 choose less invasive treatments think, "Oh, well, this may
11 just be another way to deny care," so I want to give you
12 another focus group participant. This was a man who was
13 over 80 who had been very active all his life, but now knee
14 pain was making him feel that he was no longer going to be
15 able to participate in his favorite activities. He thought
16 he wanted knee replacement surgery. His doctor told him,
17 "If you were my father, I would advise against it, but I
18 have some material you should look at."

19 After seeing the video, he realized that rehab was
20 much longer and harder than he had anticipated, and success
21 would depend on how hard he was willing to work at rehab.
22 He went on to have the surgery, was prepared for the

1 recovery, and was very happy with the result.

2 Now Katelyn is going to talk to you about the use
3 of shared decisionmaking to reduce health care disparities.

4 MS. SMALLEY: As Joan mentioned, empirical
5 evidence about shared decisionmaking's ability to reduce
6 disparities is limited at this point, but some programs show
7 promise in both reducing disparities and engaging low-income
8 populations. Your mailing materials provide more
9 information about efforts to reduce disparities in end-of-
10 life care and end-stage renal disease. But today we'll focus
11 on efforts to implement shared decisionmaking with the low-
12 income, low-literacy population.

13 In November of last year, staff visited the Public
14 Health Management Corporation, a nonprofit group of
15 federally qualified health centers led by nurse
16 practitioners in Philadelphia. The population served by
17 these clinics is largely Medicaid-eligible and public
18 housing-eligible. A large portion of the patients in one
19 clinic are chronically homeless.

20 As required by the FQHC, the clinics are organized
21 as patient-centered medical homes. Nurse care managers
22 coordinate the care provided by nurse practitioners, social

1 workers, and mental health specialists for the patient.

2 The care manager is also responsible for
3 distributing decision aids to appropriate patients and
4 addressing their questions in preparation for a follow-up
5 visit with the nurse practitioner to discuss a decision.
6 Despite initial concerns, nurse practitioners have found
7 that the decision aids have led to more efficient office
8 visits and deeper discussions with patients.

9 PHMC is unique in the population that it serves
10 and in some of the strategies it uses to engage patients.
11 While the clinics offer many acute-care decision aids, the
12 most widely used are for chronic disease management.

13 The most popular decision aid is for diabetes.
14 Patients and clinicians reiterated the importance of
15 community in managing chronic conditions, and thus patients
16 diagnosed with diabetes can choose to watch the decision aid
17 with a group of patients like them and participate in a
18 discussion facilitated by a nurse that helps them consider
19 their preferences with regard to lifestyle changes and
20 medication. One of the nurses we spoke with told us that
21 the peer group was an important part of the program, saying,
22 "The patients in the videos were a different kind of expert

1 than the health care provider."

2 Family is also encouraged to be involved in the
3 shared decisionmaking process. Patients often watch the
4 videos with their families so that they can discuss
5 lifestyle changes together. Some patients have also asked
6 for decision aids on behalf of family members.

7 Patients often reported feeling overwhelmed by
8 their diagnoses. The decision aids showed them that small
9 changes that they make could have a large impact on their
10 health. It was helpful to them to know that it is normal to
11 struggle with managing a chronic condition like diabetes.
12 Because they saw the patients in the videos acknowledge
13 their difficulties, they felt more comfortable being honest
14 with their nurse practitioners about their own challenges.

15 One of the most striking findings from
16 Philadelphia is that medication adherence in this population
17 after engaging in shared decisionmaking is comparable to
18 other shared decisionmaking demonstration projects that
19 predominantly serve higher-income patients.

20 On the slide, the green bars show medication
21 adherence for the PHMC population, and the blue bars are
22 other demonstration sites associated with the foundation for

1 informed medical decisionmaking. The darker color at the
2 bottom shows adherence before shared decisionmaking. Taking
3 cholesterol medication adherence as an example, the Public
4 Health Management Corporation adherence was 46 percent, and
5 the adherence at the other sites was 63 percent before
6 shared decisionmaking. While adherence rose in both groups
7 after participating in shared decisionmaking to 72 percent
8 and 74 percent, respectively, we see that the gains in
9 medication adherence were much greater for the Public Health
10 Management Corporation population in this case. PHMC is
11 still exploring ways to best measure shared decisionmaking's
12 impact on outcomes and other quality measures.

13 Reactions to shared decisionmaking have been
14 largely positive. However, it is important to note that the
15 evidence base for shared decisionmaking's effects on quality
16 of care and health outcomes is still small. Evaluations of
17 shared decisionmaking generally involve small programs, and
18 while patients are enthusiastic about participating, shared
19 decisionmaking's ability to improve health outcomes is still
20 unclear.

21 In addition, interest in shared decisionmaking is
22 growing, especially with the adoption of ACOs and medical

1 homes, but that growth is slow.

2 Finally, staff has collected much more information
3 about shared decisionmaking and patient engagement than we
4 were able to share with you today. In future conversations,
5 we plan to discuss more work on disparities, patient
6 activation, other innovative programs in shared
7 decisionmaking, and continue to report the progress on
8 developing and testing quality measures.

9 This slide is a reminder of the major findings on
10 shared decisionmaking thus far. As we move into discussion,
11 we look forward to hearing your comments about what we know
12 and suggestions for directions for further research.

13 Thank you, and we look forward to your discussion.

14 MR. HACKBARTH: Thank you. Good job.

15 Scott, since Group Health is so prominently
16 mentioned in the materials, anything that you want to say to
17 kick off discussion?

18 MR. ARMSTRONG: No. I think the work that the
19 group has done is excellent. I think this raises some very
20 interesting questions. Obviously, there is tremendous merit
21 in the shared decisionmaking approach, both with respect to
22 the engagement of patients and the application of evidence

1 to the different alternative courses of treatment. But I
2 think there's a real question that remains, and that is, how
3 does shared decisionmaking actually change the cost trends
4 over the course of time? And while in our organization we
5 believe that this is a good approach to care and that cost
6 trends will be affected over time, we have very little
7 evidence to really affirm that.

8 You know, for us, in consideration of significant
9 payment policy, I think that is an important thing to keep
10 in mind.

11 MR. HACKBARTH: Okay. Round 1 clarifying
12 questions, anybody?

13 DR. NERENZ: Slide 9. Given this Commission's
14 focus on Medicare payment, it strikes me that the first
15 bullet, the first sub-bullet under challenges, lack of
16 financial incentives, may actually be an understatement.
17 Are there any payment streams for this activity in Medicare
18 fee-for-service at all?

19 DR. SOKOLOVSKY: In fee-for-service, no, although,
20 for example, in Mercy, many of the physicians are paid fee-
21 for-service, but it's within the context of an ACO.

22 DR. NERENZ: But they don't get paid for doing

1 this.

2 DR. SOKOLOVSKY: They don't get paid for doing
3 this, no.

4 DR. NERENZ: Nor does the nurse coach, nor anybody
5 else.

6 DR. SOKOLOVSKY: No.

7 MS. SMALLEY: Right. And in PPACA, there were
8 some provisions for shared decisionmaking, but no funds were
9 allocated.

10 DR. REDBERG: To state the obvious, it's kind of
11 the negative incentive because, as you saw the data on
12 surgery, the rates go down. The rate was 36 percent or so
13 for knees and 20-something at Puget Sound. And so that is
14 clearly a barrier to dissemination in a fee-for-service
15 environment, the payment goes --

16 DR. NERENZ: That's why I phrased my question the
17 way I did, to say this is kind of a gentle understatement.
18 There are some clear disincentives in some environment, I
19 would think.

20 MR. GRADISON: It seems to me I've been hearing
21 about this since I first started to read the work of Jack
22 Wennberg, and I think I was in short pants at the time. And

1 he had some very good information out there, a video about
2 prostate treatments and options and so forth.

3 I think it's a good idea. I am troubled in
4 several ways. Of course, I'd like to know more about costs,
5 and I'd like to know more about outcomes. Somehow, also,
6 I'm trying to think through the effect of adding this
7 additional responsibility to all the other things that we
8 want to accomplish. It reminds me a little bit of driver's
9 ed. Driver's ed is a really good idea, but I think when
10 it's suggested -- and I've been on a few school boards --
11 the question is: Instead of what? What are you going to
12 drop from the curriculum to add driver's ed? And maybe the
13 answer is, well, we're not going to drop anything here. But
14 I'm not so sure about that.

15 My overall view of the report is that it's
16 excellent and pretty well balanced, but I stress the "pretty
17 well" because it just happens that, by coincidence, the
18 Health Affairs issue that just came out is on this very same
19 subject and has a number of different articles, some of
20 which are cited in the references in the back of this
21 chapter, and you had it available. But I came away from
22 reading those articles with a sense -- a very different

1 sense than I did from reading this document. And at the
2 risk of just picking out one, I will pick out one, which is
3 the RAND study. Just a couple of sentences:

4 "Barriers to shared decisionmaking included
5 overworked physicians, insufficient provider training, and
6 clinical information systems incapable of prompting or
7 tracking patients through the decisionmaking process.
8 Methods to improve shared decisionmaking include using
9 automatic triggers for the distribution of decision aids and
10 engaging team members other than physicians in the process,"
11 and so forth and so forth.

12 But the reason I go through this is actually I do
13 have a question that does relate to Slide 9, please. It's
14 already up there.

15 [Laughter.]

16 MR. GRADISON: And that is, I wonder whether --
17 because none -- I haven't seen references here to the age of
18 the Medicare patient. What I'm going to say now is a gross
19 oversimplification, but I think physicians years ago were
20 considered God a little more than they are today, and that
21 patients were more willing to accept their recommendations
22 without asking a lot of questions. And that leads me to

1 wonder whether we're dealing here with a situation in which,
2 in terms of the receptivity to this approach -- and I
3 acknowledge the 80-year-old example. You know, I'm over 80
4 myself and ask a few dumb questions myself, although I do
5 seem to always end up doing what the doctor initially
6 recommended. I can't sort that one out. But I truly wonder
7 whether this is something that we'll see change over time as
8 people who are more accustomed to asking questions and not
9 just automatically doing whatever the doctor recommends age
10 into Medicare than might be the case with older
11 beneficiaries.

12 So that is my -- I did have a question, and that
13 is, do we have or over time might we get any information on
14 the impact of the effects of this approach with the old-old
15 as compared with the younger-old?

16 DR. SOKOLOVSKY: We actually do have that, only I
17 got it like the day before the presentation was in, so it's
18 not yet incorporated. But it --

19 MR. GRADISON: I'm glad I asked the question then.
20 We did not rehearse this ahead of time.

21 DR. SOKOLOVSKY: No. It does include surveys from
22 all the demonstration sites, including the one that that

1 article focuses on. And, interestingly enough, age does not
2 -- is not a barrier to shared decisionmaking. The
3 enthusiasm, the people who say that it's an excellent or
4 very good program, is as high for the elderly as for all the
5 other age groups.

6 MR. HACKBARTH: Okay. Herb, do you remember the
7 format for questions?

8 [Laughter.]

9 MR. KUHN: I'm going to stretch this one just a
10 little bit, but I think Slide 7, just kind of a bit of
11 reference here in terms of physician buy-in. So, a little
12 bit where David was, is there any CPT code that has a
13 descriptor that includes shared decisionmaking in it?

14 DR. SOKOLOVSKY: There is a code that's about
15 patient counseling that some people have suggested could be
16 used, but I believe that most physicians think that that
17 would prompt an audit if they actually tried to use it for
18 that reason.

19 MR. KUHN: And then are any of the specialty
20 societies moving to the RUC to ask for codes to be updated
21 to include this and to change the code descriptors and then
22 ultimately the valuation of codes? Are we aware of any

1 coming forward yet?

2 DR. SOKOLOVSKY: I'm not aware of that.

3 MR. KUHN: Okay. Thank you.

4 MR. HACKBARTH: So, Joan, could you just say a
5 little bit more about your response there? Why do
6 physicians fear an audit if they use a counseling code to do
7 shared decisionmaking?

8 DR. SOKOLOVSKY: They feel that that's one of the
9 triggers. Now, this came up earlier, in 2010, and our
10 former Commissioner Karen Borman said she uses that code all
11 the time and it's never a problem. But talking to
12 physicians in these different sites, they were worried about
13 that.

14 DR. HOADLEY: On Slide 3, it really is about the
15 definition. You talk here about communicating values,
16 relative importance of benefits and harms. Does cost
17 benefit come up in these discussions, and if so, how often?
18 I know that's a politically charged notion.

19 DR. SOKOLOVSKY: It doesn't come up in the
20 decision aids that we've mostly been talking to, but the
21 Mayo Clinic -- I think I talked about it a little bit in the
22 paper -- has a different approach that involves the

1 physician directly doing shared decision making, and one of
2 the issues on their radar is cost issues, and they kind of
3 go through -- for example, for a patient with diabetes,
4 there are six or seven different types of medication you
5 could take and they give you a list of what's most important
6 to you -- side effects, control of your blood sugar, and
7 there's a whole list, but one of the things on the list is
8 cost.

9 DR. HOADLEY: Okay. Thank you.

10 MS. UCCELLO: So, on Slide 6, please. You noted
11 that when looking at the reduction in surgery, that those
12 numbers included those who did and did not receive the
13 decision aids, and I was wondering if there was any
14 reduction even among those who did not receive the aid,
15 suggesting there might be a carryover to kind of physician
16 behavior component to this.

17 DR. SOKOLOVSKY: That's a really good question and
18 I don't have the answer.

19 MR. HACKBARTH: Okay. Let me kick off round two.
20 My mind is focused on two questions. One, I think, is easy
21 to answer, the other, more difficult.

22 The easy question to answer is, is shared decision

1 making a good thing? I think it is. In fact, I would say,
2 beyond being a good thing, I think it's an ethical
3 imperative. By definition, what we're talking about is, for
4 many services, there is no clinical right answer. The right
5 answer depends on patient preferences, how they feel about
6 different possible outcomes and risks, and to me, certainly
7 in that category of services, this is an ethical imperative.
8 That's the easy part.

9 The second question, which I hope we will focus
10 on, is -- if we all agree that it's a good thing -- what is
11 the Federal role, if any, in trying to promote it, and let
12 me put even a sharper point on that. What is Medicare's
13 appropriate role in trying to promote it?

14 Clearly, one thing is to change the payment
15 incentives for the reasons that Dave and Rita alluded to at
16 the outset. So let's stipulate that as a given, that if we
17 have a different payment system where there's a higher
18 premium on high-value care, managing costs and increasing
19 patient satisfaction, that's very important in setting the
20 stage for this.

21 But what beyond that, if anything, should Medicare
22 be doing? I hope people will address that in round two.

1 Actually, let's start on Rita's side this time.

2 Rita.

3 DR. REDBERG: So I want to pick up where you
4 started, because I think that's a key point. And I'll say,
5 we started -- a few years ago, I worked with a Statewide
6 group of cardiologists to try to introduce shared decision-
7 making around the decision to have elective treatment for
8 stent versus medical therapy for elective coronary disease,
9 and the first question that all the cardiologists said was,
10 "What about lost income from decreased procedures?" because
11 the data pretty consistently shows that the use of shared
12 decision-making leads to decreased procedure use, which in
13 itself suggests that perhaps we're not doing as good a job
14 as we should in informing patients at the time.

15 And I will say, certainly in that particular issue
16 of elective coronary disease, we have a lot of data to
17 suggest that we're not informing patients at the time,
18 because despite the fact that there are 15 years of studies
19 showing that the use of stents for elective coronary disease
20 does not reduce the incidence of heart attack and does not
21 change mortality compared to medical therapy, repeated
22 surveys of physicians and patients, both in 2000 and then

1 repeated more recently, in 2010 and 2012, show that the
2 majority of patients think they're getting a stent because
3 it will help them -- it will prevent a heart attack or help
4 them live longer, and a lot of them, even though they only
5 polled elective patients, think it was an emergency
6 procedure.

7 And so there's clearly a great need for -- and one
8 could call it shared decision-making, although one could
9 also say this is part of the informed consent process and
10 that we're really not doing the job we should be at informed
11 consent. It's possible that patients were told and they
12 forgot, but, clearly, people are not getting the information
13 you really need.

14 So that is kind of a long way of saying that I
15 think changing our payment structure would be essential to
16 the take-up of shared decision-making, because it's clear
17 that this has been tried, mostly in places where there's not
18 a fee-for-service structure, and it's ACOs and medical
19 homes.

20 I thought it was interesting that even at Puget
21 Sound, which is not a fee-for-service, it was hard for the
22 cardiologists to take up the idea of using decision aids for

1 coronary disease, for other reasons. I mean, there are
2 clearly a lot of entrenched ideas.

3 And you can think of a lot of different ways to
4 incorporate, not just paying for the time for shared
5 decision-making, but also ensuring that procedures aren't
6 done without ensuring that that kind of informed discussion
7 has happened beforehand, because otherwise, unfortunately, I
8 think, patients are getting procedures that they would not
9 have chosen to have.

10 The last anecdote: A few years ago when I was on
11 the cardiology service, I had an 88, 90-year-old woman who
12 had just recently had a defibrillator, a fancy one, a
13 biventricular defibrillator placed at a different facility
14 and she was DNR/DNI, meaning do not resuscitate, do not
15 intubate, and I said, do you understand that that
16 defibrillator you had placed is going to shock you, and she
17 had no idea. She said that when it was placed. I said,
18 well, why did you think you had this placed? And she said,
19 "Because the doctor told me I needed it to fix my heart." I
20 said, well, it is -- I explained how it worked and that it
21 certainly would shock her when she wanted it -- she was very
22 clear about a do not resuscitate order. So we had to

1 deactivate this very expensive device that had been put in a
2 week before somewhere else.

3 So all I'm saying is I think we really have an
4 obligation to our beneficiaries and our patients to do
5 better informed consent, and shared decision-making, I
6 certainly see as a big part of that.

7 DR. HALL: Thank you, Rita, for that. Let me just
8 speak a little bit more from the heart than the head.

9 I was itchy reading this chapter because it's a
10 professional embarrassment, at least from my part of the
11 profession, that we have to have a discussion as to whether
12 a physician should communicate with their patients, should
13 let them be informed about making critical decisions about
14 their lives and their families' lives. But the reality is
15 that it's a real problem and it needs correction.

16 If one looks at all of the various quality
17 indicators, and we'll be talking a lot more about those in
18 the months ahead, there are quality indicators about, for
19 instance, the HCAHPS, which is used as a survey instrument.
20 We ask about the quality of the food. We ask if people
21 smiled and used their names. One thing we never ask is, did
22 anybody express any kind of compassion about you as a

1 person, a very old fashioned idea. It doesn't appear there.
2 There is no -- in any of the quality indicators, anywhere,
3 there is nothing that captures the essence of why this type
4 of communication isn't taking place.

5 We can say that we're all busy, that the people
6 don't have the capacity to participate in decision making.
7 That's all just a cover-up. I mean, I shouldn't say cover-
8 up. They're lame excuses for what really should be an
9 essential part of the contract that started with whoever it
10 was, Asclepius or Hippocrates or whatever.

11 So I think that this concept should be very much
12 on the tip of our tongues and in our thoughts as we look
13 through a great deal of the inevitable changes that are
14 going to come along as we look at different structures of
15 medical care and want to ensure, again, that triple aim of
16 safety, quality, and cost effectiveness.

17 So I would think that one of the things that we
18 might want to think about is, given all of the modern
19 technology that's available to us and the complexity of so
20 many people being involved in patient care, is that this
21 become not only just a kind of an add-on and something
22 that's very nice, but really an essential part of any sort

1 of change in health care systems and in payment systems.

2 I don't know quite how you sort of pay for
3 compassion. That's also a bit of an embarrassment, too, to
4 have to say that. But I think the time has come, and I
5 don't think it's just something for doctors. I think it's
6 something for the entire health care professions to be
7 involved in.

8 And I think we could have an enormous impact on
9 that by asking the questions and then trying to creatively
10 think about how one could actually, if we need to do this,
11 pay for compassion. Or, at least let's put it this way. If
12 we're going to penalize hospitals for readmitting patients
13 within 30 days, it seems to me entirely reasonable we might
14 want to not pay them if they haven't communicated with their
15 patients. I think it's that straightforward and that
16 important.

17 MS. UCCELLO: I was really encouraged by this
18 chapter until I just heard Bill say, well, this should be
19 the default. But I thought it was a good way to kind of
20 wrap things up, and I think it has implications for all of
21 the different things that we talk about.

22 In terms of how do we promote this, definitely

1 thinking about how to incorporate this into the quality
2 metrics. You know, in terms of did you get a decision made
3 on, or do the providers provide these kinds of things, I
4 think could be helpful.

5 What I'm really interested in is thinking about
6 how these types of tools can be used at hospital discharge,
7 getting at those readmission issues we were talking about,
8 and can they be used -- it seemed like some of the things
9 that Murphy was doing really got at some of these disparity
10 issues that we're concerned about, and so are there things
11 that can -- are different organizations pursuing tools,
12 shared decision-making or similar tools on the hospital
13 discharge part of care.

14 But just in general, I was really just encouraged
15 by the findings in this report.

16 MR. BUTLER: I'm not sure this will be too helpful
17 directionally to what to do, but I kind of put three buckets
18 of shared decision-making.

19 The first is what we do in our own employee health
20 plan, and that is we engage every single employee very
21 directly in shared decision-making by requiring a health
22 risk appraisal, and if you don't, you pay a penalty. And if

1 you do surface problems, you are now required to get
2 coaching, required to engage, and, in fact, in some cases,
3 required to show improvements. And so there's a direct
4 engagement. And we can measure the impact over all of our
5 employees over time of engaging them directly in managing
6 their health. We don't have anything like that on the table
7 in this proposition, I think, but you could go that far.

8 The second is what's been brought up by Bill and
9 others, and that is you're facing an elective decision
10 around a specific acute problem. It could be which way to
11 go on surgery or whether or not to have surgery at all, and
12 in a fee-for-service system, as pointed out, it's hard to
13 kind of get at how to incentivize that.

14 And then the third is the end of life, which we
15 haven't talked about too much this morning, but may be the
16 most important of all in terms of how do you engage not just
17 the individual patient, but the family, and for that matter,
18 going back to yesterday's competitive premium concept, how
19 do you engage the players on the end-of-life issues where so
20 much of the money and so much of the kind of dysfunction
21 often occurs.

22 So I look at kind of those categories. I'm not

1 sure what that means for our work, but it's a different way
2 of looking at shared decision-making.

3 DR. BAICKER: I had actually been categorizing
4 things slightly differently in my mind and making a
5 distinction -- perhaps a false one after this conversation --
6 -- between shared decision-making over choices where there
7 are pros and cons of each and patients with different
8 preferences might very reasonably choose different options
9 based on how they feel about side effects or recovery
10 periods versus patient engagement and disease management for
11 things like medication adherence or lifestyle changes, where
12 it's very hard to argue that you're rationally not
13 controlling your blood sugar levels, or rationally not
14 taking a medication with very limited side effects and big
15 well-known effects on mortality risk.

16 And there, I think there are different
17 implications for the Medicare system and for the doctor-
18 patient relationship. I would think about distinguishing
19 between those, where, one, it's clear there's a
20 directionality that everyone should be trying to achieve,
21 whereas in the other, it's more about ensuring that the
22 incentives are such that -- and the system in place is such

1 that patient preferences are what drive the decision between
2 tough choices.

3 MR. ARMSTRONG: Yeah. I would just add, I really
4 appreciate the comments that fellow Commissioners have made
5 already.

6 To answer your question, Glenn, yes, I think this
7 is a good thing. How we apply it to our payment policy
8 deliberations, it's kind of difficult to know.

9 In a way, shared decision-making just offers one
10 window through which we can see all the problems of the
11 current fee-for-service payment structure that we talk about
12 in just about every topic that comes to our table.

13 I would just add that even in a system that has
14 all the advantages like the capitation and salaried
15 physicians in group health, there are even additional
16 impediments to actually applying this consistently: The
17 system issues alone, for example, that allow us to keep
18 track of the tools themselves and to know which patients
19 should be offered which tool, or a leadership system that
20 says, we have standards here and we are not going to
21 tolerate variation among our cardiologists and we're going
22 to exercise authority to get people in line, or just other

1 features of a system like ours that simply do not exist in
2 the real world. A reference we haven't heard in a while,
3 isn't that right.

4 [Laughter.]

5 MR. ARMSTRONG: I think another point I would want
6 to make is that shared decision-making is also just kind of
7 one vehicle -- I think Kate was getting at this -- but
8 there's so many other ways of getting through, in which you
9 get to a conversation about patient engagement. Whether
10 it's a moral issue or it's an issue about how you actually
11 have a real impact on overall expense trends or improved
12 quality, the truth is that our health care system and the
13 Medicare program will not make it if we don't find ways of
14 engaging patients more actively as owners and participants
15 in improving their health.

16 This is a topic we get into when we talk about
17 benefit design and when we talk about so many other issues.
18 This, I would just say, is just one more way of kind of
19 contributing to that goal.

20 I think a final point I would make, which comes
21 back to, well, so what can MedPAC do with this, I do think
22 that it may be that shared decision-making only really comes

1 to life through ACOs and MA plans and as a product of bigger
2 restructuring of payment policy. It's just so hard to
3 imagine making this an add-on payment in our fee-for-service
4 structure.

5 But the prospect of applying shared decision-
6 making to end-of-life decisions, I think may be worth
7 looking at and not waiting for big structural changes to
8 fee-for-service. The opportunity to have a big impact on
9 what we know is an extraordinary set of costs and the kind
10 of enlightened way in which you get into very difficult
11 conversations that everyone needs to be a participant in
12 that I think could avoid the political drama that end-of-
13 life topics tend to have. Shared decision-making just may
14 be a path for us to get into that, and that, I think, would
15 be a worthwhile consideration around payment policy.

16 DR. CHERNEW: So let me start by saying that I
17 agree completely with Glenn's opening comment about the
18 moral imperative behind this that I think Bill echoed in
19 many ways.

20 That said, I want to focus a little time on the
21 question about what we should do and say that I'm pretty
22 much where Scott was, at least in the portion of thinking

1 about how the broad system changes might encourage this, and
2 I would be reasonably skeptical of things like adding an
3 add-on payment or other various things. I worry a lot about
4 picking particular things. Then you have to define exactly
5 what is shared decision-making and when certain forms of
6 engagement are shared decision-making, when are they not
7 shared decision-making.

8 The one thing I took from the materials is that
9 the programs vary in a lot of different places, so then
10 you're going to be forced to decide which ones have to go in
11 which places. And I think it just highlights the general
12 point, which is we can understand from where we sit things
13 that we think are very good, but it's very hard in broad
14 Medicare policy to tailor that policy to how things should
15 work in a whole bunch of places. And when we start to try,
16 I think we go down a path that often creates more problems
17 than it solves.

18 So I would put this generally in the category of
19 hopefully the types of incentive changes and payment reforms
20 will push us in this direction. Hopefully, our ways of
21 measuring quality will include measures that would capture
22 the extent to which patients were informed and made

1 decisions that were consistent with their preferences or
2 things of that nature. But I wouldn't try to think of our
3 historical paradigms for encouraging things, shared
4 decision-making or any of the other things that we think are
5 good, and say, oh, we think this is good based on a body of
6 research. Therefore, we need to add a code and start paying
7 for it. I just find that general paradigm a particularly
8 frustrating way to go.

9 DR. SAMITT: So, I mean, I strongly echo what
10 everyone else has said. You know, Scott used the term that
11 this is a window into the flawed nature of our fee-for-
12 service compensation model, and I would say it's more than
13 that. I think this problem is a poster child of what ails
14 us here.

15 And I go back to Bill's comment. It just
16 resonates for me when there's an article that says I, as a
17 physician, don't spend the time to explain options to our
18 patients because I'm too busy. So I don't have time for the
19 patient to understand what I'm just about to recommend, not
20 to mention that I'm now going to incur perhaps unnecessary
21 costs because I don't have the time to explain the options
22 to the patients. So that -- it really underscores what is

1 so broken about a fee-for-service compensation methodology.
2 And so we obviously need to move forward with that as
3 quickly as we can.

4 I'm optimistic that in the world of ACOs and
5 bundled payments, I think it's too soon to really say that
6 there's low adoption for the reasons that we've described
7 that there are system issues, you know. It takes a while to
8 choose the right tools and implement the right tools and I
9 just think it's too soon. But I'm optimistic that the
10 incentives are aligned with ACOs, that we will see
11 methodologies for greater adoption.

12 And then, finally, I don't quite know what to
13 suggest to the Commission as a policy recommendation in the
14 intermediate term. There are others who know better, based
15 on prior experiences. Is this a really good pilot for a
16 fee-for-service modification, you know, that we don't
17 specify what shared decision-making is or what tool to use,
18 but we very simply say, we want to apply an incentive for
19 you to do shared decision-making. And I'd actually even
20 apply the incentive to primary care or the people who are
21 referring to specialists that do these procedures because
22 the specialists themselves are conflicted. They're

1 obviously conflicted because it reduces revenues. But do we
2 incent primary care to significantly utilize shared
3 decision-making if they're going to be referring a patient
4 to an orthopedist or a cardiologist or what have you, and
5 maybe that's what we should consider.

6 And then, finally, you know, Medicare has very
7 aggressive requirements regarding marketing. You know,
8 before physicians can market to their patients, there are
9 review processes. Well, I see this, is there a requirement
10 the other way, which is there's a requirement that you
11 market to your patients important things like this, shared
12 decision-making, and that it is essentially a necessary
13 stipulation to participate in the Medicare program that you
14 share information with your patients. And I don't know how
15 you would monitor that, and maybe that's a whole other
16 problem, but something else to consider.

17 MR. HACKBARTH: Let me pick up on Craig's comment
18 about pilots. My recollection is that the CMMI was, I
19 think, directed under PPACA to do pilots of shared decision-
20 making. Could you just tell us a little bit more about
21 what's happening there and exactly what they are testing?

22 DR. SOKOLOVSKY: They are testing being able to

1 incorporate shared decision-making in clinical practice.
2 One of them is quite large. It's run out of Dartmouth and
3 it connects 15 large health systems. But there's very
4 little I can tell you about them because it's too soon.
5 They're just getting off the ground.

6 MR. HACKBARTH: Are they looking to test, you
7 know, if we offer a payment -

8 DR. SOKOLOVSKY: No.

9 MR. HACKBARTH: And so what is --

10 DR. SOKOLOVSKY: They're testing it in health
11 systems that are more like ACOs and --

12 MR. HACKBARTH: Okay. So if it's used, what's the
13 effect, is their focus --

14 DR. SOKOLOVSKY: Yeah. Right.

15 MR. HACKBARTH: -- as opposed to what can you do
16 to increase the use.

17 DR. SOKOLOVSKY: Yes.

18 MR. HACKBARTH: Okay.

19 DR. SOKOLOVSKY: I mean, they may get best
20 practices that will --

21 DR. MARK MILLER: And we had one group in that was
22 showing us their tool and how it worked, all of that. I

1 think Cleveland --

2 DR. SOKOLOVSKY: That was Welvie, and that was a
3 very different model that's one of the other demonstration
4 projects that doesn't -- I guess would be incorporated in
5 shared decision-making, but not through the physicians.
6 It's more of a insurer-based design where somebody who's
7 considering surgery has access to an online program that
8 looks at pros and cons. And if you choose surgery, then it
9 talks to you about different places where you could get the
10 surgery and provides information about quality in those
11 different options.

12 But, again, they're testing it now in Ohio, and
13 again, it's just too soon to say, you know, whether it works
14 or not and to what extent patients adopt it and what are
15 their physicians' response to somebody who is using this.

16 DR. MARK MILLER: [Off microphone.] Yeah, and the
17 reason I brought it up is I know all of this is way too
18 early to comment on, but that one was not in the context of
19 a system, right? That was more looking across, and that's
20 why I wanted to draw that one.

21 DR. SOKOLOVSKY: There are a number of other
22 insurer-based programs that we're not looking at this time,

1 but know that's on our radar to follow up.

2 DR. HOADLEY: Yeah, this has obviously been a very
3 good presentation and good discussion. The dilemma seems to
4 be the question of how to do this, and particularly how to
5 do it or whether to do it in the fee-for-service Medicare
6 context, although I would add, from discussions not
7 specifically on shared decisionmaking but on some similar
8 things that I've been looking at in the Medicaid context,
9 some of the managed care plans who could do things like this
10 aren't necessarily doing it. So sometimes even once you're
11 in a capitated system from the point of view of the program,
12 like being in a Medicare Advantage plan that's essentially a
13 fee-for-service sort of model in terms of how it interacts
14 with the providers, you know, you're still not getting that.
15 So it really does seem to require either a more integrated
16 system like a Group Health or the ACOs or some of the other
17 things going on.

18 It strikes me there's two things that have come up
19 that, you know, could be thought about in terms of a fee-
20 for-service and don't have to be shared decisionmaking
21 specifically. I think some of Mike's concerns were, okay,
22 you know, you want to provide a payment for shared

1 decisionmaking, what does that do and what are the nasty
2 places you could end up by doing something like that that
3 wouldn't necessarily work well? But you talked about the
4 CPT for counseling and people's reluctance to use it, but
5 other examples of maybe where it can be used. So I don't
6 know if that's -- and that could be used for shared
7 decisionmaking, for care coordination, or other kinds of
8 broader kinds of things.

9 So if there are some things we could think about,
10 about how to demystify that code or create clearer
11 guidelines so that physicians aren't unnecessarily
12 discouraged from using it, although obviously you have to
13 worry about all the usual concerns about abuse of it.

14 And then I think the other thing is, you know, you
15 talk about the really important role of the coaches, and
16 I've heard the same thing in terms of care coordination
17 programs in these Medicaid interviews I've done, you know,
18 coaches or things that a clinic may be doing at the clinic
19 level that aren't part of a specific encounter, and it seems
20 like those mostly end up getting funded by grants, at least
21 when they start, and they're not easily paid for in the
22 traditional Medicare kind of world -- or traditional

1 Medicaid kind of world, for that matter. And are there ways
2 to support that kind of notion better? Is that just a
3 matter of continuing to think about how grant programs can
4 help at least get them established? But then you've still
5 got the issue of sustaining it.

6 So, you know, are there things we could do within
7 fee-for-service Medicare to make those kinds of activities
8 possible and to be paid for?

9 DR. COOMBS: So, Glenn, I agree. I think you're
10 spot on. It is a moral imperative that we address shared
11 decisionmaking. And as I think here, I was thinking about
12 what Bill said, and as an ICU doctor, I know that the whole
13 notion of shared decisionmaking is not always the patient.
14 And for me, most of the time it's actually talking to the
15 families, because at that point the patient's unresponsive,
16 on a ventilator. And I can tell you that extra time that's
17 spent, 30 minutes and 45 minutes or whatever it takes, to
18 get the family on board with coming to grips with what the
19 patient would have wanted is so much more important in the
20 whole process of how you take the whole patient's total sum
21 being as a person on a ventilator with multiple support,
22 what do you do with that patient when the family says, okay,

1 this is what he would have or she would have wanted? That
2 dictates everything. And to be honest with you, many times
3 when the patient's in the emergency room or comes in from
4 home and has aggressive therapy, the family feels much more
5 comfortable being in the ICU setting talking about it
6 because they feel like the questions are answered, and they
7 will withdraw support at that point.

8 It's that you're giving good quality, you're
9 really making the family feel that it's okay to really honor
10 the wishes, and the shared decisionmaking in the ICU is
11 really huge. I think the chapter was wonderful, and it's a
12 direction to go for quality, for cost, and especially at the
13 end of life.

14 MR. KUHN: I would just join the chorus as well.
15 I've been a big fan of shared decisionmaking since my time
16 at CMS, and I think it's a good thing, and I agree with
17 Glenn it's the ethical imperative.

18 When you look at kind of where it is now, whether
19 it's ACOs, MA plans, others, it's obviously in their own
20 interest to have that part of their tool kit to engage the
21 patients and part of the good care pattern. But we still
22 have 75 percent of Medicare beneficiaries in fee-for-

1 service, and if you look at the work of the CMS Actuary,
2 that is probably going to continue to be the case, at least
3 for the next decade.

4 So then how do you begin to deploy this tool to
5 help that population? Because it is what it is. They're
6 going to continue to be in fee-for-service.

7 So, you know, there's a lot of ways you could
8 construct a fee-for-service, but, boy, I tell you, it
9 creates a lot of decision points along the way. So, for
10 example, you could say these are preference-sensitive
11 conditions that you would want to limit it to, and say you
12 take the top 10 or 20 that have the most volume and say,
13 okay, these are the ones we're going to target where we
14 think there's a real opportunity here.

15 And then you go about the process of how do you
16 create an incentive program to do this. Do you do something
17 like we have with the hospital-acquired conditions or the
18 readmissions policies where there's a penalty if this
19 activity isn't engaged? Or do you go on the incentive side
20 where you try to induce the behavior through additional
21 payment, whether it's through a refinement of the CPT code
22 with the physician or something else as part of the process

1 to make it happen? Or do you even have CMS create some NOC
2 codes, some not-otherwise-classified codes, and kind of
3 create some things in order to kind of drive this behavior
4 where they could track it very closely in the future?

5 Then, of course, I think it sets up the whole
6 process of what is the engagement with the patients, and
7 would CMS need to certify the set of tools that are out
8 there? Because you wouldn't want someone just to have
9 something that they got off the Web that they xeroxed and
10 said, here, give is to the patient, and then they check the
11 box and say, okay, give me my extra payment or I've avoided
12 the penalty. You have to get CMS in the business of
13 certifying the tools, and they have to go through a process
14 to have all these vendors come in and say, okay, here's the
15 ones that are certified that we know are most effective.

16 So it is a lot of work to do this, but, again, I
17 come back to what I said earlier, that with 75 percent of
18 the folks in fee-for-service and for the foreseeable future,
19 I don't want us to give up on this. I want us to think it
20 through a little bit more. But if you go through a fee-for-
21 service design, there are a lot of decision points, and it's
22 very difficult, it's a very clunky system, as we all know.

1 MR. GRADISON: This is obviously a good thing, and
2 I'm supportive of it. I'm far from clear about what our
3 role might be. I think our main activity ought to be
4 monitoring the efforts of others to implement different
5 approaches.

6 I started to jot down just quickly a moment ago
7 some of the different things that might be considered tools
8 that could be used in enhancing patient and family
9 participation. And then the question crossed my mind, which
10 Herb mentioned. Can we write regulations around these
11 things? I mean, I wrote down, "Give the family a video."
12 That was really what Wennberg had for prostate cancer, and
13 it was a video which, as I recall it, had several physicians
14 who had made different decisions about the same procedure
15 for themselves explaining. That's pretty good stuff.

16 Is that adequate? I don't know. You might give
17 people a series of links if they have a computer and let
18 them go home and do the work themselves, and then come back
19 if they have a few questions. A printout, that was
20 mentioned. Print out some of the stuff.

21 Maybe what we ought to do is require that every
22 new Medicare patient receive a copy of the updated version

1 of the Mayo Family Health Book and the revisions -- I think
2 they're up to the fourth or fifth revision now -- from time
3 to time, because those are pretty good, actually, in terms
4 of professionally indicating some of the choices and side
5 effects. It doesn't cover everything, but it is three or
6 four inches thick, so it's impressive.

7 I'm not trying to kid about this. I think that
8 it's so early in terms of dealing with this that I think it
9 sort of has to bubble up from actual practice and experience
10 rather than something that might be a bit top-down.

11 DR. NAYLOR: So I'm not sure what I'll add, but
12 let me just highlight that I think about shared
13 decisionmaking the way that Kate does, which is it's broader
14 than tests and procedures. It's about whatever treatment
15 options are available.

16 So in that context, I really thought the chapter
17 was fantastic, highlights the complexity of it. I mean,
18 starting with the very basics of health literacy, which, I
19 mean, you don't get to shared decisionmaking unless we
20 measure who is health literate or not, and then how it is
21 that we get them to informed let alone to then participate
22 in the decisionmaking.

1 I think the focus on patients and families, family
2 caregivers, the Home Alone report that shows how critically
3 important, especially for some older adults, engagement of
4 families is.

5 So in terms of Medicare's role, I think promoting
6 the measurement of health literacy, promoting the
7 measurement of the extent to which practices are eliciting
8 what people want, what they consider most relevant, and
9 their capacity to participate in informed decisionmaking.

10 In terms of workforce, we're talking about people
11 doing things dramatically differently than before. This is
12 not teaching. This is coaching. And so we need to think
13 about how you prepare the workforce. But I think the
14 Cochrane Review told us a great deal about this will never
15 work just by giving people aids, the counseling that is
16 critical for the outcomes that they have been able to
17 demonstrate so far.

18 I think we should be pushing PPACA to fund the
19 things that they said they were going to do in the act,
20 which includes building that repository of shared decision
21 tools, that are evidence based, that meet the standards, and
22 creating that entity to do that.

1 I do think as we think about payment value-based
2 purchasing should have a criteria that we do these things,
3 that practices really do inform patients, and that they are
4 given the opportunity.

5 Finally, I think some of this is going to come
6 back, and I really do agree that we should be thinking about
7 that last few years of life, and what it is that we can do
8 as a program to promote policies that provide access to what
9 people want that they currently don't have, palliative care,
10 focus more on quality of life. So it's not as simple. At
11 the end of the day, this is going to be about cultural
12 change. It's not easy, but I think it is, as has been
13 described, a moral and ethical imperative. And it's not
14 just about being patient centered. Someone used the word
15 yesterday in another meeting "patient embeddedness." This
16 is where patients are partners, and that's a real big change
17 for us.

18 DR. NERENZ: I think at the moment I'm much more
19 favorably inclined than Mike is to working out some sort of
20 way of having a payment model for shared decisionmaking in a
21 fee-for-service system. And on that basis, I would
22 encourage staff to perhaps work up two, three examples for

1 our consideration of tangible ways how that might be done.

2 Now, I would acknowledge that maybe the reason I'm
3 more favorable is I just haven't given it enough thought,
4 and if in a few more minutes I would come around to
5 appreciating the difficulties. And I will grant there
6 clearly are difficulties and challenges. How do you do it?
7 Who receives it? For what exact body of activity? Clearly
8 concerns.

9 The reason I think I favor it is that we struggle
10 a great deal to find examples in the fee-for-service
11 environment of where a payment of a certain smallish amount
12 now can be linked to some downstream net savings. We talk
13 about that with care coordination, and it's a struggle.
14 It's very hard. And coming into this discussion, it has
15 struck me that this particular topic may be one of the most
16 promising examples of that happening. The case has not yet
17 formally been made. I appreciate Scott's comments about, in
18 spite of the positive reductions in some of the procedures,
19 that's not quite the same as showing total net savings. But
20 I still consider to think that this is a very promising area
21 for that kind of net offset; therefore, I would like us to
22 keep pushing to see if there's a way to do it.

1 Okay. Then why fee-for-service? Well, part of it
2 is, as I think either Herb or bill said, we're going to be
3 in that environment for most beneficiaries for quite a
4 while. So I think we have to look there.

5 If I understand the ACO payment dynamics
6 correctly, I don't think as currently configured either the
7 CMS shared savings or the CMMI ACO structures are going to
8 support this activity or encourage it very much. The key
9 reason is that although there's a shared savings component,
10 the fundamental payment unit in those is still fee-for-
11 service to all the providers up and down throughout the
12 system.

13 So an entity that's going to invest in shared
14 savings is, first of all, going to incur the cost just to
15 program development, then will incur the cost of doing it,
16 without any direct reimbursement for either of those things.
17 We'll then see income or revenue reduction if it successful,
18 and only part of that will come back in terms of a shared
19 savings payment. So I just don't see the incentives for
20 this in the current structures.

21 Now, in different ACO structures, future, maybe
22 so, but I don't see it now.

1 Finally, I think, you know, Medicare Advantage
2 presumably is a situation where this could be more
3 aggressively pursued, but in that case as well, I think you
4 have to either -- you have to have one of two things.
5 Either the MA plan has to pay providers to do this in the
6 same way we think about Medicare in general fee-for-service,
7 if the providers are the locus at which this activity will
8 occur. So there has to be acceptable mechanisms through
9 which the MA plans pay the providers.

10 Or there was your comment made about some insurer-
11 based models where maybe that would be a place where MA
12 plans themselves would actually take up the cost of creating
13 and offering the decision aids. So perhaps we should
14 explore that in a little more detail, but I'd basically
15 like, in every respect that we can try, to look for ways to
16 pay for this and make it happen.

17 MR. HACKBARTH: Let me just ask a question about
18 Dave's last point. There are a number of companies that
19 have been out there using the insurer-based approach where
20 they sell a product to an insurer, usually involves a nurse
21 advice line coupled with distribution of some materials. Is
22 there any empirical data on how well those programs work as

1 opposed to programs that are embedded in the care delivery
2 system?

3 DR. SOKOLOVSKY: There is some data for some of
4 the older programs, but I think it's controversial in terms
5 of how to understand that data and the extent to which it's
6 working.

7 I think we're going to look further at that and
8 how it's going over time, but I don't think we can say too
9 much about it yet.

10 I guess there's one thing in terms of when Jack
11 brought up Medicaid, there's one interesting new take that
12 some insurers who are wanting to get into Medicaid managed
13 care are talking about having the same people who sign up
14 people for plans being trained to do some coaching, not
15 necessarily on specific decisions but in kind of activating
16 patients to be able to ask questions, what is a decision,
17 and I think that's a very interesting approach as well.
18 But, again, the data is just not clear yet.

19 MR. HACKBARTH: Okay. Well, I'm sitting here
20 making notes, trying to sort out what we have said. I think
21 there's agreement on a few broad points, but then it sort of
22 dissolves as we go deeper. We agree it's good. We agree

1 that probably the most important thing that could happen
2 would be a change in the incentives. At least several
3 people have indicated agreement with, well, it really seems
4 odd -- you know, take this issue of the code for counseling.
5 To say that shared decisionmaking doesn't qualify as
6 counseling, that seems pretty odd to me. So long as we have
7 the construct of fee-for-service, which we're going to have
8 for a fair amount of time -- this does involve time, and
9 we've got 7,000 codes specifying other uses of physician
10 time. Why we would say that this is not a use of physician
11 time that's worth paying for is -- well, it seems odd to me.

12 Personally, I wouldn't expect that even if we
13 clarified that shared decisionmaking was a payable form of
14 counseling, that that would mean it would skyrocket because
15 of all of the other incentive issues that exist. But it
16 does seem anomalous.

17 Several Commissioners have said, you know, this is
18 something that we ought to be looking at from the patient
19 perspective, we ought to be surveying patients. I'm not
20 sure exactly how to structure the questions, but monitoring
21 how well patients feel like they're engaging with their
22 physicians and other clinicians.

1 You know, there are questions about communication,
2 broadly defined, as I recall, in the CAHPS surveys and the
3 like, and certainly that's a very important component of the
4 CAHPS surveys. But I don't think there's much that really
5 goes into shared decisionmaking.

6 So, you know, we could say there should be more
7 monitoring, but that whole area of how you structure surveys
8 and how you really effectively elicit information from
9 surveys is a really technical area that I think is way
10 beyond our expertise and time.

11 Now, as I dig deeper, I sense less and less
12 agreement. Several people said, you know, we ought to just
13 require it, this is something that should be required. But
14 the problem is what is the "it" that you're requiring? To
15 have a regulatory approach, you need really precise
16 definitions, and even at that, we'll end up with 34 pages in
17 the Code of Federal Regulations that, frankly, will be
18 unenforceable. Nobody will be out there able to monitor
19 adherence to it.

20 So, you know, I guess my summary of all that is
21 that beyond it's good and the most important thing is to
22 change the overall incentive environment, you know, I think

1 our agreement sort of breaks down pretty quickly after that.
2 That's how I heard the conversation, and I welcome other
3 people who heard it differently.

4 DR. REDBERG: I didn't hear it differently. I
5 just wanted to first say we use a patient counseling code,
6 and I've never heard any discussion of any problems with
7 auditing on it.

8 But then, more generally, you know, I think we had
9 talked about a few different kinds of shared decisionmaking,
10 because, quite frankly, some of what -- which is still good,
11 but it's not always about a decision, you know, the typical
12 surgery or not, stent or not, because like the PHMC --
13 there's more patient education, it seemed like, that they
14 were getting than actually shared decisionmaking, which was
15 still good. I mean, maybe they were discussing lifestyle
16 choices, but it seemed a lot more in the patient education
17 realm.

18 In terms of the code, I think it is tricky because
19 it's not easy to pin down, and just adding on a code saying
20 you talked to your patient is not going to -- there might be
21 a lot of takeup, but I don't think it's going to change the
22 quality of what we're really trying to get at.

1 What came through in the mailing materials is
2 physicians right now tend to, when we do discuss procedures,
3 emphasize the positive and don't talk about the negative or,
4 you know, the adverse events. And perhaps in a survey mode,
5 you know, asking patients did your doctor -- or did you
6 understand the risks and the benefits before you had this
7 procedure, it might be one way to try to get at it. You
8 know, we could talk offline because there are a lot of very
9 more detailed -- I mean, that's a general way you could --
10 and this is certainly a good thing. I mean, patients should
11 understand the risks and the benefits, and there's certainly
12 a lot of data that patients have major procedures without
13 understanding risks and benefits of those procedures or that
14 there were choices.

15 So that kind of -- oh, and the last thing I was
16 going to say, in terms of physician time -- and I we're all
17 very sensitive to physician time, although this is clearly,
18 I think, a high priority, I would think in the big context
19 of performance measures, perhaps we could relook, because I
20 think right now we're cluttered with performance measures
21 that are not adding to patient -- improving patient
22 experience or outcomes. Maybe get rid of some of those

1 because this one clearly I think has been shown to improve
2 patient experience and patient outcomes. So I think of it
3 kind of in the quality measures, this is a high-priority
4 one, and I think we have some much lower-priority ones that
5 are taking a lot of physician time. And there's a lot of
6 concern that there are a lot more measures coming down the
7 pike without improving, so there will really be a concern
8 for physicians, and I think we do have to be sensitive to
9 that.

10 DR. MARK MILLER: I just want to ask this while
11 we're talking about physician time, and I don't know the
12 answer to this question. Particularly with the two of you,
13 I'm always a little worried about asking.

14 On the physician code and the use of the code, my
15 understanding in a lot of these models is it isn't -- the
16 actual shared decisionmaking process is not the physician
17 being present for it. It happens outside of the physician's
18 office, either through video or some discussion with a nurse
19 or groups of patients. Then they come back into the
20 physician's office and ask a more clear set of questions.

21 So I think there's -- first of all, right or not?
22 And then that kind of goes back to, well, am I using this

1 code correctly? It may involve the physician spending more
2 time with the patient as a result of going through those
3 questions, but I'm not under the impression that the
4 physician is actually spending the time going through the --

5 MR. HACKBARTH: I think you're right, there is
6 activity that happens outside of the physician's office
7 without any health professional. And then in some settings
8 it may be a nurse or other professional, at least as the
9 initial contact ultimately there needs to probably be in
10 many cases some physician interaction.

11 I just wanted to be clear and beg Mary's
12 forgiveness. When I used the term the "physician fee
13 schedule" here, you know, technically we're talking about
14 the fee schedule for physicians and other health
15 professionals, and having a code for non-physician health
16 professionals who engage in this activity, and not just MDs.

17 DR. NAYLOR: I do want to stress, though, that the
18 data are very compelling that aids alone are not achieving
19 anything. You know, they are -- so it is the addition of
20 the counseling, the interaction, often not necessarily with
21 a nurse practitioner. I mean, most of the data are with
22 nurses. But that being said, I think -- I don't want us to

1 walk away thinking make more access -- at least is that your
2 assessment?

3 DR. SOKOLOVSKY: Absolutely.

4 DR. NAYLOR: You know, that it's the combination
5 of the personal interaction with evidence-based tools that
6 are achieving the outcomes we're seeing.

7 DR. SOKOLOVSKY: Could I just interrupt for one
8 second? Because it keeps coming up about survey questions,
9 and I don't want to leave you with the sense that there
10 aren't survey questions. In fact, CAHPS has now -- we don't
11 have any results yet. They're just beginning to roll these
12 out. But they're very much specifically the kinds of things
13 you're talking about. For example, just to read three
14 questions:

15 When talking about surgery or procedure, provider
16 asked you what was best for you?

17 Provider talked about the reasons you might want
18 to have surgery or procedure.

19 Provider talked to you about the reasons you might
20 not want to have surgery or procedure.

21 And the same set of questions on prescription
22 drugs, for example, so they have developed these questions

1 in CAHPS.

2 MR. KUHN: Glenn, I think you captured it very
3 well, and I think Rita's point was well taken. If you kind
4 of put the check the box things, will you really accomplish
5 what you want? And I know CMS did a demonstration seven or
6 eight years ago that looked at symptom management for cancer
7 patients and looked at fatigue, nausea, and pain management.
8 And there were a lot of reasons that demo was put together,
9 but in terms of kind of accomplishing that kind -- those
10 results, it just wasn't there.

11 So a couple thoughts as we continue to look at
12 this. One is it may be a distinction without a difference,
13 but is going through the door the conditions of
14 participation? Would that be a better route to go where
15 then you would have the interpretive guidelines that would
16 help manage that for the facilities as they go forward
17 rather than a larger regulatory process, but do it through
18 that stage? Would you accomplish the same thing and would
19 it be less regulatory? And would it be as effective or not?
20 I don't know. That's something that we might want to look
21 at.

22 And then if now this is part of the CAHPS survey

1 and since CAHPS are part of value-based purchasing, are we
2 starting to capture that as part of this process? And could
3 the VBP program be enhanced in order to capture this as we
4 go forward? So another possibility.

5 MR. HACKBARTH: So let me ask the clinicians in
6 the group a question, and I think this would be a question
7 that could arise, Herb, under the conditions of
8 participation approach.

9 As you said in your first set of comments, you
10 know, you could have CMS or somebody at HHS certifying
11 decision aids. Now, what's not clear to me as a layperson
12 is how much is involved in that certification process. The
13 evidence isn't always, you know, all real clear on exactly
14 what the probabilities are of this outcome versus that
15 outcome, and so the development of aids, it's not like, oh,
16 anybody can do this, or anybody can certify this is a good
17 one, that's a bad one.

18 I think a big part of the challenge here is there
19 is a lot of disagreement among clinicians about how this
20 information -- what the data show and how it should be
21 characterized. And I suspect, Scott, that was one of the
22 issues that you ran into with your clinician group, even in

1 a rather ideal environment.

2 And so the idea that some federal bureaucrat is
3 certifying aids, that this is the right characterization of
4 the evidence, I worry about that. Am I off base,
5 clinicians, on this?

6 DR. SAMITT: I mean, I'd be worried about it as
7 well, but I want to go back to a comment that you actually
8 made yesterday, which is putting some of the responsibility
9 in the hands of the specialty societies. You know, while
10 you don't do that a lot and there are problem and maybe you
11 do it very little, but I guess my experience with this is
12 that unless some of these are derived by the physicians,
13 then you will get disagreement.

14 So the question is: Can we require that for a
15 joint replacement, you know, shared decisionmaking tool,
16 that we seek to try to get specialty society endorsement for
17 the optimal tool that does get approved and utilized? And I
18 don't know whether that's just a completely unrealistic
19 option, but who better to be asked to develop that than the
20 specialty societies themselves?

21 DR. REDBERG: Earlier you said you thought primary
22 care doctors should be the ones doing the decision aids,

1 and, you know, the specialty society, that's a little
2 different.

3 DR. SAMITT: To assure that they're actually
4 distributed, but not necessarily the design. So the
5 question is: Do we not feel we'll get an accurate or
6 unbiased decisionmaking tool if put in the hands of the
7 specialty?

8 DR. REDBERG: You don't ask the barber if you need
9 a haircut.

10 [Laughter.]

11 DR. REDBERG: I think to address your question,
12 Glenn, there are groups -- and you're right, that is a big
13 issue because clearly, particularly in areas where there
14 isn't evidence, but even when there is evidence, there's a
15 lot of disagreement and discussion among clinicians, and I'm
16 sure that is one of the things that Scott observed.

17 As you know, there are groups -- I think FIMDM --
18 the Foundation for Informed Medical Decision Making -- and
19 Health Dialogues do a lot of the decision aids. I was
20 involved in the development of a decision aid, and I can
21 tell you there was a lot of back and forth because we all
22 saw the evidence differently to come up with that decision

1 aid. So that is definitely an issue.

2 You know, I always think more information is still
3 always better, but you're right, a lot has to do with the
4 quality of the information, and that is certainly not
5 something I don't think CMS would want to get in the
6 business of certifying.

7 DR. SAMITT: Can I ask, are there any other third
8 parties that are viewed as unbiased, Quality Forum or some
9 other committee that is charged with sort of taking a very
10 unbiased view, you know, reviews the potential options for a
11 shared decisionmaking tool, and blesses the one -- whoever
12 creates them, you know, if we believe that specialty
13 societies can't do it, well, let's have someone else do it.
14 But it still needs to be blessed and approved by an unbiased
15 third party who would endorse it and say this is the one we
16 would suggest you use.

17 DR. NAYLOR: So this is where my thoughts about
18 suggesting that PPACA fund what they've already recommended,
19 which is an independent entity that would rely on -- and
20 they established a set of standards that would be used, what
21 conditions or decisions should be targeted in the initial
22 rollout, et cetera, and recommend that the Secretary convene

1 that.

2 I think it's really important that we just don't
3 think about decisions in the way we think about them as
4 tests or procedures. There are decisions around medications
5 and all of those areas. So I don't necessarily -- I think
6 that we don't want to rely on the traditional medical model
7 in decisionmaking, and these provisions I think are quite
8 specific about how this could unfold.

9 MR. HACKBARTH: So I remember reading the text box
10 that was in the chapter about the PPACA provisions and the
11 fact that they have not been funded. Has there been any
12 discussion within the Department about, you know, if money
13 is made available, you know, what sort of entity, would it
14 be creating a new one, would it be using an existing body
15 like NQF? Can you provide any additional color on that,
16 Joan?

17 DR. SOKOLOVSKY: There is nothing that has been
18 made public, but, remember, this amends the Public Health
19 Act. It was never considered something that CMS would do.

20 MR. HACKBARTH: Right. Right, yeah. Okay. Now
21 that we've sorted all that out, Mark?

22 [Laughter.]

1 MR. HACKBARTH: You have a plan here, right? I've
2 seen you writing.

3 DR. MARK MILLER: Yes, I feel we have sorted this
4 out, and I'll get back to you.

5 I don't have a plan. If the Commission were to
6 say -- one of the things that I heard, but as I was thinking
7 through it, I was already immediately running into problems
8 in my own thinking. But a few ways you could align the
9 comments could work like this.

10 If there was this sensation on the Commission that
11 there was a place to go, understanding all of the pitfalls,
12 but where do you start? There's obviously piloting. But
13 just to be a little bit more focused, many of you spoke to
14 end of life, and that made me wonder about, you know, the
15 hospice decision as a place to think about is there a tool
16 and use of it there in a payment structure which we've
17 already laid out its problems, but it's not unit payment,
18 you know, service by service. You pay on more of a block
19 payment.

20 So I started to think if somebody were to force me
21 to think about this and think about it in a fee-for-service
22 context as opposed to the ACO/MA comments, which I took

1 fairly strongly, I would probably at least sit down and
2 think first there whether there was some opportunity because
3 of the concerns about end of life.

4 Now, one of the things that is immediately wrong
5 with that thought is it's not after the person gets into
6 hospice.

7 MR. HACKBARTH: That's what I was thinking.

8 DR. MARK MILLER: It's before they get into it,
9 and so this thinking, you know, begins to fall apart pretty
10 quickly. But, again, if I were forced to think about it in
11 fee-for-service, I would probably at least spend a little
12 time circling that problem or that area.

13 DR. HOADLEY: I don't know, I mean, this wouldn't
14 help for some of the kinds of decisions, but the Wellness
15 Visit that was created, which has a lot of flaws in other
16 ways, but maybe this is something for at least chronic
17 conditions decisions aids could be an opportunity. I don't
18 know if that has been thought about at all.

19 DR. CHERNEW: The only thing I was going to say --
20 and I'm sympathetic to a lot of the efforts, and I think
21 it's worth thinking about how to go further, but, remember,
22 it's not just what you're going to do at one point in time.

1 Then you get into figuring out, well, how are you going to
2 update it? So now you've decided that this was the right
3 tool for a given procedure for whatever it is. Now a new
4 study comes out. Now someone -- or, you know, a new
5 physician says, "Well, I know you haven't got the official
6 evidence yet, but what we've been seeing in our clinic is
7 that we're bale to get the complication rates down, and the
8 decisionmaking tool we're now supposed to use is a little
9 bit outdated." Then you have a process you have to -- so
10 there's a lot of complexities that arise between the words
11 of "we like shared decisionmaking" to "we like this tool in
12 this context for these people to meet these criteria." And
13 that's why I think for me in the end, the more we can do
14 make sure people get access to the best information or the
15 best care is important, but the more we create structures
16 around how to do that, the more careful we have to be; that
17 it's hard to start with, and even once you start with it,
18 it's hard to update it, and then you get distracted with
19 updating all these particular things, and lose track of the
20 bigger picture. That's my basic concern.

21 But I am supportive of doing this, and I'm really
22 supportive of the CMI demos and stuff like that.

1 MR. HACKBARTH: Rita, go ahead and then --

2 DR. REDBERG: I just wanted to address Jack's
3 point because I found -- it was page 19 in the mailing
4 materials. But Mercy evidently is doing just what you had
5 said. In the Welcome to Medicare physical, they receive a
6 decision aid on advance directives. So it might be helpful
7 to see if they're tracking that and how it's going and what
8 their uptake is on it.

9 DR. HOADLEY: That's the one-time Welcome to
10 Medicare. The Wellness would at least be an annual
11 opportunity as well. Again, it's a concept that's not as
12 broad as some [off microphone].

13 MR. HACKBARTH: Sometimes MedPAC's role is to say,
14 you know, here's a problem and here's a fix. But sometimes
15 our role is to say here's a problem and, you know, it's just
16 not a problem that is amenable to being fixed by Medicare
17 payment policy in a targeted way, you know, as we've said
18 over and over again. In a broad way, changing the Medicare
19 payment incentives could make a huge difference. But, you
20 know, targeted, specific solutions sometimes just are not
21 within our reach, and that's one of the things that the
22 Congress looks to us for as well as advice on do this, do

1 that, and don't do something may be right.

2 It could well be that activities outside of
3 Medicare, you know, in the Public Health Service, of the
4 sort that Mary was describing would be, you know, good
5 things to at least test, develop. But as far as Medicare is
6 concerned, it may be that what we can do is pretty limited.

7 So let us think some more about this. This is
8 obviously a very important subject, but not an easy one to
9 get a grip on, and we'll come back with some ideas about how
10 to proceed. So thank you, Joan and Katelyn. We appreciate
11 your work on this.

12 We'll now have our public comment period, and
13 please begin by introducing yourself and your organization.
14 And when the red light here, when this red light comes back
15 on, that is the end of your two-minute period.

16 MS. CARLSON: Hi. I'm Eileen Carlson from the
17 American Nurses Association.

18 I think it's wonderful that you all are looking at
19 shared decision-making, and I'd like to suggest that the
20 staff especially look to some of the models and resources
21 that the nursing profession has created. This has been an
22 enormous priority for us for decades.

1 And just to give you some examples, the Magnet
2 Program and Pathways to Excellence that the American Nurses
3 Credentialing Center certify hospital nursing programs for.
4 Every nurse in those hospitals has to check off that they've
5 done patient education for that patient during their shift,
6 realizing, of course, that physicians don't use the same
7 charting standard documents, but it's -- there are ways to
8 implement this in the current health care system.

9 I see the difficulties, because this is a -- this
10 issue raises issues of health care finance and efficiency,
11 ethics, coding and reimbursement, and quality, and you're
12 usually -- there aren't many issues where you really have to
13 look at each aspect of those.

14 There are payment disincentives for requiring
15 counseling. For example, the Evaluation and Management
16 codes, when you increase the level of your counseling, that
17 changes how you calculate the level of your visit. And I've
18 been working -- ANA has been working with RUC and CPT on
19 several new codes that involved care coordination,
20 immunization counseling, et cetera, et cetera. And,
21 basically, if nobody's going to pay for it, nobody's going
22 to come up with a code.

1 But I also want to let you know that there is a
2 CPT work group that is looking at doing some tweaking of the
3 Evaluation and Management codes, and I think you all could
4 provide guidance on -- and probably some suggestions that
5 some changes could be made in those codes.

6 Also, I'm glad you talked about performance
7 measures and quality reporting. The Physician Quality
8 Reporting System, you know, I honestly don't know if it has
9 aspects of patient engagement, but that's one area where
10 changes could happen very quickly.

11 Thank you.

12 MR. HACKBARTH: Okay. Thank you.

13 Oh, are you coming?

14 MS. BOWEN: Hi. Thanks. I'm watching the red
15 light. Good morning. I'm Meg Bowen. I'm the
16 Implementation Management for the Foundation for Informed
17 Medical Decision Making in Boston. Thank you very much for
18 allowing me to be here today, and hi, Joan.

19 So I worked very closely with the sites that were
20 mentioned today in the report and I wanted to add so many
21 things that there's just not enough time.

22 One thing I do want to address, though, is the

1 end-of-life issue and starting that conversation, especially
2 at Mercy Clinics. They have a transition coaching model
3 through their ACO and those nurses actually go into the
4 unit, to the ICU. And when patients have an algorithm of
5 different comorbidities and multiple hospitalizations, they
6 start the conversation about the end of life. And they
7 introduce a decision-making tool to them at that time and
8 then they pass off the care to the local health coach in
9 their primary care clinic.

10 And another thing that they also do, when the
11 patients are discharged -- this may all be in your
12 materials, I'm not sure -- but what they do is they do
13 what's called -- it's very simple. It's called a tuck-in
14 call. So before the weekend, they'll call the patient on a
15 Thursday or a Friday morning to make sure they have their
16 medications, make sure they have everything they need, they
17 have the resources available to keep them from being
18 readmitted over the weekend through the ER.

19 So these simple little fixes are coming out of
20 these demonstration projects and I really encourage support
21 for funding and additional grants so we can keep learning
22 about these best practices.

1 Thanks.

2 MR. HACKBARTH: Okay. Thank you all.

3 We're adjourned. See you the first week in April.

4 [Whereupon, at 11:32 a.m., the meeting was

5 adjourned.]

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