

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 15, 2015
9:39 a.m.

COMMISSIONERS PRESENT:

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KATHERINE BAICKER, PhD
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WILLIAM J. HALL, MD
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1 P R O C E E D I N G S [9:39 a.m.]

2 MR. HACKBARTH: Okay. Good morning. Before we
3 begin with our first presentation, I want to provide just a
4 quick overview of the agenda for those of you in the
5 audience.

6 At this meeting we complete our work for our March
7 report to Congress, including our recommendations for update
8 factors for the various Medicare payment systems, plus a few
9 additional recommendations.

10 The Commission has, for the last couple years at
11 least, had a series of recommendations which we have not
12 revoted on each year but simply rerun a prior year's
13 recommendation. And three of those were handled that way
14 last year, and those are the recommendations for home
15 health, skilled nursing facilities, and physicians. And
16 what those three had in common is that the Commission's
17 prior recommendations had two features: One, the
18 recommendations were a package of items. It wasn't just a
19 simple update. There were other facets to the
20 recommendation. And the recommendation spanned more than
21 one year, for example, because of a transition provision.
22 So we decided, given those two characteristics, that we

1 would not each year revote on the recommendation but simply
2 rerun the previous recommendation.

3 This year we are adding to that group of three a
4 fourth, and that is the hospital recommendation from a year
5 ago, which also has those two characteristics, namely, there
6 are multiple components to the package and it spans more
7 than one year.

8 Because of how we are handling those
9 recommendations, there will not be staff presentations and
10 Commissioner discussions of those four packages at this
11 meeting. But they are very important recommendations, and
12 so what I'd like to do is begin by briefly summarizing those
13 four package recommendations.

14 The first tier on the screen is the physician
15 payment recommendation. I'm not going to go through each of
16 these packages item by item but just give you a brief
17 overview.

18 The key elements of our physician recommendation
19 in the past have been repeal the SGR payment system;
20 rebalance the payment system so that we have more
21 appropriate payment for both primary care and evaluation and
22 management services more broadly; and then, finally,

1 encourage physician participation in new payment models,
2 migration away from fee-for-service. And that has been a
3 standing recommendation, those basic elements, now for a
4 number of years.

5 Kevin, when did we first recommend that?

6 DR. HAYES: October 2011.

7 MR. HACKBARTH: 2011, so we are reiterating that
8 package again this year. We are hopeful that the Congress
9 will make progress in repealing SGR and replacing it with a
10 new physician payment system.

11 The bipartisan, bicameral package that was agreed
12 to last year in the last Congress had many of the elements
13 that we encouraged. It didn't exactly follow perhaps what
14 we would want, but it was certainly moving in the direction
15 that the Commission has advocated. As everybody knows, a
16 hang-up in that has been how to pay for repeal of the SGR
17 payment system.

18 What I would note on the issue of paying for
19 repeal is that now large sums of Medicare savings have been
20 applied to financing the Affordable Care Act and reducing
21 the budget deficit, and those have happened through ACA and
22 the sequester. And then a large amount of Medicare savings

1 has been used to patching the SGR and overriding it for many
2 years now. We are talking cumulatively, between the patches
3 and the sequester and the ACA Medicare savings, hundreds and
4 hundreds of billions of dollars of Medicare savings, yet we
5 never seem to have enough to pay for an appropriate payment
6 system for physicians.

7 I won't speak for others on the Commission, but
8 that frustrates me to no end, and I'm hopeful that the new
9 Congress will at last come to grips with this.

10 So let's put up the next slide here. So the next
11 package recommendation that we will be rerunning in the
12 March report was our hospital recommendation from a year
13 ago. This package had three basic elements:

14 One was to provide an update for both inpatient
15 and outpatient services above the current law baseline. We
16 recommended a 3-1/4 percent update, and as I recall, the
17 current law update was about 2.2 percent or something like
18 that. We did that based on our efficient provider analysis,
19 which showed that even efficient hospitals were around the
20 breakeven point on Medicare business, and so we thought it
21 was appropriate to provide an update that would allow
22 efficient hospitals to be able to at least break even on

1 Medicare. The circumstances are pretty much the same today,
2 and so we are reiterating that approach.

3 A second element of the hospital package last year
4 was to eliminate or reduce the differential in payment
5 between hospital outpatient departments and physician
6 offices for selected APCs. And now if you think of these
7 two components together, the higher-than-current-law update
8 and the reduction in payment for outpatient department
9 services -- one obviously helps hospitals, the other takes
10 money away -- the net effect of those would be positive for
11 hospitals. And the thinking behind this was that it's
12 critically important that Medicare pay sufficiently and
13 appropriately for those services that hospitals provide that
14 we all depend on hospitals for, that hospitals uniquely
15 provide. But when hospitals are providing services that can
16 be rendered by other providers, we need to pay at the level
17 of efficient providers and not pay more just because a site
18 of service has a hospital name over the door as opposed to a
19 physician name over the door. And so we find that those two
20 pieces fit well together.

21 The last component of this recommendation had to
22 do with LTCH services, specifically services provided to the

1 non-CCI patients, non-chronically critically ill patients,
2 which sometimes they're treated in LTCHs and sometimes
3 they're treated in acute-care hospitals, often as outlier
4 patients. And what we tried to do there was provide a more
5 neutral payment system between acute-care hospitals and
6 LTCHs for those patients by reducing LTCH payment to the
7 acute-care hospital level for the non-CCI patients and
8 taking those monies and transferring them to the acute-care
9 hospital outlier pool.

10 So those are the elements of the hospital package
11 that we recommended last year and we will be rerunning in
12 this year's report.

13 Next is skilled nursing facilities, and here there
14 are two basic components to what we've been recommending now
15 for a number of years, the first of which is to improve the
16 payment system for skilled nursing facilities. For many
17 years running now, we have been saying, supported by
18 analysis, that Medicare overpays for therapy services
19 provided by skilled nursing facilities and underpays for
20 medically complex patients because of how the payment system
21 works. And we have recommended very specific fixes for the
22 payment system that would redress this imbalance in payment.

1 We think it's critically important to do that step to assure
2 fair payment to SNFs and also assure appropriate access to
3 care for Medicare beneficiaries.

4 To the extent that Medicare underpays for
5 medically complex patients, access for those patients can
6 become more difficult. If you're going to be a therapy
7 patient, there's a lot of SNFs that want to care for you.
8 But if you're a medically complex patient, in some parts of
9 the country at least, finding appropriate SNF placement can
10 be much more difficult. So we think fixing the distribution
11 of dollars within the SNF payment system is a vital first
12 step.

13 Once that's in place, we also think it's
14 appropriate to rebase the rates in the SNF payment system.
15 As we've documented for years now, Medicare pays generously
16 -- we believe too generously -- on average for SNF payment
17 services, or for SNF services, and a rebasing of that system
18 needs to begin.

19 The final package recommendation is for home
20 health. Suffice it to say that there are some of the same
21 basic elements here. We think there are some flaws in the
22 payment system that need to be fixed to assure an

1 appropriate distribution of dollars across patient types and
2 home health agencies, and then a rebasing of the payment
3 system, which has been overly generous in the past.

4 And I would note, with regard to both SNFs and
5 home health, we want to be clear: We think these are vital
6 services for Medicare beneficiaries. The fact that we think
7 the payments are too high does not mean that we don't think
8 that good SNF care and good home health care is not an
9 integrally important factor in providing good care to
10 Medicare beneficiaries. I think we're unanimous in
11 believing that they are vital parts of a good care delivery
12 system. It is possible, however, to pay too much, even for
13 a good thing, and that is what we're doing in each of these
14 cases.

15 So those are the four package recommendations that
16 will be rerun in this year's March report.

17 After lunch, we will do a series of votes on
18 additional update recommendations, and I'll say more about
19 that when we reconvene after lunch. This morning we will
20 take up two recommendations that we will be voting on for
21 the March report, the first dealing with payment for primary
22 care, and then the second dealing with site-neutral payment

1 for inpatient rehab facilities and skilled nursing
2 facilities.

3 So, with that preface, let's now turn to payment
4 for primary care. Julie?

5 DR. SOMERS: Good morning.

6 Last month, as part of your discussion on the
7 March report chapter on assessing the payment adequacy for
8 physicians and other health professionals, the Commission
9 discussed the Chairman's draft recommendation for a per
10 beneficiary payment for primary care.

11 Today we would like to recap that portion of the
12 discussion, present to you the draft recommendation again,
13 and leave you with time to share your thoughts on next steps
14 for work on new payment methods for primary care.

15 To recap last month's discussion, there appeared
16 to be a clear consensus supporting the Chairman's draft
17 recommendation. Commissioners also said the March report
18 chapter should clearly explain the Commission's rationale
19 for the recommendation, and it should be clear that the per
20 beneficiary payment for primary care would not entail
21 beneficiary cost sharing. Finally, Commissioners expressed
22 the sentiment that a per beneficiary payment is really only

1 an initial step and more work should be done on improving
2 payment methods for primary care.

3 Your mailing materials now contain a clearer
4 description of the rationale for the recommendation. In
5 brief, the Commission has long been concerned that primary
6 care is undervalued by Medicare's fee schedule, and the fee
7 schedule contributes to disparities in practitioner
8 compensation. Those disparities deter clinical careers in
9 primary care and in the long run leave beneficiaries' access
10 to primary care at risk.

11 The current primary care bonus established by
12 PPACA expires at the end of this year. It is similar to a
13 2008 recommendation made by the Commission, one of several
14 recommendations the Commission has made to bolster support
15 for primary care.

16 Allowing the bonus to expire without a replacement
17 would send a poor signal to primary care practitioners, but
18 Commissioners have also expressed an interest in moving away
19 from fee-for-service where it doesn't make sense.

20 For those reasons, the Commission is now
21 considering the recommendation to continue the additional
22 payments to primary care practitioners, but in the form of a

1 per beneficiary payment in contrast to the fee-for-service-
2 based payment made under the current bonus.

3 DR. HAYES: Over the course of your discussions on
4 the per beneficiary payment, you have reached agreement on
5 its design features. The payment amount would be set at the
6 level of the current bonus. The payment would be payable
7 for beneficiaries prospectively attributed to practitioners.
8 Receipt of the payment would not be contingent on meeting
9 practice requirements. Beneficiaries would not pay cost
10 sharing on the per beneficiary payment. And as we'll see in
11 a moment, this point is now clearly stated in the draft
12 recommendation.

13 Funding of the payment would protect services
14 defined under the current bonus program as primary care
15 services regardless of whether the practitioners furnishing
16 the services are eligible for the bonus. Instead, funding
17 would come from all other services in the fee schedule.

18 This graphic is one you have seen at previous
19 meetings.

20 It shows the specifics of how the funding
21 mechanism for the per beneficiary payment would work.

22 The services defined under the current bonus

1 program as primary care services, whether furnished by
2 practitioners eligible for the bonus or by other
3 practitioners, are at the top. All other services account
4 for 75 percent of fee schedule spending. Fees for those
5 services would be reduced by 1.4 percent.

6 The draft recommendation reads as follows:

7 The Congress should establish a prospective per
8 beneficiary payment to replace the Primary Care Incentive
9 Payment program -- or PCIP -- after it expires at the end of
10 2015.

11 The per beneficiary payment should equal the
12 average per beneficiary payment under the PCIP and should be
13 exempt from beneficiary cost sharing.

14 Funding for the per beneficiary payment should
15 protect PCIP-defined primary care services regardless of the
16 practitioners furnishing the services and should come from
17 reduced fees for all other services in the fee schedule.

18 There's discussion of the recommendation's
19 implications in the draft chapter, but, briefly, on the
20 issue of spending implications, we can say that the per
21 beneficiary payment would be a budget-neutral policy. As
22 such, it would not affect federal spending relative to

1 current law.

2 On the issue of implications for beneficiaries and
3 providers, the recommendation would redistribute fee
4 schedule payments from specialty care to primary care,
5 thereby continuing to signal support for primary care.

6 Providers could -- and as Jon has pointed out,
7 there's no guarantees here -- but they could use the payment
8 to improve care delivery, care coordination, and access to
9 primary care services.

10 That concludes our presentation on the per
11 beneficiary payment. After you consider the draft
12 recommendation, we hope that you will give us guidance on
13 next steps we can take on payment methods for primary care.

14 You might frame a discussion of next steps this
15 way. Recall that the draft chapter for the March report
16 discusses the Commission's concerns about payment for
17 primary care.

18 One, physicians in some specialties are
19 compensated at rates more than double that of primary care.

20 Two, procedural services can become overpriced due
21 to technology advances and other factors.

22 Three, data collected by a Commission contractor

1 confirmed the feasibility of validating the relative value
2 units in Medicare's fee schedule.

3 And, four, fee-for-service is ill-suited as a
4 payment mechanism for ongoing, coordinated care.

5 If I can borrow a term Craig has used, the bullet
6 points on this slide arguably represent the problem we are
7 trying to solve.

8 The Commission has made recommendations to address
9 the problem, establish a primary care bonus, which you are
10 now considering for replacement with a per beneficiary
11 payment; encourage the Secretary to undertake a medical home
12 pilot project -- for that, as you know, CMMI has a number of
13 medical home demos now underway; identify overpriced
14 services and adjust fees -- here, the Congress and CMS have
15 taken some steps in this area; and repeal the SGR and a
16 rebalancing of the fee schedule with higher updates for
17 primary care than for other services. Action on this
18 recommendation is still needed, as Glenn pointed out.

19 Other ideas mentioned at recent meetings include
20 full-scale per beneficiary payment and bundled payment. Any
21 further thoughts you have on these matters would help staff
22 as we continue work in this area.

1 Thank you.

2 MR. HACKBARTH: Okay. Thank you very much.

3 So, I'd like to do two rounds here, the first,
4 clarifying questions about any of this or about the
5 recommendation, in particular. Then we'll have a second
6 round for people to make observations about this and where
7 they would like to see the Commission go in the future on
8 primary care. And then we will have our vote.

9 So, clarifying questions. Jon.

10 DR. CHRISTIANSON: Kevin, I'd like you to maybe
11 just speculate a little bit about one of the entries in
12 Table 7 in the chapter. So, you don't have it on your
13 slides. This is a table where the use of services furnished
14 by physicians and other health professionals table, and the
15 entries are divided into the different categories, and the
16 first category is E&M. Do you see that table?

17 DR. HAYES: [Off microphone.] Yes.

18 DR. CHRISTIANSON: Okay. So, under office visits,
19 it just struck me as I was looking at this table that there
20 was a five-year period before 2012 where the total -- or,
21 the average annual increase -- excuse me -- in office visits
22 was 0.5 percent, and then the last year in the table you

1 kind of break out. It jumped up to 2.8 percent, which is
2 strikingly larger. Do you have -- in your work on this, do
3 you have any sense -- is this just, like, wow, this is
4 really incredibly better access to primary care than we've
5 had in the past, or what would you suggest would be the
6 implications of that number, if any?

7 DR. HAYES: I think what we'd wanted to do is to,
8 first, recognize that there have been some increases in
9 payment for primary care, that we have, of course, the bonus
10 program that was started, you know, in 2011 under a
11 provision of the Affordable Care Act. So, that's one
12 factor. Other increases in payment that have occurred have
13 been due to changes in the relative values in the fee
14 schedule. So, there have been some increases in payment.
15 Perhaps this is a response to that.

16 The other thing to point out, though, is that
17 these are all office visits. So, we're talking about visits
18 furnished not only by the primary care practitioners that
19 we're talking about here today, but also by others,
20 physicians and other professionals across the broad swath of
21 specialties and practice settings and so forth.

22 So, it would -- it may be that it's an increase in

1 primary care and it may be increases elsewhere, but --

2 DR. CHRISTIANSON: It is an increase in E&M.

3 DR. HAYES: That's right.

4 DR. CHRISTIANSON: Yeah. So, your explanation
5 sort of embodies a provider-induced demand kind of thing? I
6 mean, some of these visits are made by patients, patient-
7 initiated visits, I assume, too. So, there's nothing on
8 that side that would have explained this dramatic increase?

9 MR. HACKBARTH: Jay, and then Bill.

10 DR. CROSSON: Well, also, benefit changes. I
11 mean, isn't the added benefit for an annual physical
12 possibly an explanation?

13 DR. CHRISTIANSON: Kevin, is that --

14 DR. HAYES: Yes, there was an annual wellness
15 visit included, and what I'd want to do is to go back and
16 double-check and make sure that those annual wellness visits
17 are in this category of service and not somewhere else, but
18 that's another possibility.

19 DR. HALL: Kevin, can you remind me -- if I read
20 this correctly, primary care services and inpatients are not
21 part of the -- are not included, is that right?

22 DR. HAYES: That's right. We're talking about

1 visits -- you're talking about the services defined as
2 primary care --

3 DR. HALL: Yes.

4 DR. HAYES: -- for purposes of the bonus program?

5 DR. HALL: The primary care physician attends on a
6 patient in the hospital.

7 DR. HAYES: That's right. So, we would -- the
8 categories of E&M services that are eligible for the bonus
9 include office visits, visits to patients in --

10 DR. HALL: Right.

11 DR. HAYES: -- in long-term care facilities,
12 essentially, and to in-home visits.

13 DR. HALL: So, why was that excluded, the hospital
14 visit? Is there --

15 DR. HAYES: Well, you know, the origins of the
16 services eligible for the bonus can be traced back to a
17 recommendation that the Commission made in its June 2008
18 report, and there, the intention on the part of the
19 Commission was to support primary care, and specifically
20 outpatient primary care as furnished by certain types of
21 practitioners.

22 DR. HALL: I may want to come back to that in

1 round two.

2 DR. MILLER: And, I think the other thing that
3 plays into all these decisions, at that time as at this
4 time, we were saying, you know, this is about moving
5 resources inside the fee schedule, and so there was also
6 some concern of, like, how much is being drawn at any point
7 in time in making the definition.

8 MR. HACKBARTH: So, before we get too far away
9 from Jon's question, I do think that that's an interesting
10 observation, that seeming change in the trend, but it is one
11 year's data point, and it is all evaluation and management
12 services, not just primary care E&M services. And, my guess
13 is it's probably not just one thing going on, or maybe some
14 benefit issues, maybe some other things. We'll just need to
15 watch it and see if it persists, and then if it does,
16 whether some analysis can be brought to bear.

17 DR. CHRISTIANSON: And, we also don't know whether
18 it's a change in the trend, because we don't have the yearly
19 changes.

20 MR. HACKBARTH: Fair enough.

21 DR. CHRISTIANSON: So, that may be a lot of
22 bouncing around in those five years.

1 MR. HACKBARTH: Yeah. Sure. Okay. So, we're on
2 clarifying questions. I have Kathy and Jack.

3 MS. BUTO: So, not having been here, the earlier
4 recommendation that the Secretary undertake medical home
5 pilot, were we anticipating a large increase in payments to
6 primary care physicians, or just a greater degree of sort of
7 authority and direction being -- and status being given to
8 primary care services?

9 DR. HAYES: Well, the -- you know, the point of
10 the Commission's set of recommendations in that June 2008
11 report was to try and improve payment for primary care
12 broadly. And, so, the bonus was one step and, you know,
13 with a rationale very similar to what we're talking about
14 today in terms of compensating for some imbalances in the
15 fee schedule and so on.

16 The medical home recommendation was founded more
17 on a perspective that primary care, you know, in a very
18 fundamental way, needs to change, needs to improve. There
19 needs to be more focus on care coordination and 24/7 access
20 to someone in the practice and on down the line. And, so,
21 there was a recognition there should be -- a pilot is a way
22 to take a step in that direction.

1 MR. HACKBARTH: If I could, let me just pick up on
2 what Kevin said. So, for me, there were two aspects of that
3 recommendation for medical home pilot. One was a change in
4 the payment method for primary care, and second was an
5 increase in the resources for primary care that might allow
6 for practices to build more infrastructure, both staff and
7 systems, to better coordinate care, especially for complex
8 patients.

9 To be frank, I've often thought since the time of
10 that recommendation that it was a mistake to recommend
11 pilots because of how drawn out and, ultimately,
12 inconclusive that process often is, and hopefully, before
13 I'm too far into my own Medicare years, we will get results
14 from those pilots. I wish I were more optimistic that they
15 would be definitive results. So --

16 MS. BUTO: Glenn, the method --

17 MR. HACKBARTH: Just a couple more points, Kathy.
18 So, the notion behind doing a pilot was, would the savings
19 from better management of care be sufficient to offset the
20 higher payment in the form of a per beneficiary lump sum
21 payment to build infrastructure. That's the -- a key notion
22 that's being tested, as well as what happens to quality of

1 care. And, my own view since the time of that
2 recommendation has become that even if the savings from
3 better care management aren't as large -- large enough to
4 offset the increased payment, the increased payment still
5 makes sense, because we need robust primary care.

6 In the delivery system, we're confronted with a
7 problem where we have an aging clinician workforce in
8 primary care, a lot of baby boomers nearing retirement, at
9 the same time as we have a lot of new patients coming into
10 the Medicare system and we have new patients coming in
11 through ACA and for other reasons. And, so, even if it
12 costs money, we need to shore up the primary care delivery
13 system and make it capable of caring for as many patients as
14 possible as well as possible, even if it means additional
15 money. So, even if the pilot now comes back and says, well,
16 the savings don't offset the cost, I don't think that means
17 we shouldn't do medical homes.

18 And, so, that's why I feel like this was a mistake
19 I made. We should have never recommended pilots. It's an
20 endless loop that you get into and not necessarily a
21 productive one.

22 I'm sorry.

1 MS. BUTO: My question really was about that
2 additional payment. So, it was really more of an
3 administrative payment, if you will, and a coordination
4 payment, but the practitioners still get fee-for-service.
5 It's not a bundled payment --

6 MR. HACKBARTH: Under -- Kevin, help me here. My
7 recollection is the way the pilots are structured is it's a
8 combination of a lump sum per patient payment and fee-for-
9 service, including some fee-for-service bonuses for quality,
10 et cetera, is that correct?

11 DR. HAYES: Yes. I'm not sure about the mix of
12 quality bonuses versus per, but, yes, it's still -- it's a
13 combination of a per beneficiary payment plus fee-for-
14 service.

15 MR. HACKBARTH: Bill.

16 MR. GRADISON: Two questions. I'm trying to
17 understand which physicians get the payment. So, just two
18 quick questions. If a majority of the care in a given year
19 for E&M services were with a cardiologist, would payments go
20 to the cardiologist?

21 DR. HAYES: No. There's a two-part test,
22 essentially, for eligibility. Part one has to do with the

1 specialty designation that the physician or other health
2 professional has chosen for themselves. So, if it were
3 talking about a physician, it would be a physician in one of
4 four specialties -- general internal medicine, family
5 practice, pediatrics, and geriatrics. So, that's test
6 number one.

7 Then, the second part of the test is, is a
8 majority of your allowed charges from a previous period
9 attributable to or for the services that are eligible for
10 the bonus, you know, the office visits and visits to long-
11 term care patients and home visits.

12 MR. GRADISON: And, if there were no visits to
13 anybody per year in our patients that are in good health and
14 don't see doctors in a year, no payments to anyone, right?

15 DR. HAYES: Uh, right -- oh, so you're talking now
16 for the per beneficiary payment.

17 MR. GRADISON: Mm-hmm.

18 DR. HAYES: Right. There would have to be -- how
19 would that work? You'd have to --

20 DR. SOKOLOVSKY: Let's see. In the preceding
21 year, there would have -- or, in some time period --

22 DR. HAYES: Yes.

1 DR. SOKOLOVSKY: -- because we were saying --

2 DR. MILLER: I think this is -- just for a second
3 -- I think there's a quick answer, which is under the
4 current system, if the beneficiary never showed up at the
5 doc, the doc would never get the extra payment because the
6 service would have never been provided, first point. And, I
7 think that's your question.

8 MR. GRADISON: It's the same as it would be under
9 the current system.

10 DR. HAYES: Correct.

11 MR. GRADISON: Okay.

12 MR. HACKBARTH: Jack.

13 DR. HOADLEY: Yeah. I think this is really a
14 rhetorical question, but I want us to be crystal clear. The
15 current primary care bonus, which you said expires under
16 current law, means that if Congress takes no action, that
17 completely goes away. And, so, our recommendation, in
18 effect, is to say, don't let those dollars go away from
19 primary care. Don't cause a reduction in payments to
20 primary care, but use those same dollars, that same amount,
21 in this new way. Is that right?

22 MR. HACKBARTH: Other clarifying questions?

1 Alice, and then Jon.

2 DR. COOMBS: So, I understand the PCIP program
3 currently as it exists, but on Slide 6, is it not the case
4 that the second block does represent specialties of
5 specialists that do primary care?

6 DR. HAYES: Yes, and so it's a question, then, of
7 where the funds would come from. This is strictly a funding
8 slide.

9 DR. MILLER: [Off microphone.] Yeah, and so the
10 second part of Bill's question is those providers for those
11 services are not asked to ante up.

12 DR. CHRISTIANSON: I like the way that in the
13 revision of the chapter, and you pointed this out in one of
14 your slides, that you're really looking forward and the
15 Commission is saying that we have future concerns about
16 primary care. The beginning of the chapter reports the
17 survey results, and the table headings and the survey
18 results are all positive with respect to access -- the way
19 they're summarized -- access relative to the private sector.
20 It's not compared to some desirable standard of access, but
21 relative to the private sector.

22 So, in some of our other deliberations, we've kind

1 of used those sorts of survey results and other data to say,
2 and, therefore, we are not too worried about not giving a
3 payment update. We think access is still going to be
4 adequate. Here, we're saying, despite those -- even though
5 we have what seem to be positive results on access, we
6 believe that we should have a payment increase in primary
7 care, and I think that reflects, if I understand the
8 reasoning here, our judgment about the future and some of
9 the things that Glenn just said. So, I just want to
10 underscore that that may look like a conflict, but I don't
11 think it really is. I think we're projecting forward in the
12 non-primary care.

13 MR. HACKBARTH: That's helpful, Jon, and that's
14 exactly right. The survey is a snapshot at a point in time
15 and the recommendation is more focused on the future and
16 where we're headed.

17 Any more clarifying questions?

18 [No response.]

19 MR. HACKBARTH: Seeing no hands, let's move to
20 round two, and in particular, this is an opportunity to
21 offer thoughts about future directions for the Commission's
22 work. Alice.

1 DR. COOMBS: Thank you very much. This is a very
2 -- a timely subject, and I want to commend the Commissioners
3 and the Chair for approaching this in a way that actually
4 looks at how care is impacted, how beneficiary care is
5 impacted.

6 So, a couple of points that I wanted to talk
7 about, and one is I like the fact that we're looking at
8 demographics of both advanced practice nursing and
9 physicians and what that means, but I want to point out a
10 new transition in workforce that I don't think we fail to --
11 I think we fail to recognize, and that is this transition
12 where, both for physicians in primary care and advanced
13 practice nursing and PAs, into the hospital as a hospitalist
14 primary care person, and so that it's a little bit deceptive
15 to look at just absolute ratios alone because the
16 distribution of where those primary care workforce, where
17 it's located, I think, can be deceptive.

18 The other issue is that transition from a primary
19 care practice into a hospital, there's a gradient there and
20 that's why it happens. There's a disparity gradient in
21 terms of the earning potential for an advanced practice
22 nurse or physician in primary care, and that's what actually

1 drives the transition from being in a lone doc in a box or
2 even as a part of a group. You suddenly eradicate the
3 administrative burden, and there you find yourself. So, I
4 don't know how we would address that, because a lot of that
5 has to do with just the barriers of practicing and
6 delivering medicine in the community.

7 One thing, I think, it's local dynamics. It has a
8 lot to do with very maldistribution in terms of geography,
9 in terms of what happens in different settings, whether it's
10 urban, I think it's probably less likely that it's rural,
11 and that the numbers for the rural might be more reflective
12 of what actually happens in those areas.

13 The surveys really speak to no problems with
14 access and no problems with -- major problems, it sounds
15 like, with waiting times, and I'm glad that we combined the
16 waiting time. That was a really important issue. I always
17 question whether or not within certain areas, what happens
18 in terms of the ratio of FTEs that are actually accepting
19 Medicare and Medicaid, even though it would appear from the
20 analysis within the chapter that that's not problematic at
21 this juncture. But, that's always in the back of my head in
22 terms of disparate populations and vulnerable populations.

1 MR. HACKBARTH: I've got some hands over here:
2 Jay, Kathy, Mary.

3 DR. CROSSON: So I support the recommendation.

4 It's funny. Actually, looking through the data in
5 the report, I came to a slightly different conclusion about
6 what it says. I mean, I think if there is a leading
7 indicator in the data, to me it's the ability of new
8 patients to find primary care physicians versus specialists.

9 What we actually have is that in 2010, about 20
10 percent of Medicare beneficiaries looking for a new primary
11 care physician identified a problem, either a large problem
12 or small problem. 2014, it was 28 percent, a 40 percent
13 increase, compared with about 14 percent for beneficiaries
14 looking for a new specialty physician.

15 Now, it's true that for commercial insurance, it's
16 about 35 percent compared with 28 percent, but that
17 comparison doesn't convince me that there's not a problem
18 because, in fact, the payment for physicians tends to follow
19 very closely in commercial insurance that of Medicare. So
20 what that data tells me, whether we're talking about
21 Medicare for commercially insured patients, about a third of
22 new patients looking for a primary care physician have a

1 problem, and that there is a dynamic present here, which is
2 at least over the last four years a significant increase,
3 which points to the fact that we've got a problem coming.

4 So I support the recommendation, but I think my
5 fundamental concern is that it will prove to be inadequate
6 to reverse the flow of physicians in medical school making
7 choices about what specialty they want to pursue,
8 particularly because, as I think we've discussed previously,
9 the pipeline is long, and even if we made a substantial
10 change this year or next year, it might be close to seven or
11 eight years before we see a substantial change.

12 Now, if the rate of dissatisfaction with a new
13 primary care access continues at the rate we saw in the last
14 four years, we would get close to 50 percent of Medicare
15 beneficiaries not having a satisfactory experience trying to
16 find a primary care physician.

17 So I think the time to act is now. Certainly, in
18 the next couple of years, it would be worthwhile exploring
19 more aggressive, more impactful approaches to rebalancing
20 the payment among physician specialties.

21 MR. HACKBARTH: Jay, it seems to me that -- and I
22 am asking this, as you're a physician and I'm not, but it

1 seems to me that the issue might not just be the level of
2 take-home pay, but also the doability, if you will, of
3 practicing primary care. And I think that's potentially
4 important, both for new clinicians coming in, but also
5 clinicians that are nearing retirement age and facing the
6 question how long do I continue to do this, and to the
7 extent that we can provide additional dollars, a new payment
8 method that allows them to have infrastructure that makes
9 the practice more doable, we can hopefully improve our
10 supply of clinicians.

11 DR. CROSSON: I absolutely agree with that, and
12 there are other areas, I think, where there is differential
13 impact on particularly adult primary care physicians and
14 specialists, and some of that has to do with the complexity
15 of electronic health records, the problems inherent in both
16 documenting care and in the administrative requirements
17 surrounding that.

18 I think in some systems, including the one that I
19 worked in previously, one of the net impacts of electronic
20 health records has been to essentially push -- I don't want
21 to call it "clerical" or "administrative" -- work to the
22 physicians, which used to be done by ancillary personnel,

1 both because of regulation and because of, I guess I'd call
2 it, self-regulation or compliance risk on the part of
3 organizations.

4 I think internists in almost every system I've
5 looked at have had the heaviest burden from the
6 documentation problems or documentation issues inherent in
7 the electronic health record. So there are a range of other
8 issues that a senior medical student might look at in terms
9 of making those choices, some of which are out of our scope,
10 but some of which might very well be in scope.

11 MS. BUTO: I want to build on Jay's point. I
12 think there is an access issue for new patients in primary
13 care, and we're seeing it now, as he pointed out.

14 As we consider alternatives going forward, I'd
15 like to think we could look at -- and I think we say in the
16 paper -- that this per-beneficiary payment is a good
17 starting point. So I am hoping that we can look at whether
18 there are additional primary care payments we could consider
19 bundling in to make that a more robust payment.

20 I would even go so far as to say we should look at
21 recommending pulling primary care out of the fee schedule.
22 I've been involved in the fee schedule since its inception,

1 and there's never been a year when primary care has been
2 considered to be appropriately or funded in a way that
3 encourages the kind of primary care we're talking about.

4 We may not want to go that far. It may be
5 untenable, but it's something we at least ought to
6 entertain, so that it can be really looked at entirely
7 independent of specialty services or procedural services.

8 Kevin?

9 DR. HAYES: I just wanted to ask. You mentioned
10 bundling just now, and you've mentioned bundling earlier at
11 a previous meeting. Could you say just a few more words
12 about what you mean? What would the bundle consist of?
13 What would you put in a bundle?

14 MS. BUTO: Well, I would want to look at the data
15 to see what kinds of primary care services are typically
16 provided, but let's take the annual health assessment. It
17 seems to me that could be bundled in for each -- if you're
18 going to do a beneficiary attribution, there are other
19 services which are typically provided on an annual basis or
20 a monthly basis or whatever. So I'd want to look at the
21 data to see which ones would call out for that.

22 I think the limitation of the just building on the

1 primary care per-beneficiary amount would be that, I think
2 as Bill was starting to identify, some beneficiaries go to
3 their specialists for ongoing care -- cardiology,
4 endocrinology, et cetera. So those specialties are not now
5 included in this, so sort of the whole chronic care bundle
6 gets done outside of this notion.

7 But I think we could look at that as well to
8 incorporate some of what we thought was going to go into the
9 medical home pilot might be considered.

10 DR. NAYLOR: So I really like the idea of thinking
11 up how we might look at primary care separate from the
12 traditional fee schedule services, a growing body of
13 evidence about the elements and whether or not they can be
14 bundled, including care coordination, preventive services,
15 and so on.

16 I think that it's more important to think about it
17 given the aging of the Medicare beneficiary and the growing
18 burden on their family caregivers than ever before.

19 I totally agree that we can't be looking toward
20 our traditional ways of thinking about responding to these
21 challenges. I think this would be a great opportunity -- so
22 this is my plea -- that we begin to talk about primary care

1 and the team of qualified health professionals responsible.
2 If we continue to think about it as a physician or other
3 health professional shortage, we lose sight of what actually
4 needs to happen to deliver care and get to outcomes for this
5 population.

6 My one plea is, in this area, I think it makes
7 sense to not call it "physician and other health
8 professionals," but call it "qualified health professionals
9 of primary care," and think about the incentive that can
10 support that.

11 Let me give you some specific ideas that I think
12 about -- and by the way, I really support what is being
13 proposed today, but largely as a signal about how critically
14 important paying attention to primary care is in the future.

15 Beyond language, I think our efforts do need to
16 focus on workforce and the kind of data that Alice is
17 talking about, which is tracking who is really delivering
18 primary care, in what context. I think we have an
19 opportunity with the graduate nurse education demonstration,
20 which is only a demonstration 4 years in length, which is
21 already serving as a model about how to move primary care
22 actively into the community and grow the workforce that Evan

1 shows are achieving the same quality and cost outcomes as
2 physicians. We need to think about how we can make that an
3 integral part of the Medicare program going forward.

4 We talked about payments of bundled services of
5 teams, but I also think the last piece that I would
6 encourage us to look at is the other emerging models, beyond
7 the patient-centered medical home, the nurse-managed
8 centers, the work in the federally qualified health centers
9 that play a major role in primary care. I think that we
10 have the opportunity as we're moving forward to really
11 continue to promote and grow.

12 Access is not just about to a physician or to new
13 patients. We still do have challenges in access in
14 underserved areas, and we need to be very open to models
15 that are serving all equitably.

16 DR. SAMITT: So I fully support the
17 recommendation, as I've mentioned before. This is clearly a
18 necessary step to preserve and enhance primary care, but
19 it's not a quick enough step or it's not a substantive
20 enough one.

21 I want to comment on the brainstorming side.
22 Where do we go from there? The experience that I've had is

1 that true innovation occurs in primary care when we do two
2 things, that we liberalize resources to allow primary care
3 clinicians to truly redesign their care model. There aren't
4 sufficient resources to do so today, as you described,
5 Glenn.

6 But the other thing that needs to be done is an
7 unshackling of the incentive methodology from fee-for-
8 service, that we're never going to truly create alternative
9 care models if we're still building incentives on a volume-
10 based methodology.

11 So I would say right now, what we're recommending
12 is a compensation model where in majority, we pay fee-for-
13 service, and in minority, we pay a per-beneficiary payment.
14 I would be more provocative and say it should be the exact
15 reverse, that the large majority of the payment in primary
16 care should be for per beneficiary, with a minority being
17 for volume, but still important to reward production, as
18 well as incentives that reward access, service, and quality.
19 I think those are the more contemporary models that are
20 being designed. So, as we think about alternatives, we
21 should look at those.

22 I'm not sure I'm willing to give up completely on

1 the demonstration projects, although I agree with Glenn that
2 they take too long and the results are muddled. I'm not
3 sure we even only have to look at the demonstration models.
4 I think there are some very tangible, innovative primary
5 care models that have been created that have unshackled
6 themselves from fee-for-service that we should clearly study
7 and see the results from these models and whether we
8 actually garner any information about how to take primary
9 care away from the fee schedule and create something
10 completely new and different.

11 Let me just make one more comment, which is let's
12 even think about the ACOs in this regard. When we think
13 about the ACOs, it's beginning to think of alternative
14 incentive models for primary care, but it's still shackled
15 to a fee-for-service chassis.

16 So what if we were to think about a new version of
17 ACO that actually, for the most part, is structured
18 similarly in terms of looking at population health, but
19 rewards primary care very differently with a notion on per-
20 beneficiary financial incentives as opposed to per-visit
21 financial incentives?

22 DR. HOADLEY: Yeah. I wanted to follow directly

1 on what Craig was talking about and trying to think about
2 how some of those exam -- I think the idea of trying to
3 learn from what's been done out there is really helpful.

4 The challenge, I think is some of the existing
5 practices are operating inside organizations. So, in an
6 integrated system where they've got sort of full control
7 over how they do things, they can pay salary. They can do
8 all the kinds of things to really change the way
9 practitioners think about what the incentives are.

10 So I think in the ACO context, there may be some
11 ability because there is at least a quasi-organization
12 involved, but I think we should also be looking at whether
13 there are lessons from -- that are more payer-driven,
14 whether it's managed care plans that are operating more on a
15 -- sort of not fully integrated, but more fee-for-service-
16 like, and have they come up with ways to do some things,
17 Medicaid programs that have experimented with some of the
18 primary care case management.

19 My sense is most of those are sort of more at the
20 level of what we're talking about with this very small per-
21 person payment and not something that gets to a larger share
22 of the overall payment, but maybe there's a Medicaid program

1 out there that's kind of done. But mostly, they're doing,
2 is just turning it over to managed care plans, so that's the
3 other model.

4 But, I mean, I think if we could find some cases
5 where insurance plans or public plans like Medicaid have
6 come up with some ways to reinvent this, much along the
7 lines that Craig is talking about, that might be something
8 that allows us to think about how Medicare as a general fee-
9 for-service system can do it, as well as seeing whether we
10 could do some of this inside an ACO and take advantage of
11 the quasi-organization structure to give them a little more
12 autonomy. Maybe it's a subset of all ACOs that are more
13 organized than others that might take up that challenge, so
14 just some ideas.

15 DR. NERENZ: I just want to echo a couple of
16 excellent points others have made. I will support the
17 recommendation, but I guess this is kind of simultaneously
18 both to Jay and to Craig who talked about it as either being
19 inadequate or sort of relatively small.

20 I agree with that, but that may not necessarily be
21 a horrible problem, just because I think there are other
22 changes going on in the environment that we should watch

1 that also at least maybe will have a positive effect on the
2 financial aspects of primary care practice. I'm thinking
3 specifically in the states or regions that are doing the
4 advanced primary care demonstrations. They have a per-
5 member, per-month payment that I think typically projects
6 out larger per practice than what we're talking about here.
7 That is kind of the concept we're talking about. That
8 structure already exists. We'll see how that goes, but to
9 the extent that has staying power, that's going to be there.

10 I've heard of one or two specific anecdotal
11 examples of payouts to physicians and ACOs that are
12 significant, kind of a little skeptical, but that's broadly
13 applicable. But it can work in some places. Again, that
14 can enrich the environment.

15 The one thing that I wanted to ask about -- and
16 that's this new chronic care payment, which I guess we could
17 say is a form of fee-for-service payment, but it's different
18 in the sense that it's broader. It includes things that are
19 different from things currently in the fee schedule.

20 In the chapter on page 52, there's a discussion of
21 this, and you mentioned that CMS projects relatively low
22 uptake of this. At the same time, I've seen some

1 projections about very significant dollar amounts at least
2 potentially available in a typical primary care practice
3 with kind of an average Medicare component, up to perhaps
4 \$40,000 annually, which again is a dollar amount would be
5 much larger than what we're talking about.

6 I'm not so sure it's going to be a slow uptake,
7 but I'm curious what you think. You've told us what CMS
8 thinks. What do you think? Because it seems like that's a
9 significant change in part of the environment that we're not
10 assuming is going to have much effect. I think it may have
11 an effect.

12 DR. HAYES: The one thing to consider in this area
13 would be the experience so far with an earlier payment
14 change that's preceded the chronic care management codes,
15 and that was the transitional care management code
16 experience. And there, the uptake, at least initially, has
17 been quite low along the lines of maybe a tenth of what was
18 projected. Maybe this, what CMS is thinking here,
19 represents some kind of reflecting back on that, on that
20 experience.

21 The other thing that's come up at least in
22 comments on the chronic care management code, the comments

1 that CMS received about it was that, well, there are some
2 requirements associated with eligibility for billing for
3 this, and that they in turn may put a drag on how much
4 uptake there is on the thing.

5 Julie may want to say a little bit more about
6 that.

7 DR. SOMERS: Yeah. The only other thing I would
8 add, some of the other comments were, because this is inside
9 the fee schedule, cost sharing is required of the
10 beneficiary. So it could be that doctors or practitioners
11 would be hesitant to bill the code for a month when they do
12 non-face-to-face services that the beneficiary doesn't see,
13 that the beneficiary gets a cost-sharing bill for those
14 services. So that may be another reason why the uptake is
15 projected to be low.

16 DR. NERENZ: Okay. I mean, those all make sense.
17 I guess I just might speculate on the other side, it is
18 indeed speculation that if these non-face-to-face services
19 really are a value to the patient, at least you could make
20 this case --

21 MR. HACKBARTH: We are already a little bit over
22 time. I had Bill and then Jon, and if it's really, really

1 quick, Warner, we can squeeze one more in. But then we've
2 got to get back on schedule.

3 MR. GRADISON: Building upon some things said
4 quite well by others, I'm very supportive of this. I think
5 it's a useful first step or at least a step to help correct
6 what's going to otherwise happen at the end of the year.

7 What I find missing is what are the second and the
8 third steps, and, more particularly, what are we aiming for
9 in the long term? What is our goal to which this becomes a
10 relevant part? Craig alluded to this, so have others.

11 In that context, I just would like to make the
12 point that while I think this financial recommendation makes
13 sense in terms of where we are at the moment, it might be
14 useful from a brainstorming point of view -- the roof will
15 fall on me in a moment for making this statement -- but to
16 suggest in other silos where we identify overpayments, that
17 these overpayments be redirected towards this larger fund
18 for services which are more valuable than paying excessive
19 amounts for services which would -- in some other silos,
20 which would be services which would be rendered anyway.

21 MR. HACKBARTH: Bill, on your first point, I think
22 it's really important not to oversell the significance of

1 this recommendation. For me personally, this is a stop-gap.
2 The bonus expires at year end unless something's done, and
3 so the message, I think, from the Commission on this
4 recommendation is don't go backwards, don't let the bonus
5 expire. It's small. It's not attracting huge numbers of
6 people to primary care. It's not revolutionizing primary
7 care practice. But let's not symbolically go backwards.
8 And at the same time, let's take a very modest step away
9 from exclusive dependence on fee-for-service for primary
10 care.

11 So this is a stop-gap that then creates the
12 opportunity to consider the more fundamental changes that
13 have been mentioned in this round. That's the way I see
14 this recommendation.

15 Okay. I have Jon and Warner and Bill Hall, all of
16 whom have taken sacred vows to be really fast.

17 DR. CHRISTIANSON: I don't think I can adhere to
18 my vow, so I'll pass.

19 MR. THOMAS: I'll be brief. I certainly agree
20 with the recommendation. I also agree with Craig that I
21 think we need a more substantial shift to a non-fee-for-
22 service payment for primary care physicians.

1 The one concern I have is the amount of primary
2 care delivered by medical subspecialists who are not fitting
3 the definition of primary care. And one of the questions I
4 would have for the staff is to go back and look at
5 beneficiaries that appear to receive a majority or a
6 significant amount of their care from a subspecialist, a
7 medical subspecialist, versus a primary care doc, so we can
8 understand is that a material amount of folks, is it not? I
9 have a feeling that there is a significant amount of primary
10 care delivered outside of this group, and I think it's
11 something we need to make sure we understand as we
12 contemplate changes in the future.

13 DR. HALL: I speak in favor of this particular
14 recommendation and certainly agree with what has been said
15 by many of you, Jay about access, Mary about that this is
16 interdisciplinary care, and a lot of clinicians are
17 involved.

18 Craig, I like the idea that maybe we should think
19 outside of the box. I think this is very healthy. This has
20 been a very robust discussion.

21 Just one suggestion I might make is that primary
22 care, as we're defining it now, covers people from day of

1 birth to the time of death. Primary care for our particular
2 population where we have the most expertise and, arguably,
3 influence is on the care of the Medicare-eligible
4 population. And so what's required there to get more people
5 into a more organized, coordinated health care system?

6 I would say it's the needs, the special, and
7 sometimes unique needs of the Medicare population, and let
8 me just tick off a couple really quickly.

9 Less is more. By and large, people who are
10 successful in caring for older people tend to do less
11 procedures rather than more procedures.

12 Intelligent management of pharmaceuticals, not
13 more drugs, less drugs usually.

14 Right care at the right place, whether it has to
15 be in the home, whether it has to be in an SNF, an LTCH.
16 There are very specific decisions that have to be made that
17 are sometimes costly in terms of time.

18 But the overall management of people, the human
19 aspect, generally people who go into primary care are not
20 just doing it for the money. I think if we doubled their
21 salaries, to be sure, we would get an increase in the number
22 of primary care providers, but we would have little or no

1 impact on the kind of system of care that older people need,
2 apropos of what Craig mentioned.

3 So I would say that what -- and not to mention
4 prevention. We mentioned it once already in this session,
5 that it's very much underutilized.

6 So I think our discussions and our contribution to
7 this primary care business is to really focus on the very
8 real needs of a burgeoning Medicare population, 10,000 new
9 every day, and what are the aspects of primary care that
10 would allow us to systematize the care? If we did that even
11 halfway, I think we would have an enormous influence on the
12 whole health care system.

13 So that's my piece.

14 MR. HACKBARTH: Okay. Thank you all for this.
15 Now we've got to do our vote before we leave this session.

16 So the draft recommendation is up. All in favor
17 of the draft recommendation, raise your hand, please?

18 [Show of hands.]

19 MR. HACKBARTH: Opposed?

20 [No response.]

21 MR. HACKBARTH: Abstentions?

22 [No response.]

1 MR. HACKBARTH: Okay. All done. Thank you.

2 [Pause.]

3 MR. HACKBARTH: Okay. Next up is post-acute care,
4 in particular our recommendation on IRF and SNF site-neutral
5 payment.

6 MR. CHRISTMAN: Good morning. We'll begin this
7 presentation with a review of PAC trends, and then Carol
8 will take us through our recommendation on site-neutral
9 payment.

10 As you may recall, the post-acute service provides
11 medical and rehabilitation care for post-hospital
12 beneficiaries in one of four settings: IRFs, skilled
13 nursing facilities, home health, and LTCHs.

14 About 42 percent of hospital discharges result in
15 PAC use.

16 There were over 29,000 providers with over 80
17 percent of these being home health agencies and SNFs.
18 Medicare beneficiaries had about 9.6 million encounters
19 across the four provider types in 2013, and I would note
20 that there is also substantial geographic variation in the
21 use of PAC services, more than we have observed in other
22 sectors. For example, PAC spending varied by a factor of

1 two between the area at the 10th percentile and the area of
2 the 90th percentile.

3 Post-acute care has grown rapidly in recent years,
4 doubling to \$59 billion in 2001 to 2012. During this
5 period, the Commission has made many observations that raise
6 questions about the value of this growth. Medicare margins
7 in the PPS have been high for much of this period. For
8 example, for home health and SNF, margins have been in the
9 double digits every year since 2001.

10 Like other providers, we have noted wide variation
11 in profitability. This reflects two factors: differences
12 in cost per unit of service, be it a day or episode of care;
13 and it also reflects differences in payment per unit of
14 service. This can reflect differences in patient severity,
15 but it can also reflect that some providers have been more
16 aggressive in diagnostic coding to increase payment or
17 favoring services that pay more.

18 There has been rapid growth, particularly in
19 skilled nursing facilities and home health, in payments for
20 patients that receive therapy services. This is
21 particularly troublesome because in these settings Medicare
22 uses the amount of therapy provided as a payment factor.

1 The Commission has recommended that Medicare eliminate the
2 amount of services as a payment factor in these systems, but
3 Medicare has yet to act on this.

4 We would also note that in the last decade most of
5 the new providers that have entered the Medicare market in
6 these four settings have been for-profit. In terms of
7 quality, we have seen little improvement in most indicators
8 in our reviews of PAC payment adequacy.

9 The Commission works to improve the PAC payment
10 systems through our annual review of payment adequacy, which
11 includes our recommendations on the payment update.

12 We also make recommendations to align incentives
13 and improve care, such as our recommendations to create
14 readmissions policies for home health and SNF.

15 However, the Commission's primary concern is that
16 having separate payment systems for post-acute care does not
17 facilitate rational pricing or coordinated care. The PAC
18 settings overlap in the patients they serve and the services
19 they provide, leading to Medicare having different prices
20 for similar patients based on the site of service.

21 The Commission believes that Medicare needs to
22 move to a more unified approach to payment. We recommended

1 that Medicare collect patient assessment data in a uniform
2 manner from all four settings. This data is required to
3 develop a common PAC payment system. The recently enacted
4 IMPACT Act includes new requirements for uniform data
5 collection. However, it will take several years to field
6 and analyze this data, and 2023 is the earliest a payment
7 system could be implemented from this data.

8 In the near term, the Commission believes that
9 additional actions can be taken to improve the value of the
10 PAC Medicare purchases. Our readmissions policies are two
11 examples of this, and Carol will present a site-neutral
12 policy in a moment that is another example.

13 The Commission interviewed private sector entities
14 to identify additional strategies for improving post-acute
15 care. One popular method many ACOs and hospital systems are
16 using is the establishment of partnerships or collaboratives
17 with PAC providers. In this approach, hospitals identify
18 high-performing PAC providers and develop additional care
19 coordination and quality improvement efforts with them.

20 To the extent permissible, hospitals will
21 recommend these providers to its patients. However, these
22 hospital-PAC provider partnerships are voluntary.

1 Beneficiary choice is protected as they are not required to
2 choose a recommended provider. We will be looking into
3 approaches that allow referring entities such as hospitals
4 greater latitude to refer beneficiaries to high-quality PAC
5 providers.

6 Other approaches could rely on beneficiary
7 incentives. This could take several forms, such as the
8 increased provision of consumer information on the quality
9 of available PAC providers or the use of tiered cost sharing
10 to encourage the use of providers with better performance on
11 quality measures.

12 DR. CARTER: Evan has outlined the changes we
13 anticipate for post-acute care in the longer term and
14 strategies Medicare might consider to better manage this
15 care. But in the near term, we believe Medicare can move in
16 the direction of more uniform payments across settings. We
17 know that different PAC settings can treat beneficiaries
18 recovering from the same acute conditions. Yet, although
19 the patients and their conditions are similar, Medicare's
20 payments can differ considerably.

21 A site-neutral policy would align payments between
22 IRFs and SNFs for select conditions frequently treated in

1 both settings.

2 The Commission has taken a deliberative approach
3 to identify conditions that may be considered for site-
4 neutral payments. Consistent with other site-neutral work,
5 the Commission focused on conditions where the majority of
6 cases are treated in SNFs, even in markets that have IRFs,
7 and where the risk profiles of the patients in the two
8 settings are similar. Remember that 30 percent of
9 beneficiaries live in markets without IRFs, and these
10 beneficiaries get their care elsewhere.

11 We found that for the conditions we focused on,
12 the patients had similar risk profiles, with SNF patients
13 tending to be older and sicker. This indicates that SNFs
14 could treat even the medically complex patients, and in
15 markets without IRFs, they already do.

16 To ensure that it is proceeding cautiously, the
17 Commission has also examined differences in outcomes. Our
18 research and analysis found that IRFs do not consistently
19 have better outcomes.

20 There are 22 conditions that met our criteria:
21 the five orthopedic conditions we examined in June and the
22 17 additional conditions we discussed last month. They are

1 a mix of orthopedic, pulmonary, cardiac, and infections.
2 Together, they comprise 30 percent of IRF cases and
3 spending, but under the site-neutral policy we've outlined,
4 total payments to IRFs would be lowered by about 7 percent.

5 And note that we're not proposing specific
6 conditions for the policy. The Secretary should go through
7 its own process using explicit criteria to identify
8 conditions that would be covered by the policy.

9 The SNF-IRF site-neutral policy has several
10 components.

11 First, for selected conditions, IRFs would be paid
12 the average SNF payment per discharge as the IRF base rate.
13 IRFs would continue to receive add-on payments.

14 For select conditions, IRFs would get relief from
15 regulations regarding how care is furnished, such as the
16 "intensive therapy" requirement and the frequency of face-
17 to-face physician visits.

18 It is likely that the 60 percent rule will need to
19 be adjusted to remove site-neutral conditions from the
20 calculation. Jay, you asked for more discussion of this in
21 the chapter, which we added.

22 Finally, CMS should gather stakeholder input on

1 the criteria it used and the conditions it identified for
2 site-neutral payments using a notice and comment period.

3 It's hard to estimate how IRFs will react to the
4 policy. IRFs are likely to continue to treat site-neutral
5 conditions because they will be relieved of some of their
6 regulatory requirements for site-neutral conditions. IRFs
7 can lower their costs by changing the intensity and mix of
8 services they furnish.

9 Another reason we think IRFs will continue to
10 treat these cases is their relatively low occupancy rates,
11 and we know the SNF PPS is highly profitable.

12 On the other hand, some IRFs may opt to no longer
13 treat these cases. In this case, the industry may contract
14 and shift their mix of cases just as it did with the 60
15 percent rule when that was reinforced.

16 Craig, you asked about hospital-based IRFs, and
17 we've added information in the chapter about them. While
18 the average Medicare margin for hospital-based units is
19 nominally positive, they add about a percentage point to the
20 total bottom line of the hospital.

21 Warner, you asked about the share of hospitals
22 that have both IRFs and SNFs. About 185 of the 500

1 hospitals with IRF units also have SNF units. These
2 facilities may have an advantage over other facilities to
3 shift their cases and adjust their coding to maximize their
4 total facility revenues.

5 Kathy, you asked about beneficiary liability, and
6 we added text to the chapter and discussed this at the
7 December meeting.

8 This leads us to our draft recommendation. It
9 reads:

10 The Congress should direct the Secretary of Health
11 and Human Services to eliminate the differences in payments
12 between inpatient rehabilitation facilities and skilled
13 nursing facilities for selected conditions. The reductions
14 to inpatient rehabilitation hospital payments should be
15 phased in over three years. Inpatient rehabilitation
16 facilities should receive relief from regulations specifying
17 the intensity and mix of services for site-neutral
18 conditions.

19 Note that the recommendation does not specify
20 conditions. The text below the bold-face recommendation
21 would note that CMS should use its rulemaking process to
22 gather input from stakeholders on the criteria it uses and

1 the conditions it identifies for site-neutral payments.

2 The discussion also notes that IRF base payments
3 would be set equal to the average SNF payment per discharge
4 and that the policy would not change the add-on payments for
5 IRFs.

6 In terms of impacts, the recommendation would
7 lower program spending relative to current law. The five-
8 year estimate is between \$1 and \$5 billion. This is
9 consistent with our analysis that found that spending would
10 be \$500 million a year lower, but with a three-year
11 transition, the first-year savings would be lower than this.

12 For providers, payments to IRFs would be lower.
13 We expect IRFs to continue to treat these cases and to
14 adjust their costs during the transition. If site-neutral
15 cases are shifted, SNFs will see an increase in their
16 volume.

17 For beneficiaries, we do not anticipate negative
18 impacts because we do not expect to see a large shift from
19 one setting to the other, and we do not see consistent
20 differences in outcomes between the two settings. And as
21 with any policy, we will monitor the impacts of this policy
22 and recommend a change if warranted.

1 And with that, we're glad to answer any questions
2 you might have.

3 MR. HACKBARTH: Okay. Good job.

4 Again, we'll do two rounds, clarifying questions
5 and then broader comments. We'll just come down the row
6 here.

7 DR. SAMITT: Thanks very much for a great chapter.
8 I'm looking at the reading materials, page 13, and what I
9 didn't understand was something that described the need to
10 refine and recalibrate CMGs in response to the
11 recommendations regarding site-neutral payments. And I'm
12 not sure I understood this. If we recalibrate the other
13 CMGs, would we still see a 7 percent reduction in payments
14 to IRFs? So that's the piece of the report that I didn't
15 fully understand.

16 DR. CARTER: So the reason why we think that the
17 payments for the non-site-neutral cases need to be
18 recalibrated is, relative to site-neutral cases, if you
19 don't recalibrate, the other cases might appear more costly
20 in relative terms, even though nothing about them has
21 changed. And so in relative terms, we need to sort of
22 recalibrate the weights just so that as a result of

1 implementing the site-neutral payment, we don't want
2 payments for the other cases to increase. And so it's a way
3 of keeping the policy budget neutral, if you will, for the
4 non-site-neutral patients.

5 DR. SAMITT: So the 7 percent impact would still
6 be preserved --

7 DR. CARTER: Yes.

8 DR. SAMITT: -- despite that recalibration.

9 DR. CARTER: Right.

10 DR. SAMITT: Thank you.

11 DR. MILLER: And Craig zeroed right in on multiple
12 conversations in trying to craft the language this way and
13 that way, and this was our best shot. We'll take another
14 one because it was a bit difficult to get down on paper what
15 we were trying to say.

16 DR. SAMITT: Thanks.

17 MS. BUTO: Just two questions. One was whether --
18 I know we've said in several versions of this that we would
19 not consider adjusting the teaching or disproportionate
20 share payments to IRFs. But if you're going to be paying
21 site-neutral payment amounts for certain conditions, why
22 wouldn't you look at that? I'm just curious why we didn't

1 look at that, the add-on payments. I know there's an issue
2 of not creating even more disruption for the IRF. I
3 understand that. But was there another reason beyond that?

4 DR. MILLER: I mean, what I would have said is the
5 concern over additional disruption, and, two, it would have
6 probably led to more complex questions about how to change
7 it --

8 MS. BUTO: Recalibrating?

9 DR. MILLER: Yeah, right along Craig's line. And
10 in terms of the conversation for you guys, we were trying to
11 keep it focused. We could have gone further afield, but I
12 think we would still be at this conversation.

13 MS. BUTO: Okay. That's helpful.

14 And the other one is just a question of whether
15 you consulted at all with the VA in doing this, because I
16 know you did some consultation just because they're sort of
17 in many ways the gold standard for rehab for a lot of these
18 kinds of procedures.

19 DR. CARTER: In our work looking at stroke
20 patients, we did talk with one researcher at a VA who did --
21 I should say I think she had a dual -- I think she was at a
22 university and spent some of her time in a VA. But that was

1 limited to sort of how they thought about managing stroke
2 patients.

3 MS. BUTO: I assume CMS will reach out, among
4 others, to the VA and other agencies as well as it looks at
5 this issue.

6 DR. CROSSON: Thanks, Carol. This is good work on
7 a very complicated area. I just have one question in
8 reading this text through again. For those areas of the
9 country that don't have IRFs, do we know how much of the
10 care that would have been in an IRF is rendered in a SNF
11 versus in an acute-care hospital that happens to provide
12 rehab services?

13 DR. CARTER: I personally haven't looked at that.
14 Have you looked at that?

15 MS. KELLEY: No.

16 DR. CARTER: No, so I think the answer is we
17 haven't looked at that.

18 MR. KUHN: So two questions. First, a little bit
19 about beneficiary liability, beneficiary benefit. So with
20 these procedures now in the IRF at the SNF rate or at the
21 lower rate, would this now deplete the SNF 100-day benefit,
22 or would this count towards the Part A patient benefit with

1 the ability for the beneficiary to regenerate days after the
2 spell of illness?

3 DR. MILLER: If I understand the question, this is
4 still an IRF stay. It's just a different rate.

5 DR. CARTER: Right. So we're just talking about
6 paying them a different rate.

7 MR. KUHN: Got it. That's what I wanted to be
8 clear on, because if it is, then the ability to regenerate
9 the benefit as in Part A inpatient stay. Thank you for
10 that. That's helpful.

11 And then the second thing, on page 21 and 22 in
12 the reading, we talk about the opportunity here for
13 strategies to manage post-acute care, and part of that
14 talked about quality. So obviously those folks that go to a
15 SNF to get these benefits, that information will be in
16 Nursing Home Compare, but there is no comparable public
17 reporting of the quality for IRS. Is that correct?

18 DR. CARTER: There isn't any comparable reporting,
19 right.

20 MR. KUHN: Thank you.

21 MR. HACKBARTH: Clarifying questions?

22 MR. ARMSTRONG: I think this is defined as a

1 clarifying question. I'm looking at the recommendation
2 itself, and we're very specific about a three-year
3 implementation period. Is there a reason why three years is
4 the right period of time?

5 DR. CARTER: It is a time period we've used for
6 other policies, but probably the short answer is no.

7 DR. SAMITT: So not too long, not too short.

8 DR. CARTER: Right. I think we do want to give--

9 [Laughter.]

10 MR. HACKBARTH: Exactly.

11 DR. MILLER: The answer is no.

12 DR. CARTER: I think you want some period of time
13 so that IRFs can adjust their cost structures, so I don't
14 know if three years is a magical number, but it's certainly
15 more than one.

16 MR. HACKBARTH: It also provides an opportunity to
17 assess what's going on if there are unexpected results. It
18 provides an opportunity to intervene. And it is what we've
19 commonly used for the site-neutral transitions.

20 MR. ARMSTRONG: Yeah, I just didn't know if there
21 was some particular trigger or milestone or anything.

22 MR. HACKBARTH: No. Any other clarifying

1 questions?

2 [No response.]

3 MR. HACKBARTH: Seeing none, we're open for Round
4 2 questions or comments.

5 MR. ARMSTRONG: Well, I just would quickly follow
6 up on my last comment by saying, first, I fully support this
7 recommendation. It's consistent with policy; we've affirmed
8 over and over again.

9 I actually think this is long overdue and have far
10 less concern about adjustments to cost structures, and given
11 how we've seen endless delays in the implementation of many
12 of our recommendations, I just think that I understand the
13 need to monitor the implications of this change, and in a
14 three-year period of time, that gives you that opportunity.
15 But I feel very impatient about this and just think this is
16 too slow.

17 DR. HOADLEY: Yeah, I support this recommendation,
18 and I think one of the statements that we talked about at
19 the last meeting is that we're not claiming in this that
20 we've got the definitive list of conditions that belong in
21 this. I think what we're claiming is that we've got the
22 right direction to move. It's in line with a broad

1 principle, a site-neutral payment that we've done on a
2 number of things, and that we're offering what we hope is
3 considerable insight into how to get the right list and
4 maybe even something close to the right list, but that we
5 recognize that that's open for further discussion at CMS and
6 notice and comment and all that kind of thing. And I think
7 that's just an important thing to emphasize as we have this
8 conversation.

9 I think the only other thing is that we recognize
10 that there's some regulatory relief aspects to this, and
11 that's built into the recommendation. I think that's
12 important too.

13 I guess my final thought, as I thought about this
14 issue, sometimes the conversation about this feels like it's
15 saying we don't want people to go to the IRFs anymore, and
16 as you've pointed out, I think, very clearly in the
17 presentation, this is a change in payment to them. It
18 doesn't necessarily say -- and, in fact, we expect many of
19 them will adjust and can make the adjustments readily to
20 still accept these kinds of patients under a different
21 payment mechanism. There may be some that choose not to do
22 so, and that's fine, but this isn't shutting down the use of

1 this type of facility for these types of patients.

2 MR. HACKBARTH: Dave.

3 DR. NERENZ: I think I actually had a very similar
4 comment or question to what Jack just said, so I'll build on
5 that a little bit.

6 The language on Slide 12 near the bottom sort of
7 makes a very clear statement about we don't expect shifts on
8 the site of care, and I wonder about that not only just
9 here, but in all of our site-neutral recommendations.

10 I am, I guess, maybe questioning this, but I'm not
11 sure what we as a group are thinking about this. Sort of
12 generically, if these policies do change, sort of one or two
13 things can happen. Either the site of care really does
14 shift, meaning people quit being treated in the high-cost
15 and become more treated in the low-cost setting, and I think
16 there's be some reasons to favor that as a desirable effect,
17 or I think, sort of as Jack said, you can keep receiving
18 care in the higher cost site, but perhaps with some staffing
19 and cost or other adjustment within that site or some
20 adjustment.

21 I am, I guess, just observing that as we make
22 these recommendations, to the extent we can, I'd like us to

1 be a little more specific about either what we think will
2 happen or what we want to happen. It's not just here, but
3 it's across this set of site-neutral recommendations.

4 MR. HACKBARTH: From my perspective -- and I
5 invite Carol and Dana to chime in here -- let me just focus
6 on this one and LTCHs.

7 One of the issues here is that a certain level of
8 costs are imposed on LTCHs and IRFs by regulation. It's not
9 necessarily clinically driven, that, oh, this is exactly the
10 configuration, the staffing that you'd need in order to
11 provide quality care to these patients. It is an artifact
12 of regulation, so that's a hypothesis, and that, I think, is
13 part of why we believe that if you change the payment and
14 reduce the regulation, you may find IRFs continuing to care
15 for some of these patients or LTCHs continuing to care for
16 non-CCI patients with a new cost structure. But that's a
17 hypothesis. We will only know for sure once we actually
18 start to move, and again, it goes back to the transition.
19 That's one of the things that we can look at during the
20 transition and assess are things unfolding as we anticipated
21 they would.

22 DR. NERENZ: That is reasonable, and on that line,

1 we may actually think that we're essentially agnostic to
2 what balance of these two kind of things occur because of
3 that. We say either it can move to the lower cost setting
4 because of the rules in place there and the achievable
5 outcomes there, or we say but, alternatively, it would be
6 fine if it stays in the higher cost setting with some
7 regulatory relief and therefore a reduction of some of the
8 cost-driven not by clinical, and we say both are fine. We
9 don't care.

10 But I guess I just would like us to be conscious
11 of those issues, and in some recommendations like this in
12 the future, we may explicitly want to indicate that we like
13 this response rather than that response.

14 MR. HACKBARTH: Okay. I have Herb and then Kathy
15 and Craig.

16 MR. KUHN: So, as I look at this, picking up a
17 little bit on Dave's point, in the inpatient hospital side,
18 we already have a similar-type program, at least in terms of
19 moving patients from one setting to another, and it's called
20 swingbed program.

21 So, basically, in rural hospitals of less than 100
22 beds or critical access hospital, someone can be on the

1 inpatient bed one day. The very next day, they can be
2 discharged and then immediately readmitted into a SNF
3 benefit. They don't leave the bed. All they do is start a
4 new chart and a new payment system and a new regulatory
5 framework began as part of that.

6 So this whole concept of a different regulatory
7 framework within the same kind of organization is not a
8 foreign concept to Medicare. It's been done before. It's
9 out there. The licensure groups and the states that survey
10 facilities understand it. It's functional. It's works. So
11 I don't think it's all that of a foreign concept in that
12 regard.

13 Having said that, I think this proposal has come a
14 long way since we talked about it last time. I think the
15 whole notion of the recalculation of the 60 percent
16 threshold makes a lot of sense.

17 I think just, as clarified here a little bit ago
18 for me at least, keeping this as an IRF benefit -- it's not
19 a SNF benefit -- I think is very important, not only for the
20 beneficiary, but for those organizations, those
21 institutions, not having a specific list, but a formal
22 notice and comment period that's very public as part of that

1 process. Also, it lets the community-at-large to engage
2 with Congress to think about that as well, what would be
3 appropriate.

4 A three-year transition, I think makes a lot of
5 sense because I think also the transition gives us a chance
6 to monitor for access issues. As we know, SNFs tend to a
7 have high-occupancy rate versus IRFs which has a lower
8 occupancy rate, and if we do see any kind of movement there
9 and it creates any access issues, a transition gives us a
10 chance to monitor and look at that. So I think all of these
11 are wonderful improvements and I think helps think this
12 thing through in a policy way.

13 One question I did have, at the last meeting, I
14 raised a bit of a concern about if there was any ambiguity
15 that these organizations might face. Now, they don't see it
16 in a swingbed program, but that it would create an
17 opportunity for program integrity and audit opportunities
18 out there.

19 I know there was some language added to the paper
20 about auditing, but it tended to be on the other side about
21 potential gaming by institutions, but less so on making sure
22 that there is clear bright lines of what expected of

1 performance, so that they don't get audited in a way that
2 created new vulnerabilities. Was there any more thought
3 about that, or was there any way we can think about that
4 part a little bit more?

5 DR. CARTER: Well, the one aspect -- and I think
6 it's in the paper -- that we did discuss was would you want
7 the PAC providers identifying -- how do you want to identify
8 the cases? And if you use PAC providers' coding to identify
9 cases, you might see providers steering cases towards or
10 away site-neutral conditions, and so we've thought about,
11 well, that would be one reason to use the inpatient DRG or
12 the coding from the hospital stay to identify these cases,
13 so it separates out a little bit the identification of the
14 case in terms of how it's going to be paid. That's the one
15 aspect we did have.

16 MR. KUHN: Thanks, Carol. That's helpful, and
17 it's clear you've all thought about this more. I just want
18 to make sure that we don't at least signal in one way or the
19 other that we don't create new vulnerabilities for program
20 integrity and invite more recovery contractor program
21 activity here.

22 MS. BUTO: I remain -- I have still some

1 uneasiness about this, about this area, but I am comfortable
2 with the approach knowing that the Secretary would seek
3 notice and comment on the criteria and the conditions to
4 which this would apply. And the reason is we don't have a
5 common assessment tool. We have some outcomes information
6 that would suggest that IRFs might be a better setting for
7 some of these conditions that we've identified anyway, not
8 definitive, again, because we don't do apples to apples.

9 So I'm a little bit where Dave was. I'm not sure
10 what's going to happen, and whenever there is a possibility
11 of unintended consequences, I remain nervous.

12 I think even if IRFs continue to take these
13 patients with lower payment, I think we're anticipating they
14 would lower the cost of care related to these patients. So
15 if there is any question about some patients really
16 benefitting from intensive therapy, that remains an outcome
17 or an impact that we won't know until it's actually tested.

18 So, frankly, I can support the recommendation. I
19 would really love it if the recommendation, which currently
20 reads that, "Congress should direct the Secretary of HHS to
21 eliminate the differences in payment rates between inpatient
22 rehab facilities and SNFs for selected conditions," could

1 add words like "when outcomes of care are comparable in both
2 settings," or something that points to the fact that we have
3 identified these not just based on the 50 percent rule,
4 because some of these are like 55-45, they are not 80-20,
5 but that we also considered the issue of outcomes, and that
6 we think the Secretary should consider that as well, some
7 degree of these patients really are very similar, and they
8 can be treated and paid for basically on a comparable basis.

9 MR. HACKBARTH: I agree with the basic point. I
10 think all along, it's been clear that we're talking about
11 comparable outcomes, so I have no concern about that.

12 I would like that to be crystal clear in the
13 accompanying text that that's what we're talking about is
14 for comparable outcomes.

15 I am reluctant to get into adding language,
16 changing the language in the recommendation itself, again,
17 not because I disagree with the point, but just I'm not sure
18 that we want to start tinkering with the recommendation.

19 I do think that the Secretary choosing the final
20 conditions through notice and comment is an important step.
21 I think that's the way it should be done, and my experience
22 with that -- and I think your experience with notice and

1 comment rulemaking and Herb's is that it's, A, a pretty
2 rigorous process and, B, if anything, it tends to be a
3 pretty conservative process because they get inundated with
4 comments. There's lots of pressure from various sources.

5 I feel comfortable that they will come to an
6 appropriate data-driven, conservative result here, and so
7 okay.

8 Craig.

9 DR. SAMITT: So thank you very much for the
10 follow-up information. I support the recommendation.

11 The only contribution that I would want to make,
12 we talk about the 60 percent threshold and the complications
13 of removing the site-neutral cases from both the numerator
14 and the denominator, and what struck me were all the
15 discussions that we had about the fact that these may very
16 well stay IRF admissions, and some would argue that in some
17 cases, they may be appropriate IRF admissions. They're just
18 going to be paid differently.

19 So one thing that wasn't referenced in the chapter
20 that I'd have us consider is why could we not just simply
21 leave these cases untouched, that they still apply to the 60
22 percent threshold. That may remove some of the complexity

1 of recalculating the threshold if we remove them, just
2 another way to consider this as an alternative.

3 DR. MILLER: You're moving on?

4 MR. HACKBARTH: Well, my response --

5 DR. MILLER: Okay.

6 MR. HACKBARTH: -- is that the intent of the 60
7 percent rule is to determine what type of patients should
8 carry with them a higher level of payment. We're saying
9 here that we don't think that these conditions, these
10 patients should qualify for a higher level of payment. That
11 seems to me to require that they be taken out of the 60
12 percent calculation. Correct me if I'm wrong.

13 DR. CARTER: No, I think that's right. It's sort
14 of sending a mixed signal of, "Oh, this condition counts
15 towards qualifying you as an IRF, but we're going to pay you
16 a SNF rate, and so that's why we've thought that the
17 conditions need to be pulled out of the calculation."

18 MR. HACKBARTH: Any others?

19 [No response.]

20 MR. HACKBARTH: Okay. I think we are ready to
21 vote. All in favor of the recommendation, please raise your
22 hand.

1 [Show of hands.]

2 MR. HACKBARTH: Opposed?

3 [None.]

4 MR. HACKBARTH: Abstentions?

5 [None.]

6 MR. HACKBARTH: Well done. Thank you very much.

7 We'll now have our public comment period before
8 lunch.

9 [Pause.]

10 MR. HACKBARTH: Anybody else intending to make a
11 comment? I'd like to see people line up at the microphone
12 so I know how many we've got.

13 [Pause.]

14 MR. HACKBARTH: Okay. So, let me begin with the
15 ground rules. Please begin by identifying yourself and your
16 organization. When the red light comes back on, that
17 signifies the end of your two-minute period. And, as
18 always, I'd remind people, this isn't your only or your best
19 opportunity to contribute to the Commission's work. The
20 best opportunity is to talk to our staff. Second is write
21 letters to Commissioners. And, third is file comments on
22 our -- post comments on our website.

1 With that, your two minutes begins.

2 MS. KENDRICK: Thank you. My name is Martha
3 Kendrick and I'm here today on behalf of the American
4 Medical Rehabilitation Providers Association. AMRPA is
5 extremely disappointed that the Commissioners have voted to
6 recommend post-acute care site neutral payment policy.
7 Stated most simply, the site, care, and outcomes between
8 rehabilitation hospitals and SNFs are not neutral and the
9 starting premise for the site neutral is, therefore, not
10 met.

11 When the 22 MS-DRG codes that MedPAC considered
12 for site neutral payments were shared with AMRPA after the
13 December meeting, AMRPA contacted medical directors who have
14 both rehabilitation hospital and SNF beds to help us
15 understand how this recommendation would affect the care
16 settings and the patients served. Medical directors report
17 that MedPAC substantially underestimates the impact of
18 applying site neutral payment policy to these 22 conditions.
19 One Statewide analysis concludes that the selected MS-DRGs
20 account for approximately 37 percent of Medicare fee-for-
21 service cases discharged to IRFs in 2013.

22 It appears MedPAC is targeting MS-DRG codes that

1 result in many rehabilitation hospital admissions, catching
2 both many compliant diagnoses as well as a significant
3 number of the sickest medical and general cases. Some would
4 not be able to -- some IRFs would not be able to afford to
5 care for these complex medical patients under a site neutral
6 policy. IRF patients with the identified conditions who
7 have high medical acuity may need to stay longer in acute
8 hospitals or be shifted to LTCHs if payments are equalized
9 between nursing homes and rehab hospitals. A post-acute
10 care site neutral policy may, in fact, generate new Medicare
11 spending which would offset the cuts to IRFs.

12 It's important for MedPAC to understand that the
13 MS-DRG diagnosis in an acute care hospital is not indicative
14 of the admitting diagnosis in the IRF, the patient's
15 functional status and the primary clinical needs during the
16 restorative stage of care, and is not a significant factor
17 for acute care hospitals in developing a post-discharge plan
18 of care. MS-DRGs are not used in either SNFs or IRFs, and
19 the diagnostic coding does not match or crosswalk the ICD-9
20 codes used in post-acute settings. Therefore, there's no
21 way to analyze the short-term clinical outcomes, let alone
22 the long-term ones.

1 AMRPA is concerned that MedPAC's limited analysis
2 excludes patients who die, and this is a final fatal flaw in
3 the Commission's approach. The recent Dobson DaVanzo study
4 and others have convincingly demonstrated that mortality
5 differences are related to the site of care and you cannot
6 ignore those differences for payment policy. If IRFs are
7 unable to consider factors such as the need for a
8 rehabilitation physician, the intensity of therapy services,
9 and an interdisciplinary approach to care, this policy would
10 reduce payment admissions to a financial decision rather
11 than a decision about medical appropriateness. A site
12 neutral policy will disincentivize IRFs from treating high-
13 cost patients.

14 The feedback and data provided by these medical
15 directors underscores AMRPA's concern about the scope and
16 reach of MedPAC's recommendation. We would be pleased to
17 meet and discuss our full comments received from the medical
18 directors.

19 Thank you.

20 MR. POSTELL: Hi. Good afternoon. My name is
21 Steve Postell [phonetic]. I'm representing the American
22 Academy of Physical Medicine and Rehabilitation, AAPM&R. I

1 just wanted to say that we had submitted two comment
2 letters, one in December and one yesterday, and AAPM&R
3 represents physicians both in IRFs and SNFs.

4 But, just to highlight the points that we wanted
5 to make, just two main points from our physicians, that,
6 one, the DRGs in relation to the site neutral payment model,
7 to which site neutral payments would apply, are too broad
8 and do not recognize that many of these patients have
9 moderate to severe co-morbid conditions that would make
10 treatment in a SNF a risky and perhaps dangerous
11 proposition.

12 And the second one is that there is a wide
13 variation in SNFs, nursing homes, and Medicare has minimal
14 requirements that such settings must meet in order to treat
15 Medicare patients. In order to protect patients, Medicare
16 policy must be designed to provide appropriate care to all
17 beneficiaries in need of rehabilitation services, not just
18 those who happen to be sent to a SNF that has developed a
19 substantial therapy program.

20 Thank you very much for your time.

21 MR. THOMAS: Good morning. I'm Peter Thomas. I'm
22 with the Coalition to Preserve Rehabilitation. The

1 Coalition is comprised of about 30 organizations, five of
2 which form a steering committee, including the Brain Injury
3 Association, the Multiple Sclerosis Society, the Center for
4 Medicare Advocacy, which will speak individually right after
5 me, the United Spinal Association, and the Reed Foundation
6 [phonetic].

7 I've spoken before, in December. We submitted now
8 two documents, one in December and one yesterday, to the
9 website, so we hope you'll take that into consideration.

10 It's a bit odd to be talking about this now that
11 you've already voted, so I'm not sure how relevant this
12 comment is, but I would say that the concerns that I heard
13 from some of the Commissioners about the differences in
14 quality, the differences in outcome between the two settings
15 is real. There is very good data that suggests that it's
16 real. There are peer-reviewed journal articles and evidence
17 that demonstrates that when you treat various patients, some
18 of which were on that list of 22 conditions, in both
19 settings, you get significantly different outcomes between
20 SNFs and IRFs. And, so, we can't really understand how, I
21 guess, the proposal is moving forward without really fully
22 recognizing that flaw.

1 And, we are concerned from a beneficiary
2 perspective that beneficiaries will be ultimately met at the
3 IRF front door with a financial disincentive on their back
4 if they show up with one of the conditions that the
5 Secretary determines is appropriate for site neutral
6 payment, and that's a barrier to access to appropriate care,
7 at the right setting and the right time, and the right
8 intensity and coordination of care necessary.

9 So, we have serious concerns about the proposal.
10 We've made them before. It doesn't seem to be having the
11 desired impact, but we do appreciate your at least
12 considering our views.

13 Thank you.

14 MS. EDELMAN: My name is Toby Edelman. I'm an
15 attorney with the Center for Medicare Advocacy, a public
16 interest law firm that represents Medicare beneficiaries.
17 We're a member of the Committee to Preserve Rehabilitation.

18 I spoke also in December, and I would say that we
19 agree with the points made by the three speakers before us.
20 I'd like to make three very short points of our own.

21 First, the Center believes that a diagnosis-based
22 system is not consistent with the Medicare statute's

1 requirement for individualized assessments. We have
2 successfully litigated a number of cases over the years
3 challenging the mechanistic use of rules of thumb in
4 Medicare.

5 Second, a new report by MedPAC and the Urban
6 Institute this week calling for significant changes in how
7 Medicare pays for care in SNFs, particularly because of
8 overpayments for therapy services, does not support the
9 proposal for site neutral payments at this time.

10 But, finally and most importantly, what we're
11 concerned about is what IRFs would look like after site
12 neutral payments were implemented. You recommend regulatory
13 relief as part of the site neutral payment proposal. What
14 that means to me, essentially, is watering down the
15 standards for IRFs so that they more closely resemble SNFs,
16 particularly with respect to the therapy that needs to be
17 provided and medical oversight. The result will be that
18 IRFs will probably no longer be able to provide the
19 intensive therapy that they currently provide to patients
20 who need and benefit from that intensive level of care, and
21 the IRF level of care that we know today will essentially be
22 lost for Medicare patients.

1 Thank you.

2 MR. HACKBARTH: Okay. Thank you.

3 We are adjourned for lunch and will reconvene at
4 12:45.

5 [Whereupon, at 11:34 a.m., the meeting was
6 recessed, to reconvene at 12:45 p.m. this same day.]

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1 category are ASCs, ESRD facilities, hospice, inpatient rehab
2 facilities, and long-term-care hospitals.

3 For these, as for all of our update
4 recommendations, we go through a payment adequacy analysis
5 during which we consider a variety of factors, including
6 beneficiary access to care, quality of care, access to
7 capital for providers, financial margins, et cetera, and
8 weigh those factors in reaching a final recommendation for
9 an update. And at our December meeting, there was an
10 extensive staff presentation on each of these provider
11 groups where the relevant data were presented and discussed
12 by Commissioners.

13 As I said, there was unanimous agreement in
14 December on the recommendations that we will be voting on
15 today, so based on that, I have decided that we won't go
16 through still another round of staff presentations and
17 discussions but, rather, move directly to votes for each of
18 these five provider groups.

19 I do want to emphasize for those of you who
20 weren't here in December that there has been extensive
21 discussion of these recommendations, but we won't redo it
22 all again today.

1 The reason for organizing things this way is that,
2 as you may know, we also have a June report to Congress to
3 formulate recommendations for our June report material on
4 which we don't make recommendations. We now will only have
5 two meetings left in our annual cycle, March and April, and
6 so it is important to use our time efficiently, including
7 the remainder of this week's meeting, so that we can get on
8 with the work of preparing material for our June report.
9 And so I wanted to handle the update discussions as
10 efficiently as possible.

11 In addition to these five updates that we will be
12 voting on shortly, there are four other recommendations that
13 are parts of larger packages, and those four groups are for
14 physicians, hospitals, home health agencies, and skilled
15 nursing facilities. And for those we have recommendations
16 that include multiple parts and span more than one year, and
17 so we are rerunning past recommendations we have made for
18 each of those groups -- physicians, hospitals, skilled
19 nursing facilities, and home health agencies. We will rerun
20 those multipart recommendations in our March report. The
21 Commission still stands behind and believes, indeed
22 strongly, that those are very important recommendations, but

1 they will not be voted on here. But we are simply rerunning
2 our past recommendations in those areas.

3 So have I covered everything? So, with that
4 preface, I want to turn now to our five update
5 recommendations, and I think ASCs are first up here. Dan,
6 is that right?

7 DR. ZABINSKI: Okay. We'll start with the ASC
8 update. The questions that the Commissioners asked at the
9 December meeting have been addressed in the draft chapter;
10 in particular, Alice, we have a text box about the
11 differences between the patients that are served in ASCs
12 versus those that are served in OPDs. And, Bill Hall, we
13 have added discussion about the ASC services provided beyond
14 the 20 most frequently provided listed in Table 5 of the
15 paper.

16 Facts about ASCs in 2013 are that Medicare
17 payments to ASCs were \$3.7 billion, the number of ASCs was
18 5,364, and 3.4 million beneficiaries were treated in ASCs.

19 Also, beneficiaries' access to ASC services
20 continued to increase in 2013, as the number of
21 beneficiaries treated, the volume per beneficiary, and the
22 number of ASCs all increased.

1 Also, Medicare payments per beneficiary increased
2 in 2013 by an even 2.0 percent, which is net of the
3 sequester cut of 1.2 percent.

4 In addition, growth in the number of ASCs suggests
5 that access to capital has been adequate. Moreover, the
6 company that owns and operates the largest number of ASCs
7 was able obtain a \$1.7 billion loan in 2014.

8 Unfortunately, as in previous years, our analysis
9 is limited for two reasons.

10 First, even through CMS began collecting data on
11 quality measures in October of 2012, there is not yet
12 sufficient information to assess ASC quality.

13 Second, we can't assess margins or other cost-
14 based measures because ASCs do not submit cost data although
15 the Commission has recommended on several occasions that
16 these data be submitted. Also, CMS has not yet announced
17 plans to collect cost data.

18 So we have this draft recommendation that the
19 Congress should eliminate the update to the payment rates
20 for ambulatory surgical centers for calendar year 2016, and
21 the Congress should also require ambulatory surgical centers
22 to submit cost data.

1 In terms of implication, under current law ASCs
2 are projected to receive an update in 2016 of 0.9 percent,
3 which reflects a CPI-U of 1.4 percent minus a multifactor
4 productivity adjustment of 0.5 percent. Therefore, relative
5 to the statutory update, this draft recommendation would
6 produce small savings, and we estimate these savings of less
7 than \$50 million in the first year and less than \$1 billion
8 over five years. Our smallest savings category for the
9 five-year window is \$1 billion, and the savings would be
10 much less than that.

11 Because the number of ASCs and volume of services
12 has continued to grow, we do not anticipate this draft
13 recommendation would diminish beneficiaries' access to ASC
14 care or providers' willingness or ability to furnish those
15 services.

16 Finally, ASCs would incur some administrative
17 costs to submit the cost data.

18 I'll turn things back to Glenn.

19 MR. HACKBARTH: Any clarifications needed on this
20 recommendation before we vote?

21 [No response.]

22 MR. HACKBARTH: Okay. All in favor of the

1 recommendation, please raise your hand.

2 [Show of hands.]

3 MR. HACKBARTH: Opposed?

4 [No response.]

5 MR. HACKBARTH: Abstentions?

6 [No response.]

7 MR. HACKBARTH: Okay.

8 MS. RAY: Good afternoon. With respect to the
9 questions you asked us during the December meeting, we have
10 tried to address them in the draft chapter as indicated in
11 the cover memo. For example, Jay and Rita, in the anemia
12 management quality section, we have added the distribution
13 of hemoglobin levels and several outcome measures, including
14 stroke.

15 First, I will review some key facts about this
16 sector. Outpatient dialysis services are used to treat most
17 patients with end stage renal disease. In 2013, there were
18 about 376,000 Medicare fee-for-service dialysis
19 beneficiaries treated at 6,000 facilities and total spending
20 was about \$11 billion.

21 Next, I will summarize our findings on payment
22 adequacy. Access to care variables are favorable.

1 Treatment stations, a measure of dialysis capacity, is
2 keeping up with the growth in the number of dialysis
3 beneficiaries. For-profit and freestanding facilities
4 account for the increasing capacity.

5 Quality is improving for some measures. For
6 example, home dialysis is modestly increasing and rates of
7 hospital admissions and mortality are decreasing.

8 The dialysis industry appears to have good access
9 to capital. For example, during the last several years, the
10 two largest chains either acquired or purchased majority
11 stakes in multiple health care-related companies.

12 Moving to our analysis of Medicare payments and
13 provider costs, in 2013, the 2013 Medicare margin is 4.3
14 percent, and the 2015 Medicare margin is projected at 2.4
15 percent. Both data points include the impact of the
16 sequester.

17 This leads us to our draft recommendation. It
18 reads, "The Congress should eliminate the update to the
19 outpatient dialysis payment rate for calendar year 2016."

20 Regarding the implications of the draft
21 recommendation, we anticipate that this would lower spending
22 relative to current law, which, based on current estimates,

1 would increase the payment rate by 1.15 percent in 2016.
2 There may be increased financial pressure on some providers,
3 but we do not anticipate that it will impact their
4 willingness or ability to furnish care. We do not
5 anticipate this recommendation impacting beneficiaries.

6 Now, I'll turn it back to Glenn.

7 MR. HACKBARTH: Thank you, Nancy.

8 Any clarifications needed on this recommendation?

9 [No response.]

10 MR. HACKBARTH: Seeing none, let's vote. All in
11 favor of the recommendation, please raise your hand.

12 [Show of hands.]

13 MR. HACKBARTH: Opposed.

14 [No response.]

15 MR. HACKBARTH: Abstentions.

16 [No response.]

17 MR. HACKBARTH: Thank you, Nancy.

18 Next is hospice.

19 MS. NEUMAN: I'm going to briefly summarize the
20 indicators of hospice payment adequacy that we discussed in
21 December and that are described in detail in your mailing
22 materials. Those mailing materials also include some

1 additional material in response to your questions from
2 December. For example, Jay, we added more discussion of the
3 need for payment reform. Mary, we added discussion of the
4 IOM report. And, Herb, we added more information on live
5 discharge rates.

6 In 2013, more than 1.3 million Medicare
7 beneficiaries received hospice care furnished by more than
8 3,900 hospice providers, and Medicare paid those hospices
9 roughly \$15 billion.

10 Now, looking at our indicators of hospice payment
11 adequacy, indicators of access to care are favorable. The
12 supply of hospice providers continues to grow, increasing
13 more than five percent in 2013. For-profit providers
14 account almost entirely for this growth. Hospice use has
15 also increased. About 47.3 percent of Medicare decedents
16 used hospice in 2013, up from 46.7 percent in 2012. In
17 addition, average length of stay held steady in 2013.

18 Different from most other sectors, we do not have
19 quality data to examine for hospice providers currently.

20 In terms of access to capital, the continued
21 growth in the number of providers suggests capital is
22 accessible.

1 And, then, this brings us to margins. As you will
2 recall, our margin estimates assume cap overpayments are
3 fully returned to the government and exclude non-
4 reimbursable bereavement and volunteer costs. For 2012, we
5 estimate an aggregate Medicare margin of 10.1 percent. For
6 2015, we project an aggregate margin of 6.6 percent. The
7 2015 projection includes the effect of the sequester. The
8 2015 margin would be roughly two points higher if the
9 sequester were not in effect.

10 So, this brings us to the draft recommendation and
11 it reads, "The Congress should eliminate the update to the
12 hospice payment rates for fiscal year 2016."

13 The implications of this recommendation are a
14 decrease in spending relative to the statutory update of
15 between \$250 million and \$750 million over one year, and
16 between \$1 billion and \$5 billion over five years.

17 In terms of the impact on beneficiaries and
18 providers, we do not expect the draft recommendation to have
19 an adverse impact on providers' willingness or ability to
20 care for Medicare beneficiaries, nor do we expect it to have
21 an adverse impact on beneficiaries' access to care.

22 So, now, turning it over to Glenn.

1 MR. HACKBARTH: Thanks, Kim.

2 Any clarifying questions? Herb.

3 MR. KUHN: I just have one. Kim, I'm sorry, but
4 on Slide 10, where it looks at the margin of 10.1 percent,
5 should that be 2013, or is that the 2012?

6 MS. NEUMAN: It's 2012 in hospice because that's
7 the latest year we have complete data.

8 MR. KUHN: Okay. Thank you.

9 MR. HACKBARTH: Any other clarifying questions?

10 [No response.]

11 MR. HACKBARTH: Okay. All in favor of the
12 recommendation, please raise your hand.

13 [Show of hands.]

14 MR. HACKBARTH: Opposed.

15 [No response.]

16 MR. HACKBARTH: Abstentions.

17 [No response.]

18 MR. HACKBARTH: Thank you, Kim.

19 Next is inpatient rehab facilities, and for people
20 in the audience, I will note that we had a discussion this
21 morning on site neutral payment for IRFs and SNFs, including
22 a recommendation which we voted for. This is on the update

1 for inpatient rehab facilities.

2 MS. KELLEY: That's right. This is the update in
3 the current policy environment, not assuming our
4 recommendation is in place.

5 Last month, we presented the findings from our
6 update analysis for IRFs and the findings are summarized
7 here. Our indicators of payment adequacy are generally
8 adequate -- are generally positive. I'm sorry. We looked
9 first at access to IRF services. Between 2012 and 2013, the
10 supply of IRFs remained fairly steady and the number of IRF
11 discharges was stable. The average IRF occupancy rate was
12 about 63 percent, indicating that capacity was more than
13 adequate to handle current demand for services.

14 Next, we considered changes in quality. We worked
15 with a contractor this year to develop new risk-adjusted
16 measures of patient gains in motor function and cognition,
17 discharge to the community, and readmission to the acute
18 care hospital. These measures were stable or improving
19 nominally for the three-year period we examined.

20 We then considered access to capital. We found
21 that large chains appear to have very good access to
22 capital. Hospital-based IRFs have adequate access or

1 reasonable access through their parent institutions. And,
2 we were not able to determine the ability of other
3 freestanding facilities to raise capital.

4 Finally, the 2013 margin was 11.4 percent. Our
5 projected margin for 2015 is 12.6 percent. This margin
6 projection includes the effect of the sequester. If the
7 sequester were not in effect for 2015, the projected margin
8 would be almost two percentage points higher.

9 You'll note that our projected margin for 2015 is
10 higher than the 2013 margin, and that's different from what
11 the other sectors you've seen this morning, or this
12 afternoon. This is due to statutory updates in 2014 and
13 2015 and CMS adjustments to high-cost outlier payments that
14 we think will more than offset the effects of the sequester.
15 And, in addition, we assumed the historical rate of cost
16 growth for this industry, which has been below -- well below
17 -- marketbasket levels.

18 Turning now to the draft recommendation, it reads,
19 "The Congress should eliminate the update to the payment
20 rates for inpatient rehabilitation facilities in fiscal year
21 2016."

22 Eliminating the update for 2016 will reduce

1 spending relative to the expected statutory update. We do
2 not anticipate that this recommendation would have any
3 adverse impact on providers' willingness and ability to care
4 for patients or on beneficiaries' access to care.

5 With that, I'll turn it back to Glenn.

6 MR. HACKBARTH: Thanks, Dana.

7 Any clarifications needed? Kathy.

8 MS. BUTO: Just a quick one. Do we know what the
9 projected margin would be with the site neutral policy in
10 place --

11 MS. KELLEY: We have not --

12 MS. BUTO: -- recognizing --

13 MS. KELLEY: We have not estimated that for 2016.

14 MS. BUTO: Okay.

15 MS. KELLEY: Our assumption is that it would not
16 be in place for 2016.

17 MS. BUTO: It would not be for 2015 [sic].

18 DR. MILLER: Right, and the other way I would say
19 what we're doing here is you can sort of think about this as
20 if the site neutral weren't in place, or you could think of
21 it as the update that would apply to those cases that are
22 continued to be paid under the LTCH -- I mean, the IRF rate,

1 if that helps.

2 MR. HACKBARTH: Any others? Warner.

3 MR. THOMAS: Have we estimated what the margin
4 would be with site neutral in place?

5 MS. KELLEY: We have not. We estimated the impact
6 on total payments to IRFs, but we have not gone ahead and
7 estimated a margin, in large part because we would have to
8 make pretty significant assumptions about how costs would
9 change. So, it's a -- it would -- I think it would be a
10 fairly dicey proposition without more information about
11 provider response.

12 DR. MILLER: You know, and we've talked about this
13 some, Warner, so we're relaxing the regulatory requirements
14 on the IRF side. There's some expectation that they change
15 their cost structure, and that's what's hard -- and which
16 mix of patients, all of that, some of David's comments, is
17 what we'd have to be making projections about.

18 MR. HACKBARTH: Any others?

19 [No response.]

20 MR. HACKBARTH: Okay. All in favor of the
21 recommendation, please raise your hand.

22 [Show of hands.]

1 MR. HACKBARTH: Opposed.

2 [No response.]

3 MR. HACKBARTH: Abstentions.

4 [No response.]

5 MR. HACKBARTH: Thank you, Dana.

6 And, finally is long-term care hospitals. And,
7 before you begin, Stephanie, here, too, we had a site
8 neutral recommendation in the past. It was last year. It
9 was part of a hospital package which we will be re-running
10 this year in our March report. Again, this is the update
11 factor only for long-term care hospitals. Stephanie.

12 MS. CAMERON: Good afternoon. Last month, we
13 presented the findings from our payment adequacy analysis
14 for LTCHs. In summary, indicators of payment adequacy are
15 generally positive. We looked first at access to LTCH
16 services. Remember that many beneficiaries live in areas
17 without LTCHs and receive similar services in other settings
18 with few apparent differences in quality or outcomes.

19 Remember, too, that Congress imposed a moratorium
20 on building new or expanding current LTCHs from 2008 through
21 2012 and again beginning on April 1, 2014, which will go
22 through September 30 of 2017.

1 We found growth in payment per case between 2012
2 and 2013, and while we found a decrease in the number of
3 beneficiaries discharged from LTCHs in 2013, these decreases
4 are consistent with volume reductions in other inpatient
5 settings.

6 Next, we considered changes in quality. We lack
7 patient assessment data in this area and there is no
8 available quality measures to analyze, so we rely on
9 aggregate mortality and readmission rates. Since 2008,
10 these measures have been stable or improving.

11 We then considered access to capital. The current
12 availability of capital for LTCHs appears adequate.
13 However, the moratorium has reduced opportunities for
14 expansion and, thus, the need for capital.

15 Finally, the 2013 margin was 6.6 percent. Our
16 projected margin for 2015 is 4.6 percent. This decrease is
17 because of a few factors. First, the continuation of the
18 PPACA-mandated adjustments to the annual payment update.
19 Second, the implementation of CMS's budget neutrality
20 adjustment. And, third, the full effect of sequestration.
21 Overall, we expect cost growth to be somewhat higher than
22 payment growth. If sequestration were to be lifted, we

1 would expect the estimated aggregate margin to be about two
2 percentage points higher.

3 We make our recommendation to the Secretary
4 because there is no legislated update to the LTCH PPS. The
5 draft recommendation reads, "The Secretary should eliminate
6 the update to payment rates for long-term care hospitals for
7 fiscal year 2016."

8 CMS historically has used the marketbasket as a
9 starting point for establishing updates to the LTCH
10 payments. Thus, eliminating the update for 2016 will
11 produce savings relative to the expected regulatory update.
12 Savings are estimated to be between \$50 and \$250 million in
13 2016 and less than \$1 billion over five years. We
14 anticipate that LTCHs can continue to provide Medicare
15 beneficiaries with access to safe and effective care and
16 accommodate changes in cost with no update to the payment
17 rates for cases in LTCHs for fiscal year 2016.

18 With that, I turn it over to Glenn.

19 MR. HACKBARTH: Any clarifying questions? Kathy.

20 MS. BUTO: Did the Secretary eliminate the update
21 for 2015 to LTCHs?

22 MS. CAMERON: No. There was an update for 2015.

1 MS. BUTO: There was?

2 MS. CAMERON: Yes.

3 MS. BUTO: Okay. But, we had recommended no
4 update in 2015?

5 MS. CAMERON: That's correct.

6 MS. BUTO: Thank you.

7 MR. HACKBARTH: Any other clarifying questions?

8 [No response.]

9 MR. HACKBARTH: Okay. All in favor of the
10 recommendation, please raise your hand.

11 [Show of hands.]

12 MR. HACKBARTH: Opposed.

13 [No response.]

14 MR. HACKBARTH: Abstentions.

15 [No response.]

16 MR. HACKBARTH: Thank you.

17 So, this completes our work for the March report.

18 Just to sum up, we have the update recommendations for the
19 five groups that we just voted on. There will also be
20 recommendations on the primary care bonus for physicians and
21 other health professionals and converting that to a per
22 beneficiary per month payment, and the recommendation on

1 site neutral payment for selected conditions for patients
2 treated in IRFs and SNFs.

3 In addition to those, we will also have the four
4 package recommendations, which we have not voted on again
5 but will be rerun in the March report, on physicians,
6 hospitals, SNFs, and home health agencies.

7 Just one last word about the update process and
8 recommendations for people in the audience. We make
9 recommendations to the Congress on how the Medicare payment
10 rates should change. These are the rates expressed in
11 dollars and cents in the rules published by CMS before the
12 beginning of the relevant year. That's what these updates
13 are about.

14 As people know, there's also a Congressionally
15 enacted sequester which basically reduces Medicare payment
16 rates across the board by two percent. In formulating our
17 recommendations, we have taken into account in our margin
18 projections the effect of the sequester. However, in
19 formulating our final recommendations, we recommend the
20 changes in the Medicare payment rates. The sequester is not
21 even part of the Medicare law. It's a separate statute.

22 To be very pointed about it, we do not recommend

1 rates that are designed to offset the effect of the
2 sequester. We recommend the Medicare rates that we think
3 are appropriate and the sequester operates independently.
4 To be even more clear about it, we don't think that the
5 sequester is a good idea. We don't think it is the best way
6 to achieve Medicare savings. We think a better way is
7 through targeted adjustments in payment systems and payment
8 rates. But, that's Congress's call, not ours, and they will
9 handle it as they see fit.

10 So, we're now finished with our work for the March
11 report and moving on to work for June, and first up is a
12 continuation of past discussions we've had on creating a
13 level playing field or synchronizing payment across
14 traditional Medicare, Medicare Advantage, and ACOs. Jeff.

15 DR. STENSLAND: Good afternoon. As Glenn said,
16 last year, the Commission started to discuss ways to
17 synchronize payments. The initial discussions were
18 published in our June 2014 report.

19 Today, we will continue those discussions by
20 focusing on two empirical issues. First is how does risk-
21 adjusted program spending compare across the MA model, the
22 ACO model and traditional fee-for-service. Second, we'll

1 discuss how program spending could change as benchmarks for
2 MA plans change.

3 So let's begin with a review of last year's
4 discussion. Under the current Medicare program, there are
5 three payment models: traditional fee-for-service, Medicare
6 Advantage, and ACOs. But payment rules are different and
7 inconsistent across those models. As a result, program
8 payments can be quite different for similar beneficiaries
9 across the three models.

10 A key takeaway from last year was that no one
11 payment model always resulted in lower program spending. We
12 will revisit the relative program spending of each model
13 today. We will also discuss ways to level the playing field
14 and move more toward a synchronizing benchmark across all
15 three of these payment systems.

16 The purpose of this slide is to update our
17 analysis that shows no one model is always the lowest
18 program spending. We examined 78 markets that all had more
19 than 5,000 ACO beneficiaries and over 5,000 MA
20 beneficiaries. We then looked to see which model has the
21 lowest program cost in each market; in essence, which is the
22 lowest cost model from the perspective of the Treasury.

1 Let's start with the first row. The first number
2 tells us that in 28 markets, estimated fee-for-service
3 spending was lower than either ACO or MA program spending
4 for the same beneficiary.

5 The second number in that first row tells us that
6 ACOs generated the most savings in 31 markets, and the last
7 number in that first row tells us that MA plans generated
8 the lowest program spending in 19 markets.

9 But now we're going to break down the markets
10 according to their levels of service use, meaning how much
11 service, health care services were in these different
12 markets.

13 So let's look at the second row. These are
14 markets with low levels of service use by fee-for-service
15 beneficiaries. These are places like Iowa. If we look at
16 these low-service-use markets, we see that fee-for-service
17 and ACOs tend to be the models with the lowest program
18 spending.

19 The MA model is the low-spending model in only one
20 of these markets. This is because MA benchmarks in these
21 areas have been set well above fee-for-service, and MA plans
22 often bid above the fee-for-service costs.

1 In contrast, look at the last row. These are
2 markets where fee-for-service beneficiaries have high-
3 service use. These are places like Houston. In these types
4 of markets, the MA benchmarks are often lower than fee-for-
5 service, and MA plans -- these markets often have much
6 higher fee-for-service use, and so the MA benchmarks are
7 higher, and the MA plans are able to bid far enough below
8 fee-for-service, so that they can pay additional benefits to
9 the beneficiary and generate savings for the Medicare
10 program.

11 The bottom line that we're trying to get out of
12 this slide is that there is no one model that is always
13 going to generate the lowest program spending in all the
14 different markets.

15 Now, previously, the Commission has discussed the
16 principle of financial neutrality in the context of MA
17 payments. The Commission has long supported private plans
18 in Medicare because they can be flexible and innovative in
19 developing care management techniques, and if their payment
20 rates are set appropriately, they have incentives to
21 creatively generate some efficiencies.

22 Therefore, the Commission has recommended

1 financial neutrality between MA and fee-for-service and
2 setting MA benchmarks to 100 percent of fee-for-service
3 costs.

4 Part of the reason for financial neutrality is a
5 belief that in order for plans to bid an efficient price,
6 the benchmark has to be set low enough to put pressure on
7 them to have a relatively low bid.

8 We now discuss the relative program spending and
9 benchmarks in more detail.

10 This slide looks at the relative program spending
11 of ACOs and MA plans compared to fee-for-service Medicare in
12 different markets. These are the same markets we looked at
13 in a couple slides ago.

14 So let's look at the top row. The 100 percent in
15 the ACO column tells us that after paying ACOs bonuses for
16 reducing their costs, the shared savings, the net cost of
17 the ACO model to the Medicare program was essentially equal
18 to fee-for-service cost in 2013.

19 In the second row, the 105 percent figure tells us
20 that after paying for the supplemental benefits offered by
21 MA plans, the net program spending of the MA plan is about 5
22 percent above spending for fee-for-service, on average.

1 Now, this is equivalent to the same 105 percent
2 figure we talked about in December. This also includes an
3 extra 3 percent adjustment for coding that happens in MA
4 plans that we believe is not as coded as thoroughly in fee-
5 for-service that we also discussed in December.

6 However, now let's look at the last row. We see
7 ACOs and MA plans -- excuse me. If we look at the second
8 row, here we have the low-cost quartile. In this case, we
9 have ACOs having costs of roughly 101 percent of fee-for-
10 service and program spending in MA is roughly 113 percent of
11 fee-for-service. This indicates that the program is
12 spending more for the MA beneficiaries than the fee-for-
13 service due to the higher benchmarks and higher payments for
14 supplemental benefits.

15 However, if we look at the last row, we see that
16 ACOs and MA plans cost the program roughly 98 percent of
17 fee-for-service costs in areas that have historically had
18 high service use. This means in the ACO case that they
19 reduced spending enough to cover their share of shared
20 savings and save the Medicare program over 2 percent.

21 Similarly, the 98 percent figure for MA plans
22 means they were able to reduce service use enough to cover

1 the cost of supplemental benefits and still save the program
2 roughly 2 percent.

3 The next question is how MA program spending would
4 change under different benchmark scenarios. This slide
5 looks at the program spending of MA under different MA
6 benchmarks, assuming MA plans do not change their bids, and
7 we will discuss relaxing this bid assumption later.

8 The first row is the sum for all markets. Let's
9 walk across that row. As we said in the prior slide at our
10 December meeting, MA plan program spending is 105 percent of
11 fee-for-service for 2005. However, benchmarks are scheduled
12 to move closer to fee-for-service in lower spending markets
13 by 2017. If those 2017 benchmarks had been in place, then
14 MA program spending would have only been 102 percent of fee-
15 for-service.

16 In the third column, we look at what would happen
17 if benchmarks were set to 100 percent of fee-for-service.
18 We see that, on average, MA would have program spending
19 equal to 98 percent of fee-for-service.

20 Now, it's important to note this is 100 percent of
21 fee-for-service as a firm 100 percent. What that means is
22 we assume that CMS would fully adjust for differences in MA

1 and fee-for-service coding, as we discussed in your briefing
2 paper. It also assumes there would be no increase in
3 benchmarks for higher quality scores at MA Plans.

4 The difference from 2017 is that low-spending
5 markets that currently receive benchmarks of 115 percent of
6 fee-for-service or higher would be brought down to fee-for-
7 service, and higher spending markets that are currently at
8 95 percent of fee-for-service would have their benchmarks
9 brought up from 95 percent of fee-for-service to 100 percent
10 of fee-for-service.

11 And the big message from this slide is that
12 bringing benchmarks down will generate modest savings to the
13 program; however, I want to say this is a lower bound on
14 savings, because plans may also reduce their bids as the
15 benchmarks come down, and we'll talk about that next.

16 So, over the last five years, there has been a
17 steady movement of the MA benchmarks toward fee-for-service
18 rates.

19 So let's start by looking at that first row. It
20 shows that the benchmarks averaged 116 percent of fee-for-
21 service in 2010 and then moved down to an average 106
22 percent of fee-for-service by 2015, so the benchmarks are

1 declining.

2 But despite that decline in benchmarks, the ratio
3 of the bids to benchmark remained at a relatively constant
4 at 86 percent of the benchmark. So what this tells us is
5 that the bids move down in parallel with the benchmark.

6 Now, if you look at the third row, that's the
7 bottom line, and it tells us in 2010, the bid, on average,
8 was 102 percent of CMS's estimated fee-for-service costs for
9 the A/B benefit. By 2015, that bid moved down to 92 percent
10 of CMS's estimated fee-for-service cost for the A/B benefit.
11 So the bids relative to fee-for-service were coming down.

12 Now, there is a word of caution, with that
13 asterisk that's on the slide, and that's that the 92 percent
14 of fee-for-service cost in the last row is based purely on
15 bid data and is not fully adjusted for MA and fee-for-
16 service coding differences. But even after adjusting for
17 the 3 percent additional coding by MA plans, the MA bids are
18 still 95 percent of fee-for-service on average for that
19 basic A/B benefit.

20 So the bottom line is that when there is financial
21 pressure applied to MA plans by lowering the benchmarks, the
22 plans have lowered their bids, and they've lowered their

1 bids enough to generate modest savings on average in terms
2 of just looking at the A/B bid.

3 So what will happen as benchmarks are reduced
4 further? Because we've seen that's all lined up to happen
5 under current law. If bids were reduced, we would expect MA
6 plans to generate savings for the taxpayer for two reasons.
7 First, bids are already 5 percent below fee-for-service for
8 the basic A/B benefit. So the tax payer and the beneficiary
9 would share in savings if the benchmarks were moved to 100
10 percent of fee-for-service cost or lower.

11 Second, we would also expect bids to fall somewhat
12 further as benchmarks go down, allowing for additional
13 savings to be shared by the beneficiary and the taxpayer.

14 The expectation is that bids will decline when
15 benchmarks decline, and that expectation is consistent both
16 with the historical trends we showed you on a couple slides
17 ago. It's also consistent with work we did about two years
18 ago looking at cross-sectional differences in bids, a cross-
19 sectional study, and it's also consistent with some work
20 that Song and Chernew, our own Mike Chernew, did about a
21 year ago looking at longitudinal differences in bids over
22 time as the benchmarks change.

1 But there is a limit to how far these bids can go
2 down, and plans' ability to lower bids to fee-for-service
3 may vary depending on how much fee-for-service use there is
4 in the market. It will be easier to move bids down in the
5 high-service-use markets and more difficult in the low-
6 service-use markets.

7 In the end, depending on how far benchmarks
8 decline, there could be some additional markets without MA
9 plans due to an inability to compete with fee-for-service in
10 some markets.

11 So really what we've talked about so far is all
12 about the bids and the benchmarks and a lot of discussion of
13 service use in the different markets, but the MA bids will
14 not only depend on the MA plans' ability to control service
15 use and on the benchmarks, but the bids will also depend on
16 the prices that the MA plans have to pay their providers for
17 services.

18 As we have discussed in the past, there is a
19 statute that states that MA plans can pay hospitals the
20 standard fee-for-service rate if they do not have another
21 contractually negotiated rate with the hospital, and this
22 has acted as an anchor on the MA rates that are paid to

1 hospitals.

2 The data we examined and the insurers we talked to
3 and the actuaries we talked to and the hospitals we talked
4 to all confirmed that MA plans pay hospitals the rates that
5 are almost exactly equal to fee-for-service rates.

6 Now, this is important because hospital costs are
7 roughly 40 percent of the MA plan's bid. Commercial
8 insurers in the under-65 market pay rates that on average
9 more than 50 percent above hospitals' costs and far higher
10 than 50 percent above the MA rates. Therefore if MA plans
11 paid commercial rates, their costs would go up by more than
12 20 percent.

13 Now, even if they were somehow able to negotiate a
14 rate that was halfway between fee-for-service and the
15 commercial rates, on average, the MA plan costs would still
16 rise by at least 10 percent.

17 And recall that the savings generated by the MA
18 plan through controlling service use are there, but they're
19 somewhat modest, averaging about 5 percent currently.

20 There is the issue that the MA plans might not be
21 able to be competitive of fee-for-service in most markets if
22 they had to pay the commercial rates to the hospitals. So

1 what this implies is that MA plan affordability in some
2 markets might be dependent on the existence of the Medicare
3 fee-for-service rate schedule and Medicare fee-for-service
4 as a competitor to MA or some other mechanism to keep the
5 prices paid by the MA plans to the hospitals at an
6 affordable level.

7 So we have talked about synchronizing benchmarks,
8 where MA would move toward a benchmark that is based on fee-
9 for-service, and ACOs would continue to use that fee-for-
10 service benchmark.

11 However, there are complications, including
12 adjustments for quality. Right now, MA plans receive a
13 higher benchmark and higher payments for supplemental
14 benefits if they have higher quality scores.

15 In contrast, ACOs get a lower share of savings
16 unless they have the highest quality scores.

17 A possible approach would be to make a common
18 quality adjustment to the benchmarks in MA and ACOs. Plans
19 and ACOs would get higher benchmarks if their quality
20 metrics are better than fee-for-service, and they would get
21 lower benchmarks if their quality metrics were worse than
22 fee-for-service in that market.

1 There are also some future issues for
2 synchronization that we won't talk on today, but we may
3 return to in the future.

4 First, there is the question of how to reward MA
5 plans for low bids and ACOs for low costs. Currently, MA
6 plans who bid below the benchmark get a share of the
7 savings, which is referred to as "rebate dollars," but they
8 must use those rebate dollars to fund additional benefits
9 for the beneficiaries.

10 Right now, ACOs receive an unrestricted share of
11 savings. A future question is if we move MA benchmarks down
12 to the 100 percent of fee-for-service to match the ACOs,
13 should we also allow MA plans to receive an unrestricted
14 share of the savings as ACOs do.

15 An additional question is how should we design the
16 benefit to engage the beneficiary, and we plan to bring that
17 issue up in future meetings this spring.

18 So this leads us to some potential discussion
19 topics. First, how do we set benchmarks to promote
20 competition between models? In the past, we have pushed for
21 benchmarks equal to fee-for-service. Second, there is a
22 bigger philosophical question that we could start discussing

1 today, and that is what is the objective behind setting
2 benchmarks.

3 Currently, benchmarks are set as if there are two
4 objectives. First, everyone is guaranteed fee-for-service
5 for the part B premium in all markets. Even in high-
6 spending areas like Miami, you're still guaranteed to get
7 fee-for-service Medicare for the Part B premium, if you so
8 choose. Second, the MA benchmarks are set so that MA plans
9 are encouraged to operate in all markets. To do this, MA
10 plan benchmarks are set above fee-for-service in many
11 markets. The result is MA has higher program spending than
12 fee-for-service on average. The beneficiary is also given
13 extra benefits in these markets where MA costs are
14 relatively high to encourage them to join the MA plans.

15 So a key couple of questions are, first, does the
16 Medicare program continue to guarantee fee-for-service in
17 all markets for the Part B premium, or should the
18 beneficiary pay more for fee-for-service in markets where
19 the MA program spending for fee-for-service is greater than
20 -- excuse me -- or where fee-for-service spending is greater
21 than MA program spending.

22 Second, does the Medicare program continue to pay

1 more than fee-for-service costs per beneficiary who joined
2 MA plans in markets where fee-for-service program costs are
3 low relative to MA program costs, or should this change so
4 beneficiaries pay more for MA in markets where MA is more
5 expensive for the Treasury than fee-for-service?

6 One alternative is to guarantee Medicare
7 beneficiary is the lowest cost model in their market for the
8 Part B premium. This means everyone either gets fee-for-
9 service or MA, but if a beneficiary wants the more expensive
10 model, the beneficiary would pay the difference. This would
11 save the Treasury money and may generate efficiencies by
12 incenting beneficiaries to use the model with lower program
13 spending in their market, but it may also reduce extra
14 benefits received by the beneficiary.

15 And now I will open it up for the discussion.

16 MR. HACKBARTH: Okay. Thank you, Jeff.

17 So we'll have Round 1 clarifying questions for
18 Jeff, and I urge people to adhere rigorously to clarifying
19 questions.

20 DR. CROSSON: So I'm just trying to understand, in
21 terms of comparing program costs, first of all, I think
22 based on what you said later in the presentation we're not

1 counting Part D. Or we --

2 DR. STENSLAND: Correct.

3 DR. CROSSON: Not counting Part D. But so fee-
4 for-service, I understand, that's money out the door. For
5 ACOs, I assume that then includes all the downstream costs
6 that are not part of the ACO contract, including post-acute
7 care and everything like that, or not?

8 DR. STENSLAND: For the ACOs it would be all of
9 the fee-for-service spending for those individuals, which
10 would be their primary care, their acute care, their post-
11 acute care, all of that.

12 DR. CROSSON: All of that, even though that's --
13 okay.

14 DR. STENSLAND: Plus any shared savings payments
15 that CMS makes to the ACO because we think they might then
16 use those shared savings to help fund the ACO.

17 DR. CROSSON: So the successful ones. And then in
18 terms of MA, it would be everything that's covered in the MA
19 benefit except those things which are not covered? Or would
20 it include hospice and dialysis, or not?

21 DR. HARRISON: It would cover what the MA program
22 pays to the MA plans, so it would be basically their bid

1 plus the rebates. So it's spending -- it's what the
2 Medicare program is spending for the A-B benefits, less
3 hospice and -- sorry, what was the --

4 DR. CROSSON: Dialysis.

5 DR. HARRISON: Dialysis is included, although not
6 many of the people in MA have dialysis, are in dialysis.

7 MR. HACKBARTH: So in dialysis, you'll remember,
8 if a beneficiary is already enrolled in an MA plan and needs
9 dialysis, it's covered by the plan.

10 DR. CROSSON: Right. Some are in, some are out.
11 So actually -- I'm just trying to think whether we've
12 actually got apples here or apples and oranges. It could be
13 that the MA -- this isn't what I was looking for, but it
14 could be that the MA spending all out -- all spending, which
15 would include those things not part of MA, could end up with
16 an MA number higher than what you've got here. Is that
17 right or wrong?

18 DR. HARRISON: So --

19 DR. CROSSON: Because you're including -- we're
20 including hospice spending and that portion of dialysis
21 spending on the ACO side and on the fee-for-service side but
22 not on the MA side. Or am I missing something?

1 DR. HARRISON: When we do our comparison to fee-
2 for-service, hospice is out of both MA and the fee-for-
3 service comparison that we make.

4 DR. CROSSON: Okay. All right.

5 DR. HARRISON: So there aren't any hospice
6 services in that bundle, but we're not assuming that they
7 were when we say how much fee-for-service costs.

8 DR. CROSSON: Got it. Okay.

9 MR. HACKBARTH: I have Alice, Dave, and then Kate.
10 And I also have Scott, Warner, and Kathy, and Craig. These
11 are clarifying questions, remember.

12 DR. COOMBS: So you mentioned that the MA plans
13 get a 40 percent discount on hospitalization, right?

14 DR. STENSLAND: That's not exactly the way I would
15 say it. The MA plans in general use the Medicare fee-for-
16 service schedule as their rates, so if you -- a big MA plan
17 will pay the hospital a rate for serving their people
18 basically the same way that Medicare fee-for-service would
19 pay that hospital, often using all the same adjustments and
20 have that into their contract, and --

21 DR. COOMBS: Okay. So how does that -- how do we
22 compare the ACOs? Because many ACOs are not in any distinct

1 relationship with hospitals in terms of the cost drivers and
2 that relationship. Some ACOs have a relationship with
3 hospitals predetermined, but what about that relationship?
4 Because I think that's really important in the big picture
5 in terms of the final cost. So do we have numbers on that?

6 DR. STENSLAND: The ACO I all built on the fee-
7 for-service chassis, so the ACO's expenses will all be based
8 on exactly the fee-for-service rates. So the rates are
9 really quite comparable between the rates the ACO in essence
10 is not -- in essence paying the hospital and the rates that
11 the MA plan is actually paying the hospital are comparable.

12 DR. MILLER: The other way to think about it is
13 even if an ACO was comprised only of, you know, let's say
14 physicians, nurse practitioners, a set of professionals, but
15 didn't encompass the hospital, the spending that we're
16 attributing is for the entire experience of that patient.
17 So in a sense, it's like saying this is a fee-for-service
18 patient, this is an ACO patient, this is an MA patient, and
19 here's the spending associated with each of them. We're not
20 taking part of the spending because the ACO only
21 encompasses. And, remember, in the ACO concept, even if
22 it's just an organization of, say, you know, ambulatory

1 professionals, they're responsible for the entire experience
2 of that patient, whether they have a contract with a
3 hospital or not.

4 DR. COOMBS: [off microphone] of that is different
5 based on the relationships, and I'm wondering if there's --

6 MR. HACKBARTH: It wouldn't be different based on
7 the relationship. The rates attributed for hospital care to
8 the ACO are the same regardless of whether the ACO includes
9 a hospital or does not include a hospital. They're the fee-
10 for-service payment rates in either circumstance. ACOs are
11 not negotiating rates with hospitals as MA plans are free to
12 do. It's just the ACO program is based on the Medicare fee-
13 for-service infrastructure. All the claims are processed
14 through the Medicare payment systems, Medicare contractors,
15 no difference. And it doesn't matter what type of ACO it
16 is.

17 DR. MILLER: Now, you're looking really confused.

18 DR. COOMBS: Well, the commercial side --

19 DR. MILLER: And that's what I was just going to
20 go to. It might be different on the commercial side, but
21 the ACOs we're talking about here are the Medicare ACOs, and
22 that might be why you're --

1 DR. COOMBS: So if you have a large conglomerate
2 with a large percentage of commercial, it may be that they
3 have market share that allows them greater latitude in terms
4 of negotiations?

5 MR. HACKBARTH: So a private ACO, or an ACO that
6 has both private contracts and Medicare contracts may on its
7 private side have negotiated rates with hospitals and other
8 providers, but still the Medicare portion of that business,
9 the Medicare patients, all of that care is paid for Medicare
10 fee-for-service rates. There's no negotiation in the ACO on
11 that.

12 So let me just pick up on Alice's question and
13 take it in a little different direction, focus on the MA
14 hospital rates. So a very important statutory provision --
15 or maybe it's in regulation, I don't know -- is that if an
16 MA plan does not have a contract with a given hospital and
17 one of its patients ends up in that hospital, they are not
18 required to pay anything more than the Medicare rate for the
19 services rendered.

20 So, in theory, if you set aside for a second
21 network adequacy requirements, an MA plan could say, well, I
22 have no in-network hospitals and they're all receiving

1 Medicare payment rates.

2 And so what I hear you saying -- and I just want
3 to verify -- is, given that fact, there's no reason for an
4 MA plan to pay more than the Medicare hospital rate. The
5 hospitals all know that, that the MA plan could get the
6 Medicare rate from that hospital just by knocking them out
7 of the network. And so that's sort of the starting point
8 for any negotiation. Hospital rates in MA plans can go
9 lower than Medicare, but they won't go above. Is that what
10 you're saying?

11 DR. STENSLAND: Up to the last couple words,
12 because I think --

13 MR. HACKBARTH: But those were the most important
14 words.

15 [Laughter.]

16 DR. STENSLAND: It's almost -- because of all the
17 reasons you said, it's almost exactly the fee-for-service
18 rates. We're not aware of anybody actually able on the
19 hospital side to negotiate lower than fee-for-service. In
20 some cases, they might go 1 or 2 percent higher, saying, you
21 know, we want you to be in our network so you'll schedule
22 surgeries in advance or something, that kind of thing. But

1 it's pretty much right in that very narrow range.

2 DR. MILLER: And the reason, I think, even though
3 that was really good, it's important because the MA plan
4 can't really play unless it says, look, I have a network,
5 because they have to have network requirements and they have
6 to say I can present, you know, a full benefit. So some of
7 that comes into the negotiation. But I think an important
8 point, which I think is your point, is the reference point,
9 is fee-for-service. Whether it goes a little bit up or not
10 is the point.

11 MR. HACKBARTH: This is why in the paper the point
12 is made with some emphasis that the continuation of
13 traditional Medicare -- and large enough to continue to be
14 able to command something like the current level of rates --
15 is in a way important to the success of Medicare Advantage.

16 MR. ARMSTRONG: Glenn, I just -- practical
17 experience would say I completely agree with that statement,
18 and I want to affirm that this is, at least in the Pacific
19 Northwest, the experience that we have had. Our negotiated
20 MA plan beneficiaries benefit from fee-for-service hospital
21 payments set by the Medicare program.

22 MR. HACKBARTH: Okay. I have Dave and then -- oh.

1 DR. BAICKER: I'm being rude and jumping in
2 because my question was actually exactly what yours was so I
3 just want to add one more little clarification to it.

4 MR. HACKBARTH: You may get it right [off
5 microphone].

6 DR. BAICKER: No, no.

7 DR. MILLER: The last couple words [off
8 microphone].

9 [Laughter.]

10 DR. BAICKER: That's right. Smoke and mirrors.

11 So my question is: How come the MA plans,
12 sometimes with the same insurer, can get a better rate than
13 the commercial book of business? And do we then see,
14 because of this statutory wrinkle, which seems like the key
15 thing, that any given insurer is paying substantially more
16 for the same hospital for its commercial book of business
17 than it is for its MA book of business?

18 DR. STENSLAND: That's correct, and they say two
19 things. A lot of times when we talk to them, they'll say
20 that's statute, and they'll point to the statute, and that's
21 why we're getting this good deal.

22 Sometimes there's a secondary reason in there

1 where they'll say, well, everybody knows that we're only
2 getting so much from the government and we can only pay so
3 much. And if they charge us a huge rate, if they charge us
4 the commercial rates, which could be 50, 75 percent higher
5 than Medicare, then we aren't going to be able to bid
6 competitively, we won't get the people, and they'll end up
7 getting them as fee-for-service people anyway, and they'll
8 be getting the fee-for-service rate.

9 DR. REDBERG: I think it's on the same question.
10 Is that related to the statement that I was puzzled by on
11 page 9 or Slide 9 that said commercial hospital rates are
12 roughly 50 percent above costs and 50 percent higher than
13 rates paid by MA plans on average? Because that sounds like
14 a lot.

15 DR. STENSLAND: Yes.

16 DR. REDBERG: Okay.

17 DR. NERENZ: If we could go to Slide 5, middle
18 column, please. Back in October and November when we had
19 the focused ACO discussion, I asked a question about the
20 infrastructure operating costs. You've got contracting,
21 you've got IT infrastructure, you've got care coordinators.
22 And the issue was that those are not reimbursed by CMS, so

1 those are not included in this column, right, because
2 they're not program costs?

3 DR. STENSLAND: They are not directly included in
4 that column, but what is in that column is the shared
5 savings that the program pays to them. So in my mind, I'm
6 thinking, oh, you're in a high-use area, you reduced
7 spending by 5 percent, CMS gave you 3 percent, and you spent
8 1.5 percent of that on these programs costs -- your care
9 coordinators and things -- which may have done some valuable
10 things for the beneficiaries in addition to reducing costs,
11 and then your net savings is 3 percent. So it's not
12 directly there, but it might be indirectly there through the
13 shared savings.

14 DR. NERENZ: Okay. Well, my question was: Is it
15 directly there? And it's not. And then you just mentioned
16 it's about 1.5 percent. I guess what I was going to get to,
17 what strikes me in this column is how those numbers are
18 essentially literally a hundred. Given that that 1.5
19 percent is not reimbursed, if we think about the ACO program
20 either in terms of judging success from the CMS perspective
21 or thinking about long-term sustainability, don't these
22 numbers have to be at least 97, 98, somewhere, because that

1 cost is hanging out there?

2 DR. STENSLAND: Well, again, because those numbers
3 would include the shared savings, you have to be something
4 closer to like 99 on the average. But your basic point is
5 if it's 100 percent and you're not reducing your service use
6 at all, then you're not going to have any money in shared
7 savings to cover your overhead, and you'll probably end up
8 going away.

9 DR. NERENZ: Well, that's what the hundred is
10 telling me. On average they're not.

11 DR. MILLER: This is also a little noisy, [off
12 microphone] too, because this now includes both the MSSP and
13 the Pioneer. So you also have a bunch of ACOs in here that
14 are one-sided propositions, right? And so even if they had
15 no effect, it wouldn't necessarily be bounced from -- you
16 know, be forced out of the program.

17 DR. STENSLAND: Right, and we want to emphasize,
18 too, that there is on average 100 percent savings -- not --
19 average zero savings, 100 percent of the cost, but there's a
20 spectrum here of some people saving and some people not.
21 And when you're in the one-sided model, you might just be
22 there. So the ones that aren't really generating savings

1 will continue to stay there. There's always a chance that
2 something will improve and they'll absorb the extra
3 operational cost for that. But over time, if people move to
4 a two-sided model, we wouldn't expect all the same ACOs that
5 are in there now to be in there in the future.

6 MR. HACKBARTH: Dave, I think your point, which I
7 agree with, is that at this point in time, whether the ACO
8 program is a success or even sustainable is still open to
9 question. The jury is out on that. And, you know, it may
10 be that there's a startup time that it takes a while to get
11 programs in place and to make them function at a high level
12 so that they produce more significant savings. That's sort
13 of the optimistic view.

14 You know, the pessimistic view is that at least
15 the shared savings program incentives are so weak that
16 people, when they start to think about it, realize, hey, I'm
17 really not going to be much better off if I save money than
18 if I pursue the old fee-for-service model, and so they're
19 just not doing much. I don't know. We don't know. The
20 jury is still out.

21 DR. NERENZ: I was trying to just be a clarifying
22 -- I just wanted to make sure it was under -- that that 1.5

1 operating cost was not in here.

2 MR. KUHN: An observation on that point. I would
3 just on that, another maybe possible pessimistic view would
4 be, you know, as you look at the ACOs, it's kind of a slow
5 burn model. You know, it's going to take us a long time for
6 people to really kind of convert from fee-for-service into
7 the ACO models out there. So at the same time, you're going
8 to have fee-for-service rates continue to go up. And so if
9 that happens, does it make it easier for them to achieve
10 that 98 percent somewhere down the future when you've got
11 that base fee-for-service continuing to go up?

12 MR. HACKBARTH: Dave was very good in trying to
13 frame his question as a true Round 1 clarifying question,
14 but it led us into the woods. But we won't hold him
15 accountable for that.

16 MR. ARMSTRONG: Two questions. First, the whole
17 analysis acknowledges that we take a subset of the country
18 and do this based on the 78 markets that ACOs have entered.
19 Are you worried that that's actually somehow skewing our
20 conclusion that presumably ACOs would go into markets that
21 were more likely markets that they could succeed in? You
22 know, I know the distribution between low- and high-use

1 quartiles is pretty good, but is that a concern of yours?

2 That would be my first question.

3 DR. STENSLAND: So, in general, the distribution
4 is pretty good, except we don't have a lot of rural areas,
5 and it's a little harder to have a big enough group in a
6 rural area for the ACO to be successful just in terms of
7 having 5,000 concentrated beneficiaries. And the same thing
8 kind of happens in MA. The MA in rural areas generally
9 doesn't do quite as well as the MA in the urban areas. So
10 we're leaving those rural areas largely out of our analysis.

11 MR. ARMSTRONG: So we think big enough numbers in
12 enough diverse geographic markets, particularly relative to
13 cost structure, that this give us what we're looking for?

14 DR. STENSLAND: Yes.

15 DR. MILLER: Can I just say one thing about this?
16 And if I remember correctly from the paper, it's like about
17 a third of the action in ASCs and a third in MA. Is that--

18 MR. HACKBARTH: ACOs.

19 DR. MILLER: Or ACOs, sorry -- no, ASCs. I want
20 to talk about --

21 [Laughter.]

22 DR. MILLER: Sorry. He said 100 percent savings.

1 Come on. About a third of the action. But what I would --
2 and the one thing -- I would just take your question a
3 slightly different direction. I don't think -- I don't
4 think -- our intent here is these are the numbers, lock on
5 to the numbers. I think what we're more trying to
6 illustrate is, look, different markets, different
7 performers, change the baseline, things start to move in the
8 following way. I think we're trying -- even though I think
9 we've got a lot of "n" here and a lot of density in terms of
10 the data, we're not trying to say the number is 1.2. We're
11 trying to say look how it behaves. Is that fair?

12 MR. ARMSTRONG: Yeah. I just was thinking, so if
13 I were motivated to organize an ACO, I would be -- I think I
14 would be more likely to believe I could succeed in a high-
15 use market. But it sounds like our analysis, at least to
16 the degree you can, won't be influenced by what that bias
17 might lead us to given what we're trying to accomplish.
18 Anyway, that was the source of that question.

19 Just the other one was we talk about low-use
20 quartile, high-use quartile. I'm looking at Slide 5. And
21 given that this whole conversation around, well, the payment
22 rates per unit of service are pretty well fixed, that is

1 synonymous then with high-cost quartile and low-cost
2 quartile?

3 DR. STENSLAND: It's actually fairly different,
4 just because the payments are fixed, but there's some pretty
5 big wage differentials and some pretty good teaching
6 adjustment differentials. So if you look at just the
7 payments, New York looks really bad, and they get a lot of
8 IME payments because -- not "bad." I should say they look
9 like really high spending. But on service use they're not
10 so high. And someplace like San Francisco might look
11 moderately high on spending because the wage rates are
12 higher there. But if you look at the actual service use,
13 it's pretty low.

14 MR. ARMSTRONG: Okay. That's great. Thanks.

15 MR. THOMAS: So, my question on the cost
16 comparison is what's actually in the fee-for-service and ACO
17 costs. So -- and just bear with me here for a minute -- so,
18 in the MA, if we're looking at the cost really being the bid
19 price, that would include all the admin, profit, medical
20 costs, utilization, management, all that's kind of in that
21 number.

22 In the fee-for-service, I guess the question I

1 have, does that include claims processing costs, all those
2 types of things, you know, the third-party intermediary
3 costs? Is that on top of the medical costs for fee-for-
4 service in the comparison, and do we have any idea what -- I
5 have no idea kind of what -- how big or how material that is
6 as a percentage of the total cost.

7 DR. STENSLAND: It only includes the costs that
8 are borne by the government. You know, it's essentially the
9 government payments. So, it wouldn't have things like any
10 sort of extra costs that a MA supplemental plan would have
11 or --

12 MR. THOMAS: I'm saying, outside of MA, if you
13 think about --

14 DR. STENSLAND: Not MA, but --

15 MR. THOMAS: -- the fee-for-service or ACO --

16 DR. STENSLAND: Yeah.

17 MR. THOMAS: -- so, there's a third-party
18 intermediary that's doing claims processing and all the PRO
19 work and all that. Is that cost in your comparator or not?

20 DR. STENSLAND: Well, it wouldn't be the
21 administrative costs of CMS --

22 MR. THOMAS: No.

1 DR. STENSLAND: -- wouldn't be in there, and I
2 guess the administrative costs of CMS administering the MA
3 program wouldn't be in there, either.

4 MR. THOMAS: Right. But, for the fee-for-service,
5 there's still a -- there's a third-party cost paid to, I
6 believe, paid to intermediaries that actually process claims
7 and do all the work for Medicare. Is that in the cost --

8 DR. MILLER: Jeff, I think the answer is no. It
9 isn't in there. So, if they're paying some contractor to
10 process the claims, yeah, that's not in this. This is the
11 benefit payment.

12 MR. HACKBARTH: Right. So, we looked at that in
13 the context of the MA program and how much that effects the
14 comparison, and I can't remember the numbers off the top of
15 my head, Scott, but they're relatively modest.

16 DR. HARRISON: It was, like, around maybe two
17 percent, but they're actually in the fee-for-service numbers
18 that we used to compare the MA to. I have a feeling that
19 they're out of -- you use claims, right, for the ACO --

20 DR. STENSLAND: Yes, so --

21 DR. HARRISON: -- so they're out of both sides.

22 DR. STENSLAND: There's two comparisons going on

1 here. I guess when Scott's doing -- when you're doing your
2 MA-fee-for-service comparison and you're saying that those
3 administrative costs are in there --

4 MR. THOMAS: Yeah.

5 DR. STENSLAND: -- and when we're doing the ACO to
6 fee-for-service comparison, the administrative costs are
7 out, but they're out on both sides --

8 MR. HACKBARTH: On both sides.

9 DR. STENSLAND: -- and they're in on both sides on
10 Scott's, so it's --

11 MR. HACKBARTH: But, now, when you're doing ACO to
12 MA, you've got apples and oranges, two percent different.

13 DR. STENSLAND: That's the mathematical issue here
14 that we can talk about, but --

15 DR. HARRISON: I know, but that's why we never --
16 we don't --

17 DR. STENSLAND: We don't --

18 MS. CAMERON: -- compare the two directly. We
19 only go through MA.

20 DR. STENSLAND: We don't compare --

21 MR. HACKBARTH: Oh, well, yeah --

22 DR. STENSLAND: We don't compare the two directly.

1 DR. HARRISON: -- through fee-for-service --

2 DR. STENSLAND: We say how much through fee-for-
3 service.

4 MR. HACKBARTH: Yeah.

5 DR. STENSLAND: So, we have fee-for-service in the
6 middle and we say, oh, over here, ACOs can save --

7 MR. HACKBARTH: Yeah.

8 DR. STENSLAND: -- the program two percent. And
9 then over here, the MA can save the program two percent.
10 So, we're not comparing the ACO --

11 MR. HACKBARTH: Apples-to-apples both directions.

12 DR. STENSLAND: Yes. So, we're not comparing ACO
13 to MA. We're comparing the relative savings to each other.

14 MR. HACKBARTH: Yeah. Yeah. Did you get that,
15 Warner?

16 MR. THOMAS: Not really.

17 [Laughter.]

18 MR. THOMAS: I don't know if anybody else did.
19 Maybe --

20 DR. MILLER: Well, here's the way you can think
21 about it. It's either out of both sides or in both sides,
22 whichever way you want to think about it, but it is being

1 accounted for.

2 MR. HACKBARTH: It's apples-to-apples.

3 MR. THOMAS: So, I guess the -- so, it's in --
4 it's either in or out of both sides --

5 MR. HACKBARTH: Yeah.

6 MR. THOMAS: -- on the fee-for-service and the
7 ACO. But on the MA, because you're using the bid, I mean,
8 that has all the admin costs and all the medical costs in.

9 MR. HACKBARTH: Right.

10 MR. THOMAS: So, would the comparison of ACO and
11 fee-for-service to MA be an apples-to-oranges comparison?

12 DR. HARRISON: No, because when we look at MA
13 versus fee-for-service, the admin costs are on both sides.
14 It's the way the fee-for-service costs were measured that
15 includes the claims processing.

16 MR. HACKBARTH: Yeah. It may be easier to do this
17 offline --

18 MR. THOMAS: Okay.

19 MR. HACKBARTH: -- and use a numeric example.

20 MR. THOMAS: Okay.

21 MR. HACKBARTH: But, I'm convinced, based on what
22 Scott and Jeff say, that it is an apples-to-apples

1 comparison, and we can verify that through some more
2 discussion offline.

3 MR. THOMAS: Okay.

4 MR. HACKBARTH: Did you decide, Craig, whether
5 you're in or out? You're out. Okay. Kathy.

6 MS. BUTO: Okay. So, I want to go to Slide 12,
7 and this might be -- because I know this is just a question,
8 not really a position, but the least costly model felt a
9 little bit like premium support, and I wondered if -- I
10 mean, in the sense that I didn't -- don't mean to be
11 inflammatory, but the beneficiary in that model would have
12 to pay more in fee-for-service if fee-for-service was the
13 more costly, right? Is the difference that you're thinking
14 it would be area by area depending on what was available
15 versus maybe something more across the board? What were you
16 thinking in that statement?

17 MR. HACKBARTH: You say it, Kathy, like it's a
18 disease, and --

19 MS. BUTO: No, no, no --

20 [Laughter.]

21 MR. HACKBARTH: -- like premium support.

22 MS. BUTO: Oh, no, no, no, no. I'm just wondering

1 if that's what they were trying to get at, but not wanting
2 to --

3 MR. HACKBARTH: Yeah, it is --

4 MS. BUTO: I don't think they wanted to identify
5 it, but --

6 MR. HACKBARTH: It is --

7 MS. BUTO: Is that what we're talking about here?

8 MR. HACKBARTH: Yeah.

9 MS. BUTO: Okay. That was my question. Then, the
10 second question is I'm still -- I'm looking at page two of
11 the paper, number four, "The affordability of the MA model
12 may depend on maintaining a strong fee-for-service Medicare
13 payment model," and I understand Scott's point and that
14 sounds convincing. But then it goes on to say, "Fee-for-
15 service Medicare serves as an essential competitor to MA,"
16 and "competitor" just doesn't seem like the right descriptor
17 there, because it's a payment model. It's a reference
18 price. It's not actually competing with MA area by area,
19 and the way this is presented, it makes it sound more like
20 that's what you're talking about, and I didn't think that's
21 what you were getting at here.

22 DR. STENSLAND: That's kind of what I'm getting

1 at. Like, you think of the beneficiary focus groups that we
2 go to and --

3 MS. BUTO: Yeah.

4 DR. STENSLAND: -- we listen to, talk to them when
5 they talk about whether I'm going to pick an MA plan or I'm
6 going to pick fee-for-service.

7 MS. BUTO: Yeah.

8 DR. STENSLAND: In their mind, those are the two
9 models that are, in essence, competing for the beneficiary's
10 choice of where they're going to sign up for. So, I think
11 from the MA's perspective --

12 MS. BUTO: But, let's take an area where it's
13 mostly -- what I was trying to jump ahead to was if we are
14 successful and there are more MA models competing against
15 each other, fee-for-service might still be a benchmark
16 because there will be a fee schedule for hospital services
17 produced, but it may not actually be, you know, the more
18 dynamic competition that's going on among ACOs and MA plans,
19 not fee-for-service. But, maybe it's a semantic difference.
20 I just -- I don't think of Medicare competing. Medicare
21 sets prices --

22 MR. HACKBARTH: Yeah. I --

1 MS. BUTO: -- and puts them out there.

2 MR. HACKBARTH: I think it is a semantic
3 difference. It's a competitor in the sense, as Jeff says,
4 it's an option for beneficiaries. They can go fee-for-
5 service, traditional Medicare. They can go MA. And, it is
6 a competitor in that sense. It does not compete in the
7 sense that, oh, I'm losing market share, I'm going to modify
8 what I do, because it works with standardized rate setting
9 methods, et cetera.

10 Rita.

11 DR. REDBERG: It's kind of a clarifying comment,
12 because I don't think of Medicare as competing, but it does
13 bother me a little bit, these statements about fee-for-
14 service, because inherently, I think we still need to
15 remember, fee-for-service really is a flawed model and it's
16 just paying for services, whether they're helping
17 beneficiaries or not, whether they're harming beneficiaries
18 or not. And, the fact that there are low use in the fee-
19 for-service, they're only looking good relative to high use,
20 but we really have no idea if that's still high-value care
21 in the sense that it could be nothing to do with the
22 Medicare program, why those areas are low use. And, so,

1 kind of using them as a benchmark, I think, is inherently
2 flawed, you know, and saying that we have to have fee-for-
3 service around because it competes, I don't think it really
4 -- there's nothing about fee-for-service that encourages the
5 kind of things we want to encourage, I think, which is
6 spending money on things that beneficiaries value and need
7 and improve their lives, and that was my clarifying comment.

8 MR. HACKBARTH: The point about it being an
9 essential part of the system is that if it were to go away,
10 it would likely have a dramatic effect on the rates that
11 Medicare Advantage plans could get from providers, hospitals
12 in particular. And, even if, you know, you look out into
13 the future 15 years and you imagine that at least in some
14 markets MA enrollment goes from, what, 50 percent is the
15 high now in some markets, and it's up to 75 or 80 percent in
16 Medicare Advantage, it would start to raise a question of
17 whether traditional Medicare, using its standardized rate
18 methodology, would be able to get access to care for its
19 beneficiaries in those markets. Providers are not required
20 to take the Medicare rates. They do so because Medicare has
21 a big market share and it helps them cover their costs.
22 But, if the world evolves so much that they can do that

1 strictly by contacting with MA plans, then they may start to
2 say, well, I'm not going to take the Medicare rates. And,
3 it's in that sense that Medicare is an anchor for the
4 system.

5 Jon.

6 DR. CHRISTIANSON: Well, fee-for-service Medicare
7 as we know it could go away, but the Federal Government
8 could still say, we're not going to pay more than X-amount
9 for hospital care.

10 MR. HACKBARTH: It could write a regulation to
11 say, no payer, public or private, will pay more.

12 DR. CHRISTIANSON: [Off microphone.] Or, we won't
13 pay more than that for Medicare --

14 MR. HACKBARTH: Well, but if they -- if they're
15 saying that we won't pay that for Medicare beneficiaries,
16 but there's one Medicare beneficiary left in the market,
17 providers may well say, okay, I won't serve that person.

18 DR. CHRISTIANSON: They're all Medicare
19 beneficiaries. They're getting their Medicare through
20 private plans versus through traditional Medicare --

21 MR. HACKBARTH: Well, if you do that --

22 DR. CHRISTIANSON: That's what I'm saying.

1 MR. HACKBARTH: -- then you've basically changed
2 what Medicare Advantage is, from a private plan, enterprise,
3 to a government rate-setting plan.

4 DR. CHRISTIANSON: No, it could be a private plan
5 enterprise where one particular price is a joint purchase.
6 All plans could pay the same price for one component of it.

7 MR. HACKBARTH: Yeah, and --

8 DR. CHRISTIANSON: I mean, I'm just saying --

9 MR. HACKBARTH: Yes.

10 DR. MILLER: I think the other part of the
11 response over here is fee-for-service's role in MA, which
12 you were on point about. Also, the ACO model sort of
13 assumes you have fee-for-service running, because the ACO is
14 not processing claims. The ACO is not negotiating rates.
15 That's assumed to all be taken care of. So, again, if fee-
16 for-service were to go away, then something would have to
17 play that role for ACOs.

18 And then the last thing I would say, which has not
19 been part of this conversation, but it will be part of our
20 ongoing conversations and has been in the past, and I think
21 it does speak -- I think it speaks to what you were saying,
22 and I'm certainly trying to -- is to say, well, if ambient

1 fee-for-service quality is X, you want to use that as a
2 reference point to get better quality out of ACOs and MA,
3 which is, I think, what your run-out and your thought is.
4 And, we have had some of that discussion which we have not
5 returned to for today. Today, we've been talking more about
6 the spend.

7 MR. HACKBARTH: And two other quick questions -- I
8 think quick -- for round one. It's Slide 7. So, we show
9 evidence here that bids decline as the benchmarks decline.
10 An obvious question is, well, how are plans accomplishing
11 that? One potential mechanism that they might use is
12 tightening provider networks, excluding providers that, you
13 know, have high utilization patterns and trying to steer
14 beneficiaries towards lower cost, more efficient providers.
15 What do we know about tightening of networks in Medicare
16 Advantage? This has been a hot topic in ACA, but I haven't
17 seen that much analysis of what's going on in MA.

18 DR. HARRISON: Well, we know there have been some
19 examples of large plans narrowing their networks. We don't
20 have a good quantitative base to do any comparisons on this.
21 My understanding is they're sort of changing the information
22 systems that the networks are going to go through and

1 they're not in place yet, and so even if we get that,
2 though, I think next year may be the first year that we have
3 something reliable.

4 MR. HACKBARTH: Then on page 11, or Slide 11,
5 rather, the first bullet, how should we reward low bid MA
6 plans and low cost ACOs. Now, as I see it now, being a low
7 cost ACO is punished, it's not rewarded, in that you then
8 have a lower target. If you've been a historically
9 efficient provider, congratulations. Welcome to the ACO
10 program. Your target is lower than your competitor across
11 the street who's been historically sloppy in their spending.
12 And, so, we have a very different issue in the ACO program
13 than we do in that MA program in that regard. Am I correct,
14 or am I missing something?

15 DR. STENSLAND: You're correct, and I just didn't
16 word this very well, and I was -- in my mind, I was
17 thinking, MA plans who have a low bid or ACOs who lower
18 their cost, as opposed to the bench --

19 MR. HACKBARTH: Yeah. Okay.

20 DR. STENSLAND: -- where they start at, which is a
21 completely different issue, and maybe a bigger one.

22 MR. HACKBARTH: Yeah. Okay. Let's move on to

1 round two. Who wants to begin? Craig does, I think.

2 DR. SAMITT: All right. So, I have three comments
3 to make. One, let's start with Slide 3. You know, these
4 results, especially for ACOs, were quite remarkable to me,
5 because the period of time and the data that you used was
6 really very nascent early in the ACO program. So, these are
7 brand new ACOs. And, so, of the 78 markets, 31 of the ACOs
8 were already the lower cost alternative. So, I'm not so
9 sure I'm ready to give up hope, because right out of the
10 gate, we're seeing nearly a third of the markets or more
11 with ACOs that are the top performer from a cost
12 perspective.

13 The other observation here that's interesting to
14 me is that you see that ACOs are able to achieve the lower
15 cost alternative in each of the quartiles, and I don't know
16 whether that says anything about the benchmarking
17 methodology. While in subsequent rounds if you're a higher
18 performing ACO and you lower your costs you sort of get
19 penalized because the target is harder and harder to
20 achieve, I wonder if it says something about at least some
21 component of benchmarking relating to your historical
22 performance, not just a market average.

1 So, my first comment is I'll be curious to see
2 what the next round of this looks like as ACOs have
3 developed more expertise, but this suggests that they may
4 hold a bit of promise.

5 MR. HACKBARTH: On that issue, somebody -- I don't
6 know if it was Dave -- mentioned that there -- some of this
7 may be the result of self-selection in terms of who
8 participates --

9 DR. SAMITT: Scott.

10 MR. HACKBARTH: Scott -- as an ACO. It may be
11 that the organizations that are in the first wave of ACOs,
12 especially the Pioneer ACOs, are already organizations that
13 have been doing this for a while and they're low cost
14 providers in their market.

15 DR. SAMITT: Yeah.

16 MR. HACKBARTH: It had nothing to do with the ACO
17 program. It's just the selection effect.

18 DR. SAMITT: Yeah, perhaps that's so.

19 The second comment that I want to make is about
20 your questions about what to do with benchmarking in the
21 future. One of the concerns I have, especially as we see
22 either more providers become ACOs or additional enrollment

1 in Medicare Advantage, can we continue to rely upon fee-for-
2 service as the benchmark, or do we start to skew the
3 relative nature of those comparisons? So, I wonder whether
4 -- it goes back to this notion of maybe we should be
5 thinking of benchmarking as blended benchmarking, that we're
6 not 100 percent reliant upon fee-for-service. Perhaps at
7 some point in the future ACOs could be benchmarked against
8 MA plans, not just fee-for-service. And, so, I haven't put
9 a huge amount of thought into it, but very similar to the
10 way the ACO program is benchmarked, both against market
11 trends blended with historical performance, I do wonder
12 whether we should be thinking about MA benchmarking as a
13 blended concept or ACO benchmarking as a blended concept.

14 And then the third comment I would make, I'm still
15 worried, still on this slide, about whether these results
16 truly show an apples-to-apples comparison as it relates to
17 lowest program cost, because I sense that for ACO and fee-
18 for-service, program cost is synonymous with service use,
19 but for the MA program, program costs are synonymous with
20 spend or bids, not so much service use. So, I haven't
21 talked about encounter data for nearly a month --

22 [Laughter.]

1 DR. SAMITT: -- so, it's time that -- I think we
2 need a way to compare service use that truly allows an
3 apples-to-apples comparison. I'm most curious which plans
4 or which delivery systems are truly driving clinical
5 innovation and lowering utilization costs and improving
6 quality and wellness, and I'm not sure this comparison
7 really gets at that because it doesn't feel like it's an
8 appropriate true apples-to-apples comparison in cost.

9 MR. HACKBARTH: Good point. Carlos, you're on.
10 Come to the microphone, or can Scott do this?

11 [Laughter.]

12 MR. ZARABOZO: Here is a mic.

13 DR. MILLER: We'll kind of see how this goes,
14 right?

15 We are talking to CMS. We know that they have
16 some of the encounter data, but they are still not at a
17 point where they have processed through it and said that
18 they can make it available. Some of it has come in, and
19 they are sort of working through the complexities of what
20 they've got in front of them, and I'm not sure we can give
21 you a lot of precision on what it is that they are
22 encountering with the encounter data.

1 I set that up. I've been waiting six months for
2 that.

3 [Laughter.]

4 DR. MILLER: But that they do have it, but it's
5 just not been made available yet.

6 MR. HACKBARTH: This has been in the works so long
7 that I've forgotten what exactly is included in the
8 encounter data.

9 At one point, there was some discussion about
10 trying to minimize the burden by using sort of a compressed
11 set of data from plans. Is that what's in this encounter
12 data, or is it going to be comparable to fee-for-service,
13 service information, so we can do what Craig, I think,
14 correctly, wants to do?

15 DR. HARRISON: It should be similar in that
16 they're trying to make it look like claims. What they may
17 never have, though, is dollars. So you really would have to
18 try to figure out how much an office visit is worth in terms
19 of a hospital stay or something, so you may not have dollars
20 as a metric.

21 MR. HACKBARTH: Well, but if I understand Craig
22 correctly, that doesn't matter.

1 DR. HARRISON: Right.

2 MR. HACKBARTH: What you'd want to use is a
3 standardized unit.

4 DR. HARRISON: Well, that's the thing, getting a
5 standardized unit. We could have lots of data. The
6 question is how to think about all of it as a whole.

7 MR. HACKBARTH: Well, let me make sure I
8 understand, Scott. So will we have information that says
9 that this MA patient was hospitalized with this MS-DRG, and
10 so we can make a head-to-head comparison with fee-for-
11 service?

12 DR. HARRISON: I believe you should have that.

13 MR. HACKBARTH: Okay. Round 2. Jay and then --
14 or was it on this point? Go ahead, Rita.

15 DR. REDBERG: It's actually related to Craig's
16 first question. Do we know how many of the 78 ACOs are
17 still in the market and how they fall out in terms of their
18 quartiles?

19 DR. STENSLAND: What do you mean by quartiles?

20 DR. REDBERG: Second, third, or high-use quartile.

21 DR. STENSLAND: Those ACOs are still all in the
22 program.

1 DR. REDBERG: Oh, okay. I thought that was 2012
2 data.

3 DR. STENSLAND: This is a combination of Pioneer
4 ACOs that didn't drop out and MSSP ACOs.

5 DR. REDBERG: And none have dropped out. Thank
6 you.

7 DR. CROSSON: This is Round 2?

8 MR. HACKBARTH: Yes.

9 DR. CROSSON: All right.

10 [Laughter.]

11 DR. CROSSON: It feels like a boxing match.

12 This is a complicated issue. It seems to me one
13 thing that we might do -- because we have some useful data
14 here, and then at the end of the presentation we have some
15 ideas, and I think that's all good. But it might be useful,
16 since this is going to be an ongoing discussion, to think
17 about what sort of general principles we all agree on that
18 we could then apply to the more specific complicated
19 questions.

20 I'm just listening to the discussion and thinking
21 I just have basically got three. It may not be right or
22 all, but one would be that Medicare costs for the same

1 services should be equal across the models. That brings in
2 the whole question about extra services and MA, and so we
3 could argue that point.

4 Second would be that it's a good thing to have
5 beneficiary incentives for choosing the efficient model
6 among the three and for choosing the most efficient delivery
7 entity, if you want to call it that, within the model, that
8 those would be good things.

9 And the third one would be that there should be
10 some process to provide differential payments based on
11 quality, that that would be a good thing. So that's just a
12 couple of offerings.

13 MR. HACKBARTH: I think those are good principles.
14 I can't speak for others, but those are all things that I
15 personally would agree with. And I think consistent with
16 how we got to doing this analysis, it goes to your first
17 point, the basic concept. And this goes way back before
18 there were ACOs, that there ought to be a financially
19 neutral choice for beneficiaries between traditional
20 Medicare and Medicare Advantage. It's been a longtime
21 staple of MedPAC's view of the world.

22 Now we're trying to adapt that for the arrival of

1 ACOs and now look at what that would mean in different
2 markets with a basic conclusion being, well, in different
3 markets, one might look better than the other.

4 DR. CROSSON: Okay. So I think I was saying two
5 separate things a little bit. There ought to be neutrality
6 for the Medicare program in terms of how much it pays for
7 the same services. Then the other question is to what
8 extent does that apply to the beneficiary neutrality, and do
9 we want to in fact not have it neutral, but have incentives
10 inherent in the choices that the beneficiary makes that then
11 back up into Medicare costs? And I would say yes.

12 MR. HACKBARTH: That's the way I thought of this,
13 and others can jump in on this point right now, if you want
14 to. Bill?

15 DR. HALL: Apropos of what both Rita and Jay said
16 about the quality parameters not necessarily being in this
17 particular analysis, I think this is really a good first
18 start. But as I think both of you implied, it says it does
19 not address and leaves open for question, regional
20 variations, the fact that we know that there are very large
21 quality differences between health systems in various parts
22 of the country.

1 I guess the really bang for the buck here, if you
2 will, are the real apples and oranges comparisons, is to
3 make sure that we weeded out the rotten apples or the sour
4 oranges and try to put some kind of quality metrics into
5 this as step number two and three. Otherwise, I think we
6 may be making decisions totally on cost and the assumption
7 that quality is equal, but every single meeting, we've made
8 the point that that is not the case in the United States.

9 MR. HACKBARTH: I think we all agree that quality
10 is a very important consideration in that. There are
11 different ways that you can inject quality into the
12 equation, so to speak.

13 One is at the entry point, and you create
14 regulations that weed out all of the poorer quality
15 providers. Another is that you provide information to the
16 beneficiary who faces these choices and allows them to
17 assess quality, and then the third major candidate is that
18 you provide financial rewards or penalties based on quality.
19 And what we're doing right now is some combination of those
20 three things. They are not mutually exclusive.

21 I have Bill and then Alice.

22 MR. GRADISON: May I?

1 MR. HACKBARTH: I will come back to you in a
2 minute.

3 MR. GRADISON: Very quickly on this point, there's
4 another factor here that intrigues me. I mean, these, after
5 all, are early numbers in some cases and sort of at point of
6 time.

7 Most health care is provided locally, a couple of
8 generalizations I'm trying to think through. Most providers
9 are being reimbursed in various ways, not just through one
10 method. There may be providers that are doing some of their
11 practice with MA plans and some with ACOs and some fee-for-
12 service, to say nothing of the fact that they may have a lot
13 of other patients that aren't covered by Medicare at all.

14 The reason I mention that is that I'm kind of
15 intrigued whether over time. To the extent that these new
16 options are effective in improving quality and efficiency,
17 broadly defined, it seems to me there's some evaluation that
18 that may influence the way in which they practice in other
19 spheres. In other words, there could be some application of
20 new ways of doing things. The pressure may be from the MA.
21 The pressure may be from the ACO or whatever.

22 In one sense, that means it is a moving target,

1 but in another way, particularly with supposedly 5 million
2 people now covered by ACO, as well as the very large number,
3 30 percent, which is an even larger number of the Medicare
4 beneficiaries being covered by MA, there may be some things
5 going on here, which transcend Medicare alone and even
6 influence fee-for-service Medicare.

7 MR. HACKBARTH: Kate, you've written on spillover
8 effects.

9 DR. BAICKER: Right. And I think the evidence is
10 not clear-cut, but I think that there is a lot of suggestive
11 evidence that when there is greater prevalence of managed
12 care in a local provider area, that affects other patients'
13 care as well. And if they move towards the delivery mix and
14 intensity of utilization that you see in the managed care
15 population, whether that's because of practice norms or
16 investment and shared equipment or what, I think that there
17 is at least suggestive evidence of that kind of spillover
18 influence.

19 MR. HACKBARTH: Alice.

20 DR. COOMBS: So I just wanted to speak to a couple
21 of things. One is the whole notion of bad apples or rotten
22 apples or sour oranges.

1 The article by John Ayanian in New England Journal
2 of Medicine highlighted something that was very interesting,
3 and basically, it talked about racial disparities between
4 blacks, Hispanics, and whites, under the Medicare Advantage
5 plan, which was very interesting. And I think we think a
6 lot of times at this level, but if you look at the large
7 plans, there are things that are going on.

8 This article actually pointed out that there were
9 gross disparities in three indicators. One was glucose
10 control, cholesterol control, and as simple as it is, blood
11 pressure control, and how well we do with blood pressure
12 control. It turns out, in terms of glycated hemoglobin,
13 there was a 50 percent double in some sectors in the study.
14 I would encourage everyone to look at it, but it highlights
15 the fact that you can have large robust systems of Medicare
16 Advantage where gross disparities in quality exist, and all
17 the bidding that we do does not always reflect what actually
18 happens to subgroups within the managed care plan. So
19 that's one piece of it.

20 The other thing is that I'm looking at the ACOs
21 and thinking what kind of innovative things can be done for
22 cost and quality. I know that one of the things we looked

1 at when we were working with payment reform in Massachusetts
2 was looking at global budgets within an ACO structure and
3 whether or not there were creative ways in which we can
4 incentivize both on the quality front, but also to get
5 providers to have some kind of confidence in infrastructure
6 for sustainability.

7 I think if we look at a said budget and providers
8 know that I have this infrastructure that I can depend on, I
9 have some confidence in, what my future is going to look
10 like in terms of my ability to actually practice medicine.
11 I think that helps a lot.

12 I know that the AQC product of the Blue Cross/Blue
13 Shield looked at historical controls, but in the ACO, that's
14 always something that people are worried about, is that what
15 happens five years down the road? What's my benchmark going
16 to look like, and how do you keep moving the goal post, if
17 you will?

18 MR. HACKBARTH: Okay. We're on Round 2. Let me
19 see. Just one second, Rita. Let me see who has Round 2
20 comments. We've got four of those. Rita, why don't you go
21 ahead and pick up on Alice, but let me just say about where
22 I want to go from here.

1 So I'd like to have Rita comment, then do our
2 Round 2. Then I'd like to go back, before we're out of
3 time, and pick up with Jay's suggestion about let's talk
4 about what our guiding principles are for a minute.

5 I don't want to get lost in the empirical
6 analysis. I want to end on the note of where is it that
7 we're trying to do. Okay? So that's the plan.

8 Rita, go ahead.

9 DR. REDBERG: Thanks.

10 I just wanted to comment I agree, Alice,
11 disparities are really important for us to understand, but I
12 wanted to kind of bring it back to what we were talking
13 about just a little bit earlier. We really, I think, need
14 to, even with disparities, look more at outcomes measures,
15 and the Ayanian paper, I think dealt a lot more with process
16 measures. For example, on Monday's JAMA Internal Medicine,
17 published an article suggesting that more Medicare
18 beneficiaries are being harmed by the aggressive
19 glycosylated hemoglobin levels that we're setting because of
20 overtreatment and problems with hypoglycemia. I think I
21 have stated before, I don't think cholesterol is a very good
22 measure for actual health, and so I think that disparities

1 are important, but I just want to point out, I think we want
2 to look at outcomes and not as much process measures.

3 MS. UCCELLO: So I'll just say now that I really
4 liked Jay's idea of putting these principles together, and
5 when he was laying them out, I was thinking that they also
6 go back to internal debates and discussions we have had in
7 the past on what is it we mean when we say a level playing
8 field. And I think going through some of these principles
9 again will help us clarify that for ourselves.

10 Just adding my 2 cents on some of the questions
11 that were brought up in the slides themselves, when we think
12 about whether MA and ACO shared savings policy should be
13 more closely aligned, I think that makes sense, but I think
14 in the past, we've stated a preference to having ACOs be
15 able to share savings. So I think -- with beneficiaries.
16 So moving toward more shared savings rather than less for MA
17 plans would be where I'd be interested in going.

18 So using rebate dollars to fund extra benefits or
19 something like that, rather than taking that away --

20 DR. MILLER: Sorry. You guys are following here.
21 In terms of the -- one of the questions on the slide -- and
22 Glenn and Jeff had some exchange on this, which is if you

1 come in below some benchmark, what can be done with the
2 dollar? And does the dollar have to -- does something have
3 to happen to it? And I think -- and this is what I'm trying
4 to pin down -- you're expressing an opinion that says we
5 might want -- this is your comment, that the ACO might want
6 to be treated more like the MA is treated.

7 MS. UCCELLO: Yes. Going back to our -- finding
8 ways to encourage the beneficiaries to either use the
9 services more wisely or whatever, but somehow being able to
10 share those savings with beneficiaries.

11 Everyone understands me, Mark. I don't know.

12 [Laughter.]

13 DR. MILLER: I honestly didn't mean to clarify
14 something that was clear. I was having a moment where --

15 MR. HACKBARTH: He always looks confused.

16 MS. UCCELLO: And I'm usually confusing, so I
17 understand.

18 So at risk of confusing more, Slide 12, the
19 question about subsidizing MA plans in low-use markets, this
20 is something that's really always kind of bothered me and
21 also having to try to put it in a neutral manner.

22 But I think this is -- we don't want to do that

1 unless there's a reason to. So unless there is better
2 quality, unless they are somehow providing some positive
3 spillover effects, and I'm wondering if some of our way --
4 if one way to look into this some more is tomorrow's
5 discussion about those population-based measures and whether
6 that can help inform our understanding of that question a
7 little bit more.

8 DR. HOADLEY: So I've been struggling trying to
9 figure out sort of where to play in on this, and the
10 question that always gives me pause is sort of what happens
11 in terms of this level playing field question and sort of
12 where it comes in to get the beneficiary engaged in it.

13 And I think the discussion that you and Bill were
14 having on the quality issue is really important to that.
15 You put up three sort of ways we think about quality, and
16 the problem is there are problems with some of those.

17 The first one was we exclude entities, whether
18 we're talking plans or providers or wherever, whatever the
19 noun is in a particular conversation. We exclude people who
20 don't meet some minimal threshold, and I think the problem
21 is, in Medicare typically, we don't do that very readily.
22 We exclude people only if they're like just not even

1 competent.

2 The good example of that --

3 MR. HACKBARTH: The front page of the newspaper.

4 DR. HOADLEY: A good recent example was the law
5 says -- I don't know if it's the law or rules say that the
6 MA plans with the low star ratings three years in a row get
7 excluded. Well, they were about ready to do that, and they
8 said, "Well, maybe not this year. We'll hold off a year."
9 So that's one clear example. Maybe there were good reasons
10 for that, but that's the principle that always seems to
11 happen. We don't exclude.

12 And so the risk of that is that one of these plans
13 could be very efficient, i.e., very cheap, and could become
14 the benchmark for some kind of triggering the fee-for-
15 service rate or something like that, and it's really kind of
16 unacceptable quality.

17 The information about quality, obviously, is
18 another approach. The problem there is we don't seem to
19 have very good evidence that people use that or use it very
20 thoroughly, and that empirical evidence on the star ratings
21 is that people actually prefer the higher rated plans.
22 There's pretty good evidence that it gives plan an incentive

1 to do better, but the sort of information aspect of it
2 doesn't seem to play out. So I think there are issues
3 there.

4 The pay differential, again, we have talked a lot
5 about the challenges in doing that, and risk adjustment
6 obviously is a part of it and just how you do that. So I
7 guess when it comes back to me is before we're going to get
8 to some of these questions of how do you really set level
9 playing fields and sort of particularly the kinds of things
10 that say put the beneficiary at risk for something other
11 than the lowest cost plan, we've really got to master this,
12 so that the lowest cost plan isn't going to be a poor
13 quality plan and puts everybody into paying extra for just
14 getting to sort of what we should consider as acceptable
15 quality.

16 MR. HACKBARTH: I agree with everything you said
17 about each of those three paths being imperfect, both in
18 concept and in execution.

19 DR. HOADLEY: Right.

20 MR. HACKBARTH: But having said that, those
21 imperfections apply in fee-for-service Medicare, too. So
22 even if you use that as your base in the definition of your

1 entitlement, beneficiaries can be going to poor-quality
2 providers, as Rita has often pointed out. Keeping fee-for-
3 service Medicare, free choice Medicare, as the entitlement
4 does not guarantee quality of care. We've got a huge amount
5 of evidence of that.

6 DR. HOADLEY: Yeah, a dilemma.

7 MR. ARMSTRONG: Just a couple of brief points,
8 maybe a little redundant to what's been said.

9 First, I really want to applaud the goal -- I
10 mean, just to step back, I feel like I kind of lose track of
11 the fact that really what we're looking at through our
12 payment structure is how we compare these three different
13 models, and it's kind of tricky, but I think it's a really
14 lofty goal. And I just maybe for my own benefit want to be
15 clear. This apples-to-apples kind of discussion, where it
16 clearly is apples to apples is what the program pays.
17 Underneath that, you get kind of caught up in administrative
18 costs and these other kinds of things. And so I think just
19 we need to remind ourselves of that and acknowledge that it
20 is what it is, it's kind of limited, and that a lot of our
21 questions are asking, well, okay, so that's what we pay, but
22 is that the same thing as the total cost of care for that

1 population of patients? And in a way, we want our policy to
2 be influenced by the second point as much as by the first.

3 And so, anyway, that was kind of my reconciliation
4 of this whole thing, and how we solve that I'm not exactly
5 sure, but those are really two different things. And I
6 think we need to be responsible for the total cost question.

7 Then, finally, before we get to principles, just a
8 point that is kind of off this goal, but is brought up by
9 this analysis, and that is that this whole analysis is based
10 on fee-for-service costs to the program, which compares
11 relative costs to ACOs and MA. But fee-for-service costs to
12 the program vary far more significantly region to region
13 than they do between these three different programs within
14 regions. And at some point we need to acknowledge that this
15 is what we have, but it's kind of a flawed point of
16 reference. And if our responsibility is overall program
17 costs and future trends and so forth, at some point we
18 really ought to ask, Are we giving enough attention to
19 what's driving MA plan bids in one market versus another or
20 fee-for-service costs in one market versus another?

21 But as I said, different agenda item off our goal,
22 but hard to resist making that point.

1 MR. THOMAS: Just a couple of points, and I would
2 go back I think to Craig's comments in the beginning. You
3 know, what struck me is on Slide 3 where really comparing by
4 quartile the different models, I mean, overall, with all the
5 market, you know, 50 of the 78 markets, the ACO and MA
6 programs are the most cost-effective. Even in the lowest
7 quartile, the ACO and MA, 11 out of the 20 markets are in
8 better shape there.

9 I think going back to Craig's point, with the ACO
10 model being pretty much in its infancy, and I think we would
11 all agree not having a significant amount of alignment with
12 the providers the way it could have in the future based upon
13 a lot of recommendations being made here.

14 Then if you look in the high-cost quartiles, you
15 know, 17 of the 19 markets, that model is there. So I think
16 as we think about the principles of how we try to get more
17 folks in an ACO and an MA plan, we've got to think about
18 also how we get more providers in those markets that are
19 high cost into those products as well, because it does
20 appear, based on the data, even in the low-cost markets,
21 that if we can get folks in the right model and the right
22 mechanism, they can drive a lower-cost alternative to the

1 fee-for-service market.

2 At the same time -- and I think, Glenn, it might
3 have been a comment you made -- you know, the comparison is
4 to -- for an ACO is to itself versus necessarily to the
5 market or to some other benchmark. And I think once again
6 if we want to have folks and organizations look at the ACO,
7 I think comparing to the market they're in, you know, are
8 they better than others that are in their market may be
9 another way to incent more folks to get into these types of
10 models, because there could potentially be more upside there
11 even if it was partially shared. And, once again, I think
12 we would see these trends change dramatically if we had more
13 entities in the ACO model.

14 The final thing, and it just wasn't clear to me
15 looking at the data, but I kind of wondered over time what
16 is the trend, what does the medical trend look like in the
17 fee-for-service model compared to the others? And I'm
18 thinking about what's the true total medical cost trend
19 increase, decrease, or whatever, comparing these. And I
20 know it's a little bit difficult in the MA because it's the
21 total cost, but it was difficult for me to ascertain in the
22 slides. I know you're kind of comparing to a fee-for-

1 service equivalent, then looking at 98 percent or 101
2 percent, but really trying to figure out what is the medical
3 trend of these models, you know, comparison, and how does
4 that compare to the markets that they're functioning in? I
5 mean, which one's kind of driving a different medical trend,
6 if at all? Because I think even in the ACOs that are not
7 kind of triggering additional payments, we know there's that
8 2 percent in the MSSP program. They have to beat it by 2
9 percent. I think a lot actually were better than zero,
10 which means they're probably beating the medical trend in
11 their marketplace. I think it would be helpful for the
12 Commissioners to know that type of information as well.

13 DR. MILLER: Jeff, on that, do we have the
14 cumulative ACO data to do that? That's what I'm a little
15 blank on.

16 DR. STENSLAND: Well, we have just -- it's a short
17 time period since it started, so it does look like on
18 average, if you do it in aggregate, the service use was just
19 slightly lower. I think -- I don't remember the MSSP
20 numbers off the top of my head. For the Pioneer it was
21 something like 1.7 percent lower, or something, in aggregate
22 the first year. You know, you're kind of in that 1 percent

1 range in terms of the aggregate.

2 MR. HACKBARTH: Yeah. There's also a question of
3 whether you're seeing changes in trend or the effect of one-
4 time savings, just a step down, and then the trend will
5 resume. And I would think in particular early in the ACO
6 program you're probably seeing more one-time savings as
7 opposed to fundamental changes in a long-term trend.

8 MR. THOMAS: Which is why I think it's good for us
9 to start looking at that so we can determine is there a
10 modification. I think providing that data back to ACOs at
11 the same time to say, you know, you are seeing a trend
12 differential, or it is a one-time event, I think giving that
13 feedback and making sure we're explicit about that would be
14 important.

15 But I think coming back to the more we can make --
16 especially looking at this data, the more we can make the
17 ACO and the MA model attractive, especially in the third and
18 fourth quartile areas, it seems as though it makes a lot of
19 sense from an overall cost perspective, assuming, you know,
20 quality metrics in these areas are similar.

21 MR. HACKBARTH: So, Warner, let me pick up there.
22 Your first point was: Does it make sense to benchmark ACO

1 performance against their own past experience or against a
2 market, figure what's going on in their community and their
3 market? And this is an issue that we've wrestled with for a
4 long time now, and it's a bit of a dilemma.

5 You know, on the one hand, if you benchmark
6 against the ACO's own historical performance, there's an
7 inequity there. You're punished for past good performance
8 and rewarded for past profligacy. And that really irks me.

9 On the other hand, if you use a benchmark of the
10 market and the ACO program is voluntary, what you'll find is
11 that the higher-cost providers in the market may say, I
12 don't want any part of this, I can't hit that number, and
13 especially if there's a downside risk required.

14 And so the providers that you most need to change,
15 the ones with high costs, say, I don't want to be in the
16 game. And so how you square the circle there, not be
17 inequitable to historically efficient providers while
18 encouraging high-cost providers to get into the game is a
19 real dilemma that we've wrestled with inconclusively.

20 MR. THOMAS: And I can see that's a dilemma. I
21 think that's why, you know, putting our heads together and
22 thinking about are there other reasons for or ways that we

1 could make these models attractive that would get higher-
2 cost providers into them, I'm not saying that -- I mean, on
3 the other hand, you know, someone that's a better performer
4 in the market is penalized. So, you know, that's not
5 necessarily fair either. So I know it's a difficult issue.

6 I come back to is there other regulatory relief,
7 other things that could be there that can make the ACO
8 attractive, when you think about RAC audits, you think about
9 the one-day stays, all those types of things that could make
10 the ACO much more attractive and would potentially incent
11 higher-cost providers to be getting into those types of
12 models because of other regulatory relief.

13 MR. HACKBARTH: Okay. So what I would like to do
14 is go to a discussion about principles and conclude on that
15 note. Where is it we're trying to head? And, Jay, if I
16 could ask you just to restate your three as a starting
17 point. I invite reactions to Jay's three amendments,
18 deletions, whatever people want to go with it.

19 DR. CROSSON: Sure. I mean, I haven't word-
20 processed, wordsmithed this, but --

21 MR. HACKBARTH: We'll help you with that [off
22 microphone].

1 DR. CROSSON: Thank you. I thought so.

2 So the first one is basically saying that Medicare
3 costs -- and we could say Medicare total costs or whatever -
4 - Medicare costs should be the same for the same services
5 across the three models. As I said earlier, that brings up
6 the question about, well, what about extra services? Do we
7 like that, we don't like it, whatever. But I didn't take
8 that into consideration at the moment.

9 The second one is that there should be beneficiary
10 incentives for choosing the most efficient model, and I see
11 that as, you know, the most efficient model of the three,
12 and then on a competitive marketplace basis, within those as
13 well, potentially.

14 And then the third one is that there should be
15 differential payments or you could read incentives based on
16 quality, and with all the difficulty inherent in that that
17 Jack suggested. I don't see any choice but to try to do
18 that.

19 MR. HACKBARTH: So the floor's open on Jay's
20 principles.

21 MS. BUTO: I just want to get a clarification from
22 Jay. Are you talking about sort of per beneficiary like

1 benchmarks of spending should be the same? Or do you mean
2 literally that the same amount of money should be spent on
3 each of the three options? I didn't think that's what you
4 meant. I thought particularly if we're trying to move
5 beneficiaries into ACOs and MA plans, if that -- if we
6 believe that's going to manage, be better for their care.
7 Are you saying --

8 DR. CROSSON: I guess I'm not exactly sure --

9 MS. BUTO: -- we don't want the costs to be --

10 DR. CROSSON: -- what you're saying. I think --
11 and, again, I think we're going to have to refine all this a
12 lot. But what I'm fundamentally saying is that for equity
13 purposes, the amount of money that Medicare spends for the
14 same services should not be different in fee-for-service,
15 Medicare Advantage, or through the accountable care delivery
16 system.

17 MS. BUTO: It shouldn't be any higher, right?

18 But, I mean, there shouldn't be a great -- but I think what
19 I'm trying to get at --

20 DR. CROSSON: I'm missing your point.

21 MS. BUTO: -- is don't we want some of the models
22 to save money against -- we don't really want them to spend

1 exactly the same amount for each service.

2 DR. BAICKER: Could I offer a friendly --

3 DR. CROSSON: Yeah, please.

4 DR. BAICKER: The way I was interpreting what you
5 were saying is sort of a version of site-neutral payments in
6 that the payment system shouldn't favor the delivery of a
7 bundle of care through one of these plans versus another.
8 Conditional on the bundle of care, we should be neutral
9 about which insurance plan you're in.

10 DR. CROSSON: Correct. And I think there's -- you
11 know, there's an underlying assumption to everything we do
12 here that we are looking for opportunities, through
13 benchmarking or anything else, to make sure that Medicare's
14 not overpaying. So that's an underlying assumption. But
15 I'm talking -- what I was talking about is mostly around the
16 question of these three models.

17 DR. BAICKER: And then the follow-on to link that
18 to your second point is that we want the payment systems to
19 be neutral for a given bundle of care, and we want
20 incentives to move people towards high-value bundles of
21 care. And that's incentives about which plan to enroll in,
22 incentives about what care to deliver conditional on being

1 in that plan, which bucket to be in, which example of the
2 plans offered within those buckets, et cetera. So the
3 bundle shouldn't favor one type of care or another. The
4 payment for the bundle shouldn't favor one type of insurer
5 over another. And the system should be pushing towards
6 higher-value bundles of care.

7 DR. NAYLOR: So I applaud the goal and really like
8 these principles. Kate, I'd ask if you think about the
9 principle expanding to we should be agnostic to which model,
10 but wanted to make sure the bundle of care is consistent
11 across, how would something -- you know, so something that
12 struck me in this paper about changing the rules, changing,
13 for example, for ACOs some of the regulations around
14 homebound, but that would continue in fee-for-service. How
15 would that fit with that principle? Meaning, you know, if
16 we make it easier for certain populations to enter one of
17 the models and more challenge -- it's something I was struck
18 by, and so I didn't know if that was consistent. I mean, I
19 really like the principle that the bundle of care should
20 exist and be available in all three models and we should be
21 agnostic to whatever, that the payment should be creating
22 the incentives for that bundle to get better and adapt and

1 so on.

2 DR. BAICKER: The way I think of the answer to
3 that question fitting into the framework is there should be
4 -- if some provider or insurer or plan, an ACO or an MA plan
5 or a fee-for-service provider, comes up with a better way to
6 achieve a health outcome for a patient, whether it's
7 delivering services at home that used to be delivered
8 inpatient or better management of post-acute care or
9 figuring out who really doesn't need an intervention at all,
10 there should be a financial -- the payment system should
11 promote that, not inhibit it, but we shouldn't care -- if
12 the ACO's doing the best job at it, then we want people
13 going to the ACO. If the MA plan is doing the best job at
14 that, we want people going to the MA plan. We don't ex ante
15 care where people end up if the innovation is attracting
16 them through the delivery of higher value, better services.

17 DR. NAYLOR: Great. I would like to add for
18 consideration to these principles the issue around equity
19 and thinking about these models as we look at them, a
20 principle being that they are serving well beneficiaries
21 among diverse subgroups, that that is a really central
22 principle.

1 And then I don't know if this is a principle, but
2 I think the issue of shared savings and shared risk should
3 apply to both the beneficiaries and to the providers.

4 DR. HOADLEY: So I guess I'm still trying to go
5 back to the previous exchange on what the first principle
6 really means, because where we are now with Medicare
7 Advantage, the bundle is everything. So are you thinking of
8 some kind of neutrality or equity at something less than the
9 everything bundle? Because if you're trying to say, you
10 know, a cluster of care, say, around a particular disease or
11 a particular episode, even using a fairly expansive version
12 of the episode, that's more -- that interferes more with or
13 redefines the MA model from where we are today to make it
14 more fragmented than it seems like it is. That puzzled me
15 that that was what you might mean by that.

16 DR. CROSSON: Yeah, Jack, I'm not exactly sure. I
17 see what you're saying. I --

18 DR. HOADLEY: I realize we're doing this on the
19 fly.

20 DR. CROSSON: Right. I'm talking about -- and,
21 again, I haven't worked all this through. This is just
22 right now. But to try to derive the right language to say

1 that the Medicare program should not be expending more
2 resources -- and you can say on a quality-adjusted basis or
3 however you want to do that. I added it as a third
4 principle.

5 DR. HOADLEY: Sure.

6 DR. CROSSON: Whether the beneficiary chooses fee-
7 for-service, traditional fee-for-service, an ACO, which may
8 have fee-for-service payment in it, or Medicare Advantage.
9 Now, you're right, it becomes complicated because, for
10 example, the ACO itself, as it's currently set up, is not
11 held accountable for total Medicare costs. There are some -
12 - well, Part D --

13 DR. HOADLEY: Close.

14 DR. CROSSON: Part D, for example. So you'd have
15 to basically, you know, make sure that you're talking about,
16 again, apples and apples, similar to our current discussion.
17 But I guess I missed the point of where you thought the
18 weakness was --

19 MS. BUTO: It's spending on the beneficiary [off
20 microphone].

21 DR. CROSSON: I'm talking about -- are you saying
22 is it per beneficiary total for the whole nation?

1 DR. HOADLEY: That's what I'm trying -- I guess
2 I'm trying to think all that through. I mean, when we're in
3 the fee-for-service world and we're talking about site
4 neutral, we narrow down to saying for a particular E&M
5 service, we want to be neutral whether it's delivered in a
6 hospital-owned practice or physician practice.

7 MR. HACKBARTH: Yeah.

8 DR. CROSSON: I think what I was trying to say --
9 and it may be not probably thought out yet, but if a given
10 beneficiary chooses among the three, the impact on Medicare
11 total cost for that person should be the same, irrespective
12 of which is chosen. Is that --

13 MR. HACKBARTH: So the key word is "total cost."

14 DR. CROSSON: Total cost, yeah.

15 DR. HOADLEY: So that's more like the analysis
16 that we were looking at in this paper --

17 MR. HACKBARTH: Right.

18 DR. HOADLEY: -- in making sure there's not
19 something about how we define shared savings in one sector
20 and quality bonus in another sector in different ways. So,
21 at that level, that makes some sense. I'll stop at that.

22 DR. HOADLEY: Okay. Dave?

1 DR. NERENZ: I think I share the thoughts of many
2 here that we should not be in the business of favoring one
3 of these models over another just on principle. I would
4 extend that a step and say I'm not sure we should even
5 guarantee the availability of one or two or three of these
6 as a matter of principle. I think the fundamental grounding
7 point is how do we get best outcomes most efficiently and at
8 lowest cost.

9 With that in mind, it strikes me that the ACO and
10 the MA models to some extent involve some additional
11 administrative cost. You've created structures. You've got
12 staff at CMS who are working with this. We talk about it.

13 You've added some cost, and I think you only want
14 to do that when you see that there's been an offsetting
15 savings. Where that takes me is that in areas that are
16 already low cost and high quality in the fee-for-service
17 arena, I would be reluctant to set policy to try to add
18 anything unless that added something can show in that area
19 it can save money or enhance quality.

20 MR. HACKBARTH: Could you say more by what you
21 mean, add anything? Give an example.

22 DR. NERENZ: Well, I mean, we've got a question

1 here. Should we subsidize MA in low-use markets to have an
2 MA in almost all markets? I'd say no, and that's exactly
3 where -- I mean, you've posed us that question. I would say
4 no on that principle that you don't want to subsidize to
5 create something that is not necessarily adding offsetting
6 value.

7 MR. HACKBARTH: Which incidentally is what
8 Congress did with the Medicare Advantage program and its
9 predecessors. It said we will pay higher than the cost of
10 traditional Medicare, at one point way higher than
11 traditional Medicare in some markets, just so Medicare
12 beneficiaries in those areas have a private plan to choose
13 from.

14 DR. NERENZ: And I guess I'm willing to have my
15 principle tested against that action. I would say no. I
16 wouldn't do that if it were me.

17 MR. HACKBARTH: I'm with you.

18 Herb.

19 MR. KUHN: My comments were very similar to the
20 ones just stated. One, I think these principles make a lot
21 of sense, and I think it gives us a nice framework to begin
22 the conversation.

1 Mary added the notion of equity, and then I guess,
2 as Dave was just saying, is there equity when you say there
3 will not be one of these offerings in a particular area.
4 That's something I think we'll just have to grapple with,
5 but then is it worth it to say we would overpay in order to
6 have an offering, as Congress did, to make sure we had these
7 areas? In particular, I'm thinking about rural areas that
8 are out there and whether we're going to even have ACOs
9 invested in some rural areas because there's just not enough
10 in the population out there.

11 But I guess in the backdrop, as we think about
12 those, as we go forward, I think it was the earlier meeting
13 last year where we talked about what's going on with the
14 Medicare population and with the baby boomers coming on and
15 the fact that we're going to go from 54 million to 80
16 million by 2030.

17 We also know that we've seen -- I've seen studies
18 researched by AARP that says about 80 percent of Medicare
19 beneficiaries want to age in place, so they want to stay
20 home in the communities where they grew up. And many of
21 those folks are in those rural areas, and how does that
22 equity fit with that to make sure that those folks either

1 have the choices or the opportunities for that kind of care
2 in the future? I'd like that to be part of the conversation
3 as we continue as well.

4 DR. COOMBS: I like the principles, and I just
5 wanted to add in terms of the payment models, maybe it's a
6 little similar to what we've talked about referential
7 pricing, but the sort of cost or reimbursement should be
8 based on -- the way to incorporate quality would be to have
9 it based on outcomes measures, so things that really help
10 Medicare beneficiaries would be included and paid better,
11 and things that -- services that don't help Medicare
12 beneficiaries would either not be included or reimbursed
13 much lower. And not that they couldn't be purchased, but
14 that the government shouldn't have to pay for those things.

15 Sometimes it's whole services, like, for example,
16 Medicare pays right now for PSA screening, even though the
17 U.S. Preventative Services Task Force suggests that there's
18 no benefit to men for PSA screening, or sometimes it's
19 services that Medicare pays for but made much more
20 frequently than they're recommended.

21 Like again, for cancer screening, colonoscopy,
22 routine colonoscopy is recommended every 10 years, but

1 Medicare spends a lot on every few years, colonoscopy.

2 So to incorporate those principles, so that
3 Medicare is actually paying for things that help
4 beneficiaries, I think would help to incorporate the
5 efficient model and quality into the system.

6 MS. BUTO: Yeah, I'd like to see a principle
7 added, and it might just be an add-on to Jay's third one
8 that talks about -- that gets to the issue of in each of
9 these payment models or others, whatever we come up with or
10 program comes up with, that there would be an element that
11 would encourage or that there would at least not be
12 discouragement for better coordination and management of
13 care.

14 So I think even information for example -- and we
15 sort of touched on it in the discussion on the per-
16 beneficiary primary care payment this morning, that even in
17 fee-for-service, you can add many more elements that will
18 encourage better management of care. We can sort of either
19 add that to your third principle or make that another
20 principle, which is promoting better management of care
21 through any of the models.

22 MR. HACKBARTH: Let me pick up on that, Kathy. I

1 think that's an important point.

2 To the extent that traditional Medicare is one of
3 the options, it begs the question: Does that mean
4 traditional Medicare exactly as it operates today, or do we
5 continue the process of trying to improve the payment
6 systems and encourage things like excellent care or
7 coordination?

8 I've always assumed that it wasn't an inert
9 traditional Medicare, but one that you continued to try to
10 improve.

11 MS. BUTO: I agree.

12 MR. HACKBARTH: But that's sort of a basic policy.

13 MS. BUTO: Particularly if we think these three
14 are going to continue into the distant future or fee-for-
15 service is going to be around for a long time. Then I think
16 it's sort of incumbent on policymaker and us to think about
17 improvements that will further better value care, generally.

18 MR. HACKBARTH: And that begs the question: What
19 kind of changes in traditional Medicare, as we try to
20 improve it, would fundamentally alter its character, so it's
21 no longer traditional Medicare? For me, the most
22 fundamental elements are actually in the first couple

1 sections of Medicare law. It says no infringement on free
2 choice of provider. That's its distinctive characteristic.
3 That's what it offers as an alternative for Medicare
4 beneficiaries that the others may, especially over time,
5 cease to offer, and so if we really want beneficiaries to
6 have an array of options on a level playing field, I would
7 say for sure, keep free choice of provider, but then you can
8 change within that construct.

9 MR. ARMSTRONG: Glenn, this is really close to a
10 point that I want to just pile on briefly, and that was, as
11 we're talking about principles, I do think we need -- so
12 we're kind of locked in on fee-for-service, ACO, MA. I
13 mean, what my experience is, that if not for Medicare, ACOs
14 don't have necessarily a really happy future.

15 So I think our real goal is to apply or build a
16 mechanism that is consistent with some principle like.
17 We're actually trying to promote a broad spectrum of
18 different structures, payment structures that are across a
19 full continuum, bundles -- actually, the way you came into
20 it, I think may be a better way.

21 The way we define fee-for-service is itself going
22 to have to change, and so whatever this comparative

1 evaluation that we do going forward has to be flexible
2 enough to accommodate that.

3 But just to presume we're building something that
4 will need to endure for years around ACOs, I think is kind
5 of presumptuous.

6 MR. HACKBARTH: I just would -- oh, I'm sorry. Go
7 ahead.

8 DR. SAMITT: No worries.

9 To tag onto Scott -- and I'd be curious, Jay's
10 impression of this -- the second principle around
11 beneficiary incentives for choosing the most efficient model
12 seems as if efficiency is directed at the beneficiary, and
13 then the third, differential payments based on quality seems
14 as if it's directed as the providers.

15 I see this as a two-by-two matrix. I think we
16 want to create beneficiary incentives for choosing not only
17 the most efficient model, but the highest quality model, and
18 I would argue that we would want differential payments based
19 upon both quality and efficiency.

20 And it may tag into what Scott was alluding to,
21 that if the ACO model, for example, creates an ever-escaping
22 target for becoming more and more efficient, then the ACO

1 model will disappear.

2 So, in many respects, we have to reward both
3 providers and beneficiaries for moving in the direction of
4 value, and so I don't know. It's a friendly amendment to
5 the principles, but I think we have to do it more on a two-
6 by-two-matrix manner.

7 DR. CROSSON: So I understand completely and agree
8 with the quality issue. I did separate them, I think, for
9 emphasis point or whatever.

10 But yes, I think beneficiary incentives to choose,
11 at least to some degree, beneficiary incentives, to choose
12 quality plans would be wise. There is a fair amount of
13 evidence to suggest, at least with the way quality is
14 measured and provided to beneficiaries, that that has not
15 had a lot of impact so far.

16 I got a little bit lost on the notion of rewarding
17 efficiency because I think other than a payment structure,
18 which inherently awards efficiency by allowing the delivery
19 system or the plan to retain savings, which I think is
20 inherent in both models -- imperfect, but inherent in both
21 models -- is that what you're basically talking about? I
22 mean, that would be preserved basically in these models,

1 whereas I think if you were to say you're low cost, you're
2 going to get a reward for that. Other than something that
3 was inherent in the payment system itself, I don't
4 understand that.

5 DR. SAMITT: Yeah. I think it's as much the
6 notion of assuring that we have continued incentives and
7 gain-sharing for looking at care coordination, looking at
8 wellness and prevention, looking for more innovative ways to
9 manage the total cost of care. I think we need to find a
10 way to preserve those incentives, and some of the concerns
11 around the ACO model is there aren't sufficient incentives
12 to encourage ongoing innovation around value.

13 That's why I think we need to sustain, if we're
14 talking about principles. We need to sustain sufficient
15 incentives for providers to continue to innovate around
16 prevention.

17 DR. CROSSON: No question about that. I think the
18 principle is the total Medicare cost. If you talk about
19 does that mean in year one without any investment? No. I
20 would say in some circumstances, it might be in Medicare's
21 overall interest to make investments on the sure hope or
22 potential belief that those would return later at a lower

1 cost. If that doesn't happen, then I think you have to go
2 back and rethink it.

3 But no, I'm just saying in the end, as it washes
4 out, it only works if in fact, whichever one you're talking
5 about, provides on a value basis, equal cost for equal
6 services.

7 MR. HACKBARTH: My sense is that the two of you
8 probably agree a lot in terms of the principle, and if there
9 is disagreement, it may be in terms of operationalizing it.
10 That's important, but it may be beyond what we can grapple
11 with today.

12 Bill?

13 MR. GRADISON: I certainly agree with the
14 principles, and at the risk of getting into the weeds too
15 much, it seems to me to follow these would require really
16 fundamental changes in each of the three. In other words,
17 it's not here are these three as they are today and how
18 would we compare them would be more specific.

19 If their principle is that Medicare's total cost
20 should be equal for services in all three markets, then if
21 fee-for-service is the most expensive, it would be necessary
22 to make cuts in fee-for-service in those markets, not

1 generally, which is what we generally do in terms of updates
2 and all that. So you might have some markets which -- well,
3 it speaks for itself. It would have to be a pretty
4 fundamental change in the way reimbursement takes by fee-
5 for-service.

6 To take the second point, should the incentive on
7 the beneficiaries to choose the most efficient models, well,
8 the only real choice the beneficiaries have now that they
9 actually make entirely on their own is the MA, the
10 attribution rules. You could argue that there is a choice
11 with the ACOs because you can get a chance to opt out at the
12 beginning, and maybe 5 percent of the people do, but that's
13 not exactly a choice. You're told you're going to be in
14 there, and there's a certain amount of inertia in saying,
15 "I'm not going to choose to do so."

16 To follow on one more point -- and then I'm done -
17 - with regard to this category two -- and this has been
18 mentioned before, but the current model for MA, I would
19 think, would have to change significantly as well.

20 Yes, the matter of retaining savings would be one
21 way to do it, but another way -- and I know this is
22 something we probably shouldn't talk about, but would be to

1 permit these plans, if they achieve savings, to pay it --
2 give it back in cash to the beneficiary. I think that would
3 really get people's attention because the extra services
4 don't necessarily apply to all the beneficiaries. Not
5 everybody wants to join a health club or is physically able
6 to join the health club, but they all probably wouldn't mind
7 getting some extra dollars back.

8 I'm just saying, having said -- and I repeat, I
9 like these, but I think we have to recognize how far-
10 reaching they would be to actually implement.

11 MR. HACKBARTH: Let me pick up, Bill, on your
12 comment about beneficiary choice and ACOs, and this was
13 something that we wrestled with at the retreat and we
14 wrestled with in preparing our most recent comment letter on
15 ACOs.

16 And I think where we left it was that we thought
17 at least in the short term, it did not make sense to convert
18 ACOs into an enrollment model and put them on a track where
19 they were going to become ever more like MA plans, at least
20 not in the short run.

21 Having said that, we said that we thought it would
22 be useful for ACOs to be able to share some of their savings

1 with beneficiaries in terms of reduced copays and things
2 like that, that would bond them more closely with the ACO,
3 if the ACO wanted to do that, and so it's sort of like a
4 halfway ground between going in enrollment, which we didn't
5 want to do, but not having beneficiaries engaged at all and
6 just being assigned the ACOs behind the curtain.

7 At least in the short run, that's been our MedPAC
8 position.

9 Jay, would you go back to your first principle for
10 a second?

11 DR. CROSSON: I'm trying to think how much it's
12 changed in the last 10 minutes.

13 [Laughter.]

14 DR. CROSSON: What I originally said was that
15 Medicare cost -- and I would add per beneficiary -- should
16 be the same for the same services across the three models.

17 MR. HACKBARTH: Okay. And would you put up, Jeff,
18 Slide 12?

19 So this brings us to that last point that Kathy
20 zeroed in on, that that sounds like premium support. Jay's
21 principle, even if there was unanimous agreement on it,
22 would leave important questions unanswered, and that is how

1 you define what that common amount is that the government is
2 going to play for the different models.

3 The way Medicare Advantage works right now is that
4 at least loosely, subject to some statutory modification,
5 the idea is that payment to private plans is linked to fee-
6 for-service costs in their area. Now, the benchmarks go up
7 or down based on various factors, but that's sort of the
8 underlying concept.

9 So what that means is that you pay your Part B
10 premium, and that entitles you to traditional Medicare,
11 including its free choice of provider. You don't have to
12 pay more than the statutory premium for that option, even if
13 it is the highest cost option in your market.

14 Another way to operationalize Jay's first
15 principle is premium support, and that says -- there are a
16 lot of variations on it, but the basic idea is that you look
17 at bids from the different models, and you link the
18 identical contribution across the different models to the
19 average bid, the low bid, or something like that.

20 That issue, which is one level below Jay's
21 principle, is where all the political heat is or a big hunk
22 of it around premium support. What is the nature of the

1 entitlement? Is it to fix contribution to be determined by
2 bidding, or is it the entitlement to a traditional Medicare
3 free choice of provider at the statutory premium?

4 I'm not asking that we try to resolve that, but
5 simply to illustrate that even one step below Jay's
6 principles, as compelling as they are, there's lots of
7 really important stuff to be resolved.

8 Jay.

9 DR. CROSSON: One point, just to separate them.
10 So we're talking about -- unless I'm missing something here,
11 we're talking about number one is Medicare cost being the
12 same. Number two is the nature of beneficiary incentives to
13 choose the lower cost option. In my mind, that doesn't
14 necessarily mean that the beneficiary incentive needs to be
15 the total difference. In other words, you could have
16 incentives, which would move the beneficiary without
17 necessarily burdening the beneficiary, at least for a period
18 of time or perhaps forever, with the total cost difference,
19 because it's going to take a long time for this to smooth
20 out. Does that sound right?

21 MR. HACKBARTH: So any other comments right now?
22 I feel like we or at least me is running out of energy here.

1 If there are any other comments that people want to make
2 right now, please jump in.

3 [No response.]

4 MR. HACKBARTH: Seeing no hands, I'd like to move
5 on, but let me just try to sum up where I think we are.

6 So maybe we put the cart before the horse, and we
7 talked about some empirical analysis before we talked about
8 principles, but I sense at least a high level of agreement
9 with Jay's basic principles, even though we have identified
10 several areas where there are important choices to be made
11 right below the level of those principles. They don't
12 resolve every question that needs to be answered.

13 The basic idea of choice for beneficiaries on a
14 level playing field, appropriate rewards, incentives for
15 quality, or barriers to entry by poor quality providers, I
16 think are points that we can all rally around.

17 What the empirical analysis say, if you use one
18 particular way of defining the cost performance of these
19 different types of entities, in some markets one will be
20 better than another. One will be consistently the best
21 everywhere.

22 I don't see that at all at odds with the basic

1 principle that Jay offered. In fact, I think that's a
2 reason why you want to do Jay's approach saying there ought
3 to be choice, there ought to be incentives for efficiency
4 and cost. What we have to do is construct a system that
5 achieves those goals well.

6 We don't want to say everybody needs to go into
7 MA. We don't want to say everybody needs to stay in
8 traditional Medicare. We don't want to say everybody needs
9 to go into ACOs. There is room for differences of choice
10 and performance. Right? Everybody in the same place?

11 So I think that's where we are at this point. I
12 think the next step is to try to consolidate any agreement
13 around the principles, maybe make some additions and
14 modifications to the wording, but then get to that critical
15 next level of policy issues.

16 Kathy.

17 MS. BUTO: I want to make sure we don't lose that
18 point that you were making about the continuing improvements
19 of Medicare fee-for-service and somehow building that into
20 the thought.

21 As I look at Jay's framework, it's really bigger
22 than these models. It's really about what direction should

1 Medicare be, what's the ultimate goal in improving the
2 program overall, and these are certainly delivery systems or
3 mechanisms. But there's a lot else there in almost
4 everything we do, and everything in reform would fit under
5 this framework.

6 MR. HACKBARTH: Mm-hmm.

7 MS. BUTO: So don't lower the Medicare fee-for-
8 service improvement.

9 MR. HACKBARTH: Yes, agreed.

10 Mark?

11 DR. MILLER: And the only thing that I'll add is
12 that I think there will still be a little bit of this push-
13 pull thing. The thought process next was for us to come in
14 the spring -- and I can't remember whether it's March or
15 April, which meeting this is set up for -- and talk a little
16 bit about the notion of if you started to trigger
17 differences for the beneficiary, what would that look like.

18 And then again, so we'll put some numbers up.
19 They will be illustrative and all the rest of it, and then
20 we will be back to this philosophical conversation. So we
21 are going to try and give you some things to react to
22 concretely and then get you back into the philosophical

1 conversation and just try and work our way through the
2 problems that way.

3 If somebody has a better plan, knock yourself out.
4 Give me a call. I'm happy to pursue it, but it is very hard
5 because when we've come with pure philosophy, everybody
6 goes, "Yeah, okay." And then if you bring pure numbers,
7 then it's like what are we talking about, and so we're just
8 trying to navigate those two, those two polls as we go
9 through.

10 MR. HACKBARTH: Thank you so much, Jeff and Scott.

11 We are now to our final item on today's agenda,
12 this status report on Part D, which will go in the March
13 report.

14 Craig, before we go to that, you were out of the
15 room for the vote on ASCs and the update. Do you want to go
16 on record on ASC update recommendation?

17 DR. SAMITT: Sure. Would you mind going through
18 the whole chapter in detail again?

19 [Laughter.]

20 MR. HACKBARTH: Yes.

21 DR. SAMITT: I vote in favor of the ASC
22 recommendation.

1 DR. MILLER: Thank you, Craig.

2 [Pause.]

3 MR. HACKBARTH: Okay. Shinobu and Rachel, you are
4 on.

5 MS. SUZUKI: Good afternoon. Medicare's
6 prescription drug program, known as Part D, just began its
7 tenth year, and today, Rachel and I will go over trends we
8 are seeing in the program.

9 Here's what will be covered in the presentation:

10 A snapshot that includes key trends, enrollment and plan
11 offerings, access and quality, and costs of the program with
12 a focus on plan strategies and drug price trends that are
13 keeping the premium growth in check while overall program
14 spending continues to grow. And, we'll discuss concerns
15 posed by the drug pipeline and conclude with ongoing future
16 Part D work.

17 Here's a quick overview of the Part D program. In
18 2014, 37 million, or about 69 percent of Medicare
19 beneficiaries enrolled in Part D plans, and another five
20 percent got drug benefits through former employers that
21 agreed to be the primary insurer for their retirees in
22 return for Medicare subsidies, called a Retiree Drug

1 Subsidy, or RDS. About 12 percent of Medicare beneficiaries
2 have no drug coverage or coverage less generous than Part D.
3 Part D program spending totaled \$65 billion in 2013, mostly
4 for payments to Part D plans, and \$2 billion for the RDS.
5 Part D makes up about 12 percent of total Medicare outlays.
6 Surveys indicate that Part D plan enrollees are generally
7 satisfied with the coverage.

8 Between 2007 and 2014, we've observed these key
9 trends. Enrollment among beneficiaries who do not receive
10 Part D's low-income subsidy has grown faster than growth
11 among those with LIS. Some of that growth is due to a
12 number of employers that have quit taking the RDS and
13 instead set up special employer group plans in Part D for
14 their retirees, largely because of changes in patient
15 protection in the Affordable Care Act of 2010. Today, 30
16 percent of Part D enrollees receive the low-income subsidy,
17 down from 39 percent in 2007.

18 There's a lot of variation in Part D premiums, but
19 on average, they've grown fairly slowly, at three percent
20 per year, and they've been especially stable between 2010
21 and 2014. That's the good news. The not-so-good news is
22 that total Medicare payments to plans for reinsurance have

1 grown by more than three times the pace of the premium
2 growth. It has grown on the per capita basis by an average
3 of ten percent per year between 2010 and 2014, and we'll go
4 into some of the reasons for this throughout this
5 presentation.

6 Your mailing material had a lot of detail about
7 enrollment and plan availability for 2015, so I'll just
8 provide quick highlights. In 2014, 62 percent of enrollees
9 were in PDPs, down from about 70 percent in 2007. For 2015,
10 PDP offerings are down by 14 percent, but beneficiaries will
11 still have the broad choice of plans, ranging from 24 to 33
12 PDPs. In 2014, 38 percent of Part D enrollees were in MA-
13 PDs, up from 30 percent in 2007. And for 2015, the total
14 number of MA-PD offerings remained stable.

15 As I mentioned earlier, LIS enrollees are a
16 smaller share of enrollees compared to 2007, reflecting the
17 higher enrollment growth observed among non-LIS enrollees.
18 We've seen more enrollment growth in MA-PDs in the last few
19 years, and that's true among the LIS enrollees, as well. In
20 2014, 28 percent of all LIS enrollees were in MA-PDs, which
21 is up from 14 percent in 2007.

22 There are fewer stand-alone PDPs with premiums

1 below the regional benchmarks. Still, the number of
2 benchmark plans ranges from at least four in Florida and
3 Nevada to as many as 12 in Arizona and a couple other
4 regions.

5 Beneficiaries appear to be generally happy with
6 the program. According to the Medicare Current Beneficiary
7 Survey, most Part D enrollees are satisfied with their drug
8 coverage and have good access to pharmacies. In 2012, about
9 five percent reported that they had trouble filling at least
10 one of their prescriptions.

11 The five-star rating that CMS publishes every year
12 shows that ratings have generally increased over time,
13 particularly among the MA-PDs. This may be because the
14 highest rated plans are rewarded with enrollment
15 opportunities outside of the annual open enrollment period,
16 while the lowest rated plans are flagged as such to caution
17 beneficiaries about choosing those plans. In addition, MA-
18 PDs have financial incentive to improve their ratings
19 because Part D performance affects the overall plan ratings
20 used to determine the amount of bonus payments under Part C.

21 This slide is just to remind you quickly about
22 Part D's standard benefit. The labels on the left indicate

1 the different benefit phases. Working from the bottom up,
2 you can see there's a deductible, an initial coverage limit,
3 partial coverage in what's been called the coverage gap, and
4 then out-of-pocket threshold. And, in 2015, people with
5 total drug spending of about \$7,000 or more would exceed
6 this out-of-pocket threshold and enter the catastrophic
7 phase of the benefit. As you'll see shortly, most people
8 don't have spending high enough to reach this phase, but
9 people that do account for a very high share of Part D
10 spending. Notice the area in white. That shows that
11 Medicare pays 80 percent of benefit in the catastrophic
12 phase. That's the individual reinsurance that you'll hear
13 repeatedly in this presentation. And, the plan pays for the
14 15 percent and the enrollee pays five percent.

15 Now, let's look at how the distribution of
16 spending among Part D enrollees affect Part D's premiums and
17 program spending. Here's data from 2012. That year, 75
18 percent of enrollees ended up with total drug spending below
19 the coverage gap. High use of generics helped keep their
20 spending down, and altogether, their prescriptions amounted
21 to 25 percent of total gross spending for all Part D drugs.

22 At the other end of the distribution, eight

1 percent of enrollees had drug spending high enough to reach
2 the catastrophic phase of the benefit. Altogether, spending
3 for these high-cost beneficiaries amounted to 44 percent of
4 total gross spending. Those beneficiaries use a lot of
5 medications, more than nine prescriptions per month, on
6 average, and they tend to use more brand name drugs and
7 biologics. Most are LIS enrollees.

8 The stability in the average monthly Part D
9 premium over the past few years have largely been affected
10 by what's going on on the left-hand side of this slide. The
11 entry of so many generics over the past few years has really
12 helped to keep average Part D premiums stable. At the same
13 time, Medicare's reinsurance covers 80 percent of spending
14 in the catastrophic phase of the benefit for enrollees on
15 the right-hand side. Reinsurance has been growing fast and
16 the drug pipeline suggests there's a lot of upward pressure
17 on the horizon, and that's why overall program spending is
18 growing a lot faster than premiums.

19 This chart shows the national average plan bid,
20 which is a per member, per month amount that reflects plans'
21 expectations about how much it would cost to provide the
22 benefit. The dotted line at the top shows that it has grown

1 at a modest rate of about 2.4 percent per year between 2007
2 and 2015. Beneficiary premium, on average, covers 25
3 percent of the bid, and that's represented by the yellow
4 piece. Because the total bid has been relatively stable,
5 therefore, the premiums have remained relatively stable, as
6 well. However, the chart also shows a rapid growth in
7 expected cost of reinsurance that's in red. That's provided
8 by Medicare. Plans are not at risk for this piece.

9 Between 2007 and 2015, the amount plan sponsors
10 expect to receive in reinsurance has grown by about ten
11 percent per year. On the other hand, the capitated payments
12 to plans that's in green has fallen by more than four
13 percent per year. So, the increases in expected reinsurance
14 payments have largely been offset by lower expectations
15 about the cost of providing the benefit for the majority of
16 the enrollees with the relatively low spending.

17 However, you may recall from our October
18 presentation the plans have often underestimated the amount
19 of spending for reinsurance so that CMS have, on net, had to
20 pay plans additional amounts after reconciling prospective
21 reinsurance payments based on plan bids with the actual
22 spending. This is not a topic for this presentation, but

1 just keep in mind that the stability in the premiums we have
2 seen doesn't fully reflect the true program cost experience.

3 This chart shows the total program spending in
4 billions of dollars. The growth in reinsurance is also
5 apparent here, too. Total Medicare spending for
6 reinsurance, in red, has grown the fastest, from \$8 billion
7 in 2007 to nearly \$20 billion in 2013, or by a cumulative of
8 143 percent over this period. Reinsurance now makes up
9 nearly a third of total program outlays.

10 The direct subsidy payment, in dark gray at the
11 bottom, is the monthly capitated payments that's become a
12 smaller portion of plan bids. You can see that total
13 Medicare spending for this piece has stayed fairly flat.

14 At the top, in light gray, is Medicare spending
15 for the low-income subsidy. This is not part of the basic
16 benefit, so you didn't see this in plan bids. Medicare pays
17 100 percent of the cost of the premium and cost sharing
18 subsidy for people with low income and assets. At more than
19 \$23 billion in 2013, it's the largest component of Part D
20 spending.

21 The sea take-away here is that because the
22 majority of the people who reach the catastrophic phase of

1 the benefit receive the low-income subsidy, between spending
2 for the LIS itself and reinsurance, a lot of the growth in
3 program spending is associated with low-income subsidy
4 enrollees. It's grown much faster than the growth in the
5 number of LIS enrollees. While LIS enrollees account for
6 about one-third of all Part D enrollees, when you add up all
7 the pieces of the program spending for them, the
8 reinsurance, the LIS, and their share of drug subsidy, the
9 spending accounted for by LIS enrollees comes to about two-
10 thirds of all program spending.

11 So, I've been talking about how the premiums have
12 been relatively stable. A lot of it has to do with
13 formulary tiering and cost sharing structure that use
14 financial incentive to encourage the use of lower-cost
15 drugs. In recent years, we've seen more plans use a five-
16 tier cost sharing structure with preferred and non-preferred
17 tiers for both brands and generics in addition to a
18 specialty tier. Five-tier plans did not exist before 2010,
19 and now, over 80 percent of PDP offerings have a five-tier
20 structure.

21 We are also seeing more plans with tiered networks
22 of pharmacies that include preferred pharmacies where plans

1 get rebates or discounts but lower their cost of providing
2 the benefit. Enrollees typically pay lower cost sharing at
3 pharmacies that are designated as preferred compared to the
4 other pharmacies. The difference in cost sharing amounts
5 can sometimes be substantial. In 2015, nearly 90 percent of
6 PDPs had preferred pharmacies, up from about ten percent in
7 2010. While both of these strategies may encourage
8 enrollees to use lower-cost drugs or pharmacies, thereby
9 potentially reducing program costs, a risk is that these
10 approaches could also increase Medicare spending for the
11 low-income subsidy because their cost sharing amounts are
12 set by law and so they do not face the same financial
13 incentives that non-LIS enrollees face to choose lower-cost
14 products or pharmacies.

15 There are two underlying trends that directly
16 relate to the chart you just saw about beneficiaries with
17 high and low spending. First is that -- is what some refer
18 to as the patent cliff, the fact that in recent years, and
19 in particular in 2012, a record number of blockbuster drugs
20 went off-patent and generic versions entered the market.
21 We've seen a huge shift towards generics among Part D
22 enrollees, moving from a GDR of 61 percent in 2007 to 81

1 percent in 2012. Between 2011 and 2012, that shift towards
2 generics contributed to a slight decline in average per
3 capita drug spending even as the number of prescriptions
4 filled grew. So, that has helped keep the cost down for the
5 majority. In 2012, the share of enrollees who reached the
6 catastrophic phase of the benefit also declined.

7 All of this is good news. But, there are a lot
8 fewer patent expirations on the horizon and the pipeline of
9 new drugs that will enter the market is dominated by
10 biologics and specialty drugs, many of which will have very
11 high prices.

12 Between 2009 and 2012, we began to see an uptick
13 in the use of biologics among high-cost enrollees, with
14 spending on biologics growing by more than 90 percent over
15 this period. These trends have big implications for Part D
16 spending because Medicare pays for 80 percent of benefits in
17 the catastrophic phase. Also, more than three-quarters of
18 beneficiaries who reach the catastrophic phase receive the
19 low-income subsidy, so Medicare is also picking up the cost
20 sharing, as well. The latest claims data that we have is
21 for 2012, so it doesn't reflect the cost of the newest
22 treatments for Hepatitis C, which had the list price of

1 \$1,000 per pill, or \$84,000 per regimen.

2 This slide gives you a sense of what's been
3 happening with prices for drugs covered under the program
4 since it began in 2006. Overall, prices rose 35 percent
5 between January of 2006 and December of 2012. Thus, a gray
6 line. But, when generic substitution is taken into account,
7 prices actually fell by four percent over the same period.
8 That is, the shift from brands to generics has made a big
9 difference on the average prices paid.

10 Another way to see how the switch to generics has
11 kept prices low is to look at the brand and generic
12 separately. If you look at the red line at the top, you can
13 see that prices for single-source brands, including
14 biologics, nearly doubled. So, even though our claims data
15 doesn't include the Hepatitis C and other new very expensive
16 drugs, you can see that prices for those drugs grew
17 aggressively. On the other hand, generic drugs decreased to
18 about 32 percent of the average prices observed at the
19 beginning of 2006, so the use of generics had a significant
20 effect on keeping overall Part D prices low.

21 But, newer therapies will likely pose a
22 significant challenge for Part D. The chart on the left

1 shows a double-digit increase in spending for specialty
2 drugs for major PBMs between 2012 and 2013. There are many
3 forces that will put an upward pressure on drug prices.
4 There are fewer patent expirations on the horizon to offset
5 price increases for brand name drugs, and prices for some
6 older generics have decreased sharply. Half of the FDA
7 approvals for new drugs in 2013 were for specialty drugs,
8 and spending for new treatments for cancer, Hepatitis C, and
9 multiple sclerosis accounts for the bulk of spending on new
10 brand name drugs. Launch prices for new specialty drugs are
11 unprecedented. In the case of Hepatitis C, because so many
12 beneficiaries would be candidates for the new therapy, we'll
13 likely see a noticeable spike in Part D program spending.
14 Major PBMs say that spending for specialty drugs is starting
15 to drive their overall trends in drug spending.

16 So, a key question for the future is whether Part
17 D plan sponsors will be able to negotiate lower prices for
18 these new therapies. In the case of Hepatitis C drugs,
19 we've seen PBMs and Part D sponsors starting to push back
20 against manufacturers. They've been able to do so because
21 the FDA has now approved several Hepatitis C therapies that
22 will compete with each other. FDA's pathway for approving

1 biosimilars holds promise for opening biologics up for
2 greater price competition, as well. But, PBMs and plan
3 sponsors have less bargaining leverage when there are no
4 therapeutic substitutes.

5 So, to summarize, we continue to see high
6 satisfaction among Part D enrollees, with stable premiums,
7 good access, and many plan options to choose from. But, the
8 growth in payments for reinsurance and low-income subsidy
9 that we have been talking about for a few years now
10 continues to be a major concern. The underlying trend in
11 drug pipeline towards higher-cost drugs are likely to put an
12 upward pressure on program costs, particularly in the
13 catastrophic phase of the benefit. The strategies to
14 encourage use of generic drugs or negotiate rebates with
15 manufacturers may not be as effective for the new high-cost
16 therapies if there are no therapeutic substitutes. Even
17 when there are, recent experience suggests that the pricing
18 of new therapies will be order of magnitudes higher than
19 traditional therapies so that a single therapy will often
20 put people in the catastrophic phase of the benefit. And,
21 finally, the increases in prices for some generics that
22 we've seen in recent years is also a significant concern.

1 In the spring, we're returning to the topic we
2 discussed last October, to start thinking about Part D's
3 risk sharing arrangement and plan incentives. For example,
4 is the faster growth we are seeing for individual
5 reinsurance and LIS an artifact of how the incentives work
6 under the current risk arrangement? How much of it is
7 driven by the underlying market conditions, such as the
8 shift in drug pipeline towards higher-priced biologics and
9 specialty drugs? Is there anything that Medicare or plans
10 can do to manage the cost of those new therapies,
11 particularly in cases where there are no therapeutic
12 alternatives?

13 Another area we may want to focus on is how some
14 of these strategies plan sponsors are using to keep costs
15 and, therefore, premiums in check affect Medicare spending
16 for the low-income subsidy. Because strategies that rely on
17 cost sharing differentials may increase low-income subsidy
18 costs, we may want to revisit our LIS copay recommendation
19 from 2012 and consider modifications to account for these
20 new innovations.

21 Other issues we'll be focused on include looking
22 into the effects of increases in generic drug prices and how

1 that may be affecting beneficiaries' access to drugs and the
2 programs costs. And, we'll also be looking into quality of
3 care provided under the Part D program with a focus on
4 polypharmacy and adverse drug events.

5 That concludes our presentation.

6 MR. HACKBARTH: Okay. Thank you, Shinobu.

7 Clarifying questions for Shinobu?

8 DR. SAMITT: As I look at the profound effect that
9 the LIS has on the costs of the program, it made me wonder
10 whether -- you talked about the percentage of beneficiaries
11 that are in PDP, the percentage that are in MA-PD, and then
12 the percentage that are LIS. I was curious about the
13 distinction between LIS beneficiaries in PDP versus MA-PD.
14 Did we take a look at differences in those two populations
15 in terms of generic utilization or preferred pharmacy use?
16 In essence, what I'm getting at is: Is there anything that
17 is done by MA-PDs that seems to be more effective with that
18 population than the PDPs?

19 MS. SUZUKI: So we have looked at the generic use
20 rate within the plan types. On average, for both LIS and
21 non-LIS enrollees, generic use is higher among the non-LIS
22 enrollees compared to LIS enrollees. But there is a

1 significant difference within the plans between LIS and non-
2 LIS for both types.

3 DR. SAMITT: I actually meant for the LIS
4 population between PDP and MA-PD, the other way.

5 MS. SUZUKI: So there is. So LIS enrollees and
6 MA-PDs did have higher GDR compared to those in PDPs. I
7 don't know that we have the exact number.

8 DR. SCHMIDT: We could come back to you with the
9 specifics, but, yes, there's a difference. There's higher
10 use of generics in MA-PDs.

11 DR. SAMITT: And any difference also in preferred
12 pharmacy use?

13 MS. SUZUKI: So that we don't have the answer to,
14 but we're trying to think about how we could approach that
15 issue.

16 DR. REDBERG: Thanks. That was an excellent
17 chapter. On Slide 12, you had some detail. I'm interested
18 in what you think sort of drove the increase in generic use
19 from 2007 to 2012 from 61 to 81, and you did mention five-
20 tier formularies and also some drugs coming off of patent.
21 But I'm wondering if there are any other factors and, in
22 particular, how much of that is due to beneficiaries' choice

1 towards brand name, or is it mostly due to the other market
2 factors, brand names not being available -- I mean, sorry,
3 generics not being available for some or the influence of
4 tiered co-payments? I'm just trying to get an idea of sort
5 of where we're going in the future, because as you noted,
6 there are a lot more expensive drugs, and there are some
7 drugs that had been available as generics that are now no
8 longer available as generics.

9 DR. SCHMIDT: I don't know that we can disentangle
10 those two for you, certainly not off the top of our heads.
11 But I think there's really been a huge flood of generic
12 entry, particularly in the year 2012. Not to say that the
13 cost-sharing differentials aren't important. Those clearly
14 before the entry, the mass flood of this patent cliff, that
15 resulted after this patent cliff happened, there was clearly
16 a turn towards generics beforehand. But afterwards, it was
17 just the whole-scale flood.

18 DR. REDBERG: Thanks.

19 DR. CHRISTIANSON: Thanks for this chapter. I
20 learned so much reading it. One point I need a little
21 clarification on just because I think it applies to one of
22 the discussion points. Could you go back to Slide 11,

1 please?

2 Would you explain again the last arrow point
3 there, what's the connection, how that works and everything?
4 I just didn't pick up on that when you were talking about
5 it.

6 MS. SUZUKI: So low-income subsidy enrollees have
7 a statutorily set co-payment, so when plans charge more,
8 that difference between the statutory set amount and the
9 plan's co-pay amount is picked up by the low-income subsidy,
10 so Medicare pays for that amount.

11 DR. CHRISTIANSON: Ah, okay. Thank you.

12 DR. HALL: Shinobu and Rachel, I also wanted to
13 start off by saying this is a fantastic report, not only the
14 text but the graphics are really terrific. I wish I could
15 make graphics like that.

16 When we talked about this in the spring -- maybe
17 this related to what Craig just said -- I had the impression
18 that the use of non-generics in the LIS population wasn't
19 just a little skewed but the majority of prescriptions were
20 actually non-generic. Do I have that right?

21 MS. SUZUKI: No, they do use a lot of generics.
22 You may be remembering some of the presentations focused on

1 high-cost beneficiaries.

2 DR. HALL: Right, right.

3 MS. SUZUKI: For them, we found a higher use of
4 brands. But, in general -- so, you know, from the chapter,
5 the paper, we have LIS population using about 78 percent
6 generic overall compared to 83 percent for non-LIS
7 enrollees. So they do use a lot of generics, but we've
8 found that when they do -- you know, they do incur higher
9 costs. Some of it looks like it may be due to using brand-
10 name drugs.

11 DR. HALL: And is there any attribution why that's
12 the case? Is that a decision by some of the pharmacies or
13 the --

14 MS. SUZUKI: I think there might be a mixture of
15 things. One of the things we've talked about is the co-pay
16 amounts that are set in law. It may not provide as strong
17 of an incentive to encourage them to use generics compared
18 to non-LIS enrollees who may see a bigger financial
19 incentive to switch to generics.

20 DR. HALL: Thank you.

21 DR. COOMBS: So does the discount impact the LIS
22 disproportionately, the discounted prescription plans? The

1 discount that's offered.

2 DR. SCHMIDT: You mean coupons?

3 DR. COOMBS: Yes.

4 DR. SCHMIDT: They're not permitted to use those
5 in Part D.

6 DR. HOADLEY: On Slide 5, I just had a couple of
7 questions on the numbers here. The fact that there's a
8 decrease in the percentage of Part D enrollees that receive
9 LIS, it seems like that's -- and you might have been
10 alluding to this when you talked about it. That's being at
11 least partially driven by the increase in the employer
12 plans. My numbers suggest that only about -- the employer
13 plans, only about 2 percent of them are LIS, and so by that
14 influx -- and I'm not sure, maybe it's worth sort of working
15 out how much of that difference is attributable just to that
16 one factor. It looks to me like it's probably not --
17 there's probably some decrease even without the employer,
18 but it would be nice to flesh that out.

19 And then the bullet right after that, do you know
20 how much of that increase in MA-PD might be due to the dual
21 demos or just more generally to the SNPs, growth in SNPs?
22 You may not have that, but that would --

1 DR. SCHMIDT: Yeah, we don't have that off the top
2 of our head, but we can get that for you.

3 DR. HOADLEY: Okay.

4 MR. GRADISON: Thank you. You say that the use of
5 brand-name drugs is 5 percent higher for the LIS. Question:
6 Is it possible that the conditions that are being treated
7 for the LIS folks are sufficiently different and that they
8 require -- that they involve situations where generics are
9 not available at all?

10 MS. SUZUKI: I think that's definitely possible.
11 We've also looked within narrower therapeutic classes to see
12 whether the generic dispensing rates differ between those
13 two populations, and we've found in some classes a
14 significant difference in GDRs, even for, say, diabetic
15 therapy or peptic ulcer treatments.

16 DR. MILLER: We went through this a few years
17 back, is what I'm trying to remember, and I think there was
18 a lot, including myself, this perception that, well, this
19 population is very different and they have a lot more name
20 brand drugs. And what her analysis found was for large
21 classes of, you know, the standard -- and I don't mean to
22 put it that way, but diabetes, those kinds of drugs, they

1 were using name brands there, too. But that doesn't
2 disqualify your point. There is more of what you're saying
3 in this population, too.

4 MR. GRADISON: Well, I talked to one physician
5 about this, and I said, Why, in your opinion, as somebody
6 who treats a lot of low-income people? And the answer was
7 it's the docs. I mean, the patients don't write these
8 prescriptions. And it made me wonder whether we ought to be
9 thinking about -- this is Round 2, but whether we ought to
10 be thinking about how to influence the doctors to take this
11 into account.

12 MS. BUTO: Yeah, I wondered if you could -- if you
13 have any data on the -- because I'm looking at Slide 12,
14 drug pipeline dominated by higher-priced biologics and
15 specialty drugs. Do you have data on the percentage of, I
16 guess, Part D spend that goes to biologics and specialty
17 drugs versus other? And I know there's some crossover with
18 Part B, but, you know, are there some that are more --
19 provided more through Part D than B, some of those specialty
20 drugs?

21 MS. SUZUKI: We can definitely get you a little
22 more information, but the analysis that we've done for

1 people who reach the catastrophic phase of the benefit, I
2 think we found that biologics --

3 DR. SCHMIDT: So spending -- these are just the
4 people that hit the catastrophic. Those are the ones --
5 we're looking at their biologics, not all biologics used in
6 Part D. But the gross spending on that grew -- we're
7 looking at Table 16 in the mailing materials -- by 91
8 percent over 2009 to 2012.

9 MS. BUTO: It would be helpful to know what the
10 sort of what share of Part D drug spend I think would be
11 associated with biologics versus -- since we're looking at
12 what's the pipeline going to do to us, right?

13 MS. SUZUKI: So it's about \$3.5 billion for this
14 population in 2012 out of -- I forget -- \$65 billion or
15 whatever it was in -- \$60 billion-ish.

16 DR. CROSSON: Yeah, Shinobu, this is from the
17 text. Could you say a little bit more about the medication
18 reviews, the comprehensive and targeted medication reviews,
19 which don't seem to be -- don't seem to have much update.
20 So one question is: Why is that? Are they effective? Are
21 they used for the LIS population more or less than the non-
22 LIS population? And to simplify my phase one question, is

1 there a potential solution here for something?

2 MR. HACKBARTH: That is clearly not a Round 1
3 question [off microphone].

4 [Laughter.]

5 MR. HACKBARTH: Out of order [off microphone].

6 MS. SUZUKI: So the data we had did not allow us
7 to look at the participation rates in MTM or take-up rates
8 of CMR or TMR by LIS status. So I can't answer that part of
9 the question. But you saw that participation rates are
10 fairly low. Even among the participants, take-up of the
11 comprehensive medication review is very low, around 10
12 percent, among the MTM enrollees. And, you know, this is
13 the first time CMS has published this information at this
14 granular level. So we'll see what other information will
15 become available, but so far based on the data that's
16 available, I don't think we can make a determination about
17 whether it's effective. We've seen that people who do take
18 up the CMR or TMR do have -- are more likely to have there
19 be changes or prescriber interventions. But it's hard to
20 connect that to outcomes.

21 DR. CHRISTIANSON: I have two more questions, I
22 guess. One is related to your comments about the very large

1 price increases for some generics, and so we've all been
2 reading about that, and so we're talking about in some cases
3 1,000 percent price increases over a two- or three-year
4 period. It's also hard, from the stuff I've been reading,
5 to figure out whether this is a one- or two-off instances or
6 whether this is a broader trend. And the other thing -- so
7 I'd like your -- whether you know anything about that.

8 But the other thing I'd like to know is there's a
9 lot of speculation about why, and one of the reasons people
10 have offered is there has been mergers in the generic
11 manufacturers. Others have said there are a different kinds
12 of other nuances that have contributed to this. But if it's
13 mergers, maybe it's more of a worrisome thing because I
14 don't think they're going to un-merge, so that gives them
15 some market power over time to pursue the "charge what we
16 can" strategy for generics.

17 So I guess that's my first question. Do you have
18 a sense from your reading, is the driving force here
19 mergers? In which case, I think it could be a significant
20 longer-term problem. Or is this some kind of glitch due to
21 a new regulatory policy or something like that?

22 DR. SCHMIDT: And there's a reason on the last

1 slide that we put that as an area for further research,
2 because I don't think that we have a clear answer to that.

3 DR. CHRISTIANSON: So right now no sense of that.
4 Okay.

5 DR. SCHMIDT: Well, I would say that I don't think
6 it's simply a matter of just looking at mergers across
7 generic manufacturers. It may also be that companies that
8 have been brand-name drug manufacturers are also sometimes
9 merging with generic manufacturers. So there's, I think, a
10 whole host of issues.

11 DR. CHRISTIANSON: Okay. Any sort of merger
12 explanation drives us the same place, which is it's
13 potentially a long-term problem for us.

14 The other question I had was I also had read a lot
15 about and know virtually nothing about the problem of drug
16 shortages. Do you know anything about whether drug
17 shortages have had a particular impact on beneficiaries, on
18 our beneficiaries?

19 DR. SCHMIDT: I do not know. I know that we've
20 heard anecdotally in some settings, like hospital outpatient
21 departments, some of our contacts there have kind of spoken
22 to shortage issues. In the context of Part D, I haven't

1 heard anything directly.

2 DR. CHRISTIANSON: Yeah, the Obama administration
3 had a set of policies that Jack knows more about than I do
4 about trying to address drug shortages. It would be
5 something to think about in terms of adding to our list if
6 these are really significant. Are they in drugs that are
7 particularly important for our beneficiaries?

8 DR. HOADLEY: I'll follow up real quickly. There
9 has been some talk about the link of those two issues, that
10 drug shortages or manufacturing issues have been part of
11 what's driven at least a few of the generics that have
12 soared in price. And there some evidence -- there was a
13 hearing in November and there's some interesting testimony
14 there that says that it's definitely isolated to some
15 generic drugs that have had these huge, even 1,000 percent
16 increases, but it's not just like one or two. There are
17 several, and mergers seem to be a factor, shortages may be a
18 factor, and maybe even pipeline approval kinds of things of
19 new generics may be a factor.

20 MR. HACKBARTH: Any other Round 1 clarifying
21 questions?

22 [No response.]

1 MR. HACKBARTH: So let me kick off Round 2.

2 Shinobu, could you put up Slide 10?

3 So to me, one of the important pieces of
4 information in this update is the rapid growth in
5 reinsurance expense. Much of the discussion is focused on
6 the stability in the premium, and not only what's happening
7 to total program costs, including reinsurance. And so what
8 are you going to do about this, Shinobu?

9 [Laughter.]

10 DR. MILLER: Yeah, Shinobu. Do you guys want to
11 get into this? Or do you want me to? Or do you want to go?

12 MS. SUZUKI: So in the last slide, I think we're
13 talking about what we're doing in the spring, and...here it
14 is. We are trying to think about if part of the issue is
15 the risk-sharing arrangement that we have in Part D. Right
16 now Medicare picks up a lot of the catastrophic spending.
17 Plans are doing really well on the lower part of the benefit
18 where they actually have risk. So we're going to start
19 thinking about that.

20 I think we're trying to look into generic price
21 increases, and on the low-income side, we are thinking that
22 maybe plan strategies may be contributing to the growth in

1 subsidy costs for the low-income population.

2 DR. SCHMIDT: Right, so this slide that you
3 pointed to is showing that two-thirds of program spending is
4 for the LIS, and a lot of the reinsurance costs are for the
5 LIS. So I think going back to the recommendation,
6 revisiting the recommendation, and considering the context
7 in which it sits today, where there have been some
8 innovations in how the Part D plan sponsors are delivering
9 their benefits, does that still apply today, it's still
10 trying to reach the same goal of delivering the LIS
11 prescription drug benefit efficiently, and that would, I
12 think, put some less pressure on the reinsurance costs.

13 MR. HACKBARTH: Yeah, so let me ask about the
14 risk-sharing approach in particular. I can't remember
15 exactly when it was. Maybe it was last year at this time we
16 talked about this, and I think a comment, if not universal
17 observation, was that, you know, maybe it's time to look at
18 that structure. The structure that's in place now may have
19 been appropriate when it was a new program, and there was a
20 question about whether -- how many participants there would
21 be in this market, and so the idea was to cushion plans
22 against a lot of risk in order to make sure that there were

1 an adequate number of participants. We're sort of at the
2 point now where we know there are a lot of people that want
3 to be in this market and maybe we ought to be re-evaluating
4 the approach to risk sharing.

5 I have no sense of how difficult that is, but I
6 guess I feel some urgency about getting on with that work.
7 It really seems time to me. Kate?

8 DR. BAICKER: Yeah. I wanted to build on that,
9 was what really drew my attention in this. There was so
10 much information in the chapter, but the reinsurance
11 component is clearly the major -- a very important element
12 of the spending, and it interacts with some of the other
13 issues. So I wanted to think through in more detail why if
14 we need the program to provide this reinsurance versus can't
15 the insurers -- isn't this what insurance is for, and what
16 is it about this risk that is not easily handled by a big
17 insurer?

18 And maybe there are some things, and maybe they
19 have changed over time. So the initial program risk, what
20 is this new program, how is it going to work, that's hard
21 for an individual insurer to deal with. Maybe that makes
22 sense at the beginning.

1 I think we worried at different points in time
2 about the disincentive to enroll high cost, potentially high
3 cost enrollees. If the risk adjusters aren't good, then the
4 reinsurance provides some back-end support to make it not so
5 costly to accidentally enroll sick people in your insurance
6 program. And the question is are the risk adjusters good
7 enough that it's not necessary to have this backstop, is
8 there some problem with the persistence of spending or
9 something like that.

10 And then a third reason that you might be worried
11 about the private provision of insurance comes in with high-
12 end risk insurance, comes in with this spike in new
13 expensive drugs, maybe that's something that is difficult
14 for an insurer to deal with because you can't offload the
15 risk of a new miracle cure that's very expensive that a big
16 share of your bulk of business needs. And that's what we
17 think the public provision is for, but it's not clear to me
18 what role we think the government subsidy of this particular
19 segment of the spending is playing relative to what could be
20 provided otherwise and how these play out in terms of
21 selection of enrollees.

22 Incentives for and then cost, bearing the cost of

1 innovation, how that plays out in not competitive markets
2 versus competitive markets, to me that's a framework that
3 would be very useful in thinking about alternatives to the
4 current scenario, which introduces all sorts of incentive
5 problems for the insurers once people blow through into that
6 catastrophic. Now they have to share a little more than
7 they used to, but we want to be sure there's a compelling
8 reason to incur that harm to incentives that the reinsurance
9 generates.

10 DR. HOADLEY: So I think Kate put a lot of that
11 out really well, but I think the one additional wrinkle is
12 that there is in addition to the reinsurance, there are the
13 risk corridors. There are what's sometimes called the "risk
14 sharing." So that's potentially -- and we talked some about
15 these tradeoffs the last time we talked about this, and
16 maybe that's more the mechanism that suits this what's going
17 to happen as new drugs come on the market and the sort of
18 total risks of the plan as opposed to the person-by-person
19 risk that the reinsurance is about, where there seems to be
20 a stronger case to cut that back from the 80 percent
21 reinsurance that the federal government is now paying for.

22 I have been thinking about this in terms of the

1 hepatitis C drugs where you've seen these two recent
2 announcements of companies that have cut deals. We don't
3 know all the numbers around those deals, but they've cut
4 deals with particular manufacturers, PBMs cutting deals with
5 the manufacturers, sort of what that will play out in
6 Medicare, because there's a variety of issues going on.

7 Part of what they're doing is getting higher
8 utilization by loosening some of the prior authorization and
9 saying we're going to make these drugs available to more
10 people. Well, you've got some issues within Medicare of
11 what changes they can make, so we're at least probably a
12 year off before they could really implement a significant
13 change to their formulary based on one of these deals.

14 But would the deal have the same meaning when the
15 government is picking up? And even though the eventually
16 recoups any savings that occur, the dynamic is quite
17 different given this reinsurance structure.

18 I also think that how this relates to a
19 beneficiary's cost is part of what we want to think about.
20 Maybe there is a point to think a little bit further about
21 this basic design of the benefit from the beneficiary's
22 perspective, from two points of view.

1 One is that person who uses those high-cost drugs
2 for whom the plan is protected, if we do get into a
3 situation where plans are negotiating good discounts through
4 rebates, the beneficiaries aren't benefitting from that
5 because they're paying their coinsurance or even their 5
6 percent catastrophic insurance based on the nominal price of
7 the drug. So that's something maybe we're thinking about,
8 and the structure of the plan, particularly when we think
9 about these super high-cost drugs, is so front-loaded for
10 the beneficiary, the beneficiary sort of faces all their
11 costs if they're using something like the hepatitis C drugs
12 or some of the other new expensive products. They're going
13 to face all their costs in the very first month of the year.
14 So that's good for the rest of the year, but they've got to
15 make it through January, and they're going to be asked to
16 play multiple thousand dollars in one month in order to
17 qualify for catastrophic, which still goes on at a 5 percent
18 cost.

19 So maybe this is an opportunity not just to think
20 about how we retrigger the -- how the reinsurance plays, but
21 even to think about some aspects of how the core benefit is
22 designed, create some flexibility for leveling those across

1 the year, or some flexibility for how to recoup, sort of
2 rebate savings for the beneficiary, not just for the premium
3 which benefits everybody, but in a way that would benefit
4 the people who use those drugs.

5 So those are a couple of pieces that I think would
6 be really useful to put in the framing of this issue. I
7 have some other issues I can come back to a little bit
8 later.

9 MR. HACKBARTH: Let me get Kathy, Rita, and Bill,
10 and then we'll come back to you.

11 MS. BUTO: So I wanted to go back to Slide 7, I
12 think it is, the structure of the benefit, and point out
13 that in the coverage gap, there is a discounted price for
14 brand-name drugs but not for generic drugs, and it's true
15 that many generics are still cheaper than the discounted
16 brand-name drugs. But I also think it's a disincentive to
17 switch to generics with just the discount on brand-name
18 drugs.

19 If you look at high-cost drugs in particular and
20 getting to the coverage gap, some incentive or some
21 attention paying to the use of generics in the coverage gap
22 might be something we should also look at because that would

1 slow getting to that reinsurance threshold. Again, I don't
2 know the specific numbers, but I do know that when that
3 discount was put in place, CBO scored it as a cost to the
4 federal government because they realized that the
5 reinsurance threshold would be breached more easily.

6 DR. MILLER: I don't think it is all attributed to
7 that, but part of what you see in the reinsurance is the
8 result of that effect.

9 DR. REDBERG: I just wanted to talk a little bit
10 about our continued pipeline for biologics and sort of the
11 trends particularly that I see for FDA approving a lot of
12 the newer, more expensive drugs based on Phase I data and
13 much earlier surrogate data, meaning that we have more and
14 more expensive drugs coming on the market with less and less
15 data, that they have actual clinical outcomes, the biologics
16 for rheumatoid arthritis, a lot of the new chemotherapy,
17 which may not be Part D drugs, may be Part B, and even hep
18 C. And hep C, I think for Medicare has big implications
19 because of the task force. U.S. Preventative Services Task
20 Force has recommended hep C screening for all people born
21 between ages 1945 and 1965, even though the risk factor
22 mainly for hep C is IV drug use. But that means that there

1 could be potentially a lot of people coming into Medicare
2 with hep C.

3 We know that maybe 25 percent of people that have
4 hep C positive at one screen is going to disappear on their
5 own, but the treatment is now based on just one screens, so
6 not disappearing.

7 The drugs were approved based on a virologic
8 response, but the thought is that they're going to be
9 beneficial down the line. We don't have that long-term data
10 because the studies were all 12 weeks and 24 weeks. So we
11 have potentially millions of Medicare beneficiaries and
12 incredibly expensive drugs, really skeletal data on what the
13 risks and benefits are going to be long term.

14 Certainly, my GI colleagues tell me that in real-
15 world use, the sustained biologic response is not what was
16 reported in the clinical trials with the new hep C drugs,
17 and so I just think we're going to have a lot of hep C and
18 the biologics coming on the market with very less than
19 optimal risk-benefit data and huge cost.

20 MR. GRADISON: Picking up on Kate's point, I would
21 suggest you take a look at all the dollar thresholds that
22 are in this program, that is, the deductibles and the

1 thresholds for each of the various risk-sharing categories
2 and ask the question about whether it's wise to retain a
3 fixed-dollar threshold rather than indexing it, for example,
4 against a -- if there is such a number, an index based upon
5 the average price of the products, pharmaceuticals that are
6 used by this population, because with a fixed-dollar amount,
7 all these fixed thresholds, if there's any inflation at all,
8 this thing is going to go off the charts.

9 DR. SCHMIDT: Actually, they are indexed against
10 per-capita drug spending for the Medicare population.

11 MR. GRADISON: [Speaking off microphone.]

12 MR. HACKBARTH: Jack -- [speaking off microphone].

13 MS. UCCELLO: I think we say a lot of the same
14 things over time, so I won't get in --

15 I think Kate mentioned this, but in terms of
16 reinsurance, it really kind of is a supplement to the risk
17 adjustment when that doesn't fully adjust for the relative
18 risk, and so I'm all for, as you know, continuing to look at
19 this program and figuring out what we can do to make it work
20 better or whatever.

21 But as part of that, we need to keep in mind that
22 if those risks aren't adjusted for appropriately, then we

1 run the risk of plans trying to avoid those high-cost
2 people, so just that.

3 And one more little aside, Bill mentioned how
4 great all the charts were in that chapter, and I totally
5 agree. Building off of something Rita said, when I read the
6 chapter and I read the section on specialty drugs, all I
7 could picture was Harrison Ford running away from the giant
8 boulder going down. So maybe you could add a little
9 cartoon.

10 [Laughter.]

11 DR. MILLER: I don't really find that helpful. I
12 just want to be clear here.

13 [Laughter.]

14 DR. HOADLEY: I was going to raise a couple new
15 issues. I don't know if anybody else has comments on what
16 we were just talking about.

17 MR. HACKBARTH: I think you've got the floor,
18 Jack.

19 DR. HOADLEY: Okay. I guess one small follow-up
20 on the pricing, I think we sort of put a lot of the right
21 issues on the table to think about. There are measures we
22 could think about in terms of putting more direct pressure

1 on manufacturers relative to price, particularly for those
2 drugs without competitors, and I think that's something as
3 part of a conversation about pricing or just generally more
4 price transparency.

5 And we also had the issue of how the biosimilars
6 are going to play out in terms of pricing and what's going
7 to be the ability of plans when there are biosimilars, and
8 some of the first ones may be Part B rather than Part D
9 drugs. But eventually, we get to the point, sort of
10 anticipating, how that may play out, depending on how the
11 FDA rules in terms of things like substitutability.

12 The other issues I'll raise just briefly -- and
13 there's more stuff that was in the chapter, previous
14 discussions about this, but I think if we're considering the
15 possibilities and recommendations in the June report in this
16 area, there's some things we might want to circle back to.

17 One is the appeals discussion we've had before,
18 and I think there are some -- there was a little bit of
19 discussion about that in the chapter, and I think you point
20 out again that beneficiary awareness of their appeals right
21 are low, and the process is burdensome. So it might be a
22 chance to go back and sort of see if there's some things we

1 could recommend to try to improve on those processes.

2 Another one that I don't want to spend a lot of
3 time on, but is the whole issue of plan selection and
4 information for beneficiaries. This actually relates to
5 some of the conversations from the previous discussion about
6 beneficiary engagement in selecting things bigger than just
7 Part D plans, whether it's improvements in the plan finder
8 or what steps could the program take, and again, Part D
9 specifically or program more broadly, about how to make
10 people think more about their choices.

11 So, in the Part D world, we've got the fact that
12 people don't seem to switch very often, even when it's their
13 benefit to do so, and are there better ways to frame notices
14 that go out to beneficiaries or to make the choice process
15 similar? Again, I think it's exactly the parallel issues,
16 whether we're talking about Part C, Part D, or sort of these
17 broader, more so far hypothetical questions about how we
18 think about choices among the bigger systems that we were
19 talking about in the last session.

20 But I also wanted to raise an issue on the LIS
21 side, and one thing you didn't talk about in the
22 presentation but came up at least a bit in the paper, was

1 formulary variation.

2 When I had looked and worked with the Commission
3 back in the earlier years to sort of think about whether
4 plans were varying their formulary between their offerings
5 that tend to be the benchmark plans for LIS folks and their
6 plans that were offered to others, we tended to come back
7 and find there really wasn't much difference. And typical
8 plan sponsor was using the same formulary across all its
9 products.

10 That's clearly not the case anymore, and you have
11 a table in the chapter that shows that pretty clearly. And
12 it does look like the formularies are less robust for the
13 plans being offered that are mostly be taken up by LIS
14 beneficiaries. Obviously, all plans are open to everybody,
15 but the ones that tend to get most of the LIS enrollment,
16 and that's not necessarily a bad thing if it's a well-
17 designed formulary, but some more dig into those issues.
18 Again, I think that can start to relate to this whole issue
19 of generic use.

20 One way you might be getting better generic use is
21 with those tighter formulary, but we're not seeing the lower
22 generic use. So thinking about how all those factors play

1 out, I think it is useful to go back to the recommendation
2 of a couple years ago as you proposed to do and think about
3 a series of things that interact. One is the statutory
4 copays, how they relate to the differential between generics
5 and brands, how they may relate to much more expensive drugs
6 where again there's still just the small copays, and that's,
7 in a lot of ways, a good thing, how they relate to the
8 formulary robustness which says if the drug is not on
9 formulary, basically the person is going to either not take
10 that drug or pay full price, but then also to the pharmacy
11 difference where, as you've made the clear case, the LIS
12 beneficiaries have no incentive at all to use the preferred
13 pharmacies. And if they don't use those, then the cost
14 accrues to the government.

15 I'm not sure quite what the answers are and where
16 we should land on that, but I think going back and looking
17 at that issue again, making sure we do it in a way that's
18 friendly for the beneficiaries who are in this situation,
19 but also try to make the incentives work better than what
20 they do in the statutory thing. So those are some issues to
21 put on the table.

22 MR. KUHN: Just one quick question here. As you

1 look at the ongoing and future work and particularly the
2 area of polypharmacy and adverse drug events, is that going
3 to be looking at some of the medication therapy management
4 opportunities that still might exist out there, or is it
5 going to be looking at preventable hospitalizations? Can
6 you give me just a sense of what direction it might take us?

7 MS. SUZUKI: I think we're in an early stage of
8 this research. One of the things we were going to try to do
9 in the spring is to reconcile the literature on polypharmacy
10 and adherence. I think there's some contradicting message
11 you get reading those two literatures and to sort of think
12 about what role medication therapy management or other
13 management tools that plans have could be used to deal with
14 this issue.

15 We may revisit sort of the opioid-type issues that
16 we talked about in October. We found that the people who
17 were on opioid often take many other drugs, and there may be
18 adverse effects of those drug interactions.

19 We don't have a concrete plan yet, but those are
20 the kinds of things we are thinking about.

21 DR. MILLER: I just wanted to pick up there
22 because a lot of things were said in the presentation, and

1 then there were lots of, in a sense, asks around the table.

2 I think the game plan -- I hate to do this. I'm
3 looking at Jim and you two. I think the game plan is to
4 come back next on the risk.

5 A nod? Anything, guys? Okay.

6 DR. MATHEWS: Yes.

7 DR. MILLER: Thank you.

8 And then the polypharmacy piece.

9 DR. MATHEWS: Yes.

10 DR. MILLER: Okay. And then inside the
11 polypharmacy piece, we're still trying to figure out what
12 actually the lanes will be in that one, and we will try to
13 contemplate, at least with respect to risk, the array of
14 questions we've got here.

15 But just because we've come back and we haven't
16 taken up a specific question doesn't mean it's off the
17 table. It's just what we can kind of get ourselves together
18 on and back, and these have been on the cooker for a while.

19 MR. HACKBARTH: Any other questions? Comments?
20 Jay.

21 DR. CROSSON: Just to get back to my outrageous
22 behavior earlier, the medication therapy management

1 requirement and then the comprehensive reviews that we
2 talked about before, which can be part of that, are they
3 purely directed towards quality issues, polypharmacy,
4 adverse drug reactions, or are they also directed to sort of
5 program integrity and cost issues and providing support for
6 beneficiaries to choose less expensive drugs, or is that not
7 allowed or what?

8 DR. MILLER: You go first.

9 MS. SUZUKI: My understanding is that fraud and
10 abuse angle is a separate thing from MTM. Medication
11 therapy management program is generally there to make sure
12 that there is no duplicated or therapies or other
13 medication-related issues. It's not meant to encourage
14 lower cost drugs or fraud abuse, that sort of thing.

15 DR. CROSSON: I'm sorry. I used the wrong term
16 when I said "program integrity." I meant the program cost
17 for Part D drugs, because it would seem to me -- I'm
18 thinking back to sort of my time with Kaiser Permanente in
19 terms of how you would go about managing inappropriate drug
20 costs.

21 Sitting down with high-use patients and kind of
22 reviewing the situation, particularly if the patient happens

1 to be cared for by multiple practitioners, to make sure not
2 only for quality purposes, but also from the perspective is
3 this the most efficient way to provide the services to this
4 particular patient, I'm just wondering whether that either
5 is allowed or happens or could be incented, because there's
6 such a low use of this. It could be incented if the risk to
7 the plan increases through the mechanisms we're talking
8 about.

9 MR. HACKBARTH: Let me approach the same question
10 from a little different angle. So there is a regulatory
11 requirement that plans have a therapy management program,
12 yet as Jay says, the uptake of the programs seems to be
13 pretty low, even while the logic of doing it seems pretty
14 high. And you would think that even with the risk corridors
15 and the reinsurance, there's still an incentive for plans to
16 try to manage effectively the use of drugs by their enrolled
17 population.

18 So it's a bit of a puzzle to me why, first of all,
19 you'd even need a regulatory requirement. You would think
20 the plans would want to do it in their own interest, but
21 there is a regulatory requirement, and there still isn't
22 much happening.

1 What am I missing in this picture?

2 MS. SUZUKI: I don't know that we have the answer,
3 but one of the things is that participation is optional, so
4 beneficiaries are not required to participate, even if they
5 meet the eligibility criteria.

6 What goes on within these programs vary across
7 plans. It may be a letter saying, "You are on these
8 medications. You may want to discuss this with your
9 physician."

10 MR. HACKBARTH: Let me ask. This is a hypothesis.
11 So I'm thinking about when disease management was a big
12 thing, and there was a pilot of disease management, and it
13 didn't work out all that well. It seemed nice in concept,
14 but the results were meager. And I think one of the
15 conclusions that people came to was to have a party, even a
16 well-motivated one, reaching out to patients about how to
17 improve their care without the physician involved was an
18 ineffective way. If you are really going to make progress,
19 the communication needs to be either coming from the
20 physician or at least sanctioned by the physician. Is that
21 possibly what's going on in this area as well? It's just a
22 plan-patient interaction, and that's not compelling for a

1 patient?

2 MS. SUZUKI: Well, so, I'm not sure I know enough
3 details about individual MTMs, but one of the issues that's
4 been brought up is that a lot of stand-alone PDPs don't have
5 relationship with physicians --

6 MR. HACKBARTH: Right. Sure.

7 MS. SUZUKI: -- and that can be an issue. When
8 you're trying to reconcile the prescriptions that may be an
9 issue, you may not have a good communication established
10 with the prescribers to adjust prescriptions.

11 MR. HACKBARTH: Okay. So, that naturally leads to
12 the next question. Do we see a difference between therapy
13 management in MA-PDs versus the PDPs?

14 MS. SUZUKI: At least on the participation levels,
15 the take-up of, say, comprehensive medication review, there
16 was not a huge difference between PDPs and MA-PDs, maybe a
17 little bit higher among the MA-PD enrollees, but it's still
18 a very small share of people.

19 MR. HACKBARTH: That's a bit of a conundrum to me.

20 DR. MILLER: Well, there's that, and I also think
21 -- in some of those conversations, I think I'm remembering
22 the managed care plans would talk about the notion that they

1 were doing it through other kinds of mechanisms.

2 MR. HACKBARTH: Yeah.

3 DR. MILLER: You know, they had formulary, they
4 had tiering, but also, to some extent, through the other A-B
5 care that was going to the patient, in a sense, your point.

6 MR. HACKBARTH: Yeah.

7 DR. MILLER: And, I think the PDP is an issue here
8 because you do have some incentive to say, I want to manage
9 the spend to the extent that I'm racking up a lot of drugs.
10 But, to the extent that you view a lot of MTM to looking at
11 the total cost of the patient, that, the PDP doesn't have as
12 strong of an incentive.

13 And, finally, to the extent that these populations
14 are often the low fixed copayment population, your ability
15 to kind of penetrate on that level, I think, is compromised.

16 MS. SUZUKI: And, just to add to that, one of the
17 other main goals of MTM has been to improve adherence, and
18 that may or may not be in the interest of plans from a cost
19 perspective.

20 MS. BUTO: Glenn, can I just follow on Mark's
21 point for a second --

22 MR. HACKBARTH: Kathy.

1 MS. BUTO: The other problem is, with ACOs, I
2 don't think there's any relationship, right? They are not
3 in the bundle, or, you know, they're not accountable for
4 Part D costs --

5 DR. MILLER: [Off microphone.]

6 MS. BUTO: -- so there's even less incentive for
7 communication there.

8 DR. COOMBS: I think there are systems with a
9 decision support, and I think that's what you're referring
10 to, in the sense that it not only gives you a decision of
11 what type of drugs and drug-drug interactions, but also it
12 gives you cost feedback, as well. And, in our PHO, certain
13 medications actually will send a warning to you, or you get
14 a letter or some kind of a communication regarding the cost
15 of the medication and whether or not there's an alternative
16 that would be less expensive and equally as effective. So,
17 those decision supports are out there. I mean, we have it
18 in my region and docs use them.

19 MR. HACKBARTH: Other comments?

20 DR. COOMBS: I just want to say, what might be
21 interesting, too, is to survey some of the groups to see
22 whether or not that makes a difference in cost, in quality.

1 DR. HOADLEY: I mean, one of the things, and I
2 haven't read a lot of the MTM stuff that's come out
3 recently, but what plans do is work through the pharmacist.
4 But, my understanding has been they tend to work through
5 their own pharmacist rather than community pharmacists most
6 of the time and so it becomes this sort of, you know, over
7 the phone or by letter kind of communication from a
8 pharmacist hired by your drug plan rather than even working
9 through your local pharmacist, where you might have more of
10 -- you know, it might be more like talking to your physician
11 about it. At least it's somebody you could have more of a
12 relationship with. And, there's been some push to try to
13 see more of that use of community pharmacists that maybe
14 would be more effective.

15 MR. HACKBARTH: And, so, it could be that there's
16 more of this activity going on than is registering in terms
17 of participation in MTM, in particular. It's just happening
18 through other avenues.

19 DR. HOADLEY: So, some of even what's happening
20 through MTM is not -- what's particularly not happening are
21 these comprehensive medication reviews. That's where the
22 really low percent is, and that's that chance to go over

1 everything somebody's taking and really figure -- but, then,
2 you've all made the points that, so, okay, so if it's done
3 by a bureaucrat pharmacist at the plan and then it's
4 communicated by some letters to doctors who, you know, we
5 often get told sort of if it comes from a health plan, they
6 may not take it real seriously, as opposed to having it done
7 through a physician or through at least the community
8 pharmacist who may have more of a relationship with a
9 physician. So, there are certainly avenues to try to make
10 it work better.

11 Its overall goal is the kind of stuff we're
12 talking about, these people who are using too many different
13 drugs, drugs that aren't useful for them, and presumably
14 more of that than just the, there's a cheaper option, but
15 really, are there drugs you really shouldn't be taking, or
16 you certainly shouldn't be taking these two drugs in
17 combination.

18 MR. HACKBARTH: Any other comments?

19 [No response.]

20 MR. HACKBARTH: I think we are done, then. Thank
21 you, Shinobu and Rachel.

22 We will now have our public comment period.

1 [Pause.]

2 MR. HACKBARTH: And, could I ask that anybody else
3 who wishes to make a comment get up at the microphone so I
4 can see how many there are.

5 Okay. It looks like we have two. Please begin by
6 identifying yourself and your organization. You have two
7 minutes. When the red light comes back on, that's the end
8 of the two minutes.

9 MS. HARMON: Thank you. I'm Heidi Harmon and I'm
10 a pharmacist with Booz Allen Hamilton.

11 And, in looking at how to slow beneficiaries from
12 getting into the catastrophic coverage or reinsurance phase,
13 I'm wondering if the Commission has considered or could
14 consider the benefit structure surrounding the
15 manufacturers' discount within the coverage gap phase.
16 Currently, that 50 percent manufacturer discount accumulates
17 towards the patient's true out-of-pocket expenses, and we
18 know that the TrOOP threshold is what is used to push the
19 patient into catastrophic coverage.

20 So, if the Commission would consider the
21 possibility of not having that 50 percent manufacturer
22 discount count towards a patient's true out-of-pocket

1 expenditures, you may be able to slow down the eventual
2 reaching into that phase.

3 Thank you.

4 MR. FOX: Hi there, Chris Fox with the Campaign to
5 End Obesity.

6 Obesity obviously plays a big role on Medicare
7 beneficiaries. Current estimates show that as much as 40
8 percent of the Medicare beneficiary population suffers from
9 obesity. The Campaign to End Obesity believes that CMS
10 should provide access to all the tools needed to treat
11 obesity to Medicare beneficiaries.

12 We know that there are substantial savings to be
13 found by reducing obesity rates through the reduced
14 prevalence of conditions commonly associated with obesity
15 and also reimbursed under Part D, conditions like
16 cardiovascular disease, diabetes, arthritis, certain types
17 of cancers, and I could go on and on. There are more than
18 60.

19 Current Medicare coverage for obesity therapies is
20 significantly limited. On the one end, you have intensive
21 behavioral therapy that is afforded to primary care
22 physicians and in their settings. Then, on the opposite end

1 of the spectrum is bariatric surgery. What's significantly
2 missing here is a Part D component and Part D coverage for
3 FDA-approved therapies for the treatment of obesity. I'm
4 wondering if there is any cogent rationale for denying
5 Medicare beneficiaries access to Medicare Part D coverage
6 for FDA-approved therapies for the treatment of obesity.

7 The Campaign to End Obesity would encourage MedPAC
8 to support all needed therapies to treat and reduce obesity
9 in the United States, including medical therapies under Part
10 D.

11 Thank you.

12 MR. HACKBARTH: Okay. We are adjourned until
13 tomorrow morning at 8:30.

14 [Whereupon, at 4:40 p.m., the proceedings were
15 recessed, to reconvene at 8:30 a.m. on Friday, January 16,
16 2015.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 16, 2015
8:30 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
FRANCIS "JAY" CROSSON, 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
WARNER THOMAS, MBA
CORI UCCELLO, FSA, MAAA, MPP

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Public Comment	142

2 MR. HACKBARTH: Okay. Good morning. So first up
3 this morning is hospital short-stay policy. Kim?

4 MS. NEUMAN: Good morning. Today we are going to
5 continue our discussion of issues related to short hospital
6 stays. The Commission talked about this topic at both the
7 September and November meetings. Based on those
8 conversations, we're going to discuss some policy options
9 that the Commission could consider.

10 Before we do that, we'll quickly recap the issues
11 that have arisen related to short hospital stays.

12 As you know, the inpatient admissions criteria has
13 historically been ambiguous and open to interpretation.
14 One-day inpatient stays are profitable and paid more than
15 similar outpatient stays. Because of the payment
16 difference, recovery audit contractors, or RACs, have
17 focused their audits on the appropriateness of one-day
18 inpatient stays.

19 In response to the increased scrutiny, hospitals
20 have increased their use of outpatient observation, and with
21 increased use of observation, beneficiary advocates have
22 raised concern about observation's effect on SNF coverage

1 and beneficiary liability for self-administered drugs.

2 Today's presentation will focus on issues we've
3 discussed in the previous meetings. First, we'll review the
4 policy approaches to reduce payment differences between
5 inpatient and outpatient stays. Then we'll discuss policy
6 options to reduce RAC burden, increase RAC accountability,
7 modify the SNF three-day requirement, and address concerns
8 about beneficiary liability for self-administered drugs.
9 Finally, we'll discuss policy offsets that could be
10 considered to help pay for potential increased costs
11 associated with these policy options.

12 So, first, we have some background on the
13 Commission's discussion concerning approaches to reduce
14 payment differences between inpatient outpatient stays. As
15 we've noted, short inpatient stays have been subject to RAC
16 scrutiny in part because Medicare pays more for short
17 inpatient stays than similar outpatient stays. Payment
18 policy changes could be considered to reduce or eliminate
19 these payment differences.

20 For example, we could create one-day stay
21 inpatient DRG rates for selected DRGs or pursue a site-
22 neutral approach that sets the same payment rate for similar

1 inpatient one-day stays and outpatient stays. The effect of
2 doing either of these things on incentives, though, would be
3 mixed.

4 And you can see that in these next charts. This
5 is our simulation of a hypothetical one-day stay DRG policy,
6 which you saw in November, and it shows that a one-day stay
7 DRG policy reduces the payment difference between a one-day
8 inpatient stay and similar outpatient stay, but creates a
9 new payment cliff within the inpatient payment system
10 between a one-day and two-day inpatient stay. If we instead
11 had on the screen a picture of a site-neutral approach, it
12 would be similar: eliminate one payment cliff but at the
13 same time create a new payment cliff.

14 So what this demonstrates is that we can shift the
15 payment cliffs, but we cannot do away with them entirely.
16 So it's an open question of whether the incentives are
17 better under the current system or under some type of
18 revised payment system.

19 Since there was a wide range of views among
20 Commissioners on the merits of payment policy changes at the
21 November meeting, today we are going to focus on policy
22 options in other areas where there seemed to have been more

1 consensus.

2 So now Zach will discuss policy options related to
3 RACs and the SNF three-day policy.

4 MR. GAUMER: Good morning. The next two issues we
5 desire your feedback on pertain to the Medicare RAC program.
6 As you recall, the RAC program is linked to the short-stay
7 issue because RACs have been focusing on short stays in
8 recent years, and it is widely believed that RAC audits add
9 administrative burden to providers.

10 Before we move on to the two RAC issues we have
11 been discussing, I want to alert you to a new set of rules
12 about the RAC program which CMS released in December. A few
13 of these new rules alter the course of the Commission's
14 ongoing conversations.

15 The most important of these changes involves the
16 rule stating how far back in time RACs are permitted to
17 search through Medicare claims data. CMS has now instructed
18 RACs that their patient status reviews, inpatient status
19 reviews, are limited to a six-month window from the date of
20 service. This is significantly shorter than the previous
21 three-year time limit, and this should enable hospitals to
22 rebill most denied inpatient claims under the current

1 rebilling rules. Because CMS' new rule essentially does
2 what the Commission was contemplating in November, we have
3 decided to eliminate the rebilling policy option we were
4 discussing.

5 Several of CMS' other improvements to the RAC
6 program have relevance to our discussions as well. Rather
7 than describe all of them to you now, we're going to note
8 them as we walk through each of the policy issues.

9 The first of the RAC-related issues is how to
10 reduce RAC-related audit burden. The Commission has
11 expressed interest in exploring two different approaches in
12 doing this. The first of these is through targeting RAC
13 audits to hospitals with high rates of short inpatient stay
14 utilization. Under this policy all other hospitals would be
15 exempt from RAC reviews.

16 In November, we illustrated for you that while
17 nearly all hospitals admitted patients for short inpatient
18 stays, a disproportional share accounted for many of these
19 stays. As a result of your feedback, we modeled the
20 targeted approach two different ways: one in which the 10
21 percent of hospitals with the highest one-day stay
22 utilization were targeted, and a second way we focused on

1 the top 25 percent of hospitals. These two groups accounted
2 for 22 and 46 percent of all one-day stays, respectively,
3 and would therefore, we think, possess enough one-day stays
4 to at least in part replace the amount of recoveries
5 associated with the current RAC program, if that were the
6 goal.

7 However, the new CMS rules pertaining to the RAC
8 program alter our initial assessment of this targeting
9 approach because they will begin varying the amount of
10 claims available to RACs for review. Therefore, our
11 estimate of the spending impact for the targeting approach
12 is that it would increase program spending, but the levels
13 of increase are somewhat unclear because of the shift in the
14 RAC rules.

15 The second option Commissioners expressed interest
16 in exploring to reduce RAC-related audit burden was the
17 payment penalty concept. This concept is to replace
18 existing RAC reviews of short inpatient stays with a penalty
19 on hospitals that have excessive levels of short inpatient
20 stay utilization.

21 In response to your interest, we also modeled the
22 penalty based on the rate of excess one-day stays each

1 hospital has. We modeled the concept in two ways: again,
2 first for the 10 percent of hospitals with the highest rate
3 of excess one-day stays; and, second, for the 25 percent.

4 What we found is that if the penalty were applied
5 to the 10 percent subset, a penalty on par with a 3 percent
6 reduction in all inpatient payments would generate
7 approximately 40 percent of the revenues generated by the
8 current RAC recoveries. If the penalty were applied to the
9 25 percent subset, a 3 percent reduction in all inpatient
10 payments would generate approximately 90 percent of the
11 revenues generated by the RAC recoveries. Therefore, the
12 penalty concept generated a level of revenue similar to the
13 RAC recoveries -- if it were to do that and generate that
14 level of recoveries, you would either have a relatively
15 large penalty that fell on a small subset of hospitals, or
16 you would have to penalize a large share of the hospital
17 industry. An additional concern is the added administrative
18 burden this approach would cause for CMS in terms of policy
19 and measure development.

20 We believe a payment penalty has the potential to
21 increase program spending here, and again, our exact
22 estimate of the impact is somewhat less clear as a result of

1 new rules CMS has released about the RACs.

2 The next issue for your consideration pertains to
3 holding RACs accountable for their reviews. In November, we
4 discussed the concept of adjusting RAC contingency fees to
5 make them more performance-based. For example, CMS could
6 reduce contingency fees by one percentage point if the RAC's
7 audit accuracy rate or denial overturn rate was lower than a
8 given threshold.

9 The new CMS rules incorporate a degree of
10 performance-based compensation, but do so slightly
11 differently than the Commission has been considering. We
12 estimate a small degree of savings from this policy option,
13 but the new RAC rules again limit our precision in making an
14 exact estimate.

15 The SNF three-day prior hospitalization policy is
16 the next issue for your consideration. Where we left this
17 issue in November is that the Commission had discussed
18 revising the SNF three-day policy by beginning to count time
19 spent in outpatient observation towards the three-day
20 threshold, but requiring that at least one of the three days
21 be an inpatient day.

22 In developing our policy, there were three primary

1 considerations we were balancing.

2 First was the beneficiary's concern. In recent
3 years a small group of beneficiaries incurred high out-of-
4 pocket costs because their three-day hospital stay did not
5 include three full inpatient days, leaving them without SNF
6 coverage.

7 Second, there has been interest in preserving the
8 SNF benefit as strictly a post-acute care benefit as opposed
9 to a long-term care benefit. There is some evidence that
10 removing a post-acute care requirement will result in a
11 significant increase in SNF utilization.

12 Third, there was interest in limiting the
13 financial impact of this policy change for the sake of the
14 program. This policy option is more financially
15 conservative compared to the alternatives, such as
16 eliminating the inpatient requirement or completely
17 eliminating the three-day policy altogether, because it
18 retains the requirement for an inpatient admission during
19 the hospital stay. Therefore, this policy option strikes a
20 balance between these three considerations. Also, we
21 estimate that this policy will increase program spending.

22 And now I'll turn it back over to Kim.

1 MS. NEUMAN: The next issue for your consideration
2 is beneficiary liability for self-administered drugs. As
3 you'll recall, Medicare's hospital outpatient payment system
4 does not pay for drugs considered usually self-administered.
5 By self-administered drugs, we mean in most cases oral
6 drugs. Think of things like cholesterol drugs, blood
7 pressure drugs, and other drugs for managing chronic
8 conditions.

9 Beneficiaries who receive outpatient observation
10 services may be in the hospital for an extended period and
11 require some of their oral medications while they are there.
12 If a hospital furnishes those oral medicines to an
13 outpatient beneficiary, they bill the beneficiary at full
14 charges, which, as you can see on the slide, is
15 substantially higher than the cost.

16 Some hospitals reportedly do not charge
17 beneficiaries for self-administered drugs. Other hospitals,
18 though, report that they must charge beneficiaries for self-
19 administered drugs due to laws prohibiting beneficiary
20 inducements.

21 So here we have some policy options that could be
22 considered to address issues with self-administered drugs.

1 One option is to permit hospitals to waive the
2 charges for self-administered drugs if they wish to do so.
3 We've heard from some hospitals that they would like to
4 waive these charges because they are a source of patient
5 dissatisfaction, and this option would allow them to do
6 that. This option wouldn't add any additional costs to
7 Medicare. To would be likely to eliminate financial
8 liability for self-administered drugs for some
9 beneficiaries, but other beneficiaries may still be liable
10 for full charges.

11 A second option that some have suggested is to cap
12 the amount a hospital can charge a beneficiary for self-
13 administered drugs, perhaps based on hospital costs. This
14 would protect beneficiaries from having to pay full charges
15 and would not increase Medicare spending.

16 A third approach is for Medicare to cover self-
17 administered drugs under the hospital outpatient payment
18 systems for beneficiaries receiving observation.

19 The impact of this on Medicare spending depends on
20 how you structure it. You could make it budget neutral,
21 which means no increase in Medicare spending. How this
22 would work is that the outpatient payment rate for

1 observation would increase to reflect coverage of self-
2 administered drugs, and the outpatient payment rates for
3 other outpatient services would decrease slightly to offset
4 the increased observation payment rate.

5 An alternative option would be to add new money to
6 cover this, and that, of course, would increase Medicare
7 spending.

8 In terms of the impact on beneficiaries, if
9 Medicare covered self-administered drugs under the
10 outpatient payment system, beneficiary liability would
11 decrease, and it would decrease more under the budget-
12 neutral option than the new money option.

13 The policy options presented thus far would
14 collectively increase Medicare spending. Given the large
15 federal debt and to improve the likelihood that the Congress
16 would take up these options, the Commission could consider
17 coming forward with additional policies that could help to
18 offset the costs. Of course, these additional policies also
19 have merit in their own right.

20 With that in mind, this slide presents some
21 potential offsets that the Commission could consider
22 offering. Keep in mind that if the Commission chooses to

1 offer any of these offset options, the Congress can choose
2 whether or not to adopt them or look to alternative means of
3 financing. We'll look at a couple of these offset options
4 in more detail.

5 So the first one we'll focus on is including
6 hospice in the hospital post-acute care transfer policy.
7 The hospital post-acute care transfer policy reduces
8 inpatient hospital payments for certain DRGs when a
9 beneficiary has a shorter than average length of stay and is
10 transferred to one of the settings covered by the policy.
11 The policy currently applies to hospital transfers to LTCHs,
12 psychiatric hospitals, IRFs, SNFs, and home health, but not
13 hospice.

14 Hospital transfers to hospice would remain
15 profitable even if the transfer policy applied to these
16 hospice transfers. We estimate that short hospital stays
17 that were transferred to hospice had a profit margin for
18 hospitals of 88 percent in 2012, and if the transfer policy
19 had applied to these stays, the margin would have been 31
20 percent.

21 From a budget perspective, including hospice in
22 the post-acute care transfer policy would reduce Medicare

1 spending.

2 Changes to the SNF three-day hospital stay
3 requirement would increase use of SNFs and Medicare payments
4 to SNF providers. To partially offset that potential
5 increased spending, offsets could be explored within the SNF
6 sector. For example, the \$4.5 billion overpayment to SNFs
7 that occurred in 2011 could be recovered. Another option
8 that could be explored is a nursing facility churning
9 penalty. The idea here is that nursing facilities have a
10 financial incentive to hospitalize their long-term residents
11 rather than treat them in the facility because a
12 hospitalization may lead to a new SNF benefit period and
13 higher SNF payments.

14 A penalty for nursing facilities with excessive
15 rates of potentially avoidable hospital admissions could be
16 explored as a way to counterbalance these incentives.

17 So that brings us to the end of the presentation.
18 In your discussion today, it would be helpful to get
19 feedback on several issues. Is there any additional
20 information you'd be interested in on payment policy
21 changes? How would you like to proceed as far as policy
22 options and offset options? And, in particular, would you

1 like to develop any of these items into draft
2 recommendations?

3 So, with that, we conclude the presentation and
4 look forward to your discussion and any questions.

5 MR. HACKBARTH: Okay. Thank you. Nice job, Kim
6 and Zach.

7 So we've got a lot of material to cover here, and
8 what I propose we do is have a Round 1 on clarifying
9 questions that could cover any of these topics, but then
10 when we go to Round 2, I think we ought to proceed issue by
11 issue as opposed to having people jump back and forth from
12 one issue to the other. So that would be Round 2a, 2b, 2c,
13 and then a final round on the issue of offsets. So as I
14 said, this is a lot of material to try to cover, and we'll
15 all need to be disciplined.

16 Now, keep in mind we don't need to resolve any of
17 these issues today. I hope that based on today's discussion
18 we can make enough progress that we'll be able to formulate
19 draft recommendations, if that seems appropriate, for
20 discussion in March, and assuming that went well, then
21 possibly final recommendations for a vote in April.

22 So that's my plan. Does that make sense?

1 So let me start the clarifying round with some
2 questions about the new CMS approach on RACs. As I
3 understand it, this is not a notice and comment sort of
4 process because this is a contract issue for CMS. They have
5 just issued a notice that this is what they are doing.
6 They're not requesting input on that. Is that correct?

7 MR. GAUMER: That's correct. So they recently
8 began signing the contract for DME, hospice, and home
9 health, one RAC contract for that, and these provisions are
10 a part of that contract. And at the same time, CMS said
11 that these will affect all future RAC contracts as well.

12 We asked CMS if, you know, there's great certainty
13 that this will be built into the new hospital contracts that
14 are being written up and signed now. The answer was yes.
15 So this will be implemented.

16 MR. HACKBARTH: So I guess the next logical
17 question is: If we recommend anything on RACs that's
18 directed to CMS, what's the likelihood that we will be able
19 to affect what CMS is doing in this area?

20 DR. MILLER: Do you want to take that?

21 [Laughter.]

22 DR. MILLER: First of all, throughout this whole

1 process, we've talked to CMS about these ideas to always
2 make sure that we're in the same neighborhood. So take
3 something like one of the RAC ideas is we were saying we
4 would target hospitals that had aberrant one-day stays and
5 say the RAC should focus there. They say we'll target
6 hospitals that have high denial rates. Back and forth in
7 this conversation, these were not like, you know, "we're
8 going to fall on our swords" types of conversations.

9 To me, Zach -- and you can recharacterize -- the
10 feel was, yeah, you guys are thinking about it this way,
11 we're thinking about it that way. I wouldn't characterize
12 it as hard opposition to our ideas.

13 And then the other thing I would say is if there
14 is -- you know, if the Congress had a preference, they could
15 express it to the Secretary.

16 MR. HACKBARTH: Kathy.

17 MS. BUTO: So, as I'm listening to you, Mark, I'm
18 thinking that on that issue of the targeting of hospitals.
19 As I read their approach, I sort of liked it because it went
20 beyond a hard threshold of -- I think the way we set it up
21 was we're only going to recommend that RACs look at this set
22 of hospitals. I like the fact that they have left

1 themselves open to looking at a broader set but targeting
2 the worst denial areas, so the hospitals with high denials.
3 So it was really close to ours but gave them a little more
4 flexibility as I said it, but maybe you read it differently.

5 DR. MILLER: Well, the only difference I would say
6 is, in some ways, you have a process where the RACs have
7 been engaged in that has created denial rates, and some of
8 the conversation here has been how effective and fair that
9 process has been. So, in a sense, their metric is a little
10 bit tied up with the RAC process.

11 The only thing I would ask you guys to think about
12 is our metric is at least -- you can put it on a board, and
13 people can see it and go, "Okay. I understand where your
14 targeting is going to be," but I have to say, even for
15 myself, I don't have like a strong feeling.

16 MR. HACKBARTH: My objective here was not to begin
17 the conversation on the RAC options.

18 My sense is that, A, CMS has moved in a better
19 direction than where they've been. It may not be the one
20 that we would have written up, but it's a better direction
21 than where they've been. B, since they've already done this
22 -- and I imagine it's a big deal to change course for them

1 at this point.

2 I'm happy to offer some comments on the right
3 approach on RAC, but I would move it down our priority list.
4 Given our amount of time for discussion today, I'm going to
5 put that at the end of the policy options discussion, not at
6 the beginning of it, and hopefully, we'll have time to make
7 some comments on that.

8 Yeah. Rita and then Herb.

9 DR. REDBERG: Just related to that, but for the
10 next time that we come back and discuss this, because a lot
11 of it is centered on using denial rates, I would just like
12 to understand better who is making those decisions, because
13 a lot of times, they are not medically sophisticated people
14 making the decisions, and so the denial rates are sometimes
15 arbitrary and not really a reflection of care. So I'd like
16 to understand that better.

17 MR. HACKBARTH: Herb.

18 MR. KUHN: Just two quick clarifying questions,
19 one following up on this, and that is, I do understand they
20 have made those changes on December 30, as you said, and
21 they did move forward at least on the one track with the DME
22 hospice home health.

1 But I thought I read somewhere where the RACs that
2 do the hospital space and all the others actually went to
3 court, and they got a U.S. federal claims court to block CMS
4 from implementation on the contracts. Is that still the
5 case, or has that been overruled by another court?

6 MR. GAUMER: My understanding is that this is
7 still in limbo. So, yeah, the DME thing, I think a wrench
8 got thrown into it. I don't know the exact details, but
9 yeah, that contract is still being worked out in my mind.

10 MR. KUHN: So the fact that CMS is having
11 difficulty in court, I think just for us to continue to move
12 forward makes sense because Congress could still act on
13 this, is one option, so that's kind of my point there.

14 Then the second one was on Slide 7, Zach, and I'm
15 just curious on the targeted reviews. Is that pretty much
16 standard across the country, or are there certain areas that
17 are experiencing more denials and short stays than others?

18 MR. GAUMER: We haven't looked at it
19 geographically, necessarily.

20 We looked at regions, and we don't find specific
21 differences in terms of short-stay utilization rates, but
22 there probably are differences state to state based upon

1 something you brought up yesterday, which was in New York,
2 they have their own legislation about short stays and such
3 in observation. I would expect that it would vary by state
4 a little bit.

5 MR. KUHN: Thank you.

6 DR. MILLER: I just wanted to make sure that the
7 exchange -- so, at the very end of your sentence, you said
8 variation in denial rates. What we have been looking at is
9 variation in one-day stays and saying that's where you would
10 target it, and I think your answer is that doesn't look like
11 it has a lot of geographic variation. That's what you
12 meant, right?

13 MR. GAUMER: Yeah, the one-day stays.

14 DR. MILLER: Right.

15 MR. GAUMER: The denial rates data, we have not
16 had --

17 DR. MILLER: That's what I wanted to be clear
18 about.

19 MR. GAUMER: Okay.

20 DR. MILLER: We haven't looked at the denial data,
21 if that was really what your question was.

22 MR. KUHN: Yeah. That's where I think I was

1 going.

2 MR. GAUMER: Yeah.

3 MR. HACKBARTH: Okay. We are open for further
4 clarifying questions. Jon and then --

5 DR. CHRISTIANSON: Does it have to be on the
6 record or --

7 MR. HACKBARTH: No. Any subject now.

8 DR. CHRISTIANSON: On your slide 12, you have
9 listed these as three separate options, but conceptually,
10 one could think of an option one plus two, couldn't you?

11 Yeah, okay.

12 DR. HALL: In the new CMS regulations in reference
13 to RAC, I thought I read somewhere that there were penalties
14 on the RAC for bad decisions. Is that still in the
15 legislation?

16 MR. GAUMER: Just to clarify here, there are
17 really just rules and not legislation, but there are
18 penalties in the sense that if the RACs don't meet certain
19 thresholds for overturn rates or denial rates or accuracy
20 scores in their auditing, then they can essentially have
21 their access to Medicare claims taken away from them. So
22 it's a little bit different approach than a raw penalty, but

1 yeah, they get access removed from being able to audit
2 certain claims. It hurts their bottom line.

3 DR. HOADLEY: On Slide 10, I don't remember if you
4 had given us information before on how many of the
5 observation stays ended up being associated with inpatient
6 day, sort of mixed-stay kind of things. Is that common? I
7 don't have any sense of whether that's a common pattern.

8 MR. GAUMER: Just to make sure I understand, how
9 many of the inpatient stays include observation?

10 DR. HOADLEY: Or realizing the other way around,
11 the issue from the point of view of the SNF three-day policy
12 is what happens if you go into an observation and you don't
13 qualify. So we're saying the option is that you would have
14 to maintain one of the days being an inpatient day.

15 So of all the outpatient -- sorry -- of all the
16 observation stays, how often do they have one inpatient day
17 in them? Are we dealing with many of the observation stays,
18 or are we dealing with just sort of a rare subset?

19 MR. GAUMER: Yeah. The exact number is escaping
20 me, but of the folks that are in observation, a significant
21 portion of them to go on to use inpatient or get admitted.
22 Yeah.

1 DR. HOADLEY: Okay.

2 DR. MILLER: And we did go through some of that,
3 and I'm trying to remember. Did it end up in the paper?
4 Because I know we talked through some of this last time we
5 talked.

6 MR. GAUMER: Yeah. I think it was in the paper
7 last -- in November or possibly September.

8 DR. MILLER: Okay. So, Jack, we'll surface it and
9 make sure it gets back to you guys.

10 MR. HACKBARTH: Okay. Clarifying questions? Bill
11 Gradison and then Craig and Jay.

12 MR. GRADISON: I seem to recall that in November,
13 the Health Subcommittee of the Committee on Ways and Means
14 came out with a discussion draft on this subject, and
15 frankly, I don't recall its content. I wonder whether it
16 cast any useful light on this or suggested any alternatives
17 that we should consider that might not otherwise have ended
18 up in your excellent, excellent piece of work.

19 DR. MILLER: The way I think about this -- and I'm
20 going to do a real kind of brief -- you know, there's a lot
21 of moving parts and all that, but the way I think about it
22 is they were focused on a payment change, and here's the way

1 I think about it. You'd have your inpatient PPS, you'd have
2 your outpatient PPS, and they create a new payment system --
3 I'm going to use that term -- which is comprised of the
4 short one-day stays, and in a sense, it will be observation
5 stays and short inpatient stays, and they create a new
6 payment around that.

7 In a sense, they use like site-neutral, that type
8 of thing, and sort of this new vector would kind of sit
9 between an inpatient system and your outpatient system.
10 That's conceptually what it's about.

11 MR. GRADISON: Thank you.

12 MS. BUTO: [Speaking off microphone.]

13 DR. MILLER: Say it again?

14 MR. HACKBARTH: Microphone, please.

15 MS. BUTO: Does it count toward the three-day
16 stay?

17 DR. MILLER: My recollection is it does.

18 I feel like I've said something wrong. No? Okay.

19 [Laughter.]

20 DR. SAMITT: This was a fantastic report. Thank
21 you very much.

22 Two questions. Starting on Slide 5, when we

1 reviewed this topic for the first time in September, we had
2 reviewed the payment-to-cost ratio at the various length of
3 stays. Have we redone that payment-to-cost ratio under this
4 notion of a one-day-stay DRG to assess what we estimate the
5 payment-to-cost ratio would not be for the two-plus days
6 versus the inpatient one day and so on and so forth?

7 MS. NEUMAN: So we haven't explicitly done that,
8 but what I can tell you is that the way you set up the
9 payments for the one-day-stay DRG and the two-plus-day-stay
10 DRG, that on average, the profitability for that one-day-
11 stay DRG is going to be the profitability of the underlying
12 PPS at that point.

13 DR. SAMITT: Sure. Sure.

14 MS. NEUMAN: And similarly, within the two-day-
15 stay DRG and the aggregate, it will reflect that same
16 profitability roughly. But within that two-day-stay DRG,
17 the two-day stay is going to be the most profitable. The
18 three-day stay will be the next most profitable, and it will
19 go linearly or in that kind of progression, from shorter
20 stay to longer stay, more profitable to less.

21 DR. SAMITT: So we believe the two-day-stay DRG
22 will still clearly be more profitable than the one-day-stay

1 DRG, even with the reshifting or the creation of this new
2 one-day-stay DRG.

3 MS. NEUMAN: A two-day stay under a two-day-stay
4 DRG will be more profitable than a one-day stay in the one-
5 stay-stay DRG.

6 DR. SAMITT: Great. Thank you.

7 And then on slide 12, under option 1, the second
8 sub-bullet, you talked about other beneficiaries may still
9 be liable for full charges. Does that imply that while
10 hospitals will be allowed to waive the charges, they may not
11 choose not to? Is that why you feel that there may still be
12 liability for charges for beneficiaries?

13 MS. NEUMAN: It will be up to the hospitals, so it
14 will depend on the hospital.

15 DR. SAMITT: So if they choose to do so or not.
16 Thank you.

17 DR. MILLER: Jon made an interesting connection
18 where you could couple one and two and say, "You can forgive
19 it if you want, but if you charge, you can't."

20 DR. SAMITT: Capped, got it.

21 DR. CROSSON: If we could turn to slide 8.

22 Pursuing this direction may become moot, depending

1 upon how we prioritize the RAC reviews going forward, but,
2 Zach, in your comments about the penalty direction, I heard
3 you mention that one negative might be that it would
4 increase CMS administrative cost. However, if we ended up
5 going in that direction, CMS would no longer have the
6 administrative responsibility for the RAC audits, the
7 contracting process, and all the rest of that. Was that a
8 net observation or just simply additive or what?

9 MR. GAUMER: That was not a net comment.

10 Really, the point of that was to say that this is
11 a measure that we have tried to model. This penalty is kind
12 of a thing we've tried to model. If this were to be
13 implemented by CMS, I think there is a lot of policy and
14 measurement development that would need to take place,
15 rulemaking, a lot of input from various sources, to get this
16 number or this method exactly right. So that's what that
17 was about, and thinking as researchers, there's some burden
18 attached to CMS and what they'd have to do to get this thing
19 put out right and happily.

20 MS. BUTO: I just wanted to add, Jay, that I think
21 there would have to be created an appeals process because
22 anytime you put in place what looks like a formulaic

1 approach to denials and payment reductions, I think for
2 hospitals that have whatever extraordinary circumstances,
3 you'd have to have some kind of -- so there would be that
4 whole mechanism.

5 MR. HACKBARTH: Well, I think of Jay's notion here
6 as analogous to the readmissions penalty where there is no
7 appeals process. It's just a formulaic approach.

8 MS. BUTO: Right. But I think -- well, my own
9 view is it would go through notice-and-comment rulemaking,
10 and unless it was absolutely prohibited in the statute not
11 to provide for some relief -- if there's, let's say, a
12 pandemic and there is a need to bring people in quickly and
13 it turns out there are a lot of one-day stays, you'd want to
14 have some kind of exception to that. You'd want to be able
15 to deal with that, and to me, it falls into a different
16 category than readmissions, which I think are also the
17 criteria are clearly laid out for the types of readmissions
18 that really don't meet acceptable standards.

19 MR. HACKBARTH: Right.

20 DR. CROSSON: I think the point I was just going
21 to make, if we take that as issue of CMS costs under
22 consideration, we would also have to estimate what reduction

1 in administrative work would result by eliminating the whole
2 RAC process.

3 MS. BUTO: Yeah, absolutely.

4 MR. THOMAS: I have a couple of questions. On the
5 December 30th ruling and guidance from CMS, how does that
6 impact? You said it's going to impact in a future contract
7 with DME. How does it impact existing RAC contracts with
8 existing RAC providers?

9 MR. GAUMER: Okay. This is a little bit tricky.
10 Technically, it does not impact existing contracts, but CMS
11 does have the ability under the period that they're --
12 they're in a pause, essentially, right now. They have the
13 ability, once the pause is over in March -- Kim, correct me
14 if I'm wrong in saying any of this, but once the pause is
15 lifted in March, CMS has the ability, once they restart the
16 program, to make decisions about adding these types of
17 policies into the operating procedures as they go.

18 So they could have the RACs limit the time period
19 to six months rather than three years for the look-back
20 window. So this is kind of a discretionary thing that CMS
21 can do. Is that accurate, Kim?

22 MS. NEUMAN: [Nodding affirmatively.]

1 MR. GAUMER: Yeah? Okay.

2 MR. THOMAS: Have they indicated kind of what
3 their plan is?

4 MR. GAUMER: I think it's kind of unclear how it's
5 exactly going to play out, but it sounds to me as though the
6 plan going forward are these 18 new rules for the RACs, and
7 that they will probably, after the pause is lifted in March,
8 slowly implement these in a subtle way. Yeah.

9 MR. THOMAS: Okay. And if those are in place, so
10 if a six-month time period is in place, what is the time
11 period usually that it takes to -- and I don't know if
12 there's any sort of average -- that once a claim is
13 identified, reviewed, if there's a process between the
14 provider and the RAC kind of back and forth as far as some
15 sort of appeal, what's the time period to actually get that
16 process done?

17 What I'm getting at is, is there enough time for
18 that process to take place and for the provider to still
19 have a chance to rebuilt within the one-year timely filing
20 limitation?

21 MR. GAUMER: I don't have a specific answer in
22 terms of how long it takes for all of this to play out. It

1 seems to me that CMS has taken some of that into
2 consideration in here because there are some other rules
3 within here that say things such as the RAC has 30 days to
4 get back to the hospital and begin a discussion period about
5 the claim. So it seems to me like they are taking that into
6 consideration to increase the likelihood that rebilling
7 could take place.

8 MR. THOMAS: But we're not sure of kind of what
9 time period that actually takes to kind of go through that
10 process?

11 MR. GAUMER: I can't think of exactly what it
12 would be.

13 MS. NEUMAN: I don't think we can give you
14 specific numbers.

15 It seems that if a hospital wishes to rebuilt when
16 they get the denial that this new rule should allow them to
17 rebuild at that point. If the hospital wants to take it
18 through multiple levels of appeal, they might lose the
19 window there. But there has been concern that up to this
20 point, if a hospital got a bill and it was denied, they
21 didn't have an opportunity to even rebuild at that very
22 point in time. This seems to have addressed that part of

1 it.

2 MR. GAUMER: Yeah, I agree.

3 MR. THOMAS: And then one last question. We're
4 talking about the profitability of the one-day and the two-
5 day, and maybe it's been done previously, and I haven't seen
6 it, being relatively new, but have we looked at the
7 profitability or whatnot on the observation and the adequacy
8 of the payment rates for observation for hospital? Has that
9 been done? Has that been looked at?

10 MR. GAUMER: I would say for the September
11 meeting, we did look at that a little bit, and you will find
12 some of that, I think, in your material for September.

13 It appeared to us that the observation was not
14 profitable, and we are not exactly sure where to draw the
15 line or what number to use because we still have some more
16 work to do in this area, but our sense was that it was below
17 80 percent, essentially, of payment -- of cost. Excuse me.
18 So we're still working on that, but it seemed as though the
19 outpatient observation was less profitable than the
20 inpatient.

21 MS. NEUMAN: I'd just add that the outpatient
22 observation rate, payment rate, has gone up a fair amount

1 between the time period we're looking at and today. So it's
2 hard for us to say currently what that profitability would
3 look like.

4 MR. GAUMER: Yeah.

5 DR. MILLER: And also, Warner -- and I think we've
6 had some of these conversations -- it provokes that whole
7 conversation of when you look separately at lines of
8 business within the hospital. They will look negative, but
9 then you look at the aggregate, and do they contribute to
10 the patient margin? That whole conversation is provoked by
11 that question.

12 MR. THOMAS: I just think if we're going to look
13 at kind of the accuracy of payment of a one-day and a two-
14 day length of stay, we may want to look at the observation
15 component of that at the same time if we're looking at this
16 as kind of a basket of services.

17 MR. HACKBARTH: Other clarifying questions? Rita.

18 DR. REDBERG: Related to that, I think on Slide 5,
19 I'm not clear on why there is that cliff between the one-day
20 inpatient and two-day. It's such a big jump from 910 to
21 3,140.

22 MS. NEUMAN: So the way the payment rate is set

1 for the one-day and the two-plus-day is it's based on
2 effectively the cost of the stays in each one of those
3 columns, and the two-plus-day column doesn't just have two-
4 day stays; it has two days and beyond. And so that's where
5 you get the big jump.

6 DR. NERENZ: If I could just follow on that
7 quickly, I understood that to be the answer to that
8 question, but also was a little surprised in that in the DRG
9 model and system in general, it's often the first day that's
10 the most expensive day. So it must be factored into this,
11 and the gap is still that big, right? Yeah, okay. Okay.
12 It's the long tail that carries it, even though the first
13 day is the expensive day.

14 MR. HACKBARTH: Any other clarifying questions?

15 [No response.]

16 MR. HACKBARTH: Let me just ask one last about the
17 RAC. Herb mentioned, well, one possibility would be for us
18 to make recommendations to the Congress on RAC, and so I
19 just want to understand a little bit more about that. Is
20 there any precedent for Congress directing down to this
21 level of detail the RAC review approach? I had always
22 assumed that there was just a general authorization for CMS

1 to do RACs and funds appropriated without Congress saying
2 this is how the reviews should be done.

3 MR. GAUMER: I'm not certain of this, but I can't
4 think of a specific piece of leg. that says, you know, you
5 must do this detailed thing about the RAC program.

6 MR. HACKBARTH: Do you know, Herb?

7 MR. KUHN: First of all, Congress did authorize
8 the RAC program, so they kind of claim parentage to it to a
9 degree. But beyond that, there is -- I guess not in this
10 new Congress but in the last Congress, there was legislation
11 in both the House and the Senate where legislators were
12 talking about RAC reform provisions, and then I think Bill
13 Gradison mentioned that in that, at least, proposal floated
14 by the Ways and Means Committee last year, there was RAC
15 reform legislation. So they have moved back to look at
16 something that they created.

17 MR. HACKBARTH: Okay. In some other cases, we've
18 been actually trying to move away from Congress writing
19 detail into legislation, and so I would have that reticence
20 about making a legislative recommendation on how RAC reviews
21 ought to work on observation days in short stays. But
22 that's not the final word on the subject but just my

1 thought.

2 So would you put up Slide 3? We'll now move to
3 Round 2, and so what I'd like to do is first focus on
4 payment differences. Then we'll lump together the
5 beneficiary protection issues, Items 4 and 5, and then we
6 would finally move to the two RAC issues at the end. And
7 then at the very end, we'll come back to offsets.

8 Now we're on Round 2, payment policy options, and,
9 Herb, since you weren't here when we last discussed that in
10 November, I'll lead with you.

11 MR. KUHN: Thank you. I did have a chance to go
12 back and look at the transcript from that November meeting,
13 and it was a really spirited conversation on that. And as
14 we look at what I think came out of that, we have this
15 notion between the one-day stay where you try to come up
16 with a new set of DRGs, or do you collapse the current one
17 down closer to the observation stay?

18 I'm kind of in the camp of the first one where we
19 look at kind of a new set of DRGs. I really do think that
20 we need to think as hard as we can to make sure that
21 payments are as accurately for the services that are being
22 delivered, and if there are truly one-day stays out there,

1 they need to be reimbursed appropriately. So I think the
2 simple nature of collapsing the two and creating a site-
3 neutral between observation and one-day stay just doesn't
4 really work for me versus a refinement of the DRG system.

5 How we do that refinement is tough. I know at the
6 September meeting I talked about could we take the current
7 MS-DRG system where it looks at the complications and co-
8 morbidities, whether it's an absence of the presence of a CC
9 or a major CC and add a fourth category to help kind of
10 refine that a little bit, was one option I thought about
11 then.

12 Since then, I've thought about it a little bit
13 more, and I'm not necessarily sold on this, but at least I'm
14 thinking it through a little bit in my own head, is looking
15 at the MDCs, the major diagnostic categories, where we have
16 25 of those, and would there be a way to create a short-stay
17 policy within those MDCs out there. Like I said, I haven't
18 thought through all the mechanics out there, but maybe
19 another way to look at this that's out there. But bottom
20 line for me, I think a one-day stay DRG policy seems to make
21 more sense.

22 MR. HACKBARTH: So, Herb, do you want to address

1 the issue of cliffs? If you were to go this way, you would
2 still have cliffs, albeit in different places. What's your
3 thought about that?

4 MR. KUHN: Yeah, so on the cliffs, I mean, I could
5 see where you all struggled in November with the cliff
6 conversation, but cliffs are going to be there in any
7 prospective payment system that we have, whether it's in
8 home health or SNF or wherever we are. The best I think
9 that we can do until you get to some kind of global payment
10 or, you know, bundling or whatever the case may be is how do
11 you moderate those cliffs as much as you can. So I think on
12 that one slide where you showed observation and one-day stay
13 versus the three, at least you're beginning the process of
14 moderating those cliffs that are out there. And then I
15 think if you have an appropriate auditing process, you can
16 kind of manage that process.

17 But, you know, as I kind of sorted through my
18 head, I just think the toolkit is pretty bare when it comes
19 to cliffs in terms of within a prospective payment system,
20 and that's the nature of a prospective payment system. You
21 win on some, you lose on some, and on average you come out.

22 MR. HACKBARTH: So let me just pursue this a

1 little further. So I agree with you that cliffs are almost
2 inherent in having these siloed payment systems. And to
3 address the problem of cliffs, you've got, I think, three
4 basic approaches. One is review, which is what the RAC
5 thing is all about and which has prompted a lot of
6 controversy. A second is what I'll call Jay's approach,
7 where you have a formulaic adjustment that tries to modify
8 the incentives around the cliff. And the third is moving to
9 still bigger bundles that span multiple silos.

10 You know, many times we've said we favor the big
11 bundle approach, but that's sort of a separate track of work
12 and policy. So really the options are if you still have
13 cliffs, you're going to have to do some sort of
14 administrative review or some sort of formulaic penalty
15 approach.

16 So what I'm searching for is why moving to one-day
17 DRGs or new DRGs, what problem have we solved? It's just
18 sort of shuffling the chairs on the deck, isn't it?

19 MR. KUHN: I mean, for me it's an imperfect system
20 now as we see. I mean, look what's going on. The only
21 thing I can say on that is we make an imperfect system a
22 little less imperfect by trying to refine it and create a

1 little bit more glide path.

2 MR. HACKBARTH: Okay. So Round 2, we'll go down
3 this way.

4 DR. REDBERG: So clearly this is a very complex
5 area but I -- on the payment differences because, as we've
6 talked about before, I think it really is hard from a
7 beneficiary or clinical point of view to separate an
8 observation stay and a one-day inpatient stay. I favor a
9 site-neutral approach, as we have discussed for other
10 things, you know, paying really the same amount for the same
11 care, no matter what you want to call it.

12 MS. BUTO: My thoughts on this are complicated,
13 but they go back to when PPS was initially developed, one of
14 the notions was there would be variability in the numbers of
15 days of stay in any given DRG, and that the system was --
16 imperfectly, admittedly -- designed to try to allow the
17 flexibility for hospitals to manage the resource, try to get
18 the stays down, actually, and there was a big drop the first
19 year in the length of stay, the average length of stay for
20 hospitals. So I go back to that, and I think this actually
21 is not like the rest of the PPS system in the sense that it
22 begins to take on the length of stay. And if we start to

1 adjust for the length of stay here, I think we are just
2 beginning to unravel the notion of the system.

3 I mean, I listened to Alice yesterday talk about
4 having to certify that it was, you know, a physician's
5 belief that the patient would be in the hospital for two
6 days. If we implement a one-day DRG, assuredly that's going
7 to be -- we're going to start seeing a big jump up in two-
8 day stays.

9 So I just feel like this will not get us there,
10 and it begins to -- I would just take the other side. There
11 is no kind of, I don't know, alignment in the policy. In
12 other words, if there's a really long stay, the beneficiary
13 ends up picking up some of the cost sharing after a period
14 of time, and there are other things that happen. But the
15 hospital -- and so you'd have to start looking at, you know,
16 is this policy going to be looked at by proponents of longer
17 stays as a way to justify changing the PPS system to add
18 more payment on the other end? So I really think it begins
19 to unravel the original intent.

20 And one thing I'd just comment on is there is an
21 annual recalibration process that's intended to pick up big
22 changes within a DRG of length of stay, cost, and other

1 things. If it's not working, I think we need to figure out
2 what's wrong with that recalibration system, because it's
3 probably not just the one-day stay issue; but there might be
4 technology issues, there might be cost issues that are not
5 being picked up as well. So I actually think that process
6 is either working or it's not. If it's not working, we
7 really need to figure out -- or help the agency address that
8 issue.

9 DR. SAMITT: So my thinking is evolving on this.
10 At the prior meeting I probably would have been a strong
11 advocate for a site-neutral payment approach as well, and
12 that's what's hard for me about teasing apart each of these
13 issues, because they're now all interrelated. And it goes
14 back to what you've already said. You know, what problem
15 are we trying to solve. When we reviewed this the last
16 time, the sense I got is we're seeing appropriate scrutiny
17 of longer hospitalizations and a shift from longer
18 hospitalizations to shorter hospitalizations. And the RAC
19 process has applied appropriate scrutiny to one-day stays to
20 see if they should be observations.

21 So aren't we seeing the type of appropriate
22 scrutiny around utilization as we wanted? The problem we're

1 trying to solve was the burden on hospitals with the RAC
2 process as well as the unintended consequences for
3 beneficiaries.

4 So now I'm thinking that we should do nothing with
5 the first issue and leave the payment differences the way
6 they are and focus instead on resolving the problems that
7 were really the core to focusing on this in the first place,
8 which is 2 through 5.

9 MR. HACKBARTH: Round 2 on the payment issue?

10 MR. THOMAS: So I think the other thing is
11 exacerbating this is we're going to continue to see shorter
12 lengths of stay. I think that is -- you know, if you go
13 back over the past five to ten years, we just continue to
14 see more of the beneficiaries, more of our patients in
15 shorter lengths of stay, and I think that is what is driving
16 a lot of this change as well. And then I think the RAC
17 review and the fact that these areas have been targeted has
18 exacerbated this issue, quite frankly.

19 My thinking on it has evolved as well, although I
20 think that there is complications with setting up a short-
21 stay DRG. At the same point, I think we are going to
22 continue to see shorter lengths of stay in the future as

1 well. So I'm kind of torn on that issue.

2 The reality is that, you know, we're in a
3 situation where we have folks that are reviewing these
4 three, six, 12 months later, and, you know, hindsight always
5 gives us a lot of clarity as to what's going to happen. And
6 I think that's where providers get into a very difficult
7 situation here, and, unfortunately, going to Craig's point,
8 beneficiaries get put in the middle with their out-of-pocket
9 expense.

10 So, you know, I think that either we need to have
11 much more clarity about what types of patients we want to
12 see in observation versus an inpatient stay, because today
13 it is not clear. Or I think we ought to go to a shorter-
14 stay DRG and make sure that we can try to create enough
15 clarity in that short-stay DRG.

16 I still think you're going to have cliffs. I
17 would agree with that. Perhaps they're actually smaller
18 because you've got a couple of different options there. But
19 you're not -- I don't think in either situation you're not
20 going to get away from the cliff. You're either going to
21 have the cliff from observation inpatient, or you could have
22 a cliff from observation to one-day stay to a two-plus

1 length of stay. And I think it is important to note that
2 that's two-plus. It's not a two-day length of stay; it's
3 two-plus.

4 So, you know, my thinking on this is we either get
5 a lot clearer about the definition of an observation versus
6 an inpatient or we look at more of a short-stay DRG.

7 MR. HACKBARTH: Round 2.

8 DR. HOADLEY: I'm trying to wrap my brain around a
9 number of these issues. Are we assuming that if we create
10 the one-day-stay DRG, that will lead to a change in the
11 number of observation stays? I can leave that as a
12 rhetorical question for future thought.

13 [Laughter.]

14 MS. NEUMAN: I would say the idea of the one-day-
15 stay DRG is to pay the one-day stays on the inpatient stay
16 closer to their cost, so that there's less concern about
17 whether you got the observation versus the inpatient
18 admission decision correct. What that does to hospital
19 behavior is an open question.

20 DR. HOADLEY: Yeah, okay.

21 DR. MILLER: And the other way [off microphone] --
22 and I need a lot of close support here, Kim. If there's a

1 block of observation stays and there was no change, if this
2 helps answer the question, some portion of those would now
3 be paid in this one-day-stay DRG, if that's what we're
4 talking about now. And then I think what Kim is saying is I
5 don't know what the behavioral response -- would that
6 generate more observations, less observations, that type of
7 thing? Because in a sense, if an observation crosses over
8 into one day, it would be paid under the one-day DRG.

9 DR. HOADLEY: What I'm trying to think about is
10 how -- in terms of these secondary impacts on beneficiaries,
11 how many of the cases sort of shift situations?

12 DR. MILLER: Right, and again, Kim and Zach, just
13 to be clear, some bloc of the current observation would
14 become one-day stays and paid under the inpatient, you know,
15 this revised inpatient, if I'm picking up with Herb's idea.
16 Is that right?

17 MS. NEUMAN: It sounds like...

18 DR. MILLER: Let's say you have an observation
19 stay that's, you know, 40 hours or something like that.

20 MS. NEUMAN: The way the one-day-stay DRG would
21 work is that that observation stay that's 48 hours would
22 still get paid under the outpatient payment system. A one-

1 day-stay DRG would maintain the sort of admission
2 requirement to get the inpatient payment. And so if it's an
3 inpatient one-day stay, you get a lower rate than you're
4 currently getting right now, but it wouldn't change the
5 outpatient rate. Site-neutral kinds of approaches could
6 change both rates to bring them closer, but the one-day stay
7 doesn't.

8 DR. MILLER: Fair enough. But to the extent that
9 somebody had what -- and, again, the whole problem here is
10 what's really an observation stay and what isn't. But to
11 the extent that someone can make the decision to admit that
12 person and they're in for a day, that would be one less
13 observation stay under the existing set of observations.
14 But, Kim, you're right to kind of bring us back to it does
15 depend on what the decision is, to admit or to keep the
16 person in observation status.

17 DR. HOADLEY: That makes sense. And is there a
18 difference in -- would there be in this any difference in
19 the cost sharing for the beneficiary in the one-day DRG
20 versus the two-plus-day DRG?

21 MS. NEUMAN: So as we modeled it, no, but that's a
22 policy decision that could be contemplated.

1 MS. UCCELLO: I think I am where Craig is. You
2 know, last time we talked about this, we were both intrigued
3 by this kind of site-neutral, but I do worry that, you know,
4 maintaining cliffs or adding cliffs, it's not -- I'm not
5 convinced that that puts us in a better place than we are
6 today.

7 And I'm also -- I thought that last time the
8 clinicians voiced some concern that there really is a
9 difference between observation and a one-day stay. So --

10 MR. HACKBARTH: Cori, did you say there is or
11 isn't a difference?

12 MS. UCCELLO: Is a difference. That's what I
13 thought I heard last time. And so maybe I misremember that,
14 but I'd be interested in what they have to say about that.

15 MR. HACKBARTH: So let's ask the clinicians. So I
16 think one way to frame the question is: Is there a clear
17 difference between a patient who's appropriate for
18 observation versus an inpatient or a one-day inpatient
19 versus a two-day inpatient?

20 DR. HALL: So I'll try to be dispassionate about
21 this topic, but I'm anything but.

22 I think there is a difference. I think there's a

1 clear subset of patients where observation is probably with
2 -- the clinical thinking would be there's a very good chance
3 we're going to solve this problem in a very quick period of
4 time, but there's just a certain amount of uncertainty. So
5 there is a difference.

6 But when you get beyond that, I think this is a
7 very, very difficult problem, and I think it's very
8 important. As Craig mentioned, what is the problem we are
9 trying to solve here? And one of the problems I think we're
10 trying to solve is to make sure that Medicare beneficiaries
11 are getting the care that they need. We haven't really
12 brought that into the picture yet.

13 My thinking on this right now is that if a
14 hospital system is dysfunctional and we know by there being
15 an outlier status for whether they overuse or underutilize
16 observation or one-day or two-day stays, that's a problem
17 that has to be solved in a system way.

18 There's something dysfunctional about how the
19 entire enterprise is working. I think those hospitals can
20 be identified, and I think that they should be penalized,
21 just as we have done in many to her things with hospital
22 readmissions and all the rest. I don't think there's any

1 question about that. There has to be some regulation.

2 But let's put it this way. If you have a relative
3 or a friend or a loved one or yourself, depending on your
4 age, and you present to your hospital or your emergency room
5 with chest pain, what do you want the clinical providers to
6 be thinking about during that period, those precious hours?
7 Do you want them to really have to start worrying whether
8 they're going to be dinged by an administrator if they made
9 the wrong decision, or do you want them to spend all of
10 their time as best as they can? Whatever medical expertise
11 they have is to make the right diagnosis and have the right
12 treatment at the right place.

13 I've mentioned several times in this forum, don't
14 give us so much credit for being such wizards. We're not.
15 A lot of these decisions do take some time, and so whatever
16 we do with this whole system, let's keep in mind what's
17 going to be the impact on the patient.

18 We have talked about disadvantaging people for SNF
19 coverage, disadvantaging them for self-administered
20 medications, but let's not disadvantage them, that their
21 medical personnel are not going to be paying attention to
22 what their problem is.

1 What are the solutions here? Possibly site-
2 neutral or possibly continuing observation and then finding
3 some other system that would, by and large, approximate on a
4 large scale what is the severity of the case and what it's
5 going to take.

6 Obviously, I think that the RAC system is really
7 lacking in this way, so let's always keep that in the back
8 of our minds.

9 But yes, you can find observation. You can define
10 a lot of people who are, let's say, with 80 percent
11 certainty are going to be observation.

12 MR. HACKBARTH: I think that the tricky issue,
13 though, is at the boundary. Clearly, there are some that
14 are only observation, but I think Cori's question is, does
15 it get increasingly gray as you get to the boundary, oh,
16 that longer observation, more complicated observation
17 patient versus what's appropriate for inpatient admission.

18 Kate.

19 DR. BAICKER: I have to say that I feel a little
20 uncomfortable with the idea of moving towards one-day-stay
21 DRGs, two-day stays. It seems like, day by day, we're
22 unraveling the DRG system, and eventually, each day is going

1 to get its own per diem, and we're going to be back where we
2 started.

3 There are always going to be cliffs. We can vary
4 the size of the cliffs and/or we can pay attention to the
5 type of behavior over which the cliffs are changing. Moving
6 somebody from one day to two days seems like a very nuanced
7 decision that a clinician could have genuine ambivalence
8 about, and if there's a huge payment difference between an
9 extra night in the hospital or not, that seems like a
10 dimension over which there's likely to be a big behavioral
11 response.

12 What I thought perhaps I had heard and would love
13 to hear more information about is if we go to a more site-
14 neutral approach, there seems like there is less discretion
15 over which DRG you are putting someone in. If there are
16 certain types of conditions for which we say we think this
17 is likely to be a short-ish visit, whether it's outpatient
18 observation, inpatient observation, that we think this is
19 the type of condition for which not all that long a stay is
20 appropriate, to me it seems like there is likely to be less
21 behavioral response to that, the way that there could be a
22 lot of change -- different from how there could be a lot of

1 change over the length of stay or over whether you label it
2 an observation stay or an inpatient stay, the beds are all
3 the same.

4 We've heard a lot about how arbitrary that
5 distinction is. So I would rather make the payment policy
6 neutral with respect to things like whether you call the bed
7 an observation bed or an inpatient bed and more neutral, not
8 so response to decisions like one extra day in the hospital
9 generating a huge amount of extra payment and then focus on
10 the neutrality that will likely direct patients to where
11 they're getting the care that they need without the
12 clinician having to think about how do I label this or,
13 "Gee, an extra 20 minutes in the hospital could gain us a
14 lot of extra revenue."

15 DR. NERENZ: I think I may touch on a few points
16 and hopefully tie a few threads together here.

17 First of all, starting with Kathy's observations,
18 I do think that the DRG system, as we currently find it, has
19 already in it, or at least has had in it, short-stay
20 outliers within certain DRGs. One-day stay is already built
21 into the overall formula, and they can be recalibrated.

22 So at least from the perspective of the inpatient

1 payment, I don't know that the one-day stays should be that
2 problematic, but I understand that the essence of the issue
3 is that boundary between them and the observation.

4 Then on the cliff issue, I don't know that the
5 cliff necessarily is a problem if there is a corresponding
6 cost cliff. For example, when we're looking at the one-day
7 versus two or longer, if it actually costs you similar
8 differential amounts to provide the care, the incentive is
9 pretty weak because you can do a short thing and get paid a
10 small thing or an expensive big thing and get paid a bigger
11 amount. So I am not sure cliffs, per se, are necessarily
12 bad if the costs correspond.

13 Now back to Kathy, I do also -- and Kate, same
14 thing -- I share a concern about defining a DRG on the basis
15 of a duration because that is conceptually different. It
16 does involve unraveling. Essentially, by definition, you're
17 moving to a per diem, but as a friendly amendment, I wonder
18 if there would be a potential for an observation DRG,
19 defined not by one day but defined in its essence by the
20 work being done. It seemed like that would offer a couple
21 of benefits.

22 One, it would, in some case, avoid the necessity

1 to split the hairs and make this distinction between an
2 observation paid one way and an inpatient. If you're in the
3 same hospital bed being treated by the same hospital nurses,
4 getting the same hospital food, getting the same self-
5 administered drugs, it seems pretty hospital-ish to me, and
6 to the beneficiaries, it certainly does.

7 An observation DRG defined that way, I think would
8 have been mechanically difficult in the ICD-9 system
9 because, in my thinking of it, it's hard to define it by
10 diagnosis.

11 But I wonder if there's some traction now in ICD-
12 10 because the way you would develop the grouper is you'd be
13 coding potential for or suspicion of or risk of something
14 like that, and what you'd try to capture is that the nature
15 of the work is different, that the reason you're talking
16 about somebody in this status is you think there might be
17 something going on, but you're not sure.

18 I don't recall from our November meeting if we had
19 gone down this path, but at least I'd like to suggest it.
20 It might also then really reduce this RAC audit problem
21 because it's no longer a time issue. One of these stays
22 might be one day. It might be two days. You hope it won't

1 be all that long. It would be a relatively low payment, but
2 it strikes me as we go around on this that at least we ought
3 to think about that a little bit.

4 MR. HACKBARTH: Dave, if I could, I want to go
5 back to your earlier observation, which I think was astute.
6 You said that as opposed to just looking at the cliff in
7 payment, what you really need to look at is relative
8 profitability. So if the payment goes way up and the costs
9 go up correspondingly, then there's not an incentive to
10 exploit the system.

11 DR. NERENZ: Right. Yes.

12 MR. HACKBARTH: So I have a question for Kim and
13 Zach then.

14 Dave had pointed out in an earlier comment that if
15 there is a patient admitted, that first day is typically the
16 most expensive day, but if you move a patient, inpatient,
17 even if that first day is the most expensive day, is the
18 inpatient admission more profitable as a result of moving to
19 the higher payment? So if you have an inpatient admission
20 now with a very short stay, even if the first stay is very
21 expensive relative to the other days, it could still be a
22 very profitable admission.

1 You are looking puzzled. Should I try to restate
2 that? I know it didn't come out very clearly.

3 MS. NEUMAN: Tell me what length of stay you are
4 thinking about here.

5 MR. HACKBARTH: Okay. Say we have a patient that
6 is admitted, and they only stay for a day or two. That's
7 the issue that we're concerned about here, is very short
8 inpatient admissions. That's sort of the beginning of this
9 whole process, and so let's talk about that case. They're
10 admitted, and they stay for a very short period of time.
11 Even though that first day is expensive, relatively
12 speaking, the short inpatient stay is overall very
13 profitable. That's because it's an averaging system, as
14 Kathy pointed out.

15 MS. NEUMAN: Right.

16 MR. HACKBARTH: So my fear, Dave, is that when you
17 have this short inpatient admission, the profitability is
18 high. So it's not just that the payment goes way up; it's
19 that the profit goes way up.

20 DR. NERENZ: Well, yes and no. Again, that's just
21 part of the fundamental design of the DRG system.

22 MR. HACKBARTH: It is.

1 DR. NERENZ: But if we used, for example, some
2 surgical DRGs that currently run in one- and two-day stays,
3 the first day is phenomenally expensive. The payment
4 reflects that. The whole distribution of lengths of stay
5 kind of reflect that, and it's just sort of all built into
6 the system.

7 One of the reasons I was thinking about this
8 observation DRG is the shape of the cost trajectory within
9 the DRG would not necessarily be as sharply expensive first
10 say as something like a surgical DRG because, in this
11 observation status, clearly there's some tests you're
12 running. There's some things you're doing, but it seems
13 like the term "observation" is telling us that you're kind
14 of watching. You're looking. So if a such a thing was
15 created, the first day of that might not be phenomenally
16 more expensive.

17 MR. HACKBARTH: I think it's almost certainly the
18 case that the cost profile over the course of an admission
19 varies by DRG. Surgical DRGs would tend to have high costs
20 at the beginning, but I don't think the cases that we're
21 talking about here are surgical cases, typically. They
22 would be more likely medical cases, and so, in that

1 instance, you might have a different cost profile and not as
2 much of the cost front-loaded on the first day. And
3 therefore, the short-stay inpatient admission could be very
4 profitable.

5 I don't think that the costs go up with the
6 payments, but that's an empirical question.

7 MS. NEUMAN: I would just stay in the one-day-stay
8 DRG, the thing that you've seen on the screen, the payment
9 increase from a one-day stay to getting to two days is going
10 to be higher than the cost increase by definition because
11 the cost of a two-day stay is going to be the lowest cost on
12 average of stays two days or more. But the payment is going
13 to have increased to be at the average for all those stays,
14 and so, by definition, the payments will go up by more than
15 the costs at that cliff.

16 DR. NERENZ: I'll buy that, but that's part of
17 what I was trying to solve with this observation DRG. I'm
18 trying to say let's not define the DRG by one- versus two-
19 day and create that cliff. Let's create a DRG not defined
20 by time, and its length of stay may vary somewhat.

21 They're all going to be pretty short. I mean,
22 we're not talking about week-long observations, I don't

1 think. I look at my clinicians. I don't think that's going
2 to happen, but that's part of what I was proposing, this
3 alternative, is to avoid that, that you just stated.

4 MR. HACKBARTH: Okay. Alice.

5 DR. COOMBS: Thank you, David, because you got me
6 interested in that now. I was really over in Craig's camp.

7 [Laughter.]

8 DR. NERENZ: It's not designed to be a
9 competition.

10 DR. COOMBS: No, no.

11 [Laughter.]

12 DR. COOMBS: No, I know it wasn't, but as I was
13 thinking about the process, I thought about the fact that
14 the RAC is like the school teacher, and if the teacher is
15 not up to par to functioning to do what it needs to do, then
16 there are ways we can optimize in which the teacher delivers
17 the message, her message, his message.

18 The issue with the observation status -- and I so
19 agree with Bill -- there is a difference. In the majority
20 of patients, we know that there is a difference. Patient
21 comes in, in the process of a bowel prep, and gets
22 dehydrated and passes out. I am thinking about the syncope

1 on the list that a one-day is going to be \$4,972 and an
2 observation is going to be \$1,600. That patient is going
3 into observation. I am going to hydrate that patient, going
4 to get better, going to go home, and that's it.

5 So the differential between that observation in
6 that one day is huge, and I guess Kate would call it a
7 behavioral change, but there might constitute a behavioral
8 change if we were to tinker with the system whereby we
9 decided that, okay, there's just the one day and let's just
10 be a lump and lump everything together. So I think that's
11 an issue.

12 But the other issue about observation and one-day
13 stays is this resource and labor intensive in terms of the
14 amount of investment into the patient. Hydration is very
15 different than someone who comes in with acute chest pain
16 and has to go to the cath lab, is a one-day, gets a stent,
17 and has gone home because he's stabilized. That's a very
18 different type of patient than someone who is dehydrated who
19 gets hydrated. I just want to have that face of a patient
20 who has the two very different entities.

21 I think that lumping these two together or doing
22 things where we changed the cliff, the cliff exists, and I

1 think it's a reflection of the resources that go with the
2 cliff. There are other things other than cost that go with
3 that cliff, and there are resources. So if there's a cliff,
4 there's a reason I think that that cliff is correlated with
5 the amount of investment of resources in the patient's care.

6 I guess I'm still over in the village where Craig
7 lives, but --

8 MS. BUTO: [Speaking off microphone.]

9 [Laughter.]

10 DR. COOMBS: It's actually growing as we go around
11 the table.

12 But I just want to say that it's not a prefect
13 science, and I think the beneficiaries of the key
14 ingredients here, they're the tyrosine hydroxylase in this
15 whole process, and we want to make sure that we deliver the
16 kind of quality that's necessary and have the right care at
17 the right time.

18 MR. HACKBARTH: Jon. And then I'm anxious to move
19 onto the beneficiary issue.

20 [Laughter.]

21 DR. CHRISTIANSON: I'm anxious to move on too. So
22 I'm in the Craig, Cori, et cetera, village, and I like the

1 recap sheet that you guys did.

2 Let's just assume for a minute that the CMS change
3 in the approach to the RACs works to some degree. That
4 would mean that there would be ultimately pure observation
5 days, because the story is that there's a lot of observation
6 days because people are afraid to put people into the
7 hospital because they're going to get dinged by the RAC. So
8 let's assume the RAC effort can be restructured to be more
9 efficient.

10 And by the way, I think the RAC effort is
11 structured pretty well now in terms of incentives. I think
12 there are the right incentives in it. I think the way that
13 it's operationalized is not so good, and we need to work on
14 that.

15 So there, I think I agree with what you were
16 saying, Bill.

17 If that happens, then we're going to get more one-
18 day inpatient admits. If there's a lot of observation
19 stays, now you're afraid you'll get dinged, and if we are
20 going to have fewer observation stays, you're less afraid
21 you'll get dinged, so there's going to be now more one-day
22 admits.

1 I don't understand in the level of detail that
2 Kathy does with the recalibration process, but it seems like
3 that's where you now turn, is you say, "Okay. Do we have
4 the DRGs calibrated correctly?"

5 I'm kind of thinking that we don't want to do a
6 lot on this right now, and I think we want to follow what's
7 happening. We want to see whether the recalibration process
8 works or needs to come into play in a different way than it
9 has in the past.

10 I remember being convinced a couple months ago
11 that in terms of the amount of money involved, the amount of
12 admissions involved and all of that, maybe it wasn't as
13 large, as we seem to have created the problem in some sense,
14 and that we should kind of do what Craig had suggested at
15 this point.

16 It is an interesting problem when we like to hold
17 it up and admire it. I understand that.

18 MR. HACKBARTH: Okay. We are now onto the issues
19 numbered 4 and 5 on this list, and we'll start with Mary.

20 DR. NAYLOR: So if I were a village leader, I
21 would spend all our time figuring out how to keep people out
22 of observations or that one day to begin with. And I think

1 we have a lot of knowledge about how to do that.

2 But on the issue of the SNF three-day-stay policy,
3 I actually think you -- first of all, it was a terrific,
4 terrific piece of work, and you made a great argument around
5 why we should continue to think of this as post-acute. But
6 just for a moment, I'd like to say we may at future times
7 want to think about skilled nursing facility not just as
8 post-acute. Taking people from the nursing home into a
9 skilled nursing facility to get treated for an acute illness
10 to prevent that one-day visit might be something we would
11 want to do.

12 But buying into the post-acute sector for now, I
13 like the idea very much that the two-day observations count
14 because it protects the beneficiary, and I think that's
15 very, very important.

16 I also like Options 1 -- the combination of
17 Options 1 and 2 on page 12 around the liability for self-
18 administered drugs. I think we should encourage hospitals
19 to waive those, but given that 75 percent currently have
20 that opportunity and choose not to, I think we should cap.
21 So I like the encouragement to not charge for observation
22 beneficiaries' drugs and then -- but for those that do, to

1 cap them.

2 And, finally, I don't know if you want me -- but
3 I'll just end with the offset options. I think -- or do you
4 want to stop? Okay.

5 MR. HACKBARTH: Let's hold for now on the offsets,
6 Mary.

7 On your first point, you know, I'm with you. The
8 notion that the SNFs should be used in a limited way only
9 for post-acute services is one that I find problematic, and
10 the three-day rule -- I think I said at the last meeting --
11 I think is antiquated. And it's one of the reasons that I
12 like the idea for ACOs, for example, when they assume full
13 responsibility, that those rules are waived and so that they
14 can use SNFs in a different sort of way that you're
15 referring to. I'm there on that.

16 The problem that we face is that eliminating the
17 three-day rule and using SNFs in a very different way has a
18 potentially very large budget impact. And I think
19 furthermore one of the fears is that if there's no inpatient
20 requirement whatsoever, patients can be easily moved from
21 long-term-care facilities into SNFs for the higher Medicare
22 payment, which could have a huge fiscal impact.

1 So that's a constraint that we're dealing with,
2 albeit it makes some of the options suboptimal from a
3 clinical perspective.

4 DR. NAYLOR: So I think that this is in some of
5 the ways that we think about transition, a transitional
6 opportunity to really think about a little loosening of the
7 three-day policy in a way that helps us prepare to think
8 about SNFs in different ways than we have.

9 MR. HACKBARTH: Going to the requirement of just a
10 one-day inpatient stay is that sort of loosening without
11 opening the flood gates.

12 DR. NAYLOR: Exactly. It's helps us to get right
13 place, right time, right services.

14 MR. HACKBARTH: Right, right.

15 DR. MILLER: And can I just say, I also like that
16 you commented at the same time on the self-administered --
17 you were saying you were interested in the 1 and 2
18 combination. If other people can also mention their
19 interest.

20 MR. HACKBARTH: On beneficiary options, we'll go
21 this way this time.

22 DR. CROSSON: Yeah, just briefly, I came down the

1 same place that Mary did. I think the change from three-day
2 to one-day, we can argue it's probably imperfect for the
3 reasons you said, but I couldn't think of something that
4 made more sense.

5 And I agree with John's suggestion to do Option 1
6 and Option 2 with respect to the self-administered drugs.

7 MR. HACKBARTH: Other comments on beneficiary
8 options?

9 MS. BUTO: I agree with Jay and Mary on 1 and 2,
10 but I also wondered if we could get an estimate of getting
11 the hospitals just to cover the cost. I know it would cost
12 more, but we've recommended site-neutral policies in other
13 things that would generate savings, and I think it just
14 makes no sense that they have to waive a requirement. It
15 should be incorporated into their -- into what they provide
16 the beneficiary, in my view. So I'd just be interested in
17 the cost and whether we could somehow consider that as well.
18 That's for the self-administered drugs.

19 Then on the three-day-stay policy, I agree with
20 the recommendation. I wish we could somehow connect this
21 liberalization on the SNF side to our recommendations that
22 the agency move ahead on case mix and some other things. In

1 other words, this is going to be a boon to SNFs. Right now
2 we've already said SNF payment is not efficient and ought to
3 be reformed. There's no support for that, I guess, in the
4 SNF provider community, or a lot of resistance to it. Yet
5 this is going to actually boost the beneficiaries who go
6 into SNFs, I think.

7 So, you know, I really wish we could connect those
8 two somehow.

9 DR. MILLER: That's a really good thought,
10 because, you know, the three-day rule is really pushed hard
11 by the beneficiary advocacy community, and if they made that
12 linkage, that would also probably help get that message
13 across, because you're right, the SNFs are resistant to it.

14 DR. REDBERG: Just to follow on when we're
15 thinking about the way we pay SNFs, and it's just related,
16 but, you know, the policy where if you leave the SNF and go
17 to the inpatient and then come back you're now paid at a
18 higher rate I think deserves reconsideration, because there
19 are a lot of inappropriate hospital transfers. I never
20 realized -- I always wondered why these patients were coming
21 from SNFs for things that didn't make any sense to me that
22 could have easily, it seemed to me as the inpatient

1 attending, been handled at the SNF, and kind of a light went
2 on when someone mentioned that. So while we're looking at
3 differences in payment, I'd like to look at that.

4 MR. KUHN: Just a quick question about the self-
5 administered drugs, and I can't recall whether we talked
6 about this previously on this issue. But obviously we're
7 focusing on the beneficiary -- you know, the liability of
8 the beneficiary or on the hospitals. But isn't there some
9 responsibility here in the Part D space given that most of
10 these drugs are coming through the Part D benefit?

11 MS. NEUMAN: So if the beneficiary has Part D,
12 then the beneficiary may be able to submit the bill to the
13 Part D plan. The hospital pharmacy will likely be out of
14 network, and so the Part D plan would potentially pay some
15 amount. But it's unlikely to be the sort of full charge
16 amount that the beneficiary is going to get on that bill.

17 MR. HACKBARTH: Round 2 comments over here?

18 MS. UCCELLO: So building off of what Herb said,
19 when I read the chapter, I had actually also thought of
20 can't somehow we work the Part D element in this, and I had
21 thought that, well, like you said, most are -- would be out
22 of network. Can there be a requirement that cost sharing be

1 based as if it was an in-network? I think this would
2 parallel something for qualified health plans under the ACA
3 in terms of emergency room care that that has to -- that
4 can't have cost sharing greater than the in-network cost
5 sharing? But I still think there are other issues with this
6 that would require maybe some negotiations between the plans
7 and the hospitals that might just not make this worthwhile,
8 and it's also not going to help the people who don't have
9 Part D plans. So I do think that combining Options 1 and 2
10 would be superior to going down the Part D route.

11 And in terms of the three-day rule, I like the
12 balance that that -- the way we're thinking about it is, I
13 think that's an appropriate -- and we can re-evaluate as we
14 move forward, but I -- and I really like Kathy's idea with
15 trying to link them.

16 DR. HOADLEY: So on the three-day rule, I actually
17 wonder -- I mean, we sometimes are talking about this as if
18 we're just reducing the three-day requirement to one, and
19 it's only if the one is also combined with a total of two
20 days of observation. So we're still not going to be talking
21 about a lot of cases that are going to be added through
22 this. So I assume the cost of this has to be pretty modest.

1 And, actually, with that same thing in mind, I
2 wonder if you could actually say three total days combined
3 of observation inpatient, because you're not -- I assume you
4 don't have a whole lot of three-day-long observation stays
5 either. I mean, I'm fine with the way this is structured,
6 but I actually think you could loosen it without a lot more
7 impact.

8 DR. MILLER: The only thing I missed in your last
9 statement there, we're saying three days could be any
10 combination of inpatient/observation as long as one is
11 inpatient. Were you saying something --

12 DR. HOADLEY: So I would be -- I was putting out
13 the option of any three days where it doesn't have to have
14 one inpatient. It could be all three observation. And I
15 say that because I assume that's a fairly rare circumstance
16 where somebody's lasting three days in observation, or more.

17 MR. GAUMER: I think we can speak a little bit to
18 that. So we've tried to count up, using 2012 data, how many
19 of these cases fall in each of these buckets you're
20 describing, and, you know, there's about 100,000 cases of
21 folks that have been in the hospital for three days and they
22 don't qualify for SNF. Some of them, about half of them

1 exactly, have an inpatient stay there, so about 50,000 of
2 those, and about 50,000 have been in the hospital for three
3 days, and they don't have inpatient under their belt.

4 DR. HOADLEY: So it is a fair number who are
5 having that lengthy an observation-only stay.

6 MR. GAUMER: And as we were doing some back-of-
7 the-envelope estimates of what this would cost, you know, I
8 think the way I'm thinking about it is essentially if you
9 don't have the one-day stay limitation in there, it
10 essentially doubles the cost.

11 DR. HOADLEY: Okay.

12 MR. GAUMER: Doubles from what, I'm not exactly
13 sure, but --

14 DR. HOADLEY: Right, what number.

15 MR. GAUMER: -- that's kind of where we are.

16 DR. MILLER: That's been the frustration in this,
17 and I understand it, but we've been talking to, you know,
18 scorers both in the executive branch and in the legislative
19 branch, and they point us to the concerns about how
20 behaviors can change. The churning notion comes up in those
21 conversations all the time. But I just do want you guys to
22 know, they're sort of saying you need to understand this can

1 have a cost, but they will not tell us what the cost is.

2 And so we don't exactly know what we're working with.

3 DR. HOADLEY: So given those data points, I mean,
4 that makes a better logic for including the one-day that has
5 to be inpatient.

6 On the self-administered drugs, I still -- a
7 little bit like Kathy was saying, it still feels like Option
8 3 shouldn't be that expensive given the cost of most of
9 these drugs. And so I think that's my preferred option. If
10 it turns out to be -- and maybe we can't figure this out
11 very well, but if it turns out to be more expensive, you
12 know, I would be okay with the 1 and 2 combination.

13 I think part of the problem with the Part D thing
14 that we were just talking about is, you know, if you're in
15 for -- have two days' worth of drugs, the whole process of
16 having to submit a claim is going to mean most people will
17 never do it, even if they're -- that's probably what's
18 really happening today. A, they don't get a lot of it back;
19 and, B, the hassle of going through and filing a paper claim
20 or whatever kind of claim is a further disincentive to take
21 advantage of what they could do today.

22 But, again, I think I would like Option 3 if the

1 cost is not crazy, but the 1 and 2 combination would be a
2 reasonable alternative.

3 MR. HACKBARTH: Can we say anything about the cost
4 of Option 3, ball park?

5 DR. MILLER: We figured in the \$50 million -- is
6 that what I recall?

7 MS. NEUMAN: In that rough area, I would say.

8 DR. MILLER: Yeah, annually, so that's not a
9 multiple-year score. So I don't think it's huge. The one
10 thing that I thought there was some sympathy for -- because,
11 remember, we're talking to the hospitals about this. If you
12 build it into the payment system -- and, you know, again, we
13 can get the costs nailed down, and there's no, you know,
14 resistance to it, if that's the direction you want to go.
15 But then the beneficiary does have cost sharing, and it's
16 now institutionalized. And the other approach, at least to
17 the extent that the hospital says I want to forgive it, that
18 has gone away because then there's no forgiving. It's you
19 get the drug, you pay your co-payment.

20 DR. HOADLEY: And the cost sharing is simply that
21 the total outpatient amount goes up by whatever amount, and
22 the 20 percent, therefore, goes up. So I mean, again, if we

1 can get the cost and know what kind of magnitude we're
2 talking about, that would help. But I don't know, maybe
3 that's too precise.

4 DR. MILLER: And, again, can't you just give us
5 the opportunity to get away from [off microphone].

6 DR. CROSSON: Just to be clear, if we went in that
7 direction, we'd be talking about beneficiaries' liability
8 increased by hospital charges likely, not the cost of the
9 medications, right?

10 MS. BUTO: Coinsurance is based on charges [off
11 microphone].

12 DR. CROSSON: No?

13 DR. MILLER: Just a second. I need you guys. I'm
14 thinking no. You would end up constructing a payment, so
15 this would involve kind of going through and figuring out
16 what the charges are. For those of you who are in this kind
17 of detail, you know, converting charges to cost, and then
18 you would set a rate, and the beneficiary would pay 20
19 percent of that. And the only thing I do -- but I do want
20 to give you some quarter here in the sense that, to the
21 extent that there are charging behaviors that influence that
22 cost-to-charge ratio, yes; but they won't be exposed to the

1 charge directly. Kim?

2 MS. NEUMAN: Agree.

3 DR. MILLER: Okay.

4 MR. HACKBARTH: You look puzzled, Jay.

5 DR. MILLER: Yeah, I'm sorry.

6 MR. HACKBARTH: If it's part of the outpatient
7 department payment system, there the payments aren't based
8 on charges. It's reduced to --

9 DR. CROSSON: Got it.

10 DR. MILLER: But he's not wrong that the charging
11 behaviors end up getting partially reflected in the
12 payments.

13 MR. HACKBARTH: Yes. Okay. Shall we --

14 DR. MILLER: [off microphone] happy about --

15 [Laughter.]

16 DR. CROSSON: Got it.

17 MR. HACKBARTH: Okay. So we are five minutes from
18 the scheduled end of this session. What I'm going to
19 propose is that we go to -- take 20 minutes to finish this
20 off, and we still have two things to cover: any additional
21 comments on RAC and then the offsets. So we're going to
22 have to pick up the pace a little bit to get all the way

1 through this.

2 So let's start with RAC issues. Anybody want to
3 say more on that? Let me see hands of everybody who wants
4 to get in on RACs. So I have Warner, Jay, and Herb.
5 Warner, why don't you go ahead?

6 MR. THOMAS: So my comment is, going back to the
7 village that started earlier --

8 [Laughter.]

9 MR. THOMAS: Which I understand, if we go to a
10 situation where we really don't want to make modifications
11 in the observation versus the one-day stay, you know, my
12 comments would just be to make sure we have more clarity
13 around the definition of observation. And I think the two-
14 midnight rule is, as we all know, extremely problematic
15 because this is not based, as we hear from the clinicians,
16 on time. It's based on the clinical situation with the
17 patient.

18 With that being said, also I'm concerned about the
19 fact it seems like even though this December 30 information
20 from CMS may address some of the issues, I'm still concerned
21 that, number one, we're not sure if it's actually going to
22 take place in all of the existing RAC situations. And,

1 number two, I don't think we're really clear as to whether
2 the one-year timely filing is going to be adequate to give
3 organizations time to have a claim pulled, go through the
4 process of potentially appealing it, which, you know, if you
5 feel like you've done the right thing, you want to appeal
6 it, and then have an opportunity to refile after that. So I
7 would just put that out there, that I think we need to have
8 more guidance and oversight of the RAC process, which,
9 frankly, has probably exacerbated much of what's going on
10 with the whole one-day-stay issue anyway.

11 DR. CROSSON: So I'll be brief on this. I think
12 that it's entirely possible that our best approach would be
13 to do nothing in this area and wait and see to what degree
14 the changes that CMS has made in the RAC process, you know,
15 results in a better outcome than we have now and all the
16 rest of that.

17 That said -- and I guess this is more
18 philosophical than anything else -- I think the whole notion
19 of adding all these costs to the health care system, to pay
20 for the RAC reviews, for CMS to add all the expenses to
21 manage this process, just, you know, strikes me as
22 potentially unnecessary. If we were able to create -- and I

1 think, Glenn, earlier you mentioned the readmission policy,
2 and that's what sort of attracted me to the notion of a
3 penalty. If we're able to create and construct the
4 incentives in such a way that we get the same result, which
5 is to have more observation rather than one-day stays, we
6 end up with a policy that gets us to the same place, but
7 without all this added cost and hassle and administrative
8 problems for the hospitals.

9 Now, having said that, it isn't easy to do that.
10 So, for example, you know, on Slide 8, the model we have
11 here of, let's say, 25 percent, which would generate 90
12 percent of RAC recoveries, well, that might be the right
13 policy in the beginning. But if, in fact, it was a
14 successful policy and we began to move towards more
15 observation and less one-day admissions, you wouldn't want
16 to continue to hit 25 percent of the hospitals, because
17 eventually, you know, you'd be getting to a state where,
18 even within that 25 percent, there was probably the
19 appropriate clinical decisions being made. And so you would
20 need to construct something which was more flexible in that.

21 Having said that, if it was successful, the
22 penalty approach was successful, you should also, you know,

1 not have this same bogey of the current RAC recoveries to
2 deal with, because, in fact, you would be getting, you know,
3 more and more appropriate utilization. So it's a very
4 complicated kind of approach with a lot of moving pieces.
5 Nevertheless, it's attractive to me because I think in the
6 end it's better policy. Whether we choose to do that or
7 wait a few years and see how the current approach works I
8 think is a reasonable judgment.

9 MR. KUHN: So I'm kind of where Warner is in terms
10 of continuing to move forward on this, and I guess what I
11 reflect on is just the action we look yesterday dealing with
12 LTCHs. If you think about the action we look, Congress
13 acted a year ago to reform the payment system for LTCHs in
14 terms of ICU activity, but instead of the Commission saying,
15 "Let's wait. Let's see how this implements, and then we'll
16 come back and relook at our proposal that we did before," we
17 said, "No. Let's go ahead and rerun our proposal and move
18 forward."

19 And I think that's where the Commission has always
20 been. If we think something is right and we need to move
21 forward and put a stake in the ground in terms of a policy,
22 let's do so. I don't think we should wait till things sort

1 themselves out. If we think it's the right thing to do to
2 provide clarity in the system, I think we need to move
3 forward, and I think RAC is one of those areas where we need
4 to move forward on that clarity.

5 Having said that, I would not like us to be self-
6 limiting in that regard. We know CMS has this December 3rd
7 -- 30 announcement out there. There is this court case
8 that's pending, but if we still think this is the right
9 policy, let's move forward in these areas. So I think that
10 means bringing back the timely filing issue, and looking --
11 and I think what we have on the menu right now of issues 2A,
12 2B, and the accountability makes sense. That's where I
13 would be.

14 MR. HACKBARTH: So, Herb, Jay is offering a
15 potential alternative that says let's not have RAC-type
16 review at all with all of the associated costs and issues,
17 but rather move towards a formulaic approach. What is your
18 reaction to that?

19 MR. KUHN: So a formulaic in terms of --

20 MR. HACKBARTH: Of payment adjustment.

21 MR. KUHN: Payment adjustments.

22 MR. HACKBARTH: Really, it's one way of sort of

1 ameliorating the cliff of fact, at least for the hospitals
2 that seemed to be the most aggressive and exploiting the
3 cliff.

4 MR. KUHN: I mean, I think there's some real merit
5 there too, in that if you can get the payment system as
6 accurate as you can and avoid all this pay-and-chase
7 scenarios that the RACs operate in that world now, that's
8 certainly a better outcome.

9 MR. HACKBARTH: Other comments on RAC or Jay's
10 related proposal of graduated penalty? Kathy.

11 MS. BUTO: On one level, Jay's proposal really
12 appeals to me because it sort of removes us, removes the
13 policymaker from having -- or the contractor getting in the
14 middle of it.

15 What concerns me is some of the complexity you
16 were talking about, which is we're setting it based on the
17 sheer number or percentage of one-day stays, regardless of
18 whether ultimately those turn out to be medically necessary.

19 I see a little difference with the readmission
20 policy, because there, there is an expectation that
21 following discharge, the discharge will be done at the
22 correct time, and appropriate post-acute care will be

1 recommended and followed through. Then if there is a
2 readmission under the circumstances that are stipulated by
3 the agency, it seems to me there is a strong case that that
4 was not appropriate.

5 So I am more troubled by this sort of just let's
6 take every one-day stay and count it, and then once you get
7 beyond that to things like, well, let's look at their
8 penalty rate, how often are they penalized for having one-
9 day stays, then it gets more complicated.

10 I like the idea intellectually, but I just think
11 it would be difficult to pull off in a way that would be
12 viewed as fair and not just formulaic and penalizing
13 hospitals.

14 MR. HACKBARTH: Other comments on RAC or payment
15 adjustment? Alice.

16 DR. COOMBS: So one of the things that I was
17 thinking about is how a policy like this might be linked
18 with the readmission rates and whether or not we've done any
19 kind of analysis to see if we were to implement this, what
20 would be the impact on readmission rates, period.

21 I am just kind of curious as to whether or not we
22 would see an impact as a result of a policy like this.

1 DR. MILLER: You see somehow this influencing --
2 at first, I thought you were asking what's the intersection
3 of these policies, but then it sounded like you were saying,
4 "Well, would the implementation of this influence the actual
5 rate of readmissions?" and I wasn't sure I caught the
6 connection.

7 DR. COOMBS: You have some fixed winners and
8 losers as I see it here, right? We have a bottom 10 percent
9 and --

10 DR. MILLER: I'm going to take that on, just
11 because it's come up three or four times.

12 This was an exercise in trying to flesh the idea
13 out. You know this works. Somebody says something. We try
14 it. All right. Here is how it looks like, and we start to
15 talk through it.

16 Generally, what the Commission has done with
17 things like this -- and Jay is -- we wouldn't actually, if
18 we constructed this, say we're going to always have 25
19 percent losers or whatever the case may be, because chasing
20 an average just kind of defeats the purpose of it.

21 What you want it to do, if the distribution
22 shifts, you stop penalizing, and you've got the behavior you

1 want. One thing I wanted to just make -- I let it go a
2 couple rounds, just trying to see how this gelled out, but
3 one thing I would say is if this was pursued, it wouldn't be
4 a constant percentage thing. We'd pick a number and say,
5 "If you improve past this point, there is no penalty. It's
6 over," or let me put it this way. That's generally what the
7 Commission has done because chasing this inevitable tail is
8 sort of --

9 MR. HACKBARTH: And we have made a point of that
10 on the readmissions policy that we don't like the way it's
11 written in statute now because of --

12 DR. MILLER: Yeah. Okay. So I just wanted to
13 clear that off.

14 So yes, there -- I'm sorry. There would be
15 winners and losers, but it would be a static, "Here is the
16 number. You know it in advance. If you as a hospital clear
17 the bar, then there is no penalty," but go on with your --

18 DR. COOMBS: So it might be possible that there's
19 two things at work here with the one-days. It might be the
20 readmission signal might be something that would make that
21 observation admission still prevalent, even in the midst of
22 whatever RAC reform there is.

1 MR. HACKBARTH: Oh, I see what you're saying.
2 Okay. Now I see it, and the answer is no. We have not
3 looked at that. Sorry to drive you through all of that to
4 get that answer. Now I understand what you're saying, so
5 we'll go back and talk about that.

6 MR. HACKBARTH: Okay. Other RAC payment
7 adjustment suggestions?

8 [No response.]

9 MR. HACKBARTH: Okay. Let's move on then to
10 offsets. Any comments on those? Mary, then Craig.

11 DR. NAYLOR: So, in terms of three proposed
12 offsets, I really think the extension to hospice in the
13 hospital post-acute transfer policy makes sense for the
14 DRGs, for the selected DRGs, so to extend that work to
15 hospice.

16 I also think, consistent with other
17 recommendations of MedPAC over the years, recovering
18 overpayments for any service makes sense.

19 The one that I would really like us to pursue a
20 little bit more is the exploration of nursing facility-
21 churning penalty. There is massive work going on right now
22 in multiple states led by CMS. I happen to be on the

1 technical advisory panel. It's pretty far advanced. It is
2 helping to uncover the complexities in care, in the legal
3 system, in regulatory, with a multidimensional challenge
4 associated with hospitalizations, rehospitalizations of
5 nursing home residents.

6 So I think it would be very helpful to take
7 advantage of what we're learning. This is really intended
8 to get best practices out there to prevent avoidable
9 readmissions, and before we pursue penalty, I think it would
10 be very helpful to make sure we know all of the dimensions
11 of that challenge.

12 MR. HACKBARTH: Craig.

13 DR. SAMITT: In the case of this particular
14 discussion, I'm more inclined to focus on the SNF-related
15 offsets as opposed to the hospital-related ones. It seems
16 as if the driver of the incremental cost of these
17 recommendations is primarily related to the cost of the SNF
18 components of this, and as we've discussed, the SNFs are the
19 ones that would likely benefit from these proposed
20 modifications. I would direct our offsets to the SNF
21 component of this slide.

22 Now, I think we should come back at some point to

1 the transfer policy to hospice. Perhaps that would be
2 relevant in discussions elsewhere as it relates to hospital,
3 but for this particular case, I would concentrate if there
4 are sufficient dollars there in SNF.

5 MR. HACKBARTH: Other comments on offsets? Jack.

6 DR. HOADLEY: Pardon my question, I guess, and I
7 can leave this as rhetorical for the moment, because we
8 haven't settled on what options, what changes we're doing
9 and sort of what magnitude, and even to the point that Craig
10 makes, if we were doing certain things on the RAC reform
11 that was going to reduce the recovery and create some costs,
12 those might be appropriate on the hospital side if most of
13 the cost is the three-day SNF and the other logic.

14 MR. HACKBARTH: Yeah.

15 DR. SAMITT: So I am just wanting some scaling and
16 targeting, and maybe that's just premature.

17 MR. HACKBARTH: Well, and your point is entirely
18 legitimate. It's a little awkward to talk about these in
19 the abstract without saying what are we trying to offset.

20 The way I interpret this was similar to what Jack
21 said. I would think that the hospital offsets would be done
22 for changes related to RAC or whatever, that were specific

1 to hospitals, increased hospital payment, and if we cut back
2 on RACs, so more money flows to hospital and we need an
3 offset, we would look at these.

4 I thought the SNF-related offsets related
5 specifically to moving from a three-day inpatient
6 requirement to something less than that as opposed to, well,
7 we can sort of mix and match.

8 I think that's what you were saying, Jack.

9 DR. HOADLEY: Yeah.

10 And within the options, I thought Mary's comments
11 were -- I would associate myself with her comments.

12 MR. HACKBARTH: Yeah. Okay.

13 Other comments on offsets? Kate.

14 DR. BAICKER: Just briefly, I think it is very
15 important that we offer these, you know, a menu of offset
16 options. That's great, and I like the idea of then being
17 related to the things that we are offsetting. I think it
18 would also be okay to have a package without -- I don't
19 think we need to go overboard in saying this one offsets
20 this one and this one offsets this one and thinking that
21 they have to go together in that way. It's okay to say,
22 "Here's a package of reforms that we think improves this

1 bundle of care, and here is a package of offsets that we
2 think is a legitimate way to align payments, and together,
3 they're neutral."

4 MR. HACKBARTH: Okay. Other comments on this?

5 [No response.]

6 MR. HACKBARTH: I confess to some personal
7 ambivalence about this. On the one hand, I'm with Kate. I
8 think it's an important part of our discipline that when we
9 say payments ought to go up that we say here's a way to pay
10 for that change. Money is short, and that's part of the
11 reality of the world we live in, like it or not.

12 On the other hand, I do worry sometimes that if
13 something is good policy, for example, transfer police to
14 hospice -- and I'm not saying that that is good, but if it
15 is good, to have it characterized as an offset makes it sort
16 of sound like, "Oh, we wouldn't have done this, but we
17 needed some money, so we're offering this thing up to pay."

18 I would like to think we'll recommend it if it's
19 good policy, regardless of whether we need an offset or not,
20 and we won't recommend it if we don't think it's good
21 policy, regardless of whether we need an offset or not.

22 Kate.

1 DR. BAICKER: That seems like a really important
2 point, and one way that folds in is we're not recommending
3 anything here that we think is harmful for beneficiaries,
4 but we're biting the bullet because we have to find an
5 offset. So I think characterizing the places that we
6 suggest or places to lower program spending are all things
7 that we think are good policy, and for your information,
8 here's -- we've recommended some things we think are good
9 policy that might increase spending, but we're not in the
10 business of just increasing spending. But it's important to
11 characterize these not as things we think, "Boy, we wish we
12 didn't have to do these, except for this other spending."

13 DR. MILLER: Some of this is my fault in the way
14 it's organized and put up here. I mean, if none of this had
15 ever happened down the line, you would have seen the hospice
16 transfer policy. We just didn't have the bandwidth, and
17 then it was like, "Okay. You're moving up in line, bud. We
18 need to talk to you now," that kind of thing, and
19 characterized it as offsets. That's kind of our vocabulary,
20 but I think this exchange is really what's going on here.

21 MR. HACKBARTH: Just one last thought on this, and
22 this pertains specifically to the SNF change. It sounds

1 like the cost of this is potentially pretty modest based on
2 the earlier exchange between Jack and Zach. So we're not
3 talking about a huge number of offset here.

4 It is a benefit enhancement. It's an expansion of
5 the Medicare benefit package.

6 Separately from all of this, we've recommended
7 redesign of the Medicare benefit package in a budget neutral
8 way that would not increase beneficiary out-of-pocket costs
9 on average. So one way to think about this is this would be
10 something to potentially include in a redesign of the
11 Medicare package where there are puts and takes, cost
12 sharing on some things, may go up a little bit and some
13 things down. So as opposed to saying separate policy with
14 its own dedicated offset, it ought to just be considered in
15 a context of a redesign of the Medicare benefit package,
16 would be one way to think about this.

17 Does that make sense to people? Again, it sounds
18 like we can do some more investigation, but it sounds like
19 it's not a huge number that would dramatically influence a
20 redesign of the benefit package, so that's a further thought
21 on that one.

22 We are out of time for today. Thank you very

1 much, Kim and Zach. Good work. We will be back to this in
2 March. Once we have a chance to review the transcript and
3 talk to Mark and Jon, we may well be coming back with draft
4 recommendations in March. If that is the plan to offer
5 draft recommendations in March, I think I will be calling
6 you individually before we even finalize draft
7 recommendations.

8 [Pause.]

9 MR. HACKBARTH: Okay. Our final session is next
10 steps in measuring quality. Katelyn, are you leading the
11 way or John?

12 MR. RICHARDSON: I am.

13 MR. HACKBARTH: John.

14 MR. RICHARDSON: Thank you. Good morning,
15 everyone. In this session, Katelyn and I will present for
16 your discussion some potential next steps in the
17 Commission's development of a new quality measurement policy
18 for Medicare.

19 First, we will briefly review the Commission's
20 discussion in its June 2014 report to the Congress about the
21 problems with Medicare's current path for quality
22 measurement and the new conceptual approach that we outlined

1 in that report.

2 Then we will summarize the methodology and present
3 preliminary results from a data analysis of a new quality
4 measurement concept that we are calling "Healthy Days at
5 Home," and then we will conclude by teeing up potential next
6 steps where we seek your input and guidance on where to take
7 this research and policy development.

8 The Commission's report last June discussed a
9 number of problems with Medicare's current approach to
10 measuring the quality of care. We reviewed the rapid growth
11 in the number of clinical process measures in Medicare's
12 inpatient and outpatient hospital quality programs and cited
13 the findings in the literature that providers' performance
14 on these types of measures are at best weakly correlated
15 with performance on outcome measures, such as mortality and
16 readmission rates.

17 Over the last few years, CMS has made some
18 progress in reducing the number of process measures,
19 particularly in the inpatient hospital and ACO quality
20 programs, but we are concerned that their use will expand
21 with full implementation of the physician fee schedule value
22 modifier by 2017.

1 At last count, the CMS Measures Inventory for the
2 physician value modifier included about 290 measures of
3 which about three-quarters are process measures.

4 A list of new measures under consideration
5 published by CMS in December included another 100 potential
6 measures for the value modifier program. While we have not
7 combed through each of these roughly 400 measures, we have
8 observed in the past that many of the process measures
9 reflect marginally effective care or basic standards of
10 care, and as Rita and other experts have pointed out, using
11 them in a fee-for-service payment system can actually
12 encourage inappropriate overuse of services.

13 The larger point here is that the uncoordinated
14 growth in the size and complexity of Medicare's quality
15 measurement activity has become overly burdensome for
16 providers to comply with and for CMS to administer. The
17 measures inventory I mentioned a minute ago, which was
18 published in July 2014, was 18 separate fee-for-service
19 Medicare quality measurement programs that use over 700
20 quality measures. Most of these measures are used in only
21 one program, although there is overlap, for example, among
22 the five different hospital quality programs.

1 Last, the Commission expressed its concerns that
2 Medicare's current quality programs are overly prescriptive
3 because providers will focus where Medicare creates the
4 incentive for them to focus. The literature examining
5 Medicare's hospital quality programs has found that
6 providers, not surprisingly, devote clinical and
7 administrative resources to ensuring good performance on the
8 exact process measures that are specified by the program,
9 while diverting resources from areas of care that are not
10 measured. When this happens, it's reasonable to conclude
11 providers may have fewer resources available to develop
12 their own community-tailored ways to achieve the outcomes of
13 care that we value, such as reducing potentially avoidable
14 hospital admissions, readmissions, and emergency department
15 visits.

16 The combination of all these issues is that we
17 have concluded and the Commission has said it is time to
18 stop and ask if there might be a better way for Medicare to
19 measure quality.

20 So in the June 2014 report, we explored a new
21 approach that would measure and report quality at a
22 population level in Medicare's three main payment models:

1 traditional fee-for-service Medicare, Medicare Advantage,
2 and Medicare Accountable Care Organizations.

3 This alternative policy would use a small set of
4 population-based outcome measures to assess the quality of
5 care in each of the three payment models within a local
6 area.

7 The local measurement areas would be defined to be
8 consistent with the organization of local health care
9 delivery markets and with Medicare payment policy, such as
10 those that the Commission has recommended for local MA
11 payment areas.

12 For public reporting, CMS would publish results
13 for each of the measures for aggregated fee-for-service
14 Medicare and then for each MA plan and ACO that serves
15 beneficiaries in that area.

16 For payment policy, Medicare could use the
17 measures to determine quality-based payment adjustments for
18 the ACOs and MA plans in the area, as long as their quality
19 was at least as good as that of fee-for-service Medicare.
20 However, the Commission did not think that population-based
21 outcome measures would be appropriate at this time for
22 making payment adjustments to providers under fee-for-

1 service Medicare, because unlike in the case of an ACO or MA
2 plan, there is no single entity that would be accountable or
3 could be held accountable for the quality of care.

4 The Commission acknowledged that Medicare would
5 have to continue to use provider-based quality measures to
6 make fee-for-service payment adjustments, but ideally, in a
7 more focused, parsimonious, and comprehensible way than it
8 does today.

9 The Commission's report presented a small set of
10 population-based outcome measures that could be used in this
11 new framework, which are listed on this slide.

12 The first three items are measures where the
13 technology to analyze performance at a population level
14 already exists and could be readily applied to the quality
15 measurement approach we've been considering.

16 In particular, our work last year analyzed the
17 feasibility of using existing measures of potentially
18 preventable admissions and emergency department visits as
19 population-based outcome measures. I should also note that
20 we looked at, and continue our work on, the potential
21 application of overuse measures in this context.

22 But today's main topic is the measure concept we

1 call "Healthy Days at Home." Katie will now outline our
2 initial foray into developing the concept of this measure
3 and present the preliminary results of our first data
4 analysis from it and then conclude with some next steps for
5 your discussion and guidance.

6 MS. SMALLEY: Our working definition of Healthy
7 Days at Home is the total number of days over a set time
8 period, such as six months or a year, that a given
9 population, such as all fee-for-service beneficiaries in a
10 Hospital Referral Region or Hospital Service Area is alive
11 and did not have a non-ambulatory interaction with the
12 health care system.

13 For this analysis, we chose to exclude ambulatory
14 visits, because they do not necessarily imply ill health.
15 Nevertheless, deciding which services should be components
16 of the measure or not is a judgment call, and Commissioners
17 should feel free to discuss the inclusion or exclusion of
18 certain categories of services.

19 Healthy Days at Home was an attractive measure to
20 explore because it aligns with several of the principles the
21 Commission has articulated for quality measurement: it is
22 comprehensive and outcomes-focused, it is relatively easy

1 for beneficiaries and policymakers to understand, and it
2 could potentially be used to compare performance across
3 delivery systems.

4 While Healthy days at Home is new, clinical
5 researchers have been using a similar measure called "Days
6 Alive and Out of the Hospital" in clinical trials
7 specifically to test the efficacy of heart failure
8 interventions. Days Alive and Out of the Hospital is
9 measured starting from the day of the intervention. In some
10 cases, patients were followed for a specific period of time,
11 such as six months after the intervention, and
12 hospitalizations and mortality during that period are
13 recorded. In others, patients were followed until an
14 incident occurred.

15 This was viewed as an innovation because it was
16 able to capture the combined morbidity of a condition or its
17 treatment, rather than focusing solely on one negative
18 outcome at a time.

19 Unlike Days Alive and Out of Hospital, Healthy
20 Days at Home is not triggered by any event in particular.
21 Beneficiaries are followed for the entire year, and Healthy
22 Days at Home is calculated by subtracting from 365, the days

1 in which beneficiaries' claims data suggest they were in
2 less than optimal health. These include institutional
3 stays, observation and emergency department use, post-acute
4 care, and mortality.

5 In order to begin crafting the preliminary Healthy
6 Days at Home measure, MedPAC staff worked with a contractor
7 team from Harvard School of Public Health. The population
8 analyzed came from a 20 percent sample of Medicare
9 beneficiaries from 2011. Beneficiaries not continuously
10 enrolled in fee-for-service and beneficiaries enrolled in MA
11 were excluded. The final sample was about 6.8 million
12 beneficiaries, about 60 percent of whom had at least one
13 chronic condition. About 18 percent were under age 65.

14 Using the formula described on the previous slide,
15 we first calculated Healthy Days at Home by hospital
16 referral region. The median beneficiary was healthy and at
17 home 343.8 days in 2011, with the 25th percentile
18 experiencing about 4 days fewer at home, and 75th percentile
19 about 4 days more at home.

20 However, we can see in the composition of the
21 measure that home health, and to a lesser extent SNF use,
22 drives a lot of this variation. When home health is

1 excluded from the measure, there is virtually no difference
2 in Healthy Days at Home between the 25th and 75th
3 percentiles.

4 Because the differences in Healthy Days at Home by
5 HRR were due mainly to differences in home health use and
6 were otherwise quite small, we decided to limit the sample
7 further to beneficiaries with at least one chronic
8 condition. We chose this criterion as a proxy for
9 beneficiaries at-risk for an adverse health event because
10 about 75 percent of beneficiaries in the sample had no
11 Healthy Days at Home-related events at all.

12 Commissioners should consider to which population
13 this measure can most appropriately be applied. On one
14 hand, if we intend to detect differences in the treatment of
15 patients, this should be done for the population most at
16 risk for needing treatment. On the other, this method may
17 capture differences in practicing and coding patterns,
18 rather than quality.

19 Regarding the data for this subgroup, Healthy Days
20 at Home overall goes down by about 10 days, but the overall
21 pattern is similar. When home health is excluded from the
22 calculation, the overall variation decreases.

1 When we look at Healthy Days at Home by race, a
2 few interesting points jump out.

3 First, beneficiaries whose race is identified as
4 Asian American had the highest number of Healthy Days at
5 Home, and beneficiaries identified as African American and
6 Hispanic had the lowest total Healthy Days at Home, but the
7 underlying utilization patterns differed.

8 African Americans had more acute inpatient
9 hospital stays than any other group, with nearly four days
10 on average.
11 Hispanics on average were in home health for 27.6 days, the
12 highest by far. African American home health use was also
13 relatively high at 23.2 days.

14 Both whites and African Americans had relatively
15 high SNF use, with about five days for each group. However,
16 Hispanics utilized over twice as much home health as whites,
17 and African Americans nearly twice as much.

18 As shown in the final two columns of the table,
19 variation in home health explains much of the difference in
20 healthy days between these groups as well. In fact, when
21 home health is excluded, Hispanics experience on average
22 more healthy days at home than whites, and the gap between

1 whites and African Americans narrows.

2 I'd like to remind you, however, that this is not
3 a multivariate analysis. To some extent, geographic factors
4 may be influencing these patterns.

5 Nonetheless, the ability of home health to explain
6 differences between subgroups is borne out in other analyses
7 as well, such as differences among age groups and dual
8 status, as was discussed in your mailing materials. This
9 raises questions about how best to account for home health
10 utilization in the Healthy Days at Home measure.

11 Healthy Days at Home is still in very early
12 stages, but we think it may be a useful addition to the
13 suite of quality measures that were laid out in the June
14 2014 report. However, our initial analysis raises some
15 questions that must be answered moving forward. We'd
16 appreciate Commissioner input on the following issues in
17 order to refine the measure.

18 First, the unit of measure. We used HRR for this
19 analysis, primarily because it is a larger unit of measure
20 than HSA and was more appropriate for the 20 percent sample
21 we used. Going forward, should this measure be calculated
22 instead at the HSA or MSA level or some other level?

1 Next, especially if Healthy Days at Home is to be
2 used for the purposes of adjusting payment, it will need to
3 be adequately risk adjusted.

4 As we touched on earlier, beneficiaries with
5 chronic conditions, which population is Healthy Days at Home
6 most relevant to? Should all beneficiaries be counted, or
7 just those who are sick? Furthermore, how should we think
8 about who is sick when diagnostic coding may drive this?
9 Should the measure be further refined to compare outcomes
10 for patients with specific conditions?

11 Additionally, in measuring Healthy Days at Home
12 over time, we want to be sure that we are capturing true
13 changes in outcomes and not random variation, and thus, that
14 the measure is stable over time.

15 As we discussed earlier, Healthy Days at Home can
16 be influenced by practice patterns in a given area and is
17 particularly susceptible to differences in utilization of
18 home health. However, if we use Healthy Days at Home to
19 compare providers within a local area, does this mean that
20 the geographic variation between areas becomes less
21 important?

22 One possible solution would be the weighting of

1 the measure components, given that certain component
2 outcomes, such as mortality and hospitalization, could be
3 viewed as more severe than others, like a SNF or home health
4 stay. We would need to think through the implications of
5 this and the best weighting scheme to do so.

6 Finally, are there other service types that the
7 measure should include, such as certain types of physician
8 services?

9 That concludes our presentation, and we look
10 forward to your discussion.

11 MR. HACKBARTH: Thank you. This is really
12 intriguing.

13 So you looked at -- put up slide 9 for a second.
14 So you looked at this without requiring that the population
15 have one chronic condition, and you didn't see much spread
16 in the numbers between the 25th and 75th percentage, and so
17 you took the step of adding one chronic condition to the
18 population, and you got a little bit more spread. Did you
19 look at the possibility of adding more than one chronic
20 condition?

21 MS. SMALLEY: We have considered that. We just
22 haven't gotten to it yet.

1 MR. HACKBARTH: Okay.

2 MR. RICHARDSON: And, Glenn, that also touches on
3 the issue of whether the measure could be applied to people
4 with just a specific chronic condition, so let's just look
5 at people with COPD or CHF or diabetes or something like
6 that.

7 MR. HACKBARTH: Okay. Clarifying questions,
8 starting with Bill.

9 DR. HALL: A really very interesting report. I
10 just have a couple clarifying questions.

11 On slide 8, you talk about the sample itself, so
12 it's a 20 percent sample of Medicare beneficiaries. The 18
13 percent that were under age 65, did you try pulling that
14 group out and then reanalyzing? I assume that that is going
15 to be a sicker group of people, right? Probably some people
16 on dialysis even? There are only a couple of reasons why
17 you're on Medicare under age 65.

18 MR. RICHARDSON: Yeah.

19 DR. HALL: Just various disabilities. It is
20 subset that is likely to have more disease. I would wonder
21 if you had a pure Medicare population by age, whether that
22 would change these statistics at all.

1 MS. SMALLEY: So we did look a little bit by age
2 group. The slide that's up right now shows the Healthy Days
3 at Home for different age groups, and for the under-65
4 population, we do see that they are generally sicker. They
5 trend towards looking more similar to the 80-plus population
6 than the two groups in the middle, but we could look a
7 little bit more into what exactly the makeup of that
8 population is.

9 DR. HALL: And then the other related question is,
10 on the previously published data on the use of Healthy Days
11 at Home, you mentioned a lot of it has been done in
12 congestive heart failure. Was there any age separation
13 there as well?

14 MR. RICHARDSON: I don't remember off the top of
15 my head.

16 DR. HALL: I should have looked that up.

17 MR. RICHARDSON: Yeah. There may have been some -
18 -

19 DR. HALL: But I think we ought to make sure that
20 we are defining the population that we are serving. I think
21 that's my point here.

22 MR. RICHARDSON: Right.

1 DR. HALL: This is a wonderful start.

2 MR. RICHARDSON: Right. And to the extent there
3 are systematic differences, say, between people under 65 and
4 over, that's a good dividing line in addition to chronic
5 condition.

6 MR. HACKBARTH: Clarifying questions?

7 DR. COOMBS: On slide 11, do you have site days
8 for the same chart?

9 MS. SMALLEY: We don't, but I think that we could
10 break that up.

11 DR. COOMBS: Thank you.

12 DR. NERENZ: On slides 9, 10, and 11, the footnote
13 is quite clear that what we see here is not risk-adjusted.
14 Were there models that you looked at and tried and didn't
15 have any effect, or is that still for future to try some
16 things?

17 MR. RICHARDSON: That's for future work.

18 DR. MILLER: Just on the inpatient psych, that's
19 in the other days. It's just not broken out.

20 DR. COOMBS: Okay.

21 MR. HACKBARTH: Clarifying questions on this side?
22 Rita? Jack?

1 DR. HOADLEY: So, I assume -- I can come back to
2 this on Round 2, but I assumed hospice is just not included,
3 and dialysis and a couple of things like that?

4 MS. SMALLEY: Yes. For this preliminary analysis,
5 we didn't look at those, but we can put those in.

6 DR. HOADLEY: Okay. I'll come back to that then.

7 DR. REDBERG: Thanks. It was a really interesting
8 chapter and very promising.

9 I was just trying to understand how many of the
10 over-65 beneficiaries have one chronic condition, because
11 you say 4 million had a chronic condition, but then 1.5
12 million, on page 11 of the mailing materials, were under 65.
13 Should I assume that everyone who was under 65 had one
14 chronic condition? I'm just trying to get in the idea of
15 what percent of our over-65s.

16 MR. RICHARDSON: I don't have an empirical answer,
17 but that's a reasonable inference, is that the reason for
18 their disability status is captured there.

19 DR. REDBERG: Thanks.

20 MR. HACKBARTH: Other clarifying questions?

21 DR. MILLER: Can I --

22 MR. HACKBARTH: Let me ask a Round 2 question

1 about risk adjustment. If this measure were used to assess
2 the performance of accountable care organizations, some
3 organization that has a defined population responsibility, I
4 would think risk adjustment would be very important. I'm
5 not sure I can articulate this well. Does risk adjustment
6 get easier or more difficult when you move to this sort of
7 measure, you know, aggregated measure, as opposed to risk-
8 adjusting for a particular hospital admission, surgical
9 intervention, et cetera? Or is there no connection between
10 level of aggregation and the difficulty of risk adjustment?

11 MR. RICHARDSON: Yeah, the more aggregated, the --
12 I won't say easier it becomes, but you can -- first of all,
13 you have more information, just more data points, because
14 the population is larger. But your likelihood of making an
15 error and assigning a value saying this population is sicker
16 or less sick will be diminished. And I just can't remember
17 from grad school if that's a Type 1 or Type 2 error, but,
18 you know, you're assuming something, and it's going to be
19 the wrong kind. But, David, did you want to --

20 MR. HACKBARTH: Dave.

21 DR. NERENZ: Well, just one point, and I'm not
22 sure whether it was fall into easier or harder, but I think

1 the breadth of things you have to consider probably gets
2 bigger as you go to these very distal population-based
3 outcomes. If you're looking at a geographic region, for
4 example, these things can be affected by built and natural
5 environment; they can be affected by community-level
6 resources; they can be affected by median income. They can
7 be affected by things in addition to the clinical variables
8 we are more familiar with when we're in more proximal
9 outcomes. If I want to know, you know, somebody's
10 likelihood of an infection, there are a range of things that
11 can affect that outcome. And in this case, we've gone about
12 as far out to the outer edge of this concept as you can go,
13 and what we've done is we've just brought in a whole range
14 of, call them "noise factors," if we're actually trying to
15 look through this back to medical care. So it has to get
16 broader.

17 DR. MILLER: I want to pick up on a couple things.
18 To that point, I also wouldn't get too hung up, yet at
19 least, anyway, on the geographic comparisons. We had to
20 pick a unit to compare. Keep in mind, you know, we're
21 probably talking about something that would work within a
22 market, which still doesn't mean there aren't geographic

1 variations, but they're -- but I do want to -- I wanted to
2 go back to a couple things, because a couple things, lines
3 got crossed, I think, and I just want to parse this out.

4 There is a difference, you know, when you get
5 below 65 disability population. There's one thread of the
6 conversation which is: Why are you disabled? Cognitive,
7 physical, ESRD, whatever the case may be. But then there
8 are a lot of comments about chronic conditions and what
9 kinds of conditions -- the medical condition of the patient.
10 That's kind of a different concept, and you shouldn't
11 necessarily assume that those things are all coincident
12 together.

13 Remember, the disability population is very
14 diverse. A person can be incredibly sick and disabled or
15 disabled but not necessarily a lot of chronic conditions.

16 So I felt like in the conversation we were sort of
17 crossing chronic conditions and that type of conversation
18 with disability, and those are both legitimate strains of
19 discussion, but I felt like in some ways we're crossing them
20 over. I'm getting confused looks now from --

21 DR. CROSSON: But, Mark, wouldn't you have to have
22 at least one? No?

1 DR. MILLER: No. You could qualify for
2 disability without being, you know -- and, again, it depends
3 on what you mean by "condition," but, you know, you don't
4 have diabetes, you don't have congestive heart failure; you
5 might have a physical disability. And so I'm just trying to
6 parse -- you know, people were using the words "chronic
7 conditions," and I'm trying to make sure that --

8 DR. CROSSON: So that really depends upon the
9 definition of "chronic condition," what's included in that.

10 DR. MILLER: Exactly, and that's all I [off
11 microphone].

12 DR. REDBERG: What are the most common chronic
13 conditions?

14 MS. SMALLEY: We can find that out.

15 DR. CHRISTIANSON: Yeah, just one quick comment.
16 We are actually seeing some risk-adjusted results here when
17 we look at chronic conditions and subsets and things like
18 that. That's a crude way of risk-adjusting. It's not a
19 statistical way of risk-adjusting. But chronic conditions
20 is often a major driver in differences when you do estimate
21 the risk-adjustment models. So we're getting some glimpse
22 of what the results will look like when we do finally risk-

1 adjust. Obviously what I would like to see as you go
2 forward is sort of presenting us the full amount risk-
3 adjustment model results, but also really focusing on the
4 things that are really driving it, like you were kind of
5 doing here, which is great. It gives us some insight into
6 that. But I think one of the things that we're looking for
7 feedback here is whether this -- to date, whether what we've
8 seen to date looks promising enough so we should encourage
9 you to go ahead and work in these different areas, and for
10 me the answer is clearly yes.

11 DR. BAICKER: So I think this is really
12 interesting, and I would agree absolutely that it seems
13 worth going further. And in thinking about directions to
14 go, I think risk adjustment, I'd like to see fully risk-
15 adjusted models. And just to clarify this previous
16 exchange, my understanding is the risk adjusters would
17 always be at the individual level. So when you're doing
18 that for a whole big group of people, you worry a little
19 less about the noise because it averages out, where any one
20 person you might have mis-measured, but that washes out.

21 The question that you were raising is: How much
22 do environmental factors versus individual risk adjusters

1 affect the outcome? And that hinges on the breadth of the
2 outcome, not the geographic unit of analysis. So if you're
3 thinking about an outcome like do you get diabetes, all
4 sorts of things factor into that besides your individual
5 risk adjusters about your environment. Maybe do you break a
6 hip -- it's going to be hard for me to come up with
7 something that doesn't have some environmental context,
8 input, but those things to me are about how broad a measure
9 of the person's health are you looking at, and for there, if
10 you think the environmental factors are important, then when
11 you go to a bigger unit of geography, you don't wash those
12 out because those are correlated across people who are
13 within the geography. So thinking about the role of
14 individual factors versus contextual factors gives us a
15 different interpretation of how the outcome varies across
16 geographic units.

17 Where I'd like to look is probably a smaller unit
18 of geography, so I like the breadth of the outcome for the
19 individual. Healthy days at home seems like a really
20 important component of overall well-being. If we're
21 thinking about using these as an input into encouraging
22 management of population health, nobody manages an HRR's

1 population of health. It's too big a unit in some sense.
2 It's interesting from a perspective of how much variation is
3 there across the country and what's going on. I think those
4 are important facts to know. But then as we go towards
5 thinking how might this affect the structure of Medicare
6 payments, to me that's about a system that could change as a
7 unit, and that's a smaller unit of analysis. So good to go
8 broad on the measure. I'd also like to see the
9 complementary smaller unit of analysis with the full set of
10 risk adjusters, because as we've seen in so many different
11 contexts, you certainly don't want to penalize systems that
12 are trying to manage the health of a population that's at
13 greater disadvantage. You want to take that into account.
14 And so I'd want to know what the value added of the system
15 is to this important measure of overall well-being.

16 MR. HACKBARTH: This kind of thing is way over my
17 head. I don't even know exactly how to get a grip on it.
18 But one of the things that Dave said that struck me is that
19 the good part of this is that this is what patients care
20 about or one of the things that they really care about. But
21 implicit in it is that you're holding health care providers
22 accountable for things over which they have limited control.

1 It's sort of a -- we've talked about this in the context of
2 readmissions, Dave and I often. This is like that times
3 ten. And to the extent that that's true, how useful is it
4 as a performance measure for health care systems, even those
5 that assume population responsibility? That's what I'm
6 struggling with.

7 DR. NERENZ: And just hopefully directly on that,
8 you know, to me one of the absolute core concepts here is
9 this thing we observe, the weak correlation between the
10 process and outcome measures. One take on that is that the
11 entities we're talking about are truly accountable for these
12 outcomes, and the problem is with the process measures, that
13 they're not the right things, they're not measured well,
14 blah, blah, blah.

15 But another view you could take is actually the
16 process measures aren't bad; they really reflect pretty much
17 what we pay and expect the entities to do. The problem is
18 there's a whole bunch of noise between that and the outcome,
19 and there's some debate about the extent to which entities
20 are truly accountable for those outcomes. And here we've
21 just now stepped into that, and fairly enough, because these
22 are really broad, far-reaching outcomes.

1 So, yes, you know, and I think maybe I tipped my
2 hand here, but my read is that we may be accurately
3 measuring the processes for which we have entities
4 accountable, and then if we want to look through the outcome
5 back into the behavior or the performance, you have to
6 adjust for the noise.

7 DR. CHRISTIANSON: So we stepped into that not
8 inadvertently. We stepped into that very consciously, you
9 know, over the last several months, knowing that these
10 issues were there.

11 DR. NERENZ: Yeah.

12 DR. BAICKER: And just to close the loop on that
13 and then cede the mic, I don't think the goal is to drill
14 down to find a population for which there is sufficient
15 geographic variation. Like the fact that there isn't
16 geographic variation in the overall population doesn't mean,
17 therefore, we need to look at one chronic condition, not a
18 lot of variation, let's look at two chronic conditions.

19 If the answer really were there's not a lot of
20 variation in this outcome, that's an important fact to know,
21 and it suggests payment policy going forward.

22 Now, I think the HRR is a little bit too big a

1 unit, and so the fact that there isn't geographic variation
2 there doesn't tell me that there isn't something important
3 to address with payment policy. But if we went down to what
4 looks like a more system manageable population and we didn't
5 see a lot of variation in these outcomes overall but it was
6 all in home health or something like that, that tells us
7 something going forward. It doesn't tell us that we need
8 even further sub-population parsing out to find the
9 variation that might be there.

10 DR. HOADLEY: So I'm going to take this in a
11 slightly different direction. I think this is really
12 interesting and really provocative kind of stuff.

13 In trying to think about what it means to say
14 healthy days at home, I mean, obviously in a very
15 superficial way, you know, when you think about the days
16 that are going to get included, when you're not in the
17 hospital and you're not under these other types of care,
18 there's a lot of days when we're very healthy and doing
19 things and, you know, completely good, and there's other
20 days when you're actually pretty sick, but nothing that
21 actually requires intervention. And maybe that's beyond the
22 scope of what's possible to try to think about, but it does

1 raise to me the issue that I hinted at on the clarifying. I
2 mean, what are some of the -- and you raised it in terms of
3 what kind of physician services might also be included. So
4 if somebody goes in for dialysis treatment, is that a
5 healthy day at home, or is that a day that should be
6 subtracted out?

7 If somebody's going through a process of
8 chemotherapy and they go to a series of chemotherapy visits,
9 is that something that should be counted as a healthy day?
10 You know, it's not clear.

11 Hospice maybe is its own particular case, and
12 maybe people that go through hospice -- I don't know. I
13 don't have answers to these, but these are the things that
14 it seems like go at what we think we mean by these
15 categories.

16 The other thought I wanted to offer was
17 intuitively it strikes me that this might be more
18 interesting for the kinds of cases that are triggered by a
19 particular chronic condition or a particular health
20 intervention. So how good does one system of care versus
21 another do on treating people once they've had a cardiac
22 event? And what's the course of care over the next six

1 months? It was sort of the example from the literature you
2 pulled. And maybe then that's less about some of the things
3 I was saying in the first set of questions. You're given
4 that a person is in a certain kind of health status or
5 certain kind of health event, and you want to see what
6 happens from that, or even people diagnosed with more truly
7 chronic conditions as opposed to health event, and what's
8 the course of the situation from there?

9 But what I worry about is that these more sort of
10 institutional -- defining non-healthy days as institutional
11 might create some bias, as that isn't really what we're
12 about. If we -- you know, I'll stop there. I think that
13 puts the questions on the table.

14 MR. ARMSTRONG: Actually, I was going to make very
15 similar to Jack's. The way I was thinking about it is that
16 there are a lot of ways in which we would invest in better
17 health by having more home health visits or by having more
18 of some of these things. And so, you know, I'm just so used
19 to like inpatient, you know, days per thousand. It's kind
20 of the inverse. So that's what I'm having a little hard
21 time wrapping my head around, is that this longer list of
22 services that many of which are, you know, actually

1 investments in better health, categorized as, you know, one
2 big kind of statistic that defines non-healthy days, it just
3 is -- I'm having a little bit of trouble with that.

4 Second, I just would say, you know, I think it is
5 good for us to look for ways to get beyond process measures
6 and look for outcome measures. But process measures are
7 really important, and part of the issue I think we're going
8 to need to talk about is what's actionable about this.
9 These are good statistics for us to have, and it's really
10 important to push for these population health statistics.
11 But you really need inside of it to know what to do about
12 it.

13 And then the third point I would make -- I think
14 it is a little redundant to points made earlier and
15 certainly redundant to points I've made in the past -- is
16 when we look at what is the point of comparison,
17 particularly when we look at comparing quality between -- I
18 don't know whether it's groups or systems within a
19 geographic market versus more broadly. Limiting to
20 geographic region comparisons tolerates some regions'
21 perpetuating really poor outcomes. And it makes it hard in
22 areas that are already good to be recognized for their

1 relatively good performance. We're going to run into that
2 again, too, as we move forward with this.

3 MR. HACKBARTH: Scott, on your point about process
4 measures being actionable, I think that is one of the
5 virtues of reduced need for risk adjustment is, I think,
6 another virtue of process measures. I really am not at all
7 expert in this field, quality measurement, but I've heard
8 some people who are more expert say that one way to think
9 about this is there are certain types of measures that you'd
10 want to use to assess, you know, a care delivery system's
11 performance. And then for the people within that system
12 that are responsible for improving care, they may use a
13 different type of measure. And there, they very much want
14 actionable measures that help them drive their systems and
15 the work of individual teams and the like. But that doesn't
16 mean that those are the measures that we should be trying to
17 use for public reporting or payment policy, and so it could
18 be processes very actionable and good for within Group
19 Health Cooperative of Puget Sound, but we still ought to be
20 for payment policy trying to move towards more aggregate
21 outcome-focused measures for public policy. I don't think
22 it's an either/or. I think that each have their role,

1 albeit a different role.

2 MR. ARMSTRONG: Just to be clear, I agree with
3 your point. I'm really not pushing for one or the other.
4 But, you know, we need a system that can take both and apply
5 them where --

6 MR. HACKBARTH: Yeah.

7 MR. ARMSTRONG: Because they both offer different
8 kinds of benefit.

9 MR. HACKBARTH: Yeah. Okay. Coming around here,
10 I have Craig, Mary, Kathy, Rita.

11 DR. SAMITT: So I thought this report was
12 fantastic, and I applaud sort of the innovative thought to
13 resolving the morass of quality measurement problems. For
14 me, I was surprised by the lack of variation that we saw,
15 and so the jury is still a bit out. So I would love to see
16 the analysis all over again at a far deeper level, and I
17 would even be so pointed as to say I'm most curious to do
18 this analysis with risk adjustment at the Pioneer ACO, ACO
19 level, comparing institution to institution, because that's
20 where we envision that we would see some of the greater
21 innovation. I don't think that any of those institutions
22 think of quality measures with this bundled intent in mind,

1 you know, the farthest possible view of outcome measurement
2 that you could. But I'd be very curious to see if they're
3 making a dent in this result, because I think if we see some
4 significant variations, especially between the Pioneers and
5 the more standard MSSP ACOs, that we may think that this
6 actually has some merit and this could be a good outcomes
7 measure to consider.

8 So I love it. I think we should go deeper and see
9 what the analysis can show.

10 DR. NAYLOR: So I'm Craig's village. I also
11 really think this is extraordinarily important and exciting
12 work. I mean, we have spent a couple of years talking about
13 how we don't have quality metrics that will help us to look
14 at differences in payment models, et cetera. So I go
15 forward. A couple of things.

16 One, I think this notion of comprehensive and
17 outcomes-focused, I would really like to see much more
18 attention on the outcomes beyond -- inclusive of what you're
19 talking about here, but beyond health resource utilization
20 outcomes. You mentioned in the report all the work that's
21 going on with PROMIS and the global health ratings. I mean,
22 the chance, you know, that one single item that older adults

1 get to answer how would they rate their overall health --
2 excellent, fair -- and the relationship that we've been able
3 to demonstrate with use of health resource utilization, or
4 even a single item rating about how they rate their overall
5 quality of life, so I would really hope that you would think
6 about health -- the healthy -- I love -- don't lose the
7 title, but don't stick it with just how we use resources,
8 because I think we'll lose something in that.

9 That will make it not just easy for beneficiaries
10 -- easier for beneficiaries to understand, but really
11 connect with what matter most to them. Most of them don't
12 care about readmissions. They care about being able to
13 function in their homes and do things that give them a sense
14 of meaning and purpose.

15 So I really -- I think there's a lot of work going
16 on in parallel in the PROMIS world that I think could
17 connect with this in very exciting ways and give us a tool
18 that we have not had as a program to look at ACO performance
19 or differences in payment model performance, et cetera.

20 MS. BUTO: Yeah. I wanted to say that I thought
21 this was really exciting work and is very promising. I'm
22 excited about anything that's going to simplify the quality

1 measures that providers and patients have to deal with. I
2 think it's been very confusing, time consuming, resource
3 intensive, et cetera, and I'm not sure it has produced the
4 kind of result -- or, I'm pretty sure it has not produced
5 the result everyone was hoping for.

6 Just on -- and, again, I'm not from this field at
7 all, but my sense of it is that this information, whatever,
8 you know, subset of measures and enhanced measures, as Mary
9 was talking, we come up with, that this kind of information
10 is very helpful in making choices, assuming we get it right.
11 So, I think it helps people understand, and particularly
12 once you get down to certain kinds of conditions or chronic
13 conditions. You know, if I've got cardiac disease or I've
14 got arthritis or back problems, this system does really well
15 in keeping people healthy and at home, or this particular
16 plan does that. So, I think I like its use for that
17 purpose.

18 I don't see it used as a payment policy tool yet.
19 Maybe, I'm thinking, before it got there -- I'm not saying
20 it couldn't get there -- I would think you'd want -- it
21 would be useful to policy makers as an indicator of areas of
22 improvement, so policy makers, whether they are heads of

1 health systems or health plans or policy makers who are
2 payers, insurers who are paying the bill, of maybe some
3 areas where they would want to look. But, I don't see
4 dinging anybody based on this set of parameters just yet,
5 because it seems to me that if they are not doing well, you
6 wouldn't want to take payment away from them necessarily.
7 You might actually want to focus more payment in certain
8 areas, or training or other resources.

9 So, again, I'm not keen on using it as a payment
10 policy thing right out of the gate, but I think it's
11 terrific for -- potentially terrific -- for beneficiary
12 choices, for plan performance kind of metrics, but not for
13 specifically dinging payment.

14 MR. ARMSTRONG: Just a comment, and Kathy, I
15 really think a lot about and support the perspective you
16 just described, but I have to say that I see little evidence
17 that reported comparative quality outcomes influences
18 beneficiaries' choices. And, it seems to me we ought to
19 learn a little bit more about, so, what do we know about how
20 beneficiaries' choices, in fact, are influenced by
21 comparative quality reporting? We're talking about the
22 prospect of investing a lot in getting quality reporting

1 better. Maybe we should spend just a little bit more time
2 on what really would have an impact on those choices.

3 You know, our experience, as one of the very few
4 five-star MA plans in the country, is that I think very few
5 members have joined Group Health in the last three or four
6 years because we are a five-star plan. And, if CMS is
7 serious about this being a criteria that should move
8 beneficiaries, then I think we should spend -- CMS should
9 spend a little more time really understanding, if that's
10 true, what would it actually take. And, this is, you know,
11 not just specific to five-star, but quality -- comparative
12 quality reporting, in general.

13 So, I really support the idea, but I'm not
14 convinced that it's making much of a difference at this
15 point.

16 MR. HACKBARTH: Rita.

17 DR. REDBERG: I also really like the chapter and
18 the idea of finding measures that are outcomes-based and
19 meaningful to beneficiaries, which I do think healthy days
20 at home are, and moving away from all of the process
21 measures, which take an inordinate amount of time and energy
22 and don't -- we don't have any data that they're doing a lot

1 in terms of our goals of improving beneficiary care. And,
2 so, for that reason, I actually would consider sooner,
3 rather than later, linking these to payment policy, because
4 it's a very effective way to make changes.

5 I just wanted to comment on the home health
6 aspect, because that's the biggest variable. You know, it
7 had the biggest standard deviation. It clearly made the
8 difference in your percentiles. And, I just think we need
9 to think more about can you be healthy and still be getting
10 home health, because I think there's a lot of variables into
11 who gets home health and who doesn't, and it probably has a
12 lot of other things, like who else is at home, family
13 values, cultural values, and we should just look. And, I
14 think, also, home health has a pretty big range of things,
15 including, you know, just a home health aide or more
16 intensive visiting nurse services, physical therapy, and
17 things like that. And, clearly, that was moving around the
18 most and causing the most wiggle in the data. But, I think
19 the concept is great.

20 MR. HACKBARTH: Along those lines, Slide 9, any of
21 these tables that show the aggregated numbers, sort of
22 implicit in that is that they are equally weighted when, in

1 fact, both from a beneficiary perspective, you know, which
2 is the worst kind of deviation from a healthy day at home,
3 is very different among these services, and certainly the
4 costs are very different among them. So, if you just
5 average them all, add them all up, you're obscuring
6 something important. Does that make sense?

7 DR. REDBERG: [Off microphone.]

8 MR. HACKBARTH: Yeah. Yeah. Herb.

9 MR. KUHN: So, let me join with others, John and
10 Kate, really nice work, and John, I particularly liked your
11 opening comments today when you talked about the over-built
12 system of measures and the whole measure development process
13 and some rationality. Hopefully, we can help in that
14 conversation.

15 So, when I read this chapter, what it took me back
16 to, the conversation we had around this table a couple years
17 ago when we were looking at the rehospitalization program
18 and the risk between mortality and readmission of hospitals
19 that were out there and keeping patients alive. And, we
20 talked about tertiary care hospitals, academic medical
21 centers, and that perhaps they were being penalized for
22 those readmissions because they'd done a good job of keeping

1 those people alive and there was a higher risk of a
2 rehospitalization there.

3 So, when I looked at this, I thought, you know,
4 this might be a way for us to deal with that competing risk
5 of controlling for death, and I kind of -- at least as I
6 read this, I thought, this takes us in that direction and I
7 like that work.

8 But, then, as I listened to David, and as also I
9 read this and also listened to Kate about the environmental
10 issues, I think we're introducing some noise in here,
11 particularly with emergency department issues there. And,
12 what worries me is that it may impose an undue hardship,
13 particularly in those communities where you don't have a lot
14 of community support services and people are using the
15 emergency department for ambulatory primary care that's out
16 there. So, that's just one thing I'd like us to continue to
17 look at as we move forward here.

18 MR. HACKBARTH: Any other -- Bill and Alice.

19 DR. COOMBS: So, a couple of things that I thought
20 about. Specifically, the process measures, when they're
21 linked to outcomes, I think, becomes very valuable. And, I
22 was looking at an article in the JAMA that talks about

1 community-wide cardiovascular disease prevention, where a
2 cohort was tracked for 40 years looking at three specific
3 things: Smoking cessation, blood pressure control, and
4 cholesterol levels. And, they were able to show that there
5 was a marked reduction in mortality and admissions. That's
6 the kind of thing that would make a difference.

7 If you look at process measures and you are able
8 to link them to the outcomes, I think that's when process
9 measures become very valuable, and I think that, as Scott
10 has said, process measures are very, very important. I
11 would hate to see that we put so much focus on the outcomes
12 that we have to go backtrack and say, well, why did this
13 happen, and we discover the role. The reason why the
14 process measures are there is because there has been a body
15 of literature to support them. I think that the number of
16 process measures are a problem.

17 And, so, looking at process measures, if we can
18 begin to focus at process measures that are linked to
19 outcomes, I think it becomes very valuable.

20 I like the chapter. It was -- I learned a lot
21 from it, but I just thought about me in my former days of
22 being an internist and I was being rated on these things and

1 several things came to mind.

2 Number one, if I were to look at mortality, Dave,
3 and I'd say, oh, my goodness, I have a lot more mortality
4 days in my health care world where I am, I know that a lot
5 of the patients that I may be taking care of may say, you
6 know what? I'm DNR. I don't want anything aggressive done
7 after I leave the hospital with my congestive heart failure.
8 I don't want to come back again. And, so, that's a piece of
9 the tool set that we're looking at. It doesn't tease out
10 the aggressiveness for how you care for certain people.

11 The other thing is psych admissions. Psych
12 admissions in an area -- and I just read another article in
13 the same journal where the number of psychiatrists that are
14 available to Medicare beneficiaries is 50 percent that say,
15 "I'm not going to" -- some 50 percent say, "I will accept.
16 Fifty percent say, "I don't take Medicare." Psychiatry is
17 key in a primary care clinic. If you have someone that
18 comes to see you and you don't have psych access, you may
19 have a wait time to see a psychiatrist, which directly
20 impacts psychiatric admissions.

21 So, I'm looking at some of these things,
22 especially home health -- as Scott has said, home health may

1 keep a COPD-er, aggressive measurements, tinkering with the
2 bronchodialators and things like that, may keep them out of
3 my ICU being intubated. So, there are some of these things
4 that are just gross measures, but if you drill down to the
5 whys of why it might -- why there might be variation, then
6 you might find that some of this is actually preventing a
7 worser [sic] outcome or worser [sic] state if you implement
8 some of these things earlier.

9 And, so, I would say that I like it on first
10 blush, and when I think of healthy days at home, whatever
11 you can do to stay home is good and a good quality, and I do
12 agree that a lot of patients are, because of health care
13 literacy and empowerment, they may not have the decision
14 making tools to make a decision between a good system or a
15 good provider, and that's the big leap that we have. That's
16 our next challenge.

17 DR. HALL: I don't wish to be redundant, and I
18 certainly agree with the comments that have been going
19 around the room about that we still have a little more work
20 to do here and that maybe we ought to be concentrating on
21 quality days at home, as Mary mentioned. That might mean
22 another kind of questionnaire or something. I'm not really

1 sure.

2 But, I also worry about kind of a ceiling effect
3 here. It looks like everybody has about the same number of
4 days at home, and that's where I think the risk adjustment
5 will give us some possible leads. That would be very
6 exciting, if we could find subsets where there are really
7 phenomenal differences. So, I think this is valuable work.

8 MR. HACKBARTH: [Off microphone.] Any others?

9 Craig.

10 DR. SAMITT: One other comment that we didn't talk
11 about in this presentation, which I really liked reading
12 about in the chapter, was about the patient reported work.
13 And, I think that has promise, as well, I think in a
14 different way. The experience that I've had with the
15 patient reporting is there's a predictive element to the
16 patient reporting, that it really highlights those patients
17 that likely need more immediate observation or assistance or
18 outreach to sort of avoid an impending emergency room visit
19 or hospitalization. But, I don't think we should lose sight
20 of the importance of that set of measures, as well, and it
21 may even have some relationship here as we think about
22 quality days at home, also. Maybe these two measures can

1 find a way to be interrelated. But, I just would say, I
2 wouldn't lose that, either. I think that's important work,
3 as well.

4 MR. HACKBARTH: [Off microphone.] Good work. I
5 look forward to hearing more about it.

6 Okay. Now, we will have our public comment
7 period.

8 [Pause.]

9 MR. HACKBARTH: If I could ask everybody who
10 wishes to make a comment to line up there, so I know how
11 many there are.

12 Okay. We've got three. So I know you know the
13 ground rules --

14 MS. EDELMAN: Yes.

15 MR. HACKBARTH: -- but let me just repeat them
16 again. Please begin by identifying yourself and your
17 organization. You will have two minutes when the red light
18 comes back on. That signifies the end of your two minutes.

19 MS. EDELMAN: I am Toby Edelman with the Center
20 for Medicare Advocacy, a public interest law firm that
21 represents Medicare beneficiaries.

22 Almost seven years ago, I received a call from a

1 woman in Wisconsin whose nursing home care was not being
2 paid for by Medicare Part A because she didn't satisfy the
3 three-day stay. She had actually been in the hospital for
4 13 days, and all 13 days had been classified as outpatient.
5 She had no way of knowing she was an outpatient. This
6 hospital wasn't required to tell her she was an outpatient.
7 She was intermingled with inpatients and received medical
8 and nursing care and everything, just like an inpatient.

9 As Dr. Ann Sheehy for the Society for Hospital
10 medicine testified in Congress, the care is
11 indistinguishable for inpatients and outpatients. People
12 get whatever is medically necessary.

13 Since then, our office, since seven years ago, has
14 received hundreds of calls and represented people. Here is
15 one example. A 92-year-old man has a hematoma. His
16 physician sent him to the hospital because the hematoma was
17 visibly expanding. As he was being wheeled in for emergency
18 surgery, it exploded. He had surgery, stayed five days, all
19 called "observation." His nursing home care wasn't paid.

20 There are a lot of policy issues that you've been
21 discussing this morning. First, of course, is this three-
22 day rule itself. It's part of the original Medicare

1 statute, and when Medicare was enacted, the average length
2 of stay in acute care hospitals for people age 65 and over
3 was 13-plus days. We're now down to five.

4 There's a lot of discussion whether the three-day
5 stay should be changed entirely or repealed. Other issues,
6 you've been discussing this morning about the recovery
7 auditors and reimbursement methodology. But there are a lot
8 of people who are really being affected right now.

9 The Inspector General said in 2012, more than
10 600,000 people were in acute care hospitals for three-plus
11 days, but didn't meet a three-day requirement because some
12 or all of the days were not inpatient. Some of these people
13 need nursing home care and can't afford to pay out of
14 pocket. Nursing homes would demand up-front payment of a
15 month, \$300 and \$400 a day. People can't afford it. People
16 have gone home, returned to the hospital in worse shape a
17 couple of days later.

18 So there is a simple temporary solution to count
19 all the time in the hospital, whether it's called inpatient
20 or outpatient, for meeting the three-day stay. Legislation
21 in Congress will be introduced again this year. Last
22 Congress, it had over 160 Members in the House, almost 30 in

1 the Senate. Legislation is simple. Bipartisan just says
2 count all the time.

3 We have a group of national organizations, over
4 30, that support it, health care professionals, the AMA,
5 Society for Hospital Medicine, the emergency room doctors,
6 and advocates, AARP, and everybody. We just ask that you
7 support this simple temporary solution for people now.
8 Thank you.

9 MS. DEMEHIN: Good morning. My name is Akin
10 Demehin with the American Hospital Association, and I just
11 want to offer a couple of comments on this last discussion
12 about Healthy Days at Home measure and quality measurement
13 efforts in general.

14 First of all, we would definitely like to commend
15 the Commission for its interest in really trying to achieve
16 a much more focused and aligned set of quality measures for
17 federal programs than we have now.

18 One of the most common frustrations we hear from
19 our members is the fact that the sheer volume of reporting
20 requirements has become overwhelming and actually makes it
21 much more difficult to identify and really make progress on
22 improving quality and safety.

1 With respect to the Healthy Days at Home measure
2 that you all discussed today, I think that you all raised
3 some really interesting analytic questions, and we certainly
4 look forward to seeing the deeper analysis that sounds like
5 all of you are embarking upon.

6 A couple of things for you all to consider as you
7 move forward, first is the level of accountability and
8 really the actionability resulting from that level of
9 accountability for the measure.

10 As I heard the discussion, it struck me that this
11 kind of broad-based outcome probably doesn't make sense at
12 the individual provider level. It might make more sense at
13 the ACO level, maybe even more sense at the health plan
14 level, but it is very broad. One has to be careful not to
15 make it so broad that nobody can do anything about it.

16 Risk adjustment and the complexity around it when
17 you are measuring such a broad-based outcome is definitely
18 something that will have to be examined very, very
19 carefully. There are lots of drivers that can drive
20 variation in things, including socio-demographic factors,
21 and you all have done some really excellent work in that
22 area with respect to the Hospital Readmissions program.

1 Then finally, just a little word of caution around
2 the notion of defining a healthy patient as one that doesn't
3 use any services, which is sort of what this measure, at
4 least in its current form appears to do, and a couple of you
5 made allusions to the fact that just because a patient is
6 using a service, like a home health service, doesn't
7 necessarily mean they are unhealthy. So some deeper
8 analysis on that issue would certainly be welcome, but we
9 absolutely commend you for trying to achieve a much more
10 focused set of quality measurement efforts nationally than
11 we have now.

12 Thank you.

13 MR. QUINN: Good morning. My name is Kevin Quinn.
14 I work for Xerox. We are the fiscal intermediary for quite
15 a few Medicaid programs, and this is just my personal
16 opinion based on my work designing and implementing DRG
17 payment methods in half-a-dozen states -- California,
18 Mississippi, South Carolina, Montana, et cetera.

19 I think a lot of the power of the prospective
20 payment system over the last 30 years has been, in its
21 simplicity, very clear incentives, and so my suggestion
22 would be to set a very high bar for adding complexity to the

1 DRG system, as we were talking about in the first half of
2 today's session.

3 To my perspective, a lot of the problems that
4 Medicare faces in this area have to do with the fact that
5 observation blurs the line between inpatient and outpatient.
6 So the advice that I give to Medicaid programs is try and
7 protect that brick wall between inpatient and outpatient.
8 Medicaid programs I work with, we tend to have much tighter
9 observation policies in Medicare, and then recognize that
10 DRG payment methods are win-some/lose-some. One-day stays
11 are fine.

12 I did like the idea of an observation DRG,
13 especially under ICD-10, but in general, sort of allow one-
14 day stays that can be clinically indicated, and then look
15 for patterns where specific hospitals seem to be abusing
16 that in order to get the DRG payment.

17 And then the last thing I would just say is that
18 in the work that we do for Medicaid, I am often telling
19 Medicaid staff how useful the MedPAC reports are, how good
20 the analysis is, and even though it's done for Medicare, how
21 relevant it is to Medicaid and the rest of the system, so
22 thank you.

1 MS. HELLER: Hello. I'm Karen Heller from the
2 Greater New York Hospital Association, and I've been writing
3 in the public comment area all through the meeting, but
4 thanks for this opportunity.

5 I'm also going back to the short-stay policy, and
6 I just want to make a couple of points, first to Kathy's
7 point about DRG recalibration. One thing we are starting to
8 look at now, in addition to recalibrating the weights,
9 recalibrating the grouper, because it's possible with
10 changing treatment protocols that we might be getting sort
11 of bimodal or trimodal distributions based on cost within a
12 DRG, and that some DRG -- breaking up the DRGs, not refining
13 within the same one, that might be better.

14 And then if those are correct, then we should not
15 -- I like the idea about any formulary approach substituting
16 for the RACs, but it shouldn't be based on days, per se,
17 because in our membership, the biggest difference usually,
18 the biggest driver of the difference between one-day and
19 two-day stays is the one-day hospitals keep their ancillary
20 services available 24 hours, 7 days a week. So rather than
21 patients having to wait over a weekend to get something done
22 or to the next day to get a radiology or whatever, it's just

1 much more efficient.

2 So if we're looking at cost instead of days, per
3 se, and we something unusual that's also short, maybe that
4 is something that really ought to have been something else,
5 but there's a reason why we got rid of long stay outliers
6 and we went to cost outliers, because it really was the
7 resource use rather than days, per se.

8 MR. HACKBARTH: Okay. Thank you all, and see you
9 in March.

10 [Whereupon, at 11:38 a.m., the meeting was
11 concluded.]

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