MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 5, 2012
9:47 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
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RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:47 a.m.]

MR. HACKBARTH: Okay. Good morning. This being April, this is the last meeting in our cycle and the last meeting leading up to our June report. In our June report, we will have chapters on a number of different important issues: rural issues in response to a congressional request; a chapter on redesigning the Medicare benefit package; a chapter on dually eligible Medicare and Medicaid beneficiaries; one on care coordination; and one on home infusion, another congressionally requested report.

We will at this meeting after lunch take up the redesign, benefit redesign issue, and have a vote on a recommendation. That will be the only formal recommendation with a vote at this meeting.

First up today is a session on the planned CMS demonstrations for dual-eligible beneficiaries. Christine?

MS. AGUIAR: Thank you.

To give you a context for today's discussion on dual-eligible beneficiaries, the Commission began its work on dual eligibles a few years ago with a data analysis of Medicare and Medicaid spending. We then visited programs that integrate all Medicare and Medicaid services for dual

eligibles to understand their care management components.

In the fall of this cycle, we discussed an analysis of the PACE program, and the Commission voted on recommendations to improve PACE. During last month's meeting, we discussed an analysis of dual-eligible special needs plans, or D-SNPs, and we gave an overview of CMS demonstrations on dual eligibles. These analyses are included in your mailing materials.

During today's session, we will focus on outstanding issues with the CMS demonstrations. Please note that most of the information we will discuss today was not included in your mailing materials. Before I begin, I would like to thank Carlos and Scott Harrison for their work on this project.

First I'll go over some background information on the demonstrations. CMS offered states two types of models to implement. Under the capitated model, CMS will sign a three-way contract with a state and a health plan, and the health plan will receive Medicare and Medicaid capitation payments. CMS and the states will reduce the capitation payments to account for up-front savings. The second model is managed fee-for-service. Under this model, states will

finance care coordination programs for dual eligibles within fee-for-service. States would receive a retrospective performance payment if their programs meet certain quality thresholds and result in Medicare savings.

The demonstration process is moving quickly for states that want to begin their demonstrations on January 1, 2013. States must first post their proposals for public comment on their websites, and about 12 states have already done so. States must then submit their proposals to CMS, and CMS will post the proposals for a 30-day public comment period. To date, CMS has posted one state proposal for comment. Health plans that are interested in participating in the demonstration must submit their combined Medicare and Medicaid benefit packages in June. CMS intends to select plans by the end of July and to sign the three-way contracts by September 20th.

Bob, in response to your question from the March meeting, the Medicare authority for these demonstrations is through the CMS Innovation Center. However, states may need to apply for Medicaid waivers or state plan amendments if they are proposing changes to their Medicaid programs.

This slide lists some of the unresolved issues

with the demonstrations. In the interest of time, we will focus on the issues on the right side; however, Carlos and I can answer any questions you have about the issues on the left. The issues that we will not discuss today include how CMS should set the capitation rates under the capitated model, which risk adjustment methodology should be used, and whether the plans participating in the capitated model should have flexibility to use Medicare funds to cover non-clinical services. The issues on the evaluation methodology -- again, that we will not discuss today -- include which quality measures will be used and how the demonstrations will be compared to fee-for-service. Finally, the last issue we will not discuss today in detail is the fast time frame for the demonstrations which leaves a short time period for CMS to resolve the outstanding issues.

The first issue to discuss is the scope of the demonstrations. Most states are proposing to enroll all or the major of dual eligibles in their state into the demonstration. For example, Massachusetts has proposed to enroll all disabled dual eligibles under the age of 65, and California proposes to enroll about 700,000 dual eligibles in 10 counties during the first year of the program.

One question is whether these programs are functioning as demonstrations if most or all dual eligibles in a state are enrolled. Another question is whether all plans participating in the demonstration have the capacity and experience to provide both Medicare and Medicaid benefits to large numbers of dual eligibles. The concerns about the scope of the demonstrations become greater if dual eligibles will be passively enrolled into these programs or if the Medicare benefit package and other requirements deviate significantly from standard Medicare requirements. I'll discuss these issues over the next few slides, but keep in mind that the level of concern with the remaining issues are related to the scope of the demonstrations.

Many states are proposing passive enrollment with opt-out. Under this policy, dual eligibles are automatically enrolled in the demonstration unless they opt out. The beneficiaries can opt to rejoin Medicare fee-for-service or to enroll in an MA plan. There are a number of issues here. One is the amount of time beneficiaries have to opt out before they are passively enrolled. CMS plans to notify beneficiaries 90 days before enrollment that they will be enrolled into a plan unless they opt out. However,

some state proposals suggest that the beneficiary will first be enrolled in the demonstration and then given the opportunity to opt out. A related issue is whether there is a lock-in period after enrollment. CMS has stated that beneficiaries will be allowed to opt out on a month-to-month basis; however, some states have proposed a lock-in period.

Another issue is which entity will make the plan assignments and how beneficiaries' needs will be matched to the appropriate plan. Finally, it will be important for plans to locate and comprehensively assess beneficiaries soon after they are passively enrolled into the organization.

The next issue is plan requirements under the capitated model. A number of CMS' requirements for demonstration plans are preferred requirement standards. These are CMS' starting points for negotiations with states. However, it is unknown how much these standards will change during negotiations. In addition, the potentially large scope of the demonstrations causes concern that many dual eligibles will be enrolled into programs with benefit packages or plan standards than are less robust than traditional Medicare or the MA program. Further, state-to-

state differences in the Medicare standards for the demonstration plans could result in the Medicare program operating differently under each state demonstration, similar to how the Medicaid system currently operates.

A related issue is the plan selection process. Plans have to meet both CMS and state requirements. It is unclear whether the plans that meet both sets of requirements will have experience providing all Medicare and Medicaid benefits. As such, one issue is whether plans should meet quality or experience criteria in order to be eligible for passive enrollment. It is also not clear whether SNPs will qualify for participation in every state. This raises the question of whether beneficiaries enrolled in these SNPs will be disenrolled from those plans and passively enrolled into the demonstration.

Vermont's proposal is an example of how the concerns we have just discussed are interrelated. Vermont proposes a capitated model, where the state's public managed care entity will operate the demonstration rather than private health plans. Because the state will serve as the managed care entity, beneficiaries will not have a choice of plans to enroll in. In addition, Vermont proposes to use

the state's Medicaid pharmacy benefit and preferred drug list rather than Part D plan options. It is not clear from the proposal whether Vermont will serve as a statewide Part D plan or whether the dual eligibles' drug benefit will return to Medicaid. The concerns about the proposal are increased because the state proposes to passively enroll almost every dual eligible in the state into the program.

The final issue we'll discuss is how Medicare savings produced from the demonstrations should be allocated. CMS intends to achieve savings under the capitated model by reducing the Medicare and Medicaid capitation payments to achieve savings. CMS will estimate a savings percentage off a combined Medicare and Medicaid baseline spending on dual eligibles in a given state. However, rather than Medicare and the state keeping the savings that come from their respective services, CMS will allocate the savings to Medicare and the state based on the proportion that each program contributes to baseline spending.

One question is whether the savings should be allocated this way or whether Medicare and Medicaid should only receive the savings that are generated from their

respective services. In addition, it is not clear whether CMS intends to publish the methodology for estimating the savings or how much of the savings are derived from Medicare or Medicaid services. Another question is whether the plans will be able to provide Medicare and Medicaid services under the capitation rates. As we discussed in the March presentation, we are looking into whether integrated plans can provide Medicare services for equal to or less than the cost of fee-for-service. A final question is whether the beneficiary should benefit from the savings. Beneficiaries could benefit monetarily or in the form on extra benefits.

This slide summarizes the issues we have discussed today, and for today's discussion we would like to elicit your opinions on how to address those outstanding issues. This concludes the presentation, and Carlos and I are happy to answer your questions.

MR. HACKBARTH: Okay, thank you. So let's do our usual two-round process. Round one, clarifying questions. Herb, do you want to lead off?

MR. KUHN: Christine, thanks. Do we have a sense of how many -- you talked about a dozen states have already posted to their websites their intent to move forward here.

Do we have a sense of what percent of the dual-eligible population might ultimately be enrolled in here? I've heard or I've read where some at CMS have speculated that there might be up to 2 million, which would be -- out of the 10 million that are currently dual eligibles, that's 20 percent of the population. But is that kind of what we think they're looking at, the order of magnitude here, or do we have any sense of that yet?

MS. AGUIAR: So, yes, you're correct in that. In CMS guidance, they had said that they were anticipating to enroll between 1 to 2 million beneficiaries into one of these demonstrations. So far we've looked at proposals from 12 states, and California hasn't yet submitted their proposal, but they've given out a lot of information on where they're going. California alone will be about 700,000, and I have here in front of me just the numbers, you know, of the other states and their proposals, and I could see it going around a million now. I could easily do the calculation and come back to you with the exact number.

MR. KUHN: And of the states that are currently interested right now, I assume that those states are all in, that is, all the dual eligibles in the state are in, or are

they just taking a proportion of those folks?

MS. AGUIAR: So the states that have, again, proposed so far, most have opened the demonstration to all dual eligibles. Sometimes they'll say 21 and over, 18 and over in the state. Massachusetts is focusing on a subset, so it's disabled dual eligibles that are between the ages of -- under the age of 64, I think between 21 and 64. Most states either will enroll -- are proposing to enroll all of the dual-eligible beneficiaries in their program -- some exclude PACE from that -- or the majority. And so sort of when I was reviewing the proposals, I was trying to calculate what percent of total duals, and it's either all of them or 80 percent or 60 percent. So if they're not looking to enroll statewide everybody, it'll be the majority of it.

There's one state, Wisconsin, that is really focusing now -- for the first part of the demonstration, really looking at the institutionalized population, focusing exclusively on that. So that is not statewide. That's a much smaller segment of the population, and their intention is really to try to see if they could bring those individuals back into the community. So they may be able to

expand the population there, but that's the only state that I've seen so far that hasn't proposed all or most.

MS. BEHROOZI: I'm all for sharing savings with beneficiaries whenever possible, but I'm not quite sure I understand in this context. I just want to know a little bit more about what you're thinking about when you offer that as an item for consideration, given that, you know, duals have very little cost sharing. Would it be a matter of eliminating cost sharing or adding extra benefits, like in the MA plan or PACE? And have any of the proposals so far from the states identified beneficiary benefits?

MS. AGUIAR: The proposals, no, have not addressed that yet.

MR. HACKBARTH: This is a point that I have raised, not with any particular approach in mind but, rather, as an observation that we're talking about this significant change which could limit choices available to dually eligible beneficiaries, and there's lots of talk about how to share savings between the federal and state governments, how to structure this so that private health plans or providers can share in savings. But what about the beneficiaries? People around this table will remember that

this was one of the issues that I also rode hard on the ACO rule. It just seems to me that it's untoward to focus on how everybody else is going to benefit financially from changes in care other than the patient, and so I regularly inject this point into the conversation, but not with a particular idea about how it would work in this context.

Clarifying questions?

DR. CASTELLANOS: I think it's a great idea, what you're talking about. One of the things that really bothers me is this passive enrollment. You know, we've looked at the state issues, we've looked at the plans' issues. Have we looked at this very vulnerable population that are high risk, very fragile, with increased co-morbidities? Have we looked at any of the patient advocacy groups to see concerns that the beneficiary is being -- I hate to use the word "pushed" or "encouraged" or whatever adjective you want to use -- into a plan that they really don't know and really hasn't been worked out? Have we talked to or had any comments from the beneficiary population?

MS. AGUIAR: So when the demonstrations were first announced, before we got the specifics of what was in the proposals, I do believe there were beneficiary advocacy

groups that had sent comment letters, and we did look at them at the time, and you raise a good point that perhaps we should be talking to them more about this.

The way that the process was intended to work for these demonstrations was that the states are supposed to have a lot of stakeholder involvement and justify that they actually have met with multiple stakeholder groups and that they've informed -- had input, again, into the proposal. At least one state I could say did put in their proposal what the comments from -- what the stakeholder comments were on this issue of opt-out and passive enrollment, and said that because of that they did try to make a change to the opt-out process because of that.

Now, whether or not that's happening in all state, I don't know, but I think you raise a good issue that it would be worth it for us to go back and talk more with those organizations.

DR. CASTELLANOS: Thank you.

MR. HACKBARTH: And I'm sure, Ron, we'll come back to that on round two.

DR. NAYLOR: Can I pick up a little on the opt-out? In states where the states say all duals are in and

someone opts out, what are they opting out for?

MS. AGUIAR: So in states where they have -- so they could opt out on the Medicare side for Medicare fee-for-service. That's what they would be opting out into. In states where there are MA plans available, they can opt out into an MA plan. If there's still a SNP in that state, they could opt out into a SNP. But beneficiaries now under the current Medicaid system, Medicaid is permitted to mandatorily enroll beneficiaries into managed care plans, so there's no opt-out on the Medicaid side. It would just be on the Medicare side.

DR. NAYLOR: And demos are intended to test ideas, some of which will do well and some which will not do well. In states that are bringing everyone in, what are they comparing their success or failure to?

MS. AGUIAR: So that detail we haven't seen in the proposals that have come out so far, and that's why that is one of the concerns. So one of the issues that we were not able to talk about today on the left side was the evaluation process, and our concern there is if you do have the majority or all beneficiaries in a state in this program, who's the comparison group, essentially, for that

evaluation? And so we feel like that's still an issue that's unknown and uncertain.

MR. HACKBARTH: So I just want to pick up, Christine, on your initial response to Mary's question about opt-out. You said when you were going through the options for a beneficiary who wishes to opt out, you said Medicare fee-for-service, Medicare Advantage plans, including SNPs, and implied there is that the dually eligible SNPs, of which there are a fairly significant number right now, will not necessarily be included as options under one of these state demonstration programs. Am I hearing you correctly?

MS. AGUIAR: Right. And the reason for that is that D-SNPs now have to have a contract with a state in order to continue as a D-SNP, and not all D-SNPS -- not all states are contracting with the D-SNP.

So in the case of Vermont, for example, they don't have -- I believe that they do not have any D-SNPs in that state, and so that's not an option for a beneficiary to enroll out of the demonstration and into their...

MR. HACKBARTH: So this, some would think, anomalous situation where under Medicare we had established the SNP program, including the particular category of SNPs

for dually eligible beneficiaries that may not, in fact, be included as options under this because, as you say, they don't have contracts with the state to fully integrate benefits.

MS. AGUIAR: Yes, that's right.

MR. HACKBARTH: Okay.

DR. STUART: On Slide 7, please, can you give us just a little bit more background about how much give you think CMS is going to be prepared to give here? Because this seems just totally wide open in terms of --

MS. AGUIAR: Right.

DR. STUART: -- what the stance of the Medicare program is going to be toward this.

MS. AGUIAR: So we're unclear on that issue. The guidance that has come out from CMS, it's been very specific to the financial alignment models, so to the capitated model and then the managed fee-for-service model that we discussed today. And that's where this language of these preferred requirement standards come in.

We've heard at times -- I guess what I want to say is that we've heard a little bit of differing answers. We've heard at times that those represent a floor, and then

the final decision could be beyond what Medicare is in traditional Medicare MA plans. We've also heard that there could be some negotiations that make it different than what's in sort of perhaps a little bit less robust.

What I want to emphasize here is that there's just quite a bit of uncertainty around that, and so, you know, for example, the Vermont proposal, which is - it could be read as one of two ways. It could be read as they're going to be the statewide Part D plan, or it could be as that they are going to bring the drugs back into Medicaid. And we don't know how -- whether or not CMS will allow that to happen moving forward.

The other issue is that the tension here is that the financial alignment models, you know, again, that proposed the capitated model and the managed fee-for-service model, but there are also 15 states that got design contracts. That happened before the financial alignment models. And we're unclear, but it seems that those 15 states, even if they are proposing one of the capitated or managed fee-for-service models, they might not be held to the same requirements. So, again, we're really uncertain as to where in the negotiations -- how much these things would

change, if they would change at all.

DR. STUART: Just a very quick follow-up. In terms of -- you used the term you hear, you hear. Is this ongoing communication with CMS and is there a point at which you think most of these are going to be resolved?

MS. AGUIAR: We have been having ongoing communication with CMS. I don't know. My understanding is that the state negotiations are happening on a state-by-state basis, and so I think that -- one of the issues that we've raised is that when the contracts want to be signed, the three-way contracts want to be signed by September 20th, we're not sure exactly when all of these decisions will be made public or if they will be made public. So again, another uncertainty.

DR. MARK MILLER: We have continuing conversations going with CMS and I want to be really clear with both the Commissioners and the public. We're not trying to represent CMS's position here, just our understanding of the process at this point in time. CMS might have different statements and views about some of these things. This is what we've been able to elicit.

We are talking, Ron, you know, to -- we haven't

talked to the beneficiary groups as recently, but we're talking to all different types of groups, and also trying to get input from them as their inquiries have come about. It is still fluid and one of the ways to think about this process, what's so difficult about this, is in a sense, what you want is just to say, Where does it stand so I can decide whether I'm okay with it or not?

And the bad news might be that we won't necessarily be able to give you firm statements about this is where it stands, and the Commission may have to think about it this way. There may be things that you feel represent kind of boundaries in your thinking, and if the Commission were to make statements about the direction, maybe that's how it's structured, since absolute certainty on what the agency will do there, I think, is going to be fluid for a while.

MR. HACKBARTH: And in this context, that's not necessarily an inappropriate approach for CMS to take. This is a joint endeavor between the Federal Government and the states, both the basic design of the program by statute, the coverage for dually-eligible beneficiaries, but also trying to innovate and find new ways of doing it.

And so, if CMS were to say, Everything is this way, black and white, even before we enter into discussions with states about their ideas and their approaches, it's sort of counter to trying to develop an innovate joint Federal/state effort. So they're in a challenging position to try to move forward and be transparent and elicit comments from people, while also not making commitments that may not be consistent with a joint Federal/state partnership. I think we have to sympathize with that. Bill.

MR. GRADISON: It seems to me I recall years ago talking to somebody with a health plan that covered a number of Medicaid beneficiaries and we were talking about opt out, and if my memory serves me correctly, I was told that people could opt out if they didn't like the plan for some reason or other, opt out from Medicaid and go back to a more fee-for-service-oriented Medicaid every 30 days.

I'm just curious whether people are enrolled, either passively or actively. Do you have any idea, under these proposals, of once they're in, however they get in, how often they can get out?

MS. AGUIAR: So that differs by state. Some

states say that they could disenroll, either change plans within the demonstration or disenroll monthly. Other states have proposed a six-month or a 90-day lock-in period. So it really depends by state.

MR. GRADISON: So some do have the 30-day approach, okay. That's interesting.

MS. AGUIAR: Yes.

MR. GRADISON: Thank you.

DR. MARK MILLER: But in giving that answer, you were referring to Medicare?

MS. AGUIAR: Oh, yes. I'm sorry. That's right. I was referring to Medicare, yeah.

DR. MARK MILLER: And I think, Bill, was your question about Medicaid, their ability to disenroll out of a Medicaid plan or a Medicare?

MR. GRADISON: I was thinking of the Medicare beneficiaries.

DR. MARK MILLER: Okay. Then we're squared away.

MR. GRADISON: Yeah, okay.

MR. HACKBARTH: And just to pick up on Bill's point, it seems to me that some of these elements need to be looked at not individually, but as a whole. So if there's

going to be passive enrollment, then there's a real premium on getting a good match between the particular clinical needs of a beneficiary and the plan that that individual is passively enrolled in.

The stronger that match is, the higher the confidence one has in the quality of that match, the more comfortable you would feel with restrictions on immediate disenrollment. But if the matching process is weak and it's coupled with some sort of extended lock-in, that's when you've got potentially the riskiest situation for the beneficiaries. So I think you need to look at several elements as a whole as opposed to individually. George.

MR. GEORGE MILLER: Yes, thank you. On Slide 8, I just want to refocus my mind on the comment, question that you made, the state versus private. Those states who decide to take on this responsibility, is there still going to be a private possibility or will the state take over all of the dual eligibles in that particular state, as you described that process?

And then, if there are savings, wherever that savings goes, to those states who take on that responsibility?

MS. AGUIAR: So I'll answer based on the information that we have now. The one state that has proposed that is Vermont and we haven't seen that proposed from any of the other states that have yet submitted proposals. And what they propose to do is to have the -- so they're proposing the capitated model which has a three-way contract between the state, the Medicare, and then the health plan, but the health plan in that equation will be the state's public managed care plan.

They already have a global commitment waiver on their Medicaid side, which is run through this -- I believe it's run through this state public managed care plan. And so, they see -- it's not a private plan that would be the third entity at that table getting that contract. It would be the state.

And so, my understanding is that it would still follow -- the way that the capitated model will still follow in terms of the financing, that both the Medicare would give its capitated rate of payment and the state would give its capitated payment.

But rather than going to one or more private health plans, you know, for example, some other states

propose to have at least two plans available in each region so beneficiaries have a choice, it would go to this -- to Vermont's public managed care entity.

MR. GEORGE MILLER: Savings?

MS. AGUIAR: So under the capitated model, the way that the savings are supposed to work -- basically I should say, from what I've read, I believe that under the Vermont proposal, the savings would follow the same way that it should for the other capitated models, which is in the sense that the savings will be taken up front out of the capitation rates by both Medicare and also by the state.

And so, I haven't read anything in the Vermont proposal that would suggest that that process will change. But again, we don't know because we just don't have a lot of details.

MR. HACKBARTH: Cori?

MS. UCCELLO: Yeah, I have a question regarding something that we didn't really talk about, the capitation payment methodology. And in the text, you note that Medicare's spending baseline is going to reflect kind of fee-for-service when MA spending is low and MA spending when MA spending is high.

And I'm just trying to understand better, does that baseline mean that's what's going to be used then to determine the negotiated rates, or is that used to determine the savings? I guess maybe they're the same thing.

MS. AGUIAR: Just in case any of you asked about this, we did have a slide just up there ready just in case, so if you want to just refer to that if you could.

DR. MARK MILLER: We also run a pool.

MR. ZARABOZO: Are you an actuary, by the way?

[Laughter.]

MS. AGUIAR: But again, so the way that the capitated rates will be developed is, again, they will be looking at -- for the Medicare side, they will be looking at a baseline that includes fee-for-service and MA spending. And my understanding is that within a state, they will be looking at the MA spending within a particular region.

So for example, if you have one area that is high MA penetration, that will be included into that baseline. What we're --

MS. UCCELLO: Let me just interrupt. So it's based on MA penetration, not MA spending?

MS. AGUIAR: I believe it's based on MA per capita

spending.

MS. UCCELLO: Okay.

MS. AGUIAR: I think so, but we're not completely sure if that's yet how it will work. So again, the Medicare -- our understanding -- again, I keep caveating with our understanding because it could change, so what we know so far, this is how we think it will work, is that they will look for the Medicare side to the baseline of fee-for-service and MA spending, and then set the Medicare capitation rate based on that.

And they will do the same for Medicaid. They will look at the Medicaid spending baseline in that particular area and figure out what the Medicaid capitation rate should be.

Now, where I think -- I think how it's going to differ from the savings calculation is that when they look at the savings calculation, they'll look at a combined Medicare, so Medicare fee-for-service plus MA, and Medicaid spending in that given state. And they'll say -- they'll come up with a savings estimate.

Let's say they'll assume 5 percent reductions in hospitalizations, 3 percent reductions in nursing homes.

I'm making those numbers up, but let's say like that's what they come up. And let's say they say, Okay, off that baseline, that combined spending baseline, that means total will get 3 percent savings.

They'll split, if you will, those savings between Medicare and Medicaid depending on the proportion or the amount that each of those programs contributes to the baseline spending. So if Medicare contributes 60 percent and Medicaid 40 percent, the Medicare would get 60 percent of that 3 percent savings estimate, Medicaid 40 percent of that 3 percent savings estimate.

And those percentages will somehow be taken out of the capitation rates up front.

MS. UCCELLO: So it just seems like that baseline could be set artificially high. If you're incorporating like the greater of a fee-for-service or an MA and if most of these people are really coming from fee-for-service, is that real savings or not?

MS. AGUIAR: Again, I'm not sure exactly how that would score, and that is something that we did touch a little bit upon more in the paper that you've seen, because we were sort of saying how you set -- how you achieve those

savings really depends on how much MA and fee-for-service mix you have.

So if you have a population with low MA and just most fee-for-service, then you would have to set those rates at or below fee-for-service in order to get savings. And again, if you have a population with high MA and you're including not just MA A and B spending, but you're also including the rebates and these sort of quality bonus of total MA spending, then yes, it would be easy.

And if you're assuming that your population is coming mostly from the SNPs or the MA plans, then I do think it would be easier to set the cap rate at a level where you would be able to get savings. But again, I again just want to sort of say, this is what we think is going on, but we're still uncertain if this is the process.

MR. HACKBARTH: Clearly this is a vital issue (a) in determining whether they're real savings at all, and then (b) the allocation of those savings among the participating parties. And part of what I'm struggling with is on the one hand, these rules are very important; on the other hand, part of the construct that CMS has described, as I understand it at least, is, Well, there is a three-way

contract to be agreed upon between the Federal Government, the state, and the plan participating in a particular state.

Being a lawyer, the use of the term contract has a particular meaning to me, which is that those three parties have a joint meeting of the minds about the terms, which requires a negotiation as opposed to an establishment of these rules up front.

And so, there's this tension between, you know, we need to get everybody's buy-in and share fairly and appropriately in real savings. On the other hand, how these rules are set really is very important for the program spending implications for both the Federal and state governments.

And I just can't quite get my mind around how this is all going to work in practice. Herb.

MR. KUHN: Just one other quick kind of thought about this savings component here, is a bit of a bank shot here, because won't this also impact the Medicare Part B program and the bidding process for the dual eligibles in Part D and how would they remove them out of the Part D process?

So if you've got this large cohort of people

moving into these, quote-unquote, demos, won't this also impact Part D on a go forward basis? And would there be savings and would that begin to change the baseline in that program, too?

MS. AGUIAR: So, what I could say to that is, again, one of CMS's preferred requirement standards, which is subject to -- possibly subject to change the negotiation, is that the demonstration plans follow Part D. They follow the Part D rules and are paid as Part D plans with the exception that they wouldn't submit bids. They would receive the national average risk-adjusted.

And in the 12 or so proposals that we looked at so far, they do appear -- they do say that they expect that those plans, demonstration plans, will also be participating in the Part D process.

Now, one issue was raised and I have to say I'm not the Part D person, so we've been working with Shinobu and Joan on this, is whether or not the fact that the demo plans won't be participating in the Part D bid is whether or not that will have an impact on the LIS calculation. But again, so far it's only one state that we've seen so far that has proposed a drug -- a change to the drug benefit

that could be interpreted as not participating in Part D. Again, we're not certain about that.

And again, if that doesn't happen, if those drugs are taken back to the state under Medicaid, where we'd have to really think through the implications of that both to the beneficiary.

MR. HACKBARTH: Scott?

MR. ZARABOZO: Before you go on, sorry, on Cori's question, there is a provision that says that the Office of the -- the CMS Office of the Actuary has to certify that the methodology achieved savings, the up-front savings.

MS. UCCELLO: Right. And the issue is there, what is savings? What's the baseline you're comparing this to in the first place?

MR. ARMSTRONG: I want to go back just for another minute or two to a couple of questions that have been raised about our concern about passive enrollment. If you opt out, what do you actually opt out into? And in particular, what I don't understand is that there are some states, or at least I know that there's at least one state, where Medicaid is all managed care plans.

And so, there's actually nothing as an alternative

to a managed care plan to opt out of for the Medicaid program. So how does that work for this population of patients if they're opting out of what would be a managed care plan?

MS. AGUIAR: So it's my understanding, again from the demonstrations that we've read, that when they're talking about opt out, that that's on the Medicare side for the Medicare benefits. There are some states, New York, I believe is one, for example, that has moved to mandatorily enrolling the dual eligibles and the long-term care population into Medicaid managed care.

Some states are able to get waiver authorities that permit them to mandatorily enroll. So that's different than passive enrollment with opt out. There's no opt out there. They are mandatorily enrolled into one of these plans.

And so, reading some of the proposals, and I don't want to generalize across all of them, it is my understanding now that when they're referring to the opt out, it's really for the Medicare benefits. I'm not completely sure whether or not there's an opportunity for the beneficiaries to enroll out of the demonstration plans

for their Medicaid benefits, and if they did, really where basically they would be able to opt out to.

MR. HACKBARTH: Clarifying questions. Mike?

DR. CHERNEW: If I understand, a lot of the duals might not be residing in the community, and so there's some -- if you -- I'm still hung up by Scott's question and your answer to Scott's question, because my sense of like you're enrolling or not enrolling has a lot to do with where you live and what's going on and where you're getting care.

But if the Medicaid program in a state puts you into a managed care plan for whatever it is, it's hard for me to understand how these benefits are being separated in quite the same way. Maybe it's not just a clarifying question, a clarifying lecture of how this would all play out. But I'm concerned about how the authority of how it all works between what the state has the authority to mandatorily enroll you --

MS. AGUIAR: Right.

DR. CHERNEW: -- even if CMS isn't involved. And I understand, we make it sound like you could just enroll for the Medicare beneficiaries here and then you're enrolled in the managed care just for Medicaid beneficiaries. But

that makes it sound like these things are much more separate than I actually think they are.

MS. AGUIAR: Right. So I'll try to answer that. I just want to caveat at first. We've really been focusing on how this impacts the Medicare side and not too much -- so we may look -- I'll give you my first impression, but I want to go back and think about it more before I give you a final answer.

Basically, I think it's sort of, some of the state proposals that we have looked at, the states that have their -- New York, for example, that they have their Medicaid managed care and Medicaid managed long-term care already in place. California, I think, is another example. There's actually quite a few states that have really done that work.

They're really trying to build this demonstration off of those plans and those programs that already exist. And so, I believe, ideally, the way it would sort of work out is that those plans that are operating in the mandatory Medicaid enrollment would also have -- you know, be able to participate in the demonstration, some of them actually very well, maybe MA plans or maybe SNPs.

Some of what we've read -- in New York, for

example, I think that they said that moving towards their Medicaid managed care program, but they had the opportunity for some SNPs to participate in that, or even if it's the same company that will own the Medicaid managed care company maybe also could own an MA plan and SNPs. So I think that's how they're trying to see these plans become an integrated product.

DR. HALL: I guess we're into passive enrollment on this side of the table. I haven't read any of the state demonstrations, but is there a requirement for the states to actually follow up on people who opt out, what happens to them, what happens to the beneficiaries?

MS. AGUIAR: Not to my knowledge, no.

DR. HALL: This is a population, if we just concentrate on the beneficiary, that has at best a very difficult time to find medical care, and it's sort of like reading Miranda rights. You have the right to remain silent, everything will be held against you. The choices are pretty bleak, and one of the choices is that you go back to the standard of care, which is to use the emergency room for all minor complaints, or you just don't get medical care.

It seems to me that some of these state demonstrations really ought to look at the unintended consequences of this approach, Well, you can always opt out if you don't like it. I think that's kind of a Hobson's choice for a lot of people.

MR. HACKBARTH: Can I ask a related question to that? So states have the authority for dually eligibles not to pay co-pays if the rate exceeds the Medicaid payment rate --

MS. AGUIAR: That's right.

MR. HACKBARTH: -- the provider would receive without the additional co-pay exceeds Medicaid rate. So in a very real sense for duals in those states, they could have restrictions on access, limitations of participating providers who are willing to see them that are much more like Medicaid recipients in those states than Medicare beneficiaries in those states.

Am I right on that? And if so, has there been any systematic study of the differences between access to services, number of available providers for duals in states that have such restrictions under Medicaid versus those that do not?

MS. AGUIAR: There may be those studies. I'm not familiar with them and I could look up to see if there are. There have been press articles -- and again, we've heard anecdotally, I believe Texas is making this change now, and so there's been some action around that where there is concern, where I think provider groups have come out and said, This is going to impact their access if we're not receiving the co-insurance from Medicaid.

How that -- if that's related to these demos, I would have to go back and think about it a little bit more, because my understanding is that some of the demonstration plans will be held to some of the Medicare network adequacy. And so, I have to think sort of more about how those two will interact.

MR. HACKBARTH: Well, the relationship that I see, and I think this may be somewhere to what Bill was saying, if you think about are the duals in State X going to be better or worse off after this change? To make that assessment, you have to understand what their access to care is in the current situation.

And if, in fact, it's greatly impaired because of this policy and there aren't a lot of providers willing to

serve them because they're seen basically as Medicaid patients, or at least Medicaid pay level patients, and they have impaired access, then you may be more open to changes that could make them better off.

Whereas if in another state they have access more similar to Medicare beneficiaries as opposed to Medicaid, then you might do a different calculus about whether they'd be better off after that. Is that part of what you were getting at?

DR. HALL: I think so. And also, I think it's sort of a bland statement, well, you know, they can find another form of medical care. That form of medical care may not exist. And also, this is not a population that necessarily has all of the facilities or faculties in order to be able to even make some of these decisions.

This wouldn't be such an important point if the states weren't -- if these were really true small demonstrations. But if California puts almost a million people into this, they actually could answer that question.

DR. MARK MILLER: Can I just say something? Because in some of our conversations with beneficiary groups, there -- and it also depends on sort of whether

you're looking at it from a Medicare or Medicaid side. I've spent years and years assembling a network of providers in this complicated fee-for-service world. It may not have been easy, but I've got it.

And then I'm going to be passively enrolled into a different network and how am I certain I'm going to have, you know, the -- and so, I think when this opt out conversation occurs, there's also that scenario where somebody says, Well, wait a minute. I want to opt out back into what I had because what I was put in didn't have it.

And so, we definitely hear -- I just wanted to be sure that people understand. We also hear that side of the story very strongly. And I know you know that. I just want to make sure it's all there.

MR. ZARABOZO: Just to add, sorry, this serves to emphasize the importance of the network adequacy requirement, which is that -- I mean, one of the selling points, if you want to call it that, of the plans for Medicaid beneficiaries and for duals is they must guarantee access, which is the difference that you're pointing out between being in a plan -- the plan meeting the network adequacy requirements says, yes, we have adequate access to

the Medicare-covered benefits, which may be possibly different from what happens in fee-for-service because of the very issue that you raise, that the cost sharing is not picked up.

MR. BUTLER: I want to understand the very big picture. You have added some data in the chapter this round that kind of looks at the aggregate spending for duals. And it says that 18 percent of the enrollees in fee-for-service are duals on the Medicare side and 31 percent of the expenditures, and on the Medicaid side 15 percent are duals and it's 40 percent of the spending, right? I think I've got that --

MS. AGUIAR: Yes, I think you've got that right.

MR. BUTLER: So is the overall effort here trying to get at in particular the states' desire to control their expenditures and assume in exchange for passing along risk they can get at that 40 percent spending level. Is that kind of the major thrust of what the pilots are trying to get at? I know they will say they want to coordinate care better and provide a better service, et cetera, but that's the kind of flexibility the states are looking for to kind of get at that spend.

MS. AGUIAR: Right. I think there are a few goals of the demonstration. I think it is both in the interest of the Medicare and the Medicaid program to have a program that is -- to have an integrated care program that has responsibility for both sets of those benefits. Again, part of that is because these are both really high-cost populations that have to stratify two different payment systems.

I think that, you know, we had reported -- and I believe this was the June 2010 chapter, report to Congress, that we reported that one of the barriers to development of these integrated care programs is that there is a lot of up-front costs to the states to finance care coordination, to sort of put these systems in place, and they sort of see it as those immediate savings that come from that go into Medicare. And so I think another one of the goals of the demonstration, particularly of the financial alignment demonstration -- and, again, also the managed fee-for-service -- is to sort of get at this issue of shared savings. So, again, I think that was sort of another incentive to look at these demonstrations.

Another goal of the demonstrations was really to

sort of see can you be able to combine the financing streams and can basically spending for both Medicare and Medicaid be reduced by these programs.

Now, the way that CMS has approached it so far is really to look at that through a reduction in the capitation payments up front. There are other models, for example, that could be tested that don't include trying to get the savings up front out of the capitation rates, but the one that CMS has started with, at least under a capitated model, is looking at that one. Under the managed fee-for-service model, that one the state would finance the care coordination. If there are Medicare savings, they would be able to receive some of those if they met certain quality thresholds. So I think there's sort of multiple objectives that they're trying to achieve.

MR. BUTLER: Okay. But if I continue to look at it through the states' lens and many states have more challenging fiscal situations and more immediate than even the federal government, that 40 percent of their budget going to -- well, actually 40 percent of the Medicaid and it varies by state and what the state is looking at. But the coordination, a lot of those dollars are, what, the --

they're not, obviously, hospital dollars. That's the Medicare side. Are they mostly SNF institutional dollars that would, in effect, be coordinated and managed and reduced in some way as --

MS. AGUIAR: Right.

MR. BUTLER: -- you know, if you look at where the shared savings are likely to be? I'm trying to get a sense of what components of this are going to be coordinated and managed better through the shared savings kind of models that are put in place.

MS. AGUIAR: Sure. So on the Medicaid side, the higher expenditures come from what they refer to as long-term care services and supports, so that includes not SNF stay because -- like the nurse -- not the SNF stay that Carol covers that Medicare pays for, but the nursing home stay, the nursing home custodial stay, which is very expensive.

MR. BUTLER: Right.

MS. AGUIAR: And they also have home and community-based service, you know, that is also costly to them. Some states have personal care services, so all those sort of long-term care supports. And so I think what the

hope from the demonstration is that once the capitation rates, payment rates, are given to the health plans that are doing this management, they will be able to -- they call it long-term care rebalancing, so it's taking the population -- sort of reducing the number of people that are in the nursing homes and really moving them to community-based settings where they could be cared for hopefully in a less expensive way. So I think that's on the long-term care side where you could sort of begin to see some of the savings. And, again, some of the evidence that we looked at on the PACE program during the fall was able to show reductions in nursing home placements. So I think that's sort of --

MR. BUTLER: But the SNP experience has not really -- it's been higher levels than the fee-for-service spending so far, right?

MS. AGUIAR: Exactly. And, again, that was based on a comparison of their bids and their total payments relative to fee-for-service. So there we were not looking at whether or not they were able to reduce hospitalizations.

MR. BUTLER: So there are probably a handful of people in the country that can know what I-SNP, D-SNP, FI-SNP -- it's amazing, the -- but it does say something about

the complexity of not only the dual eligibles but all of these pathways that you may take to become a dual eligible. So I have one last question then because I'm interested particularly in the disabilities, because obviously that's a -- you can qualify for Medicare by being disabled. There's a waiting period and so forth.

Can you say anything about the -- I know within the D-SNP, you know, something like 35 percent are under 65, so they're probably mostly disabled. But the overall dual-eligible population, how much are kind of the disabled and qualifying through that? And I realize you could start as Medicare and then qualify for Medicare and become a -- there's a lot of ways you can get to a dual eligible if you're disabled, but in terms of the 18 percent of the fee-for-service enrollees that are dual eligible, how many of those are through the disability route versus over 65?

MS. AGUIAR: So I believe that it's about one-third of the dual-eligible population that are under 65 that are disabled.

MR. BUTLER: Okay.

MS. AGUIAR: And keep in mind, we group them as disabled. What we really mean are developmentally disabled,

so really mentally ill, as well as physically disabled.

DR. MARK MILLER: I think we have some of this in the more data-oriented chapter that we did. We can come back and nail this number, and sometimes there's a hierarchy thing, whether you classify the person first as this or that. But we can nail this number down for you.

I did want to follow up a little bit. I do want to be very clear and agree that I think there are motivations about coordinating and, you know, to some of Bill's comments, you know, if there's a population where coordination could help in theory, this is it, and assuring access. But I do think some of the shared savings conversations started where you were saying and where people would say, well, you know, if we manage, the first place where money's going to be saved is avoided hospitalizations and unnecessary readmissions and ER use, and that's going to all be on the Medicare side and so that's not fair, or, you know, some of the conversations. But I think what Christine is also pointing out, and I think as the debate is involved, people should pause and think about this, and Mary I think was making some of these points earlier. Some of these things are really designed about avoiding the nursing home

stay, which would be a first savings on the Medicaid side. And so exactly when this management, if it occurs and how it occurs, where it goes, exactly how that's going to shake out could work on both sides of the aisle. But I think you were zeroing in on -- at least one of the initial perceptions was it's all going to occur on that side, the state wants to share in it. I think it's a little less clear than that.

DR. BERENSON: Yeah, two kinds of questions. First, I'm trying to get a better sense of what the managed care infrastructure is for caring for duals. Traditionally, Medicaid managed care has focused on parents and children. In recent years I know states have been much -- have moved into arrangements for the duals. Do you sort of know how many of the states see SNPs as the primary vehicle and contract with SNPs and how many are actually trying to expand state-based managed care and what sort of the size of the population is that state managed care -- of the duals, how many do they take care of?

MS. AGUIAR: From the states that we've reviewed that have put something out there publicly for us to look at, it does seem that they are looking for managed care organizations to have experience both with the Medicaid side

and both with the Medicare side. Some of those states, like Massachusetts, for example, you know, some of those states already have integrated care programs in place. And so you could sort of see how they already have health -- Minnesota is another one. They have health plans in place that are both Medicaid managed care and SNPs. So some of them have been very clear that they're trying to leverage that.

There has been, I believe in the press, some concern, and also among stakeholders, that some states are preferencing the Medicaid managed care plans rather than the MA plans and the SNPs. And we don't yet -- we haven't seen anything written that we could refer to and say, okay, we've seen it here and so, yes, we know this is a problem. That has just been something more that we've heard about that are concerns among the stakeholder population.

But what I can say is from what we have seen so far, there are proposals -- and even if they already have sort of a Medicaid managed care infrastructure in place, that they are saying, you know, SNPs do have another particular to participate in this, or that they had an opportunity to participate in the procurement of the Medicaid managed care plans. So we don't really completely

have a sense of that. That is why in the presentation, you know, we wanted to raise the issue of we're not sure who the plans are going to end up being, and if you have plans that are more Medicaid managed care plans that don't have experience with Medicare -- and keep in mind that you have many Medicaid managed care plans that don't have experience managing long-term care. I believe California is one of the states that has carved out some of their long-term care services. So we raised the issue of, you know, should this be a concern then with passive enrollment? Should these beneficiaries be enrolled into those plans if they have -- should there be an experience requirement before passive enrollment is raised? Then, again, that's why we raised the other issue of to the extent a beneficiary has chosen to be in a D-SNP, will they be auto-enrolled -- I'm sorry, disenrolled by the state from that D-SNP to be then passively enrolled into another plan?

So, again, we're not really sure. There is a lot of talk about that, but we haven't seen anything concrete that would say that any state is going to preference the Medicaid managed care plans.

DR. BERENSON: The other question relates to any

experience in Medicare with passive enrollment. My understanding is that in Medicare Advantage for beneficiaries who age in, who are in a plan when they're 64 and age into a plan that's in Medicare Advantage, there's a passive enrollment option of some kind with an opt-out. Is that correct? And are there any other examples in Medicare of passive enrollment?

MR. ZARABOZO: That is correct. If you're a current member of a commercial plan and you age into Medicare, you can age into that Medicare Advantage plan. But there was also passive enrollment in the Medicare Advantage program when it began. For example, in California, CalOptima in Orange County passively enrolled people, a number of plans enrolled their current enrollees into the Medicare Advantage dual SNPs. So that was permitted initially, and then there was a court case in Pennsylvania that -- I'm not sure whether that specific court case caused the discontinuation of that passive enrollment or not.

DR. BERENSON: So there's at least some experience with communication to beneficiaries --

MR. ZARABOZO: Yes.

DR. BERENSON: -- and actually administering an opt-out --that seems to be where that is? Okay. Thank you.

MR. HACKBARTH: Carlos, I'm not sure that I understood what you were saying there. You said there has been litigation about the legality of passive enrollment?

MR. ZARABOZO: There was a Pennsylvania court case regarding -- I don't know whether it was the very fact of passive enrollment or the manner that it was undertaken in Pennsylvania. But that was where the court case was, and whether it applied to the rest of the nation, I'm not sure of the details. But we did have passive --

MR. HACKBARTH: And how long ago was that?

MR. ZARABOZO: This was, I think, 2005 or 2006.

MR. HACKBARTH: Okay. We should be really clear because our clarifying questions used up all of the allotted time for this. But I still have one more clarifying question, which is about the statutory authority for this. My understanding is that these demos are being done under the Innovation Center Authority. Is that correct?

MS. AGUIAR: That's correct.

MR. HACKBARTH: And one of the new features of the Innovation Center Authority is the notion that if a

demonstration is proven to save money without hurting quality or improve quality without increasing cost, the Secretary has authority to extend the approach in the demonstration, even nationally.

I've always been a little bit murky about exactly what that authority is and how broad it goes. First of all, I guess my question is: Does that apply to this case? Or is that just limited to certain types of demonstrations under the Innovation Center?

MS. AGUIAR: No, it is -- it does apply to this demonstration. It's all of the demonstrations run through the Innovation Center have that requirement.

MR. HACKBARTH: And the Secretary's authority includes the authority evidently then to waive the Medicare beneficiary's free choice of provider, which has always been one of the keystone provisions of the Medicare law?

MS. AGUIAR: Right. I want to go back and check on that because it is my understanding -- I know that under the demonstration the Secretary has the authority to waive any Title 18 requirements, not any Medicaid requirements but any Medicare requirements during testing. And as I've read the language -- and I've read it more than once to try to

actually understand this exact issue -- it seems to me that the restrictions around when the Secretary cannot expand a program through rulemaking really is based on whether or not it doesn't improve quality of care or it improves quality of care but, you know, it increases cost. So it sort of is about that. I'll check once again, but it is -- I do understand -- it is my understanding that I think that they are able to -- would be able to expand the programs as they are now.

MR. HACKBARTH: Okay. Despite the late time, I would like to give people another opportunity to make comments, but in the interest of time, I'll ask people to be really efficient in doing so, and if somebody else has made your point already, just say, "I agree with Cori," for example. So round two comments.

MR. KUHN: Thank you. As I listen to this conversation, it seems to me that what we have here is more than a demo, but I think what we're really looking at here is a Medicaid waiver program wrapped up in a Medicare demo. And I think we need to be -- the scope of this thing is well beyond demonstration, but I think truly is a Medicaid waiver. So having said, just three general observations.

Number one, kind of something Glenn was talking a little bit about here, and others as well, is the rights of Medicare beneficiaries. Are they fully protected in this process as we continue to go forward? We've looked at passive enrollment. Bob asked a very good question about prior experience with CMS in this area. One thing I was just curious about is how CMS deals with the LIS in the Part D. Is that a model that we might want to look at in the future? Or is that not a model -- because that's only the Part D benefit versus the entire range of services out there. So that would be something I would be interested in.

The second issue is something Mary raised, and that's kind of the evaluation. You know, if everybody is in this program, the evaluation, what are you evaluating it against? But, furthermore, if you have a problem, how do you unwind a program when everybody in the state that's in this class, these dual eligibles, how do you kind of extract yourself from that? I think that's a serious issue. Again, thinking about the rights of Medicare beneficiaries.

And the third issue really has to do with, I think, all the things that were projected up here on the screen on Slide 7, and that deals with kind of the

requirements that are out there. You know, as I've listened to this conversation, it really does seem like this is more of a financially oriented endeavor, and we're talking about a very fragile population here. And if that's indeed the case, then I think all those issues in terms of networks' efficiency and everything else has to really be quite clear as we move forward.

MS. BEHROOZI: Yes, there are a lot of important issues, and I'll leave most of them to everybody else. I'll focus narrowly on the issue of sharing savings with beneficiaries. I wouldn't want you to be out there on your own on it, Glenn. And besides a lot of the things that you said about it, I think it's the kind of thing that can help support the success of this kind of program, right? I mean, to the extent that there's any -- whether it's a choice to opt in or a choice of opting out, if beneficiaries feel like there is something more for them in it, they are more likely to stay in it. So it just seems like a good design feature. And certainly it would increase our confidence -- as you referred to the confidence about the match being good in the first place, it would increase our confidence that the providers, the entities that were managing these programs,

had to focus on ways to deliver more value, more benefits to beneficiaries in the form of savings or additional benefits.

Actually, another question occurred to me, and it kind of came out of what Cori was asking -- see, I found a way to cite Cori -- about how the rates are set to the extent that they blend fee-for-service and MA spending.

Did I understand you to say that some of these programs, depending on how they're designed, could be taken out of an MA plan and put into, you know, the demonstration programs?

MS. AGUIAR: Yes, I believe that in some states that can happen.

MS. BEHROOZI: So that seems like someone could be taken out of MA where they could have extra benefits, like dental or something like that, and put into this demonstration program where they don't have extra benefits, yet the savings that the providers and the Medicaid and Medicare programs are going to get are going to be based off of the fact that there's MA spending, you know, where they are. So I think it really does -- it really goes to fairness. It goes back to what you said, Glenn, that if you're taking spending that's based on the fact that the

beneficiaries could get extra benefits, you know, in that way that it happens through MA, but then you're only sharing the savings off of that baseline among the programs and provider and not the beneficiaries, it doesn't seem fair. So that's my...

DR. DEAN: I would certainly share all of the concerns that Herb raised. It really makes me uncomfortable that if this is theoretically a demo, we are supposedly asking a question, is this going to work and is this going to be a preferable approach? And it doesn't seem to me that we have a very good structure to evaluate that.

I would be concerned, I think, with some of the concerns that were raised earlier about matching the beneficiary with the range of services because, as has been mentioned many times, these are complicated -- some of them are very complex patients, and the relationships that they've developed, you can't just move them. Even if ideally you've got a list of providers that have those capabilities, it isn't so simple as just moving them over. There are usually lots of experience and relationships and understanding of what's happened in the past that are really going to reflect on both the costs and, more importantly,

the quality of what's done. And I would be really concerned about the passive enrollment part to the extent that, I think as Ron raised, is there adequate counseling, education, whatever the right word is, to make sure that beneficiaries understand really what's happening? Because in some cases this is not a terribly sophisticated population, and these things are frightening. So, I don't know, there are a number of things that make me uneasy.

I guess I would take a little bit -- I'm not as enthusiastic about sharing benefits with beneficiaries, but that's a whole other issue. I won't even get into that. But I think the most important thing is to be sure we get appropriate, well-delivered, well-designed care to these people and not -- to me the shared benefits could be a distraction.

DR. CASTELLANOS: I would kind of echo the same comments. I'm really concerned about the beneficiary in this area, and I'd like to focus just on the beneficiary. I'm concerned over the passive enrollment, and I think this has been brought out a number of times. What we're doing here is we're trying to control expenditures for the savings. I want to make sure these people still have the

same access to care as Bill brought up and quality of care. People can opt out, but they have to have something to opt to. And as Bill said, this population does not have access to care in the general delivery care in the United States.

You know, we can say they can opt out, but -- excuse me language -- where the hell are they going to go? And I think it's important that this be in part of the discussion with the demonstration, and as Tom said, and I agree, I think we need to make sure we really listen to the beneficiaries and their adversary groups.

DR. NAYLOR: So I really believe this population is a very, very important one for our society, meaning it represents in so many ways the complexity-of-care challenges that both delivery and payment system reform are going to have to work together, and so alignment of eligibility and benefits and services is going to be really important.

I echo all the comments so far, especially around the evaluation plan. The timing and scope of this and all of the uncertainty begs the need for a really strong a priori plan, especially when you have states that will be testing out different kinds of innovations, how will you build the right comparison groups, the right benchmarks.

I also think that even in the efforts to promote innovation we should really assure that this program capitalizes on lessons learned from other federal, state, and private initiatives. We have a lot of lessons learned both in terms of what to do and what not to do in promoting high-quality access care for this population while reducing costs.

One thing I think we should be recommending is really careful independent monitoring. The National Quality Forum has a special group in its Measures Application Partnership that's focusing on the dual eligibles. The Long-Term Quality Alliance has identified several quality measures that are really important for this group that we should begin to think about.

I worry about an appeals process that goes beyond -- and I have all of the questions around -- concerns around choice, but what will be the appeals process? Will we be using Medicare's appeals process? How will this apply? And I think a standard floor of benefits, a defined benefit package, and assuring adequate access to a Medicare network is critical.

DR. STUART: There have been a number of questions

raised about evaluation, and I just want to go back to other conversation we've had in the past about the slow pace of evaluations in Medicare in the past and to make sure that we're not flipping the page here and trying to go back to something that we know is problematic.

The Innovation Center does have the authority for something called expedited evaluation, and I think it might be useful to bring that into this chapter so that we have some better sense of what are the evaluation options that CMS has.

Then I have a specific question about shared benefits and relating to Vermont, which is obviously a very special program, and it's whether the state really is planning to give every enrollee three pints of Ben and Jerry's.

[Laughter.]

MR. GRADISON: I would hope that the evaluators are involved, the potential evaluators, in the design of the program. So often the evaluators say, well, if we only had done it this way or that way or had collected this new information, we could better perform our evaluation. Other than that brief comment, I yield my remaining 20 seconds to

Cori.

MR. GEORGE MILLER: Yes. Obviously, this is very complicated, but the goal is for better quality, lower cost. But as other Commissioners have indicated, getting it right and using the lessons learned will be very, very critical. Weighing in on the beneficiary side, I use the acronym WIIFM [phonetic], what's in it for me, and if we can drive a process that both the beneficiary and the system benefits, I think that has better traction, at least in my mind.

But I particularly want to make sure that we discuss the educational component so those beneficiaries are better educated, because as Bill indicated, unfortunately for many of the population, their provider is the ER, and if we can improve a system so they don't opt out to the ER, I think that would be very, very helpful. Then, obviously, communication is going to be critically important and that should be part of the demonstration, in my mind, both education and appropriate communication so we can assure that that population would not be opting out to something unknown, like the ED.

DR. BORMAN: I would support Mary's comments about monitoring, particularly, and many of the comments that have

been made about the transferability of people who already have wound their way to establishing a network and now how do they transfer this. They're sort of moved into one of these systems.

On the other hand, I do think we have to be careful about letting our concerns make us stifle innovation, and I think what we're trying to do here is strike a balance. Is this too much, too quickly? What are the nuggets in here that have value and what can we support about that? Because I am just a little bit concerned that we may go overboard into the point of limiting potential advances that we know have to be made and that there are some rationale, too. So I think as long as we can make sure that we projected balance, that while we have these very genuine concerns that we want to raise, that we also support philosophically some of the things there.

MS. UCCELLO: Well, I agree with the comments I made earlier.

[Laughter.]

MS. UCCELLO: And I just -- I actually want to highlight something that Christine said because I think it's really important. This issue of, you know, if we think of

enrollment on the continuum of choice and passivity and also think of a continuum of plan requirements as loose and more strict, the further we move down toward the passive enrollment and lock-in kinds of things, the more we need to be strict on the plan requirements. I think we should do so, like Karen said, in a way that -- I mean, there is a reason why we're looking at this population. This is a very challenging population. We need to look to see what kinds of things can work better for this population and have more coordination in general and between Medicaid and Medicare. So we want to make sure we look at these kinds of things, but we need to do so in a way that makes sense.

MR. ARMSTRONG: Yes. I, too. I would just point out that, as a group, I think we've done our usual excellent job of identifying all sorts of concerns that we may have with this, but I think we need to -- and so I won't pile or add or reiterate any of those. But I think we do need to balance that with an acknowledgment that this is, what, 18 percent of our beneficiaries who consume more than 30 percent of our overall resources. This is a program that needs to be changed and that I applaud the fact that we're moving forward fairly assertively with a whole series of

initiatives in the States to try to learn how this can be changed because the status quo is really not adequate. And so we really need to make sure we're balanced in our point of view on that and cautious but willing to really try some new things.

DR. CHERNEW: Picking up on Scott, I think we need to remember that we've had a lot of presentations here. The bar for doing better may not be all that high for a lot of these folks. And I understand that because of the nature of this population, the potential for harm is great, but understanding where we are and the problems, I think, are important. And a lot of it has to do with we go into this thinking about the plans you're contracting with as being good actors or bad actors, and frankly, if all the plans were -- I know some really good providers that have said this separation in the funding is a huge impediment for doing anything good. And to have a system that doesn't allow them to do some of those things strikes me as crazy. So what really matters is the selectivity and what organizations are running this. And I think that there's a number -- that that's the way you deal with this, because you can't micromanage. I think micromanaging will kill this

in a number of ways.

So just to answer the questions that we were asked, I really think it's important to combine our -- to get away from this thinking that these are Medicare services and these are Medicaid services. We've got to make sure that the dollars for the Medicaid portion went to the Medicaid ones and the dollars for the Medicare ones went to the Medicare ones or whatever, that no one gives anyone else a nickel, because that's just a recipe for regulatory and administrative disaster and incredible efficiencies.

So I think that there was a question Christine asked earlier about should we make sure that this portion of the money only goes for Medicare services and this portion only goes -- this should not be thought of as separate streams of money that have to be spent on separate things.

In that spirit, I feel strongly that we should allow these organizations to use the money for non-covered services in various ways. The whole point is that the benefit package isn't always right because people have a lot of different needs. The PACE program, I think, demonstrates. I believe we must give them that flexibility to use the money that way.

And in that spirit, and to almost finish my rant, there's -- the main savings from efficiencies, of which we believe there can be many, actually accrue to the organization, either the plan itself or the providers with whom they contract, and that's, I think, exactly the way we want it. That gives them an incentive to do a good job as long as we can monitor the quality one way or another. I think that's really the key point.

I believe we want that portion of efficiency to be able to go to the providers in a way to give them an incentive to do all the things that we want them to do. I think that the way the programs, State or Federal, capture the savings is how you set the capitation rates and not necessarily so much in the first place but how you set the way that they rise over time.

And I am completely amenable to the things going back to beneficiaries, but I wouldn't want it to be done in a sort of -- apologies to Cori -- an actuarially managed, you know, you've got this much or that much. You have to give six cents back. But through maybe a break in the co-premiums -- but these people get breaks already. So thinking about that sort of broader way of doing it is, I

think, how the beneficiaries should benefit, and we should be under no illusions that when they opt out to something, that the current system they are in is at all able to manage the complicated problems these have. And I think the financial system we have for these individuals now is more often than not an impediment to good care than a guarantee of it.

DR. HALL: Well, I think this has been a fantastically good discussion, and I think what I take away from this is that we are saying that we encourage demonstrations that look for innovations of care and that we are not in any way saying that that shouldn't be done. But, as always, we're trying to put the beneficiaries' point of view in the forefront here. So I think we have a lot of agreement here.

DR. BAICKER: Just to follow up on the spirit of Scott and Mike, that the caveats that we've all expressed are important and well taken, but I want to be sure we add weight to the other side on two points.

One, the opt in/opt out. Clearly, there need to be safeguards in place so that any beneficiary who wants to retain the package that he or she has carefully developed

should be able to do so and that we are not defaulting people into a plan that is not good for them. But along the lines that Mike was saying, people are defaulted now into a plan that we are trying to fix, and so we shouldn't start with the baseline assumption that defaulting people into the alternative is making them worse unless they opt out of it. This could very well be making everybody better off, and if that is the spirit of providing more coordinated care, we want all the safeguards in place but we shouldn't think of it as a bad thing if the new default option is different from the old default options. We're trying to improve on the old default option.

The second place that I want to interject that framework is in thinking about the demonstration aspect of the demonstration, and we are all suitably wary of a demonstration that is everyone, or close to everyone, so that it doesn't seem like an experiment, it seems like a plan change. But on the other side of that argument is the idea that we're trying to change norms of care and that coordination requires a critical mass. And I'm sympathetic to the idea that if you were to do this on a very small scale, it might not work at all. And that suggests that we

want to be sure we have really good monitoring processes in place. Other people have said that we push towards better data collection, better data availability so you can at least compare across States or within States when you can. But with that in mind, I think it's not unreasonable to think that you need a fairly large-scale change to get better coordination in place systemwide. This is a system-level change we're trying to effect.

MR. BUTLER: So, specifically, I think that the criteria used to establish who you're going to give the keys to and the authority and the accountability to is the key in my mind, not whether or not we should do it. So Mark articulated kind of the "it takes a village" kind of concept to put together a system to support those that have chronic kinds of problems, and sometimes it works sometimes it doesn't, but it's what they've got. And it's usually a combination of agencies and volunteerisms and families and all kinds of things to make that happen.

And so if you say, now I've got a private health plan -- not to pick on private health plans -- that are in the business of kind of avoiding risk or at least focusing on a little different agenda, and certainly not typically

partnering with these, it's just a whole different venue and it gets at the competencies that Bob was articulating that really just are not sitting -- the competencies nor the culture that are sitting in some of these entities, it's just not what they do day to day and not what they're incented to do. I guess the day that one of them stands up and markets this on TV or something to this population, I would feel a little bit different, but I think there's more of a -- maybe if they're passively assigned and, you know, hand them over to me, I think I can do better, kind of attitude. But it's not the kind of engagement that I think you'd need. And again, I'm not picking on private health plans, but it's an example of something that would have to be looked at carefully if that's where you're going to assign the accountability and authority.

DR. BERENSON: First, I just wanted to also echo the comments that Scott started with, that with all of our caveats, this population is not well served today, either in fee-for-service Medicare or in a system where States and the Federal Government have conflicting financial incentives. And so I applaud CMS for pushing pretty aggressively in this area. I think, in a sense, we're asking them to slow down a

little bit, but I think their impulse is correct. And I have no principled objections to passive enrollment into an excellent health plan with the protections about opt out, et cetera.

One of the purposes of demos is to test a lot of operational issues. So even so-called "failed" demos, like the physician group practice demo, which wasn't a success in and of itself, we learned an awful lot that wound up being a basis for the shared savings program. There are many other examples. In this area, it strikes me there are a lot of operational issues to deal with and it's the reason to have real demos rather than sort of a waiver program. I mean, just the issues around passive enrollment and what that involves, I can list six or eight or ten design issues that need to be tested. And so multiply that. And so I think this is an area that actually needs good demos.

And in addition to Kate's point about you need a certain threshold, I'd add one other thing is we're also testing States and Federal Government working together in a whole new way, a partnership, and you don't do that with 2,000 patients and one good health plan somewhere. Yet it has to be of a sufficient size to get everybody's attention

and interest to try to make this work.

So in the spirit of the Supreme Court's concept of limiting principles, which I learned, I would suggest two limiting principles here to the demo. One is that they can't be large enough so you can't do a robust evaluation. You need to be able to support a good evaluation. That's the requirement that CMS has in assessing whether a demo was successful and should be expanded. So I defer to the people who know how to do evaluations. It strikes me that the whole State is too large. It also strikes me that a few hundred people is too small. And so I think you want to have that be one of the principles.

And the other one would be it can't be so large that if it fails, you can't shut it down. I don't know how you would tell California, if they're going to have 700,000 people in a demo, oh, never mind, we're going to stop that because it hasn't worked or something. I think for practical political reasons, everybody needs to understand that these are demos and aren't waivers, because I don't think you do shut down an entire State's transformation of their health delivery for duals.

So there's somewhere -- there's a balance, I

think, between too small and too large, but the -- and I think we could articulate some principles around that.

MR. HACKBARTH: I find myself agreeing with a number of the recent comments. The status quo is not good for many of these patients and my own notion, which I've restated many times here, is that fee-for-service payment systems are especially problematic when you're talking about complicated patients that require sophisticated care coordination and the like. And so in that sense, this seems like a very appropriate population to focus on.

But I find myself torn between that observation and another which I've often made is that not all managed care plans are created equally, and we've got abundant evidence of that from the Medicare Advantage program. And I think that the problem is compounded greatly when you're talking about a really complicated population. There can be very good managed care plans who will not necessarily be very good for patients with severe physical disabilities or cognitive disabilities. And so I think it is not enough to say, well, fee-for-service is broken and they have really bad care now. Anything will be better than that. I don't quite get to that second point that anything will be better

than that. So I think it's really important to move with care.

I have been focused and will continue to focus on this issue of passive enrollment because I think that matching the patients, not just with plans but with care delivery systems, is what will make or break this. And if that is not done well, I think there's a great risk that rather than being a bold step forward, this could lead to wide-scale problems and it will end up being a step backward because people will draw the wrong inferences from the inevitable problems that will crop up.

So, like Bob, I applaud CMS for moving forward on what is a really important issue, both fiscally and clinically for the patients. But I think doing it right is just really important, and especially around this issue of passive enrollment.

So, thank you all for your comments and at some point in the future we will look to fold these into some sort of comment that we might provide for CMS.

We are, as I noted earlier, well behind schedule here. In fact, we are supposed to be finished with the next session. We are one session behind. Our next session is on

electronic health records and that will be followed by a public comment period and then lunch. So those of you who wish in the audience to make comments on the issue we just discussed, that will be forthcoming, but only after we have talked about electronic health records.

[Pause.]

MR. HACKBARTH: So, John, are you leading the way on this one?

MR. RICHARDSON: Yes. Good morning, everybody.

In this session, we will give you an update on the program of Medicare payment incentives for certain types of health care providers to implement electronic health record, or HER, technology.

CMS began distributing Medicare EHR incentive payments about one year ago, and the Agency recently issued a Notice of Proposed Rulemaking to define the second stage of performance criteria for EHRs under the program, making this an opportune time for an update.

To frame the discussion, we would note that the Commission has supported, for several years, the use of Medicare payment incentives to increase providers' adoption and use of EHRs and other types of health information

technology to improve the quality and efficiency of care for Medicare beneficiaries.

In our March 2005 report to the Congress, the Commission recommended that Medicare pay-for-performance programs should include measures of quality for activities that directly rely on the use of Health IT, such as tracking care over time for patients with certain chronic conditions, using clinical decision support tools during patient encounters, and securely transmitting patient care information between providers across care settings.

Then, in your March 2010 report, the Commission made a set of recommendations to improve Medicare's ability to compare the quality of care between Medicare Advantage and fee-for-service Medicare and among MA plans.

The first of these recommendations was that the Secretary should define EHR meaningful use criteria such that all qualifying EHRs can collect and report the data needed to compute a comprehensive set of process and outcome measures, and also that qualifying EHRs should have the capacity to include and report patient demographic data such as race, ethnicity, and language preference.

Also, in March 2010, the Commission submitted a

comment letter to CMS largely supporting the Agency's proposed rule on the first stage of EHR meaningful use criteria. I will come back to that in a minute.

I would also note in the research literature there is a vigorous ongoing discussion of the degree to which implementation of EHRs and other forms of health IT in care delivery settings actually increases or decreases quality and safety and service volume and cost.

For example, you may be aware of a study that appeared in the Journal of Health Affairs last month examining the impact of one type of health IT, electronic access to diagnostic imaging and lab test results, the impact of that health IT on the volume of those services in physician practices.

The paper prompted an interesting discussion between the authors and the national coordinator of health IT about the study's findings and limitations and we can talk about that on Q&A, if you like.

So, the Medicare EHR Incentive Program was enacted in the Health Information Technology for Economic and Clinical Health, or HITECH Act, which was incorporated into the American Recovery and Reinvestment Act of 2009.

The Act also included a Medicaid EHR Incentive Program with its own set of provider eligibility criteria and incentive payment amounts.

The Medicare EHR incentive program initially offers incentive payments to eligible hospitals, critical access hospitals, and physicians and other types of eligible professionals specified in the law, if those providers demonstrate the meaningful use of certified EHR technology.

Starting in 2015, these incentives will turn into payment penalties for otherwise eligible providers who do not demonstrate meaningful use of certified EHR technology.

Zach will go over how these incentives work in a minute.

Before that, though, I will take a couple of minutes to walk you through the definition of the meaningful use criteria, which is the lynchpin of the program.

CMS's current plan is to increase the stringency of these criteria in three stages between 2011 and 2016.

CMS defines the criteria through the notice and comment rulemaking process with a significant amount of technical input from experts on the HHS Health IT Policy Committee.

CMS announced the Stage 1 meaningful use criteria in a final rule published in July 2010. The criteria are defined as certain objectives or functions that a provider must demonstrate that they can perform using certified EHR technology. Each objective has a related performance measure.

In stage one, eligible professionals must meet 20 objectives, and hospitals must meet 19. In both cases, certain objectives are mandatory or in the core set of objectives, and others are selected by the provider from a menu set.

This slide gives examples of the kinds of objectives embodied in the Stage 1 meaningful use criteria. I will not go into details on the slide, because a complete list of the Stage 1 and proposed Stage 2 criteria were included in your meeting materials, but I can field questions about this as needed.

In the proposed Stage 2 criteria, CMS considers using about the same number of criteria as in Stage 1, but many of the objectives that are in the "optional" or "menu" set in Stage 1 would move to the core set of objectives that all meaningful users must meet.

CMS also proposes to raise the bar on the performance measures for almost all the criteria.

For example, a provider would have to record specific demographic information or use clinical decision support tools or exchange information electronically with another provider for a greater percentage of her, his, or its patients than in Stage 1.

This table depicts the phase-in schedule for the meaningful use criteria. For a particular provider, the stage that would apply -- that is, the criteria they must meet to qualify as a meaningful user -- depends on the year they begin participating in the program.

In the example highlighted in yellow, a provider who first achieves Stage 1 of use in 2012, must ramp up to meet Stage 2 in 2014 in order to continue as a meaningful user, and that provider must achieve Stage 3 in 2016 to continue as a meaningful user.

And the example highlighted in green, a provider who first achieves meaningful use in 2014 will have two years at Stage 1 before having to increase to Stage 2 in 2016 and Stage 3 in 2018.

Now, it may appear from this schedule that there

is a disadvantage to providers who choose to participate sooner rather than later, because they must meet more stringent criteria sooner, but the program's incentive structure is designed to financially reward providers who are early adopters by giving them larger incentive payments over the course of the program.

One last point from me before we move on to the payment incentives is to look at the timeline and milestones of the program over all. I just want to call your attention to three points on this timeline.

First, providers who wish to get the maximum amount of incentive payments under the program must start participating in 2012 if they are a physician or other eligible professional, or in 2013 for eligible hospitals.

Second, the Stage 2 meaningful use criteria are slated to go into effect in 2014.

And third, the payment penalties will begin in 2015 for providers who are eligible to be meaningful users, but who do not demonstrate that they are.

Now, Zach will describe how the incentives work.

MR. GAUMER: The specific incentive payments that providers receive once they have demonstrated meaningful use

are based on three specific formulas, depending upon the type of provider that they are. Eligible professionals receive an amount equal to 75 percent of their allowable Medicare charges, up to an annual maximum. For 2011, that maximum is $18,000. And the maximum is reduced in each of the five years that the eligible professional is eligible.

Across the five years that the eligible professional is able to receive payment, they can receive no more than $44,000.

Hospitals receive an amount equal to a base payment of about $2 million that is adjusted by the hospital's Medicare discharge volume as well as their Medicare share.

The hospital incentive payments are also designed to shrink in each of the four years that the hospital is eligible for that incentive payment.

Critical access hospitals receive an amount equal to their reasonable costs incurred for purchasing a certified EHR technology, which is adjusted by their Medicare share.

CAHS incentive payments do not shrink over the four-year eligibility period.

Now, as John said earlier, the payment penalties begin in 2015 for all the different provider types if they do not demonstrate that they are meaningful users of EHR technology, but it varies. The formula for the penalties varies for each type of provider.

For eligible professionals, the fee schedule payments will be reduced by 1 percent in 2015, and then reduced an additional percentage point for each subsequent year that they do not qualify as meaningful users, reaching a maximum of 5 percent in 2019.

For hospitals, the market basket update will be reduced 25 percent in 2015 and then 50 percent in 2016, and then 75 percent of the market basket in 2917 and beyond.

For critical access hospitals, Medicare payments are reduced from the 101 percent of reasonable costs that they normally receive down to 100.66 percent of their costs in 2015, and then reduced another third of a percentage point each year until they reach a maximum of a total 1 percent reduction in 2017. Said another way, their payments will go no lower than 100 percent of reasonable costs.

In addition, any of these three types of providers may be eligible for a temporary hardship exemption to the

payment adjustments and this might be something like proving they are newly opened or do not have sufficient access to Internet service.

The first year of the incentive payment program is now over, and CMS has released data on program participation and payments through February 2012, which is just about the first full year of payments.

Overall, Medicare paid out about $2.1 billion in incentive payments to hospitals and eligible professionals combined through February 2012, and about 70 percent of those payments have gone to hospitals.

Hospitals and eligible professionals are both registering to participate in the program, but many have not yet demonstrated meaningful use of EHR technology. Therefore, many have not yet received incentive payments.

To date, hospitals have been more active participants in the program, and approximately 66 percent of hospitals have registered overall versus 25 percent of physicians that have registered.

In terms of payments, about 16 percent of hospitals have demonstrated meaningful use and received a payment in the first year of the program compared to 6

percent of physicians.

The first year of the EHR program began slower than some assumed it would. Hospital participation increased in September of 2011, and continued to increase through the end of 2011.

In the early part of 2012, hospital participation slowed again; however, starting in about December of 2011, physician participation increased considerably, and in January and February of 2012, more payments went out to physicians than hospitals.

Now, Matlin and John will provide more insight about the characteristics of the providers that did participate in the program.

MR. GILMAN: This slide shows characteristics of hospitals and physicians receiving EHR incentive payments.

As Zach mentioned, 16 percent of hospitals have received incentive payments through February. Using data through December, which is the last month for which we have provider-specific information, we find that hospitals receiving incentive payments are more likely to be members of a large hospital system, which we defined as systems with 35 or more hospital members as opposed to members of a

smaller hospital system and hospitals that are not in any system.

We also find that hospitals receiving incentive payments are more likely to be paid under PPS and therefore less likely to be critical access hospitals, and are more likely to be large, which we defined as having 200 or more beds, and located in urban areas as opposed to rural areas.

John will now tell you about details of physician participation.

MR. RICHARDSON: We estimated the percentages of physicians in different specialties who have received EHR incentive payments through February 2012. We calculated these estimates by combining the monthly reports from CMS on physicians who have received incentive payments with an account of unique physicians represented in 2010 Medicare paid claims data.

The specialist counts were adjusted to exclude typically hospital-based specialties, such as anesthesiology and pathology, which are not -- providers in those specialties typically are not eligible for these incentive payments.

Overall, the percentages are quite low, in the

range of 5 to 8 percent for the non-primary care specialties and primary care, respectively, but they have been accelerating over the past few months from CMS's published data.

Also recall, as Zach said earlier, that about 25 percent of physicians registered for the program through February, which is the necessary precursor to demonstrating meaningful use and getting a payment. So, we would expect to see these paid percentages continue to climb in the months ahead.

Physicians in a few specialties appear to be taking advantage of the incentive program at higher rates than others. While we have not specifically looked into why this may be the case, one possible explanation is that these specialties may be organized in larger group practices that have been earlier adopters of EHRs and other kinds of Health IT, such as clinical registries.

That concludes our update on the Incentive Program, and we have touched on the meaningful use criteria and the incentive payments through February, and we look forward to your discussion of future possible policy directions, and happy to take questions.

Thanks.

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

Let me just start with a historical observations here. John recounted some of MedPAC's history with the issue, but I would emphasize that, for better or for worse, MedPAC did not endorse the subsidy approach to adoption of EHR that was ultimately included in the Recovery Act.

When we looked at this issue several years before that time, we talked about whether there should be significant subsidies offered and concluded that -- members of the Commission at that point concluded that, in fact, that was not the best approach, the best way to encourage adoption of EHR is to change the payment system and to reward the things that EHRs can help produce, better quality, more efficient care, as opposed to subsidies for the purchase of a particular piece of equipment and software.

Now, in fairness, the approach in current law tries to bring those ways of thinking about this together with the idea of meaningful use and say, we will not just subsidize people to go out and buy software and computer

terminals and all that. You only qualify for the subsidies if you engage in meaningful use and produce certain things.

And so, it sort of brought together in that sense, but I did want to be clear that our historical idea was to reward improvements in efficiency and quality much more aggressively than they are done under fee-for-service, and through that encourages investment in tools to achieve those goals.

So, let's start with clarifying questions.

Peter, do you want to leave off?

MR. BUTLER: So, I am glad we have this topic. I have encouraged us to put this on the table.

So, I might have this wrong, and that is why I am asking the question: The law itself provided something like $34 billion of potential payouts, and then the scoring of it which said you are really going to save 15 billion or something, so the net is 19 billion; is that right?

MR. RICHARDSON: That is roughly right, yes.

MR. BUTLER: Yes. And so, the major assumptions around what that 15 million in savings are all about, can you just articulate -- I think I know the answer, but I will let you.

MR. RICHARDSON: A large part of it was an assumption that some providers would not become meaningful users, and so the payment penalties would start to reduce payments over time.

MR. BUTLER: Yes.

MR. RICHARDSON: I do not remember CBO's making an explicit assumption about changes in utilization as a result of the use of the technology.

MR. BUTLER: So, the 5 percent -- ultimate, maximum 5 percent penalty on the non-critical access hospitals would be one of the major sources of that savings?

MR. RICHARDSON: The 5 percent payment adjustment is for eligible professionals. So, that would be mostly the physicians in that bucket. The market basket reduction is reduction in the otherwise applicable market basket.

MR. BUTLER: You are correct. I stand corrected.

Okay. So, that is one question I had. The total dollars is important because when you look at some of these -- the reason I think this is important, you look at some of the silo payments that we look at, this is many multiples of a one-year spending on the entire silo. So, this is a lot of money that is going out.

So, on Slide 9, you have a comment on critical access hospitals. I am just trying to understand, because some of the data I have seen in surveys kind of show quickly emerging trends about who is adopting and who is not and so forth and these are ones that are not necessarily adopting quickly.

And my understanding is they have a little -- not just a different payment penalty, obviously, if they do not adopt, but a little bit different time schedule for -- they have to have four consecutive years of adoption and it begins this year and it is a little different timeframe; is that right?

MR. GAUMER: I think it is different in that they do not get the reductions from year to year that normally accrued to a hospital or to the EPs that have declining payments.

When it begins for CAHS, I am not exactly clear, actually, if they have to come in at 2011. I can check that for you.

MR. BUTLER: I think they do have a sooner timeframe, and then they need four consecutive years, and it is a little different set of rules.

And I bring this up because part of -- what I think we do not want to wake up is, in 2015, suddenly all these penalties and we have all these haves and have-nots, and suddenly, now what do we got?

And so, the more we identify these patterns earlier on, the better off we are going to be in either making adjustments or whatever is needed.

So, my last clarifying question relates to the rollout, and that is, my understanding, also, the best I know, is that while the rollup is ramping up, it is far less than what was scored in terms of the CBO in terms of where they thought things would be at this point in time.

So, there has been about maybe three billion or something in payouts, and they had more than that expected in the last fiscal year alone. So, we are behind.

MR. GAUMER: I think the trend here is that it started later than they thought it would. I think providers starting getting more active, specifically the hospitals in the fall of 2011, and when all of the CBO projections and CMS's impact analyses were done, they started those assumptions at Day 1. And so, we have seen kind of a -- I will call it a six-month delay of the whole trend in dollars

going out the door.

MR. BUTLER: I always like the saying, "It took longer than we thought, but we knew that it would."

[Laughter.]

MR. BUTLER: Okay. So, that's it.

DR. BAICKER: Along with my second-favorite saying, "I like to get behind earlier, it gives me more time to catch up."

[Laughter.]

DR. BAICKER: So, along the lines of Glenn's initial motivation that part of the reason we are interested in the development of meaningful use is that we think it affects quality outcomes, I would imagine that it is too early to be able to measure any effect on quality, but part of that would be knowing who is actually adopting it, and can you isolate the cause of quality as this versus something else that is going on.

Are able to map the adopters to baseline quality, either measured at the hospital level through some of the existing measures or at the beneficiary level in terms of the incidents of contraindicated prescriptions or avoidable hospitalizations or the like and to see who is actually

adopting this? Are they doing other stuff? And provide a baseline for looking forward for the correlation between adoption and changes in quality.

MR. GAUMER: We have just now started getting some data on which hospitals and EPs specifically are getting paid, and the information that Matlin and John presented on the characteristics, the different specialties and the different types of hospitals, comes from our first wave of that information.

I imagine we will go back to the trough and ask for more information as it comes in. It looks like there is about a two- or three-month delay. So, that is something we could look at.

DR. HALL: It is along the lines of one of the great fathers of medicine, that was a guy named William Osler who was very popular around 1900 and he had a lot of aphorisms, and one of them about innovation. Innovation in those days was adding a new drug -- there were only three drugs that worked in medicine at the time. And he said to his young doctors, he said, "Always use a new drug when it is first introduced, before we understand the side effects." And that is something that has always made a great

impression on me because it remains true 150 years later.

What we are seeing, I think, with the introduction of the electronic medical record is that life is hard. I guess Buddha said that a long time ago, but it is hard for us to accept that. And I think that is a natural history of innovation.

So, we should not be too discouraged that there are some lags here or too quick to point figures, but along the lines that there are -- there do seem to be emerging some studies that are showing a very objective evidence of enhanced quality even now in systems that have been successful with implementation of electronic health records.

Are we keeping track of that? Are we keeping a running tally of those?

MR. RICHARDSON: Yes, we are keeping an eye on that research, and that was part of what I was alluding to when I touched on the Health Affairs paper that came out, because -- and the author has acknowledged that one of the limitations of that was what they looked at and tried to differentiate was changes in volume when the practice had access to test results or the images or lab test results electronically as opposed to not, and they fully admit that

that did not involve computerized provider order entry or any other kind of clinical decision support system, and what they found was that providers that had a system that had electronic access to the imaging and test results tended to order more imaging and tests.

And one of the rebuttals to that from the National Coordinator was that if they actually had some of the other functionalities that you have with an EHR to advise on the appropriateness on the various tests, that that would have changed the findings, and there have been some studies -- more of one, at least, that was done in Australia that did find that CPOE made a statistically significant difference in both the quality and the volume of services.

So, yes, we are keeping track of both sides of that discussion.

DR. CHERNEW: I have no quips. No, really, I just have a question about this slide.

So, when it says eligible professionals can get this amount of money, if you are in a medical group of five people, you are sharing the same basic system. You get five times it, is that --

MR. RICHARDSON: Correct. Yes, it is based on

individual condition.

DR. CHERNEW: And if you are a hospital that employs a bunch of physicians and puts this across their entire system, do you get this for all of the physicians that are using it?

MR. RICHARDSON: Well, except for the predominantly hospital-based physicians, there is a shimmy in the proposal, and so I tend to think of those as the RAPs, the radiologists, anesthesiologists, and pathologists. If they are primarily hospital based as employees, you cannot count them, but say you had a practice that is owned by the hospital, they could get the reimbursements.

DR. CHERNEW: And the requirements are things that you put up at least one X, you have done this at least one time, is that per physician or per physician that is using the system?

So, if you have four physicians using the same system and one physician never uses one electronic prescription or whatever it is, you just do not get the money for that physician, even the system could have been used by the other physicians a dozen times?

MR. RICHARDSON: Good question. I am not exactly

sure.

I think you could -- most of the performance measures are 65 percent of your patients. So, I suppose you could have a situation where somebody could count -- if the physician belongs with the practice you could count them multiple times, I am not sure.

DR. CHERNEW: Which just shows why the administration of these types of things would drive anybody crazy, but okay.

MR. HACKBARTH: Peter, did you want to...

MR. BUTLER: So, every individual physician has to individually attest, and one at a time. So, if you are in a group or a practice in the office, it is not sufficient to say this practice is a meaningful user. Every individual physician has to demonstrate that they are meaningful users.

MR. HACKBARTH: So just to make sure I understand your responses to Mike, so Mike is making an interesting point that I really hadn't focused on. So there are clearly economies of scale in the adoption of IT. What I hear you saying is that the subsidies in no way are adjusted to reflect those economies of scale?

MR. RICHARDSON: Essentially, yes.

MR. HACKBARTH: Okay. Scott? Cori?

MS. UCCELLO: I don't have a question, but I do have a Yogi Bear quote. It always gets late early here.

[Laughter.]

DR. BORMAN: Followed by, if you come to a fork in the road, take it? But just the question being, do we have any clear point in law where there is any criterion by which there's 100 percent expectation and penalty will follow for less than 100 percent?

MR. RICHARDSON: Do you mean in the performance criteria?

DR. BORMAN: Is there anything currently that will result in losing money if you don't do it 100 percent of the time or by 100 percent of providers?

MR. RICHARDSON: No. Most of the performance measures for the criteria are things like 65 percent.

DR. BORMAN: I suppose there's some 80s and 60s --

MR. RICHARDSON: These are the proposed. Yeah, some 80s and 65s, and then some of them -- well, at Stage 1, it's attesting, as Peter correctly said, without actually having to prove that you do it. You basically attest that my system can do certain things like exchange information.

The proposal also states, too, is that you actually use it once and you exchange information with another provider who's using a different system than you are. So there are a couple of other hoops there, but it's still pretty low in terms of functionality for that particular objective.

DR. BORMAN: And the reason for asking the question a little bit is that in the world of clinical practice and reality check, I think probably 100 percent of anything almost is going to be unrealistic, and particularly when you -- until we better understand what some of the trade-offs of EHR may, in fact, be, which I think we're just starting to really learn some of the side effects, if you will, and there are unexpected bonuses.

But perhaps also some things that we'll want to make that we understand before we reach that point in law. So I'm heartened to hear that we don't have that yet.

MR. GEORGE MILLER: Yes, please. A couple of quick comments. First of all, I believe critical access hospitals had to have meaningful use in 2012, not 2013. And my information suggests that only 40 critical access hospitals have met that criteria, which is only 3 percent.

And so, my comment with that as a background, my comment also raises the question, when do we come to that fork in the road, as Karen says, and when do we take it as far as -- if we see, in the example, hospitals are only 3 percent of meaningful use as we move forward, do we intervene -- not we, but should there be intervention? Should there be a policy to deal with that issue?

Another statistic I've read, only 12 to 14 percent of all the hospitals in America have met meaningful use, and again, are we going to come to a fork in the road that we need to deal with that issue from a policy standpoint at some point in time?

My small hospital, we've met meaningful use. I was, quite frankly, a little bit surprised that we had, but we did. And if compare us, we're an independent small hospital compared to very large hospitals that have economies of scale. We have a lot of up-front dollars and it's going to take us almost the entire four years to recoup our investment.

We made that investment because it was the right thing to do and we hope we will see the improvement in quality, as talked about. But as you compare the dollars,

we had to make that investment to get that meaningful use over time. We're front loading that investment. So again, I want to just raise the issue of, when do we intervene? When do we come to that fork in the road? Or will it be like deja vu all over again?

MR. GRADISON: I'm not sure I can improve on the effort as we have heard so far, and the one I have in mind is probably not relevant to the discussion, but it's, you never get poor by receiving. However, with regard to this program, my understanding is that basically it's a self-assessment, this attestation. I presume it has to be with so many -- money going to so many different entities.

MR. RICHARDSON: Yeah. It's an attestation process. The certain types of data, the way it's set up, the presumption is that certain types of the data, like the numerators and denominators for some of the measures could only be -- most efficiently would be supplied by using EHR, but at the end, it's the physician attesting that he or she is a meaningful user.

MR. GRADISON: I have a very specific question. How does this interact with HIPAA? My recollection, which isn't always accurate anymore, is that there's a provision

in HIPAA which would permit the patient to prevent the inclusion of certain medical records in the permanent records that are kept by the providers.

MR. RICHARDSON: Right.

MR. GRADISON: If somebody has an AIDS test, they may just not want that floating around.

MR. RICHARDSON: That's correct and I was just trying to see. There's language in the measures for some of the objectives in Stage 2 that makes reference to -- actually it says, subject to the eligible professional's discretion to withhold certain information. But presumably that would be in discussion with the patient.

MR. GRADISON: The patient.

MR. RICHARDSON: And it's specifically referring to some of the objectives that involve the patient's access to their own information as in more than 50 percent of the patients seen by the EP need to be provided timely access to their own information and those kinds of requirements.

But there is definitely some language intimating that there are -- it's not automatically all of the information. And there's some discretion about that. But that's certainly something we could look at.

MR. GRADISON: I'm particularly interested in how this looks from the point of view of the beneficiary and maybe you could take another look at it.

MR. RICHARDSON: Sure, sure.

MR. GRADISON: And get back at another time.

MR. RICHARDSON: I'll just really quickly say that this has been a major concern, the whole privacy issue of the policy committee and trying to balance -- you know, making the information flow more freely so that clinical quality can improve and become more efficient, against the privacy issues and very sensitive medical information, as we see with financial information which sometimes is compromised.

So I think that weighs very heavily on these discussions and trying to find the right balance between privacy, security, and making the information available as needed. Thank you.

DR. CASTELLANOS: Can you turn to Slide 13, please? You know, I don't know about you all, but I'm somewhat disappointed both by the participation both by the hospitals and the physicians, especially when we have the carrot and the stick approach. I noticed this picture that

you showed out in a handout where a good part of the United States, by the hospitals, really don't have much participation.

I know there are penalties, the stick. Is there any good answer why we're having such a slow start in this process?

MR. RICHARDSON: Somebody over here said that life is hard. I think that might be one answer. I mean, this is a complicated program and I think that there -- CMS has done a lot of communication about it, but I don't know the extent to which that's penetrated on top of all of the other issues that providers are dealing with.

The penalty phase doesn't start until 2015, and that might sound pretty far off. It's not, I don't think, but it may sound rather far off. And I think that if providers are making the decision to do something, as George said, that's going to cost them a lot of up-front money on the subsidy payments, may or may not, depending on the system you buy, cover your costs.

And so, you have to ask yourself, am I going to go through all of this trouble. It was interesting that we noticed when looking at the different kinds of specialties

that have adopted somewhat faster, cardiology, urology, and nephrology, just speculation not research, that those may be groups where if they're organized into a larger group and the costs are spread across more physicians, those would tend to be your earlier adopters of this technology, again because you have these huge up-front costs and you can spread it over more revenue coming in.

MR. GEORGE MILLER: If I could just weigh in and go into a recent rural conference, that is the issue. It is the up-front costs, particularly with critical access hospitals who, while they may get appropriate reimbursement, they just didn't have the funds for the up-front investment.

In our particular case, that was the issue. We started early, and so we believe we can spread it over a longer period of time. But that is the major issue. The physicians, what I'm hearing even in my community and around the country, is the cost, the up-front cost. Not a problem about the reimbursement, but the investment of cost up front.

So if you've got a larger group, you can spread that cost over time. And even looking at my small hospital compared to larger systems, they can spread that cost over a

larger number. If the average is 30 hospitals, I'm competing with someone with one hospital, they can spread their costs over 30 hospitals.

So I think that is part of the answer. But if you've got to do it, you've got to do it. The sooner the better and the longer you have to do it over time, then you lower your costs, from our perspective.

MR. GAUMER: The one thing I'll add, I guess, Ron, is that we also look at the registrants of the program to get a sense for who's coming and who's going to get paid and how many dollars are going to go out. You know, about 66 percent, that's a rough estimate, of hospitals are getting involved. We've got about 25 percent of physicians getting involved in the Medicare program. So we expect more money to be going out, it seems, anyway.

DR. CASTELLANOS: Thank you.

DR. DEAN: One of the frustrations that I've had for several years is the whole issue of interoperability, and I wonder if there's any movement or development or pressure to do that? I mean, you mentioned the requirement that we have to exchange information. And yet, I'm in a situation in a clinic that has one system dealing with two

hospital systems that have different systems. So we've got three different systems, none of which communicate with each other.

So in my mind, one of the major mistakes that was made a long time ago was not putting in some kind of requirements for communication protocols that would demand that the vendors produce that option. But it's going to be very difficult. I mean, I guess this is beyond the question. But it would be very difficult to meet those requirements when technically it's not there.

MR. RICHARDSON: Just really quickly, there is an HIT standards committee that is also contributing to this. I think it -- as if this weren't complex enough -- that's a very thorny issue to try and get the machines to talk to one another. And to be glib, it's because the type of information that's being exchanged between the different systems is very complex.

And so, especially if you've got notes or other kinds of so-called free text where you're trying to -- you almost have to change the way that the information is put into the system to get it back out in a consistent way, because the other thing is you don't want to have a

miscommunication between two providers about a drug or a condition or a treatment.

So the stakes are very high and the types of information being exchanged are very complex. So this is a difficult area. I know that the Department, at least, is working very hard on it, and part of the requirement to be a certified EHR technology -- I kept using that phrase -- over time will incorporate -- the certification process will incorporate being compliant with these standards. But it's going to take longer than some of the other parts of the program.

DR. DEAN: I think this may explain some of the reason for -- big integrated systems don't have this problem because they don't have to exchange information between different systems. Those of us that are out in isolated settings, it's an absolute requirement and there's nothing in the current structure, I see, that demands that they produce systems that are capable of doing the things that we need to do.

MS. BEHROOZI: Tom raised the issue that I was going to ask something about as a clarifying question, which was, is there anything in here that would require connection

to a health information exchange should it exist? But I'm kind of taking your answer as not really. It's sort of a more muted requirement to be able to exchange data with one other provider or something like that.

MR. RICHARDSON: That's right.

MS. BEHROOZI: Okay.

MR. BUTLER: Don't let that slip by, too. For Phase 1, yeah, you just have to demonstrate you've talked to one other -- by the time you get to Phase 3, there's all kinds of requirements to be able to relate to other organizations extensively and it requires that the patients do have access to your records directly. There are some fairly steep requirements by the time you get to Phase 3. Phase 1, you're right. You just have to attest and say yeah, you can talk to one other person.

MS. BEHROOZI: I just wanted to combine this with Round 2 and then I won't make a Round 2 comment, just that I haven't really been following this side of it too much, but in New York, there's a lot of work around health information exchanges, regional health information organizations and I don't know to what extent that's going on in the rest of the country.

But in terms of the third question for the future focus, rather than having every provider kind of figure out how they're going to connect with every other provider, the ability to support, whether financially or payment policy or in terms of other policies, the development of external infrastructures into which the isolated providers, the onsies, twosies in inner cities, whatever, can connect, just seems like the really -- the next qualitative leap. I'm done.

MR. KUHN: I'm interested a little bit in the notion of patient activation, and in that regard, thank you for including that comparison or that side-by-side in the final Stage 1 and the proposed Stage 2 criteria. So one of the criteria here of Stage 2 measures is that more than 10 percent of all unique patients who are discharged view, download, or transmit to a third party their information.

A 10 percent threshold. I'm just curious. Do the community at large think that's an achievable goal? I mean, where's kind of the general thinking of that? Is that too low? Is that too high? What's the expectation of patient? Because we've been talking about providers just sharing information with one another. What's the expectation on the

patient side?

MR. RICHARDSON: I've heard some discussion on one of the CMS-sponsored calls where they've described a proposal, and most of the respondents on this one call seemed to be providers and there was some question about this because they weren't sure how -- whether 10 percent was too high because they weren't sure how they would get their patients, I should say, or encourage them to do this if they didn't want to or didn't have access to the Internet or, you know, in situations like that.

So most of the questions seemed to support the idea, but they weren't sure how to actually do it, and there being some locus of control, you know, and this is the patients having to do something and then the provider being held responsible for it. I think that the CMS response was that as part of your interaction with your patients, you should be encouraging them to do this, and that was where the requirement came from. But whether 10 percent is the right amount or not didn't seem to enter into it as much as should it be more than zero.

DR. BERENSON: I'll just contribute two cents to that discussion about who is or who isn't sort of -- the

question that Ron brought up. And I think I agree with those -- including George -- who said it's the ability to have the capital up front to make the investment even though it's going to be worthwhile in the long run.

The other point about why it's worthwhile in the long run is having an EHR supports a higher level of coding, and at least the studies I've seen and some reasonable speculation, I think, is that that amount of higher coding actually is more money than the meaningful use incentives.

So if you are able to do it and are willing to go through what's a painful transition process, it pays for itself. So in addition to being larger, I think the cardiologist, urologists, and nephrologists and perhaps some others are in a better financial position to be able to have that capital investment in the first place.

I mean, if you can do it, even a small practice is going to benefit financially from it under the current rules of coding the documentation, I think.

MR. HACKBARTH: This conversation sent me to wondering whether in an unexpected way, or at least unexpected for me, this could not -- may not contribute to accelerated consolidation within the health care world. My

first take on this would be, well, by providing subsidies for individual practices and making it more feasible, all other things being equal, that may be a reason not to join a hospital-based practice or a big group to get access to information technology. It makes it more feasible to afford it while practicing in a small group.

On the other hand, given Mike's observation about these being fixed payments, if a hospital takes over a practice, their cost of adding people to their system are going to be substantially below the payments that the individual will bring with them.

And then as -- to pick up on Ron's observation, there are the penalties out there. As the penalties get closer, maybe the combination of the dollars that the physician can bring with them in meaningful use payments, coupled with the threat to the physician of, oh, penalties are now just a year away, that we could see this whole set of incentives work to give a real boost to consolidation. Whether you think that's a good thing or a bad thing, I just wonder whether the dynamics may not be pretty powerful.

I would like to give people another opportunity to make comments, but rather than just go one by one, let me

see hands of people who have something else that they want to add to this conversation. Okay. So we've got five, six. So we'll just go to those people beginning with Peter.

MR. BUTLER: Two quick follow-ups to comments made. Glenn, yours, yes, I think it is a further consolidation, further employment. Our own experience in rolling out to over 400 employed physicians as well as some private is that smaller offices, even within the group practice, are more expensive and harder to do than the bigger groups. But there are other economies beyond IT that also make those small groups more expensive. So it's not just the IT component that is part of the consolidation that is occurring.

With respect to the cost issue, the front-end cost that George highlighted, I think the AHA survey, the one I've seen, also says just being able to meet the meaningful use criteria in the time frame needed to get the payment right out of the gate is equally a challenge. And part of it was you have until like October of this year before you start not getting the maximum amount of payments. So some people are just waiting for the meter to get rolling and said, "I want to make sure I can hit the meaningful use

coming out of the gate." So it's not that they're not working on it. They have haven't attested yet.

Now, one could say, What is MedPAC's role in this? And that's what we're trying to define. And you could say if you're going to hand out whether it's $34 or $19 billion and we're thinking about Medicare money, if that ought to be smaller or bigger or directed differently to achieve, you know, the goals of the Medicare program, then I think we have a roll. And I'm not positive we do, but that's how I think I would look at it. That's how I look at it.

I would say, interestingly, in our own institution we have a graduate student who has looked already at kind of the meaningful use adapters and correlated that with performance of those same institutions on the value-based purchasing Medicare measures. So you'd think if you're incentivizing investment over here and these are the metrics you're using to -- you know, from a policy, you ought to be able to begin to -- is it making a difference, at least in the system. So to the extent we understand that better and then can find, you know, provide further guidance I think would be useful.

I think one more immediate thing that I'd like to

see as we look at efficient providers, for example, next year and we line up that column and say, okay, if you're financially stressed, whatever, we can -- those efficient providers also -- are they adapting IT or not? It would be interesting to see whether or not, you know, that is contributing to efficiency and measures are not.

So I think at a minimum, just having the relationship between those that are putting it in and those that aren't and how it's impacting the system could provide us guidance.

The last point I'd make is that all of this money -- it does address beyond just having an electronic record. It does address the interoperability. What it does not do is provide dollars for decision support or data repositories or data warehouses, which are really the heart of managing in an ACO capitated world. And so it kind of ignores some of the real tools that ultimately you need to kind of make a difference. And so you could argue and say, well, at least take some of the money and maybe pay for some of that instead of just having a record in the office. I'm making stuff up here, but I think if we truly want to have the competencies required to go where the system is headed, I

don't think these dollars are quite aligned with how they might be better used if we're going to spend all of that money.

MR. ARMSTRONG: Just a couple of comments.

First, I should disclose I do work for an organization that received the Stage 1 payments for this, and we have a strange model, but I think a couple comments about how we as MedPAC think about what we've learned here for future policy questions. Peter, I thought it was a great point, so what's the value in this kind of investment through the overall Medicare program as a point of view on this.

I would just say my point of view is that this kind of investment in system-ness is good in many different respects, and I think that this meaningful use application -- it's not just did you buy the companies, but are you using them in ways that are meaningful is kind of an interesting approach that we should think about its application to other potential, narrowly focused but overall high-leveraged investments that we might want health care systems to be making. This does improve the quality of our clinical decisionmaking. This does reduce overall expense trends.

In our practices now, 25 percent of our patient-physician encounters are done electronically, for example, and we know that that's not just convenient, but it's a lower-cost method.

MR. HACKBARTH: Do you use Epic?

MR. ARMSTRONG: We do.

One question for consideration is this is built around a very physician-centric kind of unit of service, and, in fact, we know and we talk here all the time about the value of integration and system-ness goes way beyond physician providers. And, you know, how can meaningful use of information technology extend to home health workers or extend to nurse practitioners and others who practice and care for Medicare beneficiaries in all sorts of settings? I think that's, you know, an interesting and important question for us to be asking.

Also, these Stage 2 and Stage 3 requirements are going to intersect with ICD-10 requirements or intersect with all sorts of other high demand on your information technology kind of changes. And I think we ought to just be thinking about where there is that potential intersection and ask how can we be paying attention overall to how this

affects the care system.

I think I'll leave it at that and stop there.

DR. BORMAN: I think there's some wonderful things that can happen as a result of good data sharing, and I, too, share Tom's concerns about interoperability and think that needs to continue to be monitored and will be a key thing to really getting people to use this in the maximum possible way to advance care.

I think that the requirements regarding patient accessibility of records and downloading, I think it sounds great. I hope it's driven by some background information that there are a body of patients who, in fact, will do this because it does present some additional requirements, I think, particularly to the eligible physicians and other health care professionals that are maybe a little more difficult for them to absorb than perhaps a health system or hospital entity. So, for example, the kind of privacy and security things that may need to be in a system to allow patients to do that, because you don't know what kind of computer each of your patients has out there, and if you think interoperability is an issue just in transferring to facilities, transferring to patients who have everything

from build-their-own to, you know, some high-end thing is going to be a huge issue. So I have some concerns about that particular chunk of this process.

In terms of thinking this through about -- you know, we talk in a lot of spheres of our work about unintended consequences. I think we have to be just at least attuned to where a couple of those appear to be emerging in the EHR world. And, again, in general, there's lots of things about EHR of which I'm a fan, but there are, I think, some things that we at least need to monitor and think about ways that we can put brakes or other -- not to create end-arounds, but to do things that perhaps mitigate those effects. And certainly I think one of those is -- and I hear it from patients a fair amount increasingly -- "My doctor spends all the time at the computer during the visit with me." You know, and I think that's -- I hear it just more and more, and I think that for efficiency for the doctor, advanced nurse practice, or whoever, that's exactly right. You want to do it in the same scheme of things. Is that the kind of visit dynamic that, in fact, we wish to foster? And if it's not, then how do we account for that time?

At the end of the day, there's still 24 hours in the day. At the end of the day, you know, we have people that are increasingly -- practitioners at all levels that are increasingly asking about work-lifestyle balance, and so how is that going to interact with it? And yet we have a burgeoning population of complex patients to manage who will require more clinical time. So I think that piece of, you know -- for example, how does that link across the patient satisfaction? Are there some ways that we can start to tap into that particular complaint, or concern at least, as a way that we look at patient satisfaction.

Another is that we've enabled the transfer of work that is not at the top of that practitioner's license to that practice, and so said another way, in my world, non-physician or to physician. So that while there's lots of potential safety implications to computerized patient order entry, it now shifts work to doctors that they did more quickly certainly in an environment of creating an order set that is unique to the patient and me but is exactly what I want that a clerk now deals with, that used to deal with, and yes, with all the handwriting interpretation and whatever quality and safety concerns. But now, no matter

how many specialized order sets I have, I've got to modify each one for each patient, and that takes me through pick menus and, again, slows me down.

So I think that we have to be just very careful about what kinds of work we transfer to whom and how we enable that to be the least painful if not, in fact, a positive.

And then another one that Bob alluded to, you know, there's gains in documentation and thereby coding and potentially revenue. One of the things that I think is very frustrating is that, whereas we'd like to all hope the record becomes more cogent and more useful, there's that little carry-forward function where I can take big chunks of everything I said yesterday and with great ease transfer them to today and ramp up my visit for each day to be a very high level visit, and Grandma still died of breast cancer, you know, no matter how many times I say it.

So I think there is a risk particularly in certain kinds of activities for there to be a ramp-up that's just a function of better coding and better capture, but that, in fact, is almost counterproductive to the patient care. How we get the medical record back to saying what needs to be

said for optimal patient care, you know, it may be a train that's left the station and we'll never get there. But I'm afraid that there are some elements here that will allow us to go further down the incorrect fork in the road on this particular piece.

So I would just say as MedPAC looks at, you know, what is good for the system and what we want in terms of quality outcomes, let's be careful that we don't disable some things to happen by virtue of enthusiasm for a technology that has so much potential to drive toward places we'd like to be.

MR. GEORGE MILLER: Yes, as we go through this process, you know, looking at the goal for Stage 3, I think one of the things I've heard discussed -- and I think it was Tom -- is the issue about interoperability, and I don't know from a policy standpoint if it's too late not to address the interoperability issue. And Karen just mentioned it also from the standpoint as we push information out to patients, the difficulties: Would they have the system to get that information?

But particularly going back to Tom's point about three different systems and they don't talk to each other

and the frustration that that creates, from a policy standpoint it seems to me that the federal government could put in place at least partial interoperability so that there's a standard. I liken that to in my pocket and in every one of your pockets we all have a cash flow card, although we all come from different points in the country, we can go to that ATM, no matter where your bank is, and get money out today and right now. And it would seem to me that that ought to be the same standard we should have for the medical records. No matter where we are in the country, who we talk to, we ought to be able to get that same information -- notwithstanding some of the complications of getting some of those things, like a physician -- how we put data in, as we discussed earlier, or that even within the same hospital there's different methodology of documenting the same information.

But even with that said, we still should try to have some mechanism where it is required that at least at some threshold there's interoperability so that that system -- so Tom's not frustrated, that no matter which system where he is could be able to transmit that information.

And the second part that Karen said so eloquently,

as a CEO the number one complaint I get from patients is that physician or whoever comes in my room spends more time on the computer than they do dealing with me. Now, I understand why. We certainly have to apologize and try to explain that, but it's an emerging issue that we certainly will have to address as more data is required and more information, we've got to certainly deal with that issue. And my scores reflect that also, that the patients are saying that the physician, the caregiver, spends more time on a computer. So your point is very well taken, and somehow in this we need to address that issue at some point in time.

DR. CASTELLANOS: What we're seeing here is just a significant learning curve, and we see that in everything, and I hope 10 to 15 years from now we'll look back and say, geez, it was really worth it. And it is going to be worth it. It is a learning curve. It's hard to go through this. Technology is changing, and, you know, we're just really catching up with the rest of the economy. A lot of the things that we're trying to do the economy has already done.

The second point I wanted to bring up is the subsidy. It looks like a lot of money, but really it

doesn't cover the costs, and I can tell you because I've gone through this process. It does not cover the basic costs. Yes, there are a lot of up-front costs, and I think that's the biggest hurdle why physicians are not going in, and the hospitals.

And, Bob, you're right, there are some advantages to the upcoding. Is it upcoding or is it appropriate coding? I don't know. I mean, that's an argument we're going to have for a long, long, long time.

The real question I have -- and, Glenn, you brought it up and, Peter, you commented on it. I want to preserve the private practice of medicine, and by that I mean I think there is a role for the private practice of medicine, outside of a clinic, outside of a hospital, perhaps in a small town where you only have one or two doctors and you're not part of a large group.

We talked a little bit on Slide 10 about hardship exemptions, and, you know, that's going to exist until 2020, 2025. Well, what's going to happen -- I know there's probably no discussion on it, and there was nothing in the paper. The physician that's in training now who's already up -- will be up on this curve of learning, when he or she

goes back into practice, is she going to have or is he going to have these subsidies available to him? Is it going to force him to go into a hospital setting? Is it going to force him to be an employed physician? Because that's what's happening in today's market, in my community. People are going into the hospital or an employed market because of the hassle factor, and it's a hassle going through this learning curve. And it's a cost.

So, you know, I would like to make sure that as we go down this path that we do not exclude people going into the private practice of medicine.

DR. DEAN: I guess I would, first of all, just like to second everything that Karen said because I think she said it very well, and it is frustrating from a number of issues. You know, I wholeheartedly believe that this is the direction we need to go, and it just occurs to me that, as I think I've said in other meetings, people have been saying that telemedicine and telehealth was the answer to rural health problems for probably 20 years, and we are just now getting to the point where that is really taking place and really available and really beginning to work.

I suspect that this is a similar bit of evolution

although -- and I think it's probably, as opposed to systems like Scott's where they were obviously progressive, it's a big system with the sort of resources to apply this, and obviously the leadership to do it. For the small systems, whether they be in the middle of New York City or where I'm at, I think it is a tougher challenge.

And so I guess I would just say that we have a lot of things that are big challenges. As we're doing it, there are some things that are better although there are some things that are clearly worse. We're doing some things more poorly than we did with a paper chart.

Now, I hope we can move beyond that, but we're not there yet. And so, you know, without getting into a lot of detail, it's a real challenge. But, you know, we need to keep moving forward. Bill and I were talking about one of the things that I think gets lost in this, those of us that really believe that we need to be able to acknowledge and record and recognize patient uniqueness, patient idiosyncrasies, patient stories, that gets lost in these systems. We record little bits of mechanical bits of data, and a lot of patient uniqueness gets lost, which I think is unfortunate. It sort of relates to some of the issues that

the doctor spends -- or it's a little different than the doctor spends all the time with the computer, but there is a downside, and it's frustrating, but I'll stop.

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

We'll now have our public comment period before breaking for lunch.

[Pause.]

MR. HACKBARTH: Please begin by identifying yourself and your organization. When the red light comes back on, that signifies the end of your two minutes.

MS. KIM: Hi. I'm Joanna Kim from the American Hospital Association.

We're very concerned about the requirements set out in the Stage 2 proposed rule that was recently released by CMS. Right now, only about $1.3 billion have been paid out through Medicare and Medicaid for the EHR incentive program, and that's through the end of January. But CBO had estimated that about $6 billion would be paid out by that time. And almost half of that, $3.1 billion, was for Medicaid for which you don't actually have to be a meaningful user to get your first year of payment.

So I think the money is slow to come because the Stage 1 requirements were set entirely too high from the get go. And now we've seen more overly aggressive requirements set forth in the Stage 2 proposed rule.

For example, the patient portal and summary of care record objectives actually make provider success contingent upon the action of others, such as patients, and that's just not appropriate. In addition, the patient portal requirement is very expensive. It's difficult to implement. It has uncertain benefits and poses major data security concerns if it's deployed by all providers. And taken all together, that raises very serious HIPPA concerns.

All the objectives taken together represent an extremely large increase in the meaningful use requirements, and in a world where payments are less than expected and only about three percent of the very smallest hospitals, Critical Access Hospitals have been able to successfully attest, we think that CMS's proposals are overly aggressive.

Further, CMS is accelerating the time frame for HIT penalties beyond what is set out in the law. Specifically, it's proposing to begin penalties in 2015, as required, but to base your 2015 penalty on your 2013

performance. So this essentially takes away two of the years that Congress intended to give providers to meet the meaningful use requirements because hospitals would now have to meet them by 2013 instead of by 2015 to avoid the penalties.

In addition, it allows for the possibility that you could receive both an incentive and a penalty in the same year, which is quite odd. Congress clearly intended to provide a carrot followed by a stick, and CMS's penalty proposals for that reason are inappropriate, as well.

Finally, just as a point of clarification to one of the slides in the presentation, Critical Access Hospitals actually need to achieve meaningful use in 2012, not in 2013, as is the case for PPS hospitals, in order to get their maximum incentive payments.

Thanks.

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

[Whereupon, at 12:43 a.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day.]

AFTERNOON SESSION [1:44 p.m.]

MR. HACKBARTH: Okay. It is time for us to begin the afternoon session.

First up this afternoon is reforming Medicare's benefit package, a topic that we have spent a considerable amount of time on and we will have a vote on a formal recommendation at the end.

Julie.

DR. LEE: Good afternoon.

The Commission has been considering ways to reform the traditional Medicare benefit for several years.

For the past several meetings, you have discussed various aspects of the benefit design and in the last meeting the draft chapter recommendation.

Today, we will conclude our discussion on the topic with a vote and a draft recommendation, and you have a draft chapter for the June report.

Today's presentation has four parts: First, we begin with the policy goals, then we view and summarize the key design issues in changing the fee-for-service benefit and go over the budgetary and distributional analysis of an illustrative benefit package. Finally, we conclude with a

draft recommendation.

The commission had two main goals in reforming the traditional Medicare benefit to give beneficiaries the better protection against the high out-of-pocket spending and to create incentives for beneficiaries to make informed decisions about their use of care.

The Commission has been also particularly concerned about the potential impact of such changes on low-income beneficiaries and those in poor health.

Based on your discussions and at your request, we reorganized the draft chapter around the design issues, focusing on the pros and cons of each principle. Your discussions and potential changes in the fee-for-service benefit to have focus on three key design elements: First, an out-of-pocket maximum to protect beneficiaries from the financial risk of very high Medicare costs; second, deductibles for Part A and Part B services, you discussed the combined deductible in the past meetings, but some of you raised the concerns and expressed the interest in keeping separate deductibles for Part A and Part B. You have decided not to take a definitive decision on the combined deductible.

Third, copayments rather than co-insurance that are easier to understand and more predictable for beneficiaries. Definitive copayments can be used more effectively in creating incentives for beneficiaries, and their predictability could help with the beneficiaries' need to budget their expenses and to buy supplemental coverage.

There are many different ways to combine these elements within the basic structure. Your discussions emphasized the importance of allowing for flexibility in design, especially over time.

We tried to capture your thoughts on the secretarial authority to adjust and refine cost-sharing based on the evidence of the value of services, including, for example, eliminating cost-sharing onto preventive services and imposing cost-sharing on low-value services above the out-of-pocket maximum.

The Commission has discussed the overall cost of the benefit design with respect to the beneficiary and the Medicare Program. You have decided to hold the average cost-sharing liability of the beneficiary about the same as under current law. The idea was not to shift the cost of improving the benefit package to the beneficiary.

And finally, there were two approaches that you considered in mitigating the effects of first-dollar coverage, the regulatory approach restricting the supplemental benefit, versus an additional charge on supplemental insurance. You expressed a strong preference for imposing an additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare of having such comprehensive coverage.

You raised many important design issues in your discussions. They have been incorporated and addressed in the draft chapter, but we want to highlight some here before we turn to the illustrative benefit package.

In the previous meeting, Mitra was especially concerned about the level of the deductible. In general, a deductible is used to reduce the cost of other aspects of the benefit package, such as premiums, copayments, and co-insurance. Therefore, a lower deductible would mean higher premiums or cost-sharing because the money has to come from somewhere.

There are different ways of financing a lower deductible, but ultimately the costs will be paid for by someone; the question is who.

One thing we would like to clarify here that came up in the last meeting, under the deductible, the beneficiary cost-sharing equals the allowed charge for the service, not just the copayment.

That means the $500 deductible in the illustrative package, for example, would be equal to about six primary care office visits using 2009 data.

Over the past meetings, Kate has pointed out the importance of the value of insurance provided by the out-of-pocket maximum. In general, an out-of-pocket maximum would be valuable to the beneficiary in two ways: First, it would protect those who actually reach catastrophic levels of Medicare costs.

Second, even though the beneficiaries who do not reach the maximum level still would lower the risk of paying for very high cost-sharing liability and for risk-averse beneficiaries, the lower risk and uncertainty would be valuable.

And we want to point out here that although a small group of beneficiaries would reach the out-of-pocket cap in any given year, many more would benefit from this protection over time.

We saw that a much higher percentage of beneficiaries have a hospitalization and catastrophic levels of spending over four years compared to one year.

For example, in 2009, 19 percent of full-year fee-for-service beneficiaries had at least one hospitalization, whereas 46 percent did from 2006 to 2009.

Given the extra protection that an out-of-pocket maximum would provide, beneficiaries' assessment of how much additional insurance protection they want would also change.

Consequently, our previous assumption of no change in beneficiaries' take-up of supplemental insurance might not be realistic, especially over time.

Our findings from focus groups suggest that future beneficiaries are used to the benefit design that consists of deductibles and copayments and might not get supplemental coverage if there is an out-of-pocket maximum in the Medicare benefit.

Moreover, they made explicit tradeoffs between paying for Medigap premiums and saving that amount for paying copayments.

Recent data on Medigap Plan N also suggests that beneficiaries are comfortable with maintaining some cost

sharing compared to first-dollar coverage. We will come back to this issue in our analysis of the illustrative package.

Over the past several meetings, Cori raised additional issues, including using higher Part B premiums to finance the out-of-pocket maximum, using the true out-of-pocket approach in calculating the maximum, implications of a combined deductible for Part A and Part B participation and trust funds, and applying the additional charge on supplemental insurance to those offering first-dollar coverage only.

We try to incorporate all these changes in the draft chapter and we look forward to your feedback on those changes.

And finally, Cori, we want to make it clear that we like actuaries and much appreciate their expertise in our analysis.

[Laughter.]

MS. UCCELLO: I feel like it is my birthday.

[Laughter.]

DR. LEE: Here is the illustrative benefit package we used to analyze the tradeoffs between design elements.

We want to emphasize that this is only an illustrative package and there is nothing sacred about the specific levels.

Our approach for creating this package was simple: Given the $5,000 out-of-pocket maximum and a set of copayments that are comparable to those that we see in private plans, we sought for a deductible that would keep the overall budget constraint of keeping beneficiaries' cost-sharing liability equal to current law.

In this particular example, we used a combined deductible of $500 for illustration only. The Commission has not taken a position on combined or separate deductibles.

So, let's turn to the distributional effect of the illustrative package. This chart you have seen many times before. It shows the results of simulating changes in out-of-pocket spending if the illustrative package had been in place.

This shows the effects of the illustrative package without the additional charge and supplemental insurance, assuming that beneficiaries keep their current supplemental coverage.

At the top of the bar, a little over 20 percent of beneficiaries had their out-of-pocket spending go up by $250 or more. Those are the two top segments of the bar. Mostly, these are the beneficiaries who are spending more out-of-pocket due to the deductible, but because of the assumption that beneficiaries keep their current supplemental coverage that wraps around the illustrative benefit, for 70 percent of beneficiaries, their out-of-pocket spending remained unchanged.

In this chart, we look at changes in out-of-pocket spending, supplemental premiums, and additional charge on supplemental insurance for 2009, if the illustrative package had been in place.

There are four stacked bars on this slide, each corresponds to a different assumption, and the percent of beneficiaries with Medigap and employer-sponsored retiree plans keeping their current supplemental coverage.

As we discussed a few slides ago, it is unlikely that some beneficiaries are going to either not get supplementary insurance or drop their current supplemental coverage in response to changes in the fee-for-service benefit. Their decisions would depend on their risk-

averseness, health status, income, and other characteristics, but because we do not know exactly how they would decide, we modeled their decision as random.

This assumption is not as realistic as we would like but a little more realistic than assuming no change at all.

So, let us start with the first stacked bar on the left, which is what we presented in the last meeting: If a current beneficiary with Medigap and employer-sponsored retiree plans keep their supplemental coverage.

We saw that at 20 percent additional charge on their supplementary insurance would mean that 70 percent of beneficiaries had their out of pocket spending go up by $250 or more, whereas about 30 percent of beneficiaries had little change in their out-of-pocket cost or a decrease of 250 or more.

Now, let's look at the third bar on the right that corresponds to the assumption that half of current beneficiaries with supplementary insurance would keep their coverage.

As we can see the distribution shifts noticeably, consultant the savings on supplemental premiums would

decrease beneficiaries' total out-of-pocket costs.

49 percent of beneficiaries would experience an increase of $250 or more, compared to 70 percent in the first bar, where everyone had kept their supplemental coverage.

And little over 50 percent of beneficiaries would have little change in their total out-of-pocket cost or a decrease of $250 or more.

This slide summarizes the relative change in annual Medicare Program spending under the illustrative benefit package, combined with a 20 percent additional charge and supplementary insurance.

Before we look at the numbers, we want to repeat that this is only a one-year snapshot of relative changes and it is not a score which will take into account additional factors.

The table also lists our modeling assumptions which are also discussed in your draft chapter.

So, looking at the first row, if we assume that beneficiaries who currently have supplementary insurance keep their coverage, program spending would increase by about 1 percent, and the 20 percent additional charge would

raise revenues by about 1.5 percent, resulting in a net change in direct spending of about .5 percent in savings.

On the other hand, if some beneficiaries drop their supplemental coverage, program spending would decrease and revenues would also decrease.

For example, if half of the beneficiaries kept their supplemental coverage, that is the third row in the table, then spending -- program spending would decrease by about 1.5 percent with about .5 percent in revenues, resulting in net savings of about 2 percent.

Here is the draft recommendation: It reads, "The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include: an out-of-pocket maximum; deductibles for Part A and Part B services; replacing co-insurance with copayments that may vary by type of service and provider; secretarial authority to alter or eliminate cost-sharing based on the evidence of the value of services; including cost-sharing after the beneficiary has reached the out-of-pocket maximum; no change in beneficiaries' aggregate cost-sharing liability and additional charge on supplemental insurance."

The draft recommendation may have the following effects: For the Medicare Program, spending would depend on the levels of cost-sharing and an additional charge on supplemental insurance, specified in the ultimate benefit design. Under the new benefit and additional charge, the change in beneficiaries' total out-of-pocket cost would depend on whether they keep their supplemental coverage, but an out-of-pocket maximum would protect them against the very high spending and also reduce the risk and uncertainty of potentially very high spending.

If the individual's cost-sharing were to go up, he or she is likely to reduce both the effective and ineffective care, and some beneficiaries may experience worse health because of it.

Finally, those beneficiaries with supplementary insurance would pay the additional charge if they decide to keep their coverage.

For Medigap plans, the additional charge would increase their premiums, and some beneficiaries might drop their Medigap or move to Medicare Advantage in response to the Medicare benefit change and higher Medigap premiums.

The effects on employers offering retiree benefits

are quite uncertain and will depend on various factors.

That concludes our presentation, and we look forward to your discussion.

MR. HACKBARTH: Thank you, Julie. Well done, not just this presentation but throughout this effort.

At the risk of being repetitive, I want to go back over some of the points that Julie just made to highlight them, and obviously I'm going to choose things that strike me as particularly important in this.

Let me begin by asking you, Julie, to put up Slide 8. I just want to emphasize again for people in the audience that this is an illustrative benefit package, not the benefit package being recommended by the Commission, and I'll go into that in a little bit more detail in just a minute, but please flag that.

Then also put up Slide 10, and what we're trying to do here is present a sensitivity analysis of how things would look under different assumptions as opposed to making a particular prediction about how this will unfold. As Julie has discussed both today and previously, predicting how beneficiaries will respond to, say, a charge on supplemental insurance is challenging, and that's not really

the business that we're in. And so what we've tried to do is illustrate what the impacts might be in different scenarios, and likewise with Slide 11, if you'd put that up. So I just wanted to highlight those elements of the presentation.

As for the underlying themes or principles in the recommendation itself, I want to highlight a few things.

First is that we are recommending that the Congress grant the Secretary the discretion to establish a new Medicare benefit package and change that package over time within boundaries created by the Congress. One of those boundaries and a very important boundary from our perspective is that in the aggregate expected beneficiary out-of-pocket costs should not increase, and we've referred to that idea as a beneficiary-neutral redesign of the Medicare benefit package. So that's sort of establishes a floor for the Medicare benefit package.

My own thinking about that, as I've said in previous discussions, is that, if anything, I think that the existing Medicare benefit package is too lean, not too rich, particularly given the population that's covered by the program. We recognize, however, that there are fiscal

constraints, and so what we've opted for here is to say that the actuarial value, Cori, if I can use that term, of the benefit package should not be reduced relative to current law. It ought to be restructured, made more rational, made more understandable, and in important ways made more flexible, but it ought not be reduced in value.

An important part of the discretion or important reason for wanting to give the Secretary discretion in this is that we would like to see over time the principles of value-based insurance brought into the Medicare program, and that's not a one-time event but an ongoing process and one that entails modification in Medicare coverage as more information becomes known about the value of particular services.

We would emphasize that under the concept of value-based insurance we would envision both reductions or even elimination of cost sharing for certain services based on evidence that they are very high value services and very important for Medicare beneficiaries to receive. An illustration of that is the treatment of some services under the existing Medicare benefit package where cost sharing is reduced or eliminated. The Secretary would not be limited

to those services, could do those services and additional ones where evidence warrants.

By the same token, we believe the Secretary should have the discretion to be able to impose higher cost sharing on some services that are considered to be of low or undocumented value for Medicare beneficiaries. And we would see these ideas potentially operating at both ends of the cost continuum, if you will, so that the Secretary could conceivably exempt some high-value services from cost sharing, even exempt them from the initial deductible if one exists, but also impose cost sharing on services of low value or undocumented value even after a catastrophic limit is hit, so that would operate at both ends of the cost continuum.

Finally, I want to highlight the thinking behind the charge on supplemental insurance. Going back to the beginning of this process, we considered whether there should be regulatory limits on the type of supplemental insurance that people can buy, and we decided not to do that, to respect the beneficiaries' choices and decisions about the sort of private insurance they wish to buy. However, there needs to be a recognition that those private

decisions have implications for the Medicare program and for the taxpayers.

Right now the way the system works, a beneficiary makes a private decision to buy supplemental coverage. The premium paid by the beneficiary only reflects a small portion of the cost of that decision. The vast majority of the cost of the beneficiary's decision to buy supplemental coverage is, in fact, borne by the Medicare program and the taxpayers who finance it. And we think that at least there should be a supplemental charge -- a charge on supplemental insurance, that is, that reflects at least a portion of that additional cost incurred by Medicare as a result of the private decision to buy more insurance. We have not specified exactly what the level of that supplemental charge should be. We've used the illustration of a 20 percent charge. I think, Julie, we said at the last public meeting that if you were to fully offset the added cost from supplemental coverage, we would be talking about a much larger percentage than 20 percent, perhaps 70 percent or something, in that order of magnitude. So the illustration that we've used is only a fraction of the cost, additional cost incurred by Medicare.

I do believe that the combination of the beneficiary-neutral redesign, which actually increases Medicare projected expenditures modestly, the combination of that coupled with the charge on supplemental insurance should result in at least a modest net savings for the Medicare program.

Now, we fully recognize that there are a lot of other ideas under discussion in the Congress and in the various policy fora about ways that Medicare beneficiaries might contribute to meeting the fiscal challenges of the Medicare program. People talk about increases in the Part B premium or income-related, even more steeply income-related premiums, delaying age of eligibility, premium support. There are a lot of different ideas out on the table. We're not saying that the supplemental insurance charge should be the only mechanism used by the Congress, but we think that it should be part of the mix, again, in recognition of the implications for the Medicare program when people buy supplemental coverage.

So those are the points that I wanted to highlight. Given how many times we've discussed this issue, I don't think we need to go through two rounds of questions

and comments, and so we'll have just one instead, and then proceed to a vote. Bob, do you want to lead?

DR. BERENSON: I think we are closing in on it, and I also want to thank you for all the terrific work over many sessions. I'd like to go to Slide 10 and just clarify. There it is.

I'd just note that going from all patients keep their supplemental to none, it moves in what I'd consider the right direction except for that top box where we go from 2 percent to 8 percent of people who have now higher than $1,000. And I'm assuming that's because although there's now an out-of-pocket cap for all those services up to there, they don't have any supplemental, and so I guess my question would be, in doing this, you've assumed that people keep the same Medigap policy they currently have, no shift into a different kind of a Medigap policy?

DR. LEE: That's correct. That decision was whether to keep the same coverage they have or not have it. Those were the binary decisions.

DR. BERENSON: Okay. So there could be an analysis that, let's say, people move to N, which people are beginning to pick in the market today, which has a co-

payment for doctor services and ER services, but have coverage for hospice co-pays and a number of SNF co-pays, et cetera. If people made that kind of a move, then it could well be that we wouldn't see -- we'd have some protection on the high side for -- I mean, some people would not be as bad off as this slide would show, right?

DR. LEE: That is correct.

DR. BERENSON: Is that an analysis that you could do? Would that be helpful? Forget it. I didn't go there.

[Laughter.]

DR. MARK MILLER: It is an analysis that we cannot do. I'm pretty sure, right? And it --

DR. BERENSON: I dropped it.

DR. MARK MILLER: But you make a very good policy point that I don't want to lose in this because you do -- you know, there's the technical point, and we've had to go at this simply. But remember how people can change their behaviors. We're doing very binary -- keep it/drop it. They could scale down in order to take --

DR. BERENSON: Yeah, I don't need quantitative precision. I think we might want to just point out that this analysis assumed a yes or no on their current Medigap

plan. I assume that Plan N makes a lot more sense for a lot of individuals, and maybe there would be more of a move there. And so that this is illustrative, but under other assumptions it would come out somewhat different in terms of people's choice of supplemental plans. That's all. Thanks.

MR. BUTLER: So Glenn cited the 20 percent is illustrative, even kind of like our offset list on SGR is suggestive but not a recommendation. But this is even probably less so. It's just a place holder. But you said it doesn't capture the full cost. That could be as high as 70 percent, but we really don't -- we really can't estimate that correctly. But you do have in the chapter -- and I want to make sure I understand this for messaging purposes. You cite that the -- under the 20 percent you cite the premiums for Medigap being $2,100 and employer-based being $1,000 on argument. So it's 20 percent of that number? Is that what we're talking about?

DR. LEE: That's correct.

MR. BUTLER: So it's really about 400 bucks or --

DR. LEE: $420 and $200.

MR. BUTLER: Right. Okay. It's interesting. My only other thought is, you know, Medicare Advantage plans

have some of the same problems with their incentives when all is said and done, and I realize it's a different route, but embedded in that is all the fee-for-service benchmarking and so forth that goes on, and one could argue what about those plans and how does this fit into it over time.

DR. HACKBARTH: The distinction that I see at this point is that the Medicare Advantage plan is fully at risk under the capitation amount for their own structure of benefits. So they have an incentive to choose a structure of co-payments and other benefits that helps them stay within the fixed amount that they achieve from the Medicare program.

So remember, Peter, this is the only time through, so anything else you --

MR. BUTLER: I'm done, and I'm going to support the recommendation.

DR. BAICKER: So I really like the text box on the value of insurance. That's one of my favorite things. Another one of my favorite things --

DR. MARK MILLER: [Off microphone.]

DR. BAICKER: Thanks, it's my birthday, too.

I also really like the figure shown on Slide 6

looking at the probability of hospitalization over time, not just in one year, to highlight that this is something that provides more protection than you might realize in any given year. And I recall that there are some data limitations that prevent us from applying what we saw in Slide 6 to Slide 9, where in Slide 9 we have the one bar showing the distribution over time, and here I'm going to get just technical enough to confuse myself and everyone else. I understand that because this is beneficiary neutral, the mean change must be zero. I also think that the distribution is likely fairly skewed so that even though this bar chart is probably the easiest way to convey this, the winners -- the people who are spending $1,000 or more and the people who are saving $1,000 or more probably have very different numbers on average and numbers of people. I'm guessing this isn't very symmetric. And so I'm wondering if there's a way to take the overtime figures and make a bar that shows -- with some extra assumptions, because I recall there's some data limitations that make you not able to produce this for 2006 to 2009 together. But it would be nice to see a bar next to this, if possible, that showed some of that -- showed how that was different looking

at a longer time horizon. But if that's not possible, then I wonder if there's just a summary number we could provide about the reduction in variance -- you better not be snapping at me like that.

[Laughter.]

DR. MARK MILLER: [Off microphone.]

DR. BAICKER: That's right. Get back to business.

Is there a summary statistic about the reduction in variance that we could put in a reasonable frame to say something about the benefit that people are capturing, even though it's not -- even though this looks like sort of a symmetric lump of bars, it does represent a real reduction in variance?

DR. MARK MILLER: We're very --

DR. HACKBARTH: Did I mention that this was our last discussion of this?

DR. BAICKER: Just for a number, a sentence. I like the recommendation. I think we're all in the right direction. I'm just wondering about a way to capture it.

DR. MARK MILLER: All right. We're very stuck because it's -- the data, in order to get the actual insurance coverage linked with the claims experience, that's

the uniqueness of the data set that we're working with here. And if this were years later, we might be able to do what you're suggesting even just from the data. But she's asked a more complex question, which is: Could you make some assumptions about those bar -- the stacks of the bar and make some distribution based on -- and what she's referring to is the Table 6, like what we know about hospitalizations, what we know about hitting the $1,000 cap, and just sort of say, okay, I'm going to sort of draw this out over time using that assumption. I'm not equipped to answer that.

[Laughter.]

DR. LEE: So the analysis over four years, we can look at that distribution of their cost-sharing liability on their Medicare. What we cannot look at is their out-of-pocket spending because we don't have information on their supplemental coverage. So that's the limitation.

So the question is whether -- could we make assumptions on the relationship between cost-sharing liability to out-of-pocket spending over four years and somehow that can give us that stacked bar? I am not sure about that.

DR. BAICKER: This may not be useful -- if the

assumptions are really big and not helpful, then it's not a good idea to do it, obviously. But I wondered if just the simple assumption of take the distribution of cost-sharing exposure we have in one year and assume that each person had the average four-year lookback, what would that look like? That might be one way to capture -- I really like this chart and would love to bring that flavor in wherever we can, and that could be one way to do it, or even just talking about reductions in variability or out-of-pocket risk exposure as one summary statistic number, even if you can't do the whole distribution. I just think this bears highlighting a couple of times.

DR. MARK MILLER: And you have been very consistent on this point, and we've been trying to keep up with everybody's interests here. But she has articulated a relatively simple framework. I don't know how executable it is, but we follow the framework. And so let us take this offline and see if we can do something like that.

Sorry, Scott. I thought that you --

DR. HARRISON: Glad I could help

[Laughter.]

DR. HACKBARTH: Mark says that Kate has been

consistent on this. I was actually thinking more like relentless.

[Laughter.]

DR. BAICKER: I'm so friendly about it.

DR. HACKBARTH: You are. And you're right.

DR. HALL: Julie, thank you for being so patient at getting us through this. I think I do understand what it is we're voting on. Thank you, and I'm very much in favor of this.

In terms of Kate's question, Kate, would it help you if we broke this down by age of recipient, beneficiary, if we, say, took everybody over age 75 versus those 65 to 75 in terms of --

DR. BAICKER: That seems interesting, but it doesn't necessarily speak to the particular point that I was worried about, but it would be interesting.

DR. CHERNEW: So I'm obviously thrilled by this, and I think it does exemplify, as you said in your comments, the principles of value-based insurance design, which I think are important. I just wanted to make three quick points.

The first one is -- and I think we can work

through the chapter. I want to emphasize this whole endeavor is not motivated by a desire to save money, although it's important. It's really motivated by a desire to have a benefit package that works for beneficiaries, and I don't think it takes much time to look at the current benefit package and say that it really doesn't. In fact, the only reason why the current benefit package is even remotely tolerable -- maybe that's too strong -- mildly remotely tolerable is because people supplement it with a whole bunch of other things. And I think going forward, as retiree benefits become less and less generous, the current benefit package is just not going to work at all and all those flaws will be recognized which requires there to be a change. And so even in the picture that you had up on the board when Bob was talking, that's relative to now. But if you look at that 8 percent number and say, well, what happens if retirees stop having access to coverage and supplemental premiums rise, you're not going to get 8 percent people having more than a higher -- you know, you're going to have a lot worse. And if you looked at what the future might be for the Medicare program five or ten years from now and asked yourself now with no catastrophic cap and

people having a harder time getting access to coverage, you could have real risk that is now masked because of a whole bunch of other institutional things.

And so the type of benefit package you outline -- and, you know, again I agree. We could go back and forth about a whole bunch of things, but I think it's indisputable that the type of benefit package we have now simply won't work in a world going forward. And we could probably find a bazillion ways to do it better, but this is clearly a big improvement, conceptually and I think otherwise, over that.

So the last comment I'd like to say is there's this issue about who gets the authority to do the benefit design, and I just want to go on record as saying I'm very much supportive of the tone of Glenn's comments. In particular, I want to say that because of the need to incorporate evidence and the evidence changes and things happen, you need some central place, and I think the Secretary is probably the best place, and I haven't heard any other preferable alternative, and many of the ones you could think of, like another board or commission, I think is just not worth that. And the recommendation has in it this don't change the overall actuarial value safeguard, and I

think regardless of what you think of the ability of HHS or anyone to manage a whole bunch of things, I think in this case the downside risk is really quite low and the potential for benefit is really quite high. And so, you know, I think there's -- generically you could make a lot of complaints about who has authority to do a whole lot of different things. But in this case, knowing the particulars, I think that's absolutely the -- not only is it, I think, a sensible place in an absolute sense, but I think relative to whatever you think the alternative is, it's a much better place for it.

So, anyway, I support it.

MR. ARMSTRONG: So I also support this. Mike actually just made several points I would have made about how this is solving a deficiency in a benefit package that the supplemental plans really are symptoms of those problems, frankly. So I won't make those points.

But I particularly like what we are able to do through strengthening the value of this set of benefits, the out-of-pocket maximum, the value-based features in some of the design. Let's not forget, too, how this is a step into complementing the focus that we have given to payment policy

to providers with incentives directly to the beneficiaries, which is a really important complement and defining policy work that I am sure we will be doing for years to come.

I just would add that despite supporting this, I do think that this work is long overdue. I think that this is a fairly small, incremental, conservative step in a direction that MA plans and other private insurance plans have been taking for years. I do think that, finally, too, we are only tangentially dealing with the way in which these Medigap or supplemental plans mess up some of the dynamic in our fee-for-service benefits that we're trying to fix, but I think it's a step in the right direction.

MS. UCCELLO: Okay. I think this chapter is great and I really thank staff a lot for incorporating all the crazy and reasonable ideas that I've had over, like, the past two years. I think you asked for feedback on what I think about if you appropriately incorporated my thoughts in the chapter, and yes, you have, and thank you very much for that, and I'll turn to one of those in a minute.

But I think, just in general, when we think about these recommendations, I think it's -- it just needs to explicitly say that we've done, I think, a really good job

targeting solutions to what we think the problems are. The one kind of point I'll add to that is what Julie was saying in terms of the extra charge for the Medigap or the supplemental insurance.

The point that I made recently, but not in a public meeting, was that if we are concerned that supplemental coverage is increasing Medicare spending, and in particular it's the plans with low cost sharing that are primarily the ones who are driving this, then it may be appropriate to target those extra additional charges on those plans that have the low cost sharing. But I think the way that's done in the chapter is appropriate. It doesn't need to be explicitly part of the recommendation. It's talked about in the chapter and I think that's right.

So that's kind of my general comments. Can we go to Slide -- oh, this slide. We're really pretty careful in the chapter of distinguishing between cost sharing liability and out-of-pocket costs, and I'm wondering if this recommendation, when it talks about an out-of-pocket max, needs to say "cost sharing" max.

DR. MARK MILLER: [Off microphone.] Any ideas, Julie, or are you looking at me?

MR. HACKBARTH: So what I hear you raising is that there's a passage, or more than one passage in the chapter itself that talks about out-of-pocket costs being what the beneficiary has after the supplemental coverage and the idea of a true out-of-pocket cost is discussed, and so you're associating out-of-pocket cost with that as opposed to with cost sharing under the Medicare statutory structure.

MS. UCCELLO: Yes.

DR. MARK MILLER: I mean, we can always proceed a couple of ways here. And I also want to make sure I'm understanding what you're saying, so --

MS. UCCELLO: I mean, I'm not recommending a true out-of-pocket --

DR. MARK MILLER: No, I didn't think you were.

MS. UCCELLO: Okay.

DR. MARK MILLER: Okay. Right. And --

MR. HACKBARTH: Consistency in the work.

MS. UCCELLO: Right.

MR. HACKBARTH: Consistency in the terms.

DR. MARK MILLER: Right. So we could either make it clear in the text that supports the recommendation that when we refer to this, this is what we are referring to.

That would be the simplest way to solve the problem, as opposed to beginning to line it at the recommendation. But people would have to be comfortable with that.

I don't think there's any disagreement with what you said. Julie, are we squared away there?

DR. LEE: Yes. We meant in the out-of-pocket maximum, that was referring to the cost sharing liability under Medicare.

MS. UCCELLO: Right. So whatever way -- I mean, just to make that clear. I don't think it necessarily has to be in the recommendation wording, but it needs to be in the text around it.

MR. HACKBARTH: So I'll propose that we do it in the text and make it very clear. Good catch.

MS. UCCELLO: That's all.

MR. HACKBARTH: Karen.

DR. BORMAN: Could you go to Slide 8, please, Julie. I just want to ask one thing for my own clarity of thinking. When we say outpatient, I know that at one point we specifically talked about ER, and I understand that we're trying to incentivize appropriate services. By this, however, do we now mean everything that, for example, would

fall under the hospital outpatient payment system, any service that could be delivered through that, is that what we mean would now fall under this? We're not specifically targeting ER visits?

MR. HACKBARTH: Good.

DR. LEE: Actually, the policy of which outpatient services to put which copays on, that is at the Secretary's -- what would be the right way to do it. For modeling purposes, we just counted the outpatient visits. But for actual implementation, depending on how you value the services, that you can distinguish and define the services.

DR. BORMAN: You modeled it just using a generic things that were covered under hospital outpatient payment.

DR. LEE: That's correct. It includes a whole bunch of --

DR. BORMAN: Right, a huge -- a very broad spectrum of things.

DR. LEE: Yes.

DR. BORMAN: Okay. Just in terms of general comments -- and I'm pleased to have the quantitative expert sitting next to me because I'll be more qualitative -- life really needs to be about options, and I'm very pleased with

this recommendation in the sense of the introduction of options. We're preserving options for the beneficiary in terms of choosing where their comfort zone is, allowing them to change their comfort zone over time, which at least the available research would suggest happens. And at the same time, welcoming them as a participant in the fiduciary stewardship that we all bear for the program and starting to involve them appropriately in that, I think. So I think that's a really good thing about this.

I also like that on the administrative or execution side or whatever you want to call it that we also are allowing the Secretary to have options because the world is changing so quickly, the information is changing so quickly. We are having a major shift in the demographics and size of the Medicare population, that in order to be able to respond appropriately without having to totally occupy the time of the Congress in only this when we have so many other major issues that they must deal with on behalf of all of us, that I think this is a fabulous way to continue to move forward the program and not introduce great lags or stall it because of having to fit it into other legislative priorities. So I think it's a great step in

that direction. It puts a burden on the Secretary to have a process to do it well in a transparent way and I think, hopefully, we can make sure that we sort of suggested -- inferred that at least in the chapter.

And I guess one question -- one natural thing that comes to mind is at the time, potentially, of making coverage decisions, there may be an initial cost sharing decision that goes with that. So there are many ways to get to this. The Secretary may choose to use a variety of ways. But I also really like that it leaves the Secretary to be nimble in a rapidly changing world, so I think -- I support the recommendation and I really think it really does that nicely.

And I really liked the sensitivity analysis, and even at my qualitative level, I could understand that.

MR. GEORGE MILLER: Yes. I also support the recommendation, and just -- instead of recanting everything that has been said -- my colleagues have done an excellent job of that -- but I like the fact that as beneficiaries change over time, they may choose different options that are appropriate for them, very similar to what Karen said. But the fact that they would have that option, I think, is very

positive. And also echo that the Secretary would be free to make the best evidence-based decision for the program is also, I think, appropriate and very well done. So I support the recommendation.

MR. GRADISON: I support it, as well. Unfortunately, I think that to too great an extent, the current Medicare benefit still looks like a state-of-the-art 1965 health insurance program and hardly exists in nature anymore except in Medicare itself. To me, the significance of that isn't just a wisecrack but that people who are aging into Medicare are accustomed to a very different approach and one which is much more reflected in our recommendation than in the current benefit design. To be specific, catastrophic limits are kind of ordinary. That is not unusual. Combining what we call Part A and Part B is also rather commonplace, far more commonplace, actually, than separating them in today's world.

Now, the last time there was an effort to deal with this catastrophic limit, it kind of went down in flames, and that was about 25 years ago. So maybe it's time to try again. I think part of what happened then -- there are a lot of reasons, but I think part of it was that there

was an earmarked income-related premium increase that was going to help pay for it. In this instance, we are still, as in the case 25 or so years ago, recommending something that is budget neutral, but it is neutral within the program rather than having some additional add-on. I don't know if that helps it or hurts it in terms of selling it, but I just want to make that point because, having been somewhat involved in it at that earlier stage, my sense was that there wasn't particular objection to the benefit but rather to the financing of the benefit. Count me in.

MR. HACKBARTH: And as we have discussed, Bill, it may be back in the mid-1980s you and your colleagues were leaders, taking a lot of heat on this issue of an income-related charge within the Medicare construct. Now, that actually has happened and in a relatively non-controversial way. It has become a regular feature of the program. So maybe it wasn't all for naught.

MR. GRADISON: We were ahead of our time.

MR. HACKBARTH: Right. Bruce.

DR. STUART: I support the proposal. There are parts of it that I'm more enthusiastic than other parts, and the part that I'm enthusiastic about is clearly giving the

Secretary the authority to make these changes, not just these changes -- obviously, I understand that these are illustrative -- but rather the process by which, as times change, then obviously we need to make these changes to go along with that.

But I have two questions that relate to that. The first question is essentially a procedural question, and that is what authority does CMS currently have under the Innovation Center to do these kinds of things on a pilot or demo basis?

DR. MARK MILLER: I am not sure I could answer that.

MR. HACKBARTH: When you say "these things" -- well, actually, I need a clarification. When you say "these things," do you mean changing the Medicare benefit package --

DR. STUART: Well, I'm thinking of making changes in terms of the benefit package. Does the Secretary have the authority through the demonstration authority that is granted under the Innovation Center to make changes in benefit design.

DR. MARK MILLER: And what I would want to say is

I know that that authority is fairly broad and did go through it, you know, a year or more ago when things were in play and shortly after the legislation. But unless somebody is feeling pretty firm on this, I would rather come back and answer that question for you because I don't know.

DR. STUART: I'm speaking not to the recommendation as much as the chapter, because I think the way the chapter reads in June is going to be important, and to the extent that some of that authority is already there and we, I think, would want to make the point, let's make it so that you don't actually have to go through a pilot in order to do these things. We want to have you do it more directly.

The element about this that I have been uncomfortable with relates to the 20 percent surcharge on private supplemental insurance. Two points. First of all, I fully recognize that supplemental coverage increases the cost of Medicare, not just the supplement but Medicare itself.

Secondly, I'm not opposed to trying to recoup that cost. I'm not sure that -- I'd like to get some kind of a pay-back from that, I guess is what I was thinking, in terms

of other ways of using that as a way of leveraging other changes in the program.

But the one point that has kind of stuck in my craw is we apparently don't seem to know how much extra cost the supplementation adds to the present Medicare program. But when I look at your Slide 10 -- 11, excuse me. If you go to Slide 11, it seems to me that implicitly, you've got the answer to that question, and it's in the left-hand column. So if I follow the logic here, we take the sample benefit design. We put that into place. And if nothing else changes, then the cost of the Medicare program goes up by one percent, okay. Then -- and I'll just go to the bottom of that -- then we take away all supplemental insurance altogether and the cost to the Medicare program declines by four percent.

So it seems to me that if I add one percent to four percent so that the total is minus-five percent, it sounds to me like you do have an estimate that the current supplemental insurance that beneficiaries purchase adds five percent to the overall cost of the program. Do you follow my logic on that?

DR. LEE: Yes.

DR. STUART: And if so, do you accept it?

DR. LEE: But the inference -- I'm not sure if we can make that inference. What we have in the question of how much does people with supplemental coverage, to add to have additional spending, but I think the question is how much of that additional spending is due to their selection, so that people who get supplemental coverage is different, versus how much of that is moral hazard, so because they have supplemental coverage, additional services that they use. So it's a parsing out the spending differences that we observed in two groups, one with supplemental coverage and one without, and reasonably dividing that difference into what is due to adverse selection and what is due to moral hazard.

DR. STUART: Ninety percent of the population has supplemental coverage, and you're assuming, at least as I read this, that that coverage doesn't change. I think that gets the adverse selection issue out, and it seems to me that -- this looks to me like that this is your best estimate of moral hazard. Now, if that's the case, then I would argue that the extra cost associated with supplementation is not as huge as we may have all around the

table been assuming that it is.

So that would be one of my concerns, is that when we go through the writing of this thing, the final writing, is that we do try to separate out adverse selection from moral hazard so that we have some sense about the importance of the extra charge that we're recommending.

MR. HACKBARTH: So my recollection of the chapter is that there's a passage that's several paragraphs long that talks about the existing analysis relative to this question, including how much of the apparent increase in utilization is due to moral hazard as opposed to selection differences in the population. And there's -- my recollection, and correct me if I'm wrong, Julie -- is that there are an array of estimates talked about there. Now, in doing the modeling that Julie has done, she makes some assumptions to come up with the numbers in Slide 11.

At the end of the day, what we think, what assumptions we make on this, really doesn't matter much because we won't be the authoritative source on what is the inducement for moral hazard versus selection, what is the appropriate supplemental premium. It will be either CBO or the CMS Office of the Actuary who goes through these

different studies and different estimates and says, this is the one that matters.

And so for us to try to resolve an issue around which there are a lot of different estimates really isn't probably time well spent.

DR. STUART: I won't argue the point. I think the range is actually narrower than we would argue. So I do agree with that, and I would add one final point here, which, in fact, is an argument for a supplemental charge on the standard supplements and employer coverage, and that is that this is very likely to push the market toward MA plans. So to the extent that several of us around the table have argued that the MA plans provide a much more modern version of what health insurance should look like, then that should be considered a positive step. And so to the extent that this proposal would have that effect, then I think that it should at least be recognized in the text. It doesn't have to be recognized in the draft recommendation, but at least recognized in the text.

DR. NAYLOR: So, first, let me tell you that I was reorganizing my study at home and have all of these tomes there, and I wanted to acknowledge the work of Julie and

Scott and Joan and everyone, because I think it was 2010 when I first arrived, we had a chapter on how it is that we're going to redesign the benefit system. So it's been a long journey and I want to congratulate you. Also, the work that you've done to help refine and respond to all of our recommendations has been phenomenal.

I support this recommendation. I think it meets the policy objectives. I think it meets key principles. Let me just highlight a few, at the risk of repeating.

One, the out-of-pocket maximum or cost sharing liability. I think this is really important in terms of the statement it makes about how we pay attention to our sickest beneficiaries at their most vulnerable times, and that 2006 to 2009, 13 percent, while I may not appreciate all that you recommended, I do know that all of us, or the majority of beneficiaries, at some point in time are going to be in this spot. And so 13 percent probably significantly under-represents, over time, the really critical need to protect people at that point in time.

I think the copayments that align with and promote where the health system is really trying to place our attention around prevention, around primary care, is

critically important. The emphasis on value, and as Scott suggested, where everybody else is and now we need to be, and particularly the notion of enabling the Secretary. I sit on the IOM Learning Health System Committee and I really have just come to appreciate how much science is advancing and how somebody has to be enabled and positioned, whatever mechanism the Secretary chooses, to be able to stay on top of that and to actually continue to focus on what evidence is telling us are the highest-value services. And so all of these principles, I think, are really where we need to be and applaud this recommendation.

DR. CASTELLANOS: I also support this recommendation, and I want to also say, Julie and Scott and Joan, you have done a great job, and it's been fun watching you and myself walking down this path.

Scott, I totally agree with you. We should have done it a long time ago. We're finally keeping up with -- I hate to use that word -- what's happening in the real world, and that's good.

The beneficiaries are where we are stressing, and the stress here is a beneficiary has value, choices, appropriateness, and was able to keep up with change, and I

really like the idea we're focusing on the beneficiary choices.

DR. DEAN: I, too, support what's been done. I appreciate the efforts and I think this clearly moves us in the right direction, maybe not fast enough or far enough, but it's clearly in the right direction.

MS. BEHROOZI: Thanks. In addition to thanking Julie and Joan and Scott, I want to give a shout out in Namibia to Rachel, because I think I remember when I first got here, Rachel was working on this. And forgive me if I've left anybody else out.

Yes, it's been a journey and I really appreciate all of the effort to accommodate all of our concerns, especially the little red wagon that I keep relentlessly trotting out. And thank you, Glenn, for herding all your cats here so effectively.

I do just want to make clear, just maybe to put in a pitch for the tone with which we describe some of the things in the chapter. Just a little bit to Bruce's point -- it's in addition to Bruce's point about the surcharge on the supplemental coverage, which is not my favorite part of the recommendation but I support the recommendation

wholeheartedly as a total package. Not all of the extra spending is necessarily bad, right. Some of it is because people have eliminated those point-of-service barriers because of their supplemental coverage that they've either purchased or qualified for in whatever way.

And I do think that the chapter has just gone -- it's dramatically comprehensive in discussing the whole -- a lot of the issues around first-dollar care -- coverage, rather -- and I feel like that's really evolved over time and there's a lot of recognition of the up-sides of first-dollar care in terms of eliminating barriers. So I think it would be consistent to sort of recognize that not all of the extra spending in Medicare -- maybe some of it is because the benefit is not good enough by itself, and so people really do need a little extra coverage or a little extra payment. I do not know whether that is a majority or the minority of the extra spending, but I think it is worth noting that.

And just in terms of my concerns about the combined deductible, which were taken into account and I don't mean to be more relentless, I do just want to say, though, that it's not because I think they're great and that

it's important to keep them separate. Really, my concerns come from what combining necessarily means to the Part B side.

Combining necessarily means that the Part B deductible will go up, and the $500 that's worth, as you noted, Julie, about six primary care visits if the beneficiary has to pay for all of them, means that for six visits, the beneficiary has no coverage at all and has to pay it all up front, maybe in the first month or two months or whatever of the year, where if they were going to spend that same $500 with a $140 deductible, they would get 20 visits out of the deal. So the value of $500 to the beneficiary when it's distributed, by way of copayments or coinsurance or whatever, means that they have access to more visits, and maybe in a way that they can afford better because it's spread over more time.

So I just want to make clear that it's not because I think the deductibles the way they are are so fabulous. It's because of the evidence that you cite in the chapter that when point-of-service costs -- and that's what a deductible is -- point-of-service costs, are increased, that there does seem to be more support for the notion that there

are worsening health outcomes for Medicare beneficiaries. Whether that's associated with an overall higher cost or not, whether the hospital offset is not expensive enough to make up for the imposition of front-end physician and drug costs, that's not so much the issue. It's that more people end up in the hospital because they haven't been able to go to the doctor because they've had to pay all that money out up front instead of being able to get coverage for doctor visits more quickly by passing that deductible point.

So, like I said, just about tone. Otherwise, I love it. Thank you very much.

MR. KUHN: I, too, would like to thank Julie and Joan and Scott for a job well done. These recommendations are long overdue and I fully support the recommendations.

MR. HACKBARTH: Okay. Would you put up the recommendation, Julie. So all in favor of the recommendation, please raise your hand.

[Show of hands.]

MR. HACKBARTH: Opposed.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay. Thank you. Well done. We appreciate your work, Julie.

Next up is work on a Congressionally requested report on Medicare payment for ambulance services.

MR. RICHARDSON: Good afternoon. I feel like I've been here recently. So in this session, Zach and I are going to make an initial presentation on a new report mandated by the Congress to the Commission in February to study and make recommendations as appropriate on payment policy under the Medicare ambulance fee schedule.

In this presentation, we will summarize the mandate that the Congress has given the Commission and outline our work plan for completing the report re the basic elements of the current ambulance payment system and present key findings from our initial research on recent trends in utilization and spending for ambulance services in Medicare.

Section 3007(e) of the Middle Class Tax Relief and Job Creation Act of 2012 directs the Commission to conduct a study of the Medicare ambulance fee schedule and submit a report to the Congress by June 15, 2013. The Commission is specifically directed to examine the impact on ambulance providers Medicare margins of three temporary add-on

payments which are listed on the slide. Zach will go over each of them in detail in a few minutes.

The law also directs the Commission to consider more broadly whether there is a need to reform the Medicare ambulance fee schedule, and if so, what those reforms should be, including whether the add-on payments should be included in the fee schedules' base rates.

While the formal due date for the Commission's report to the Congress under the mandate is June 15th, 2013, more relevant to the timeline is that all three of these add-on payment policies are scheduled to expire under current law at the end of December, 2012. Thus, in developing our work plan and getting our analysis underway, we have been very conscious of the fact that the Congress will need to make a decision about whether to extend and/or amend these policies no later than the end of this year.

The work plan we've designed is summarized on this slide and it includes ambulance coverage and payment basics, the claims data analysis of trends in the number and types of ambulance providers and suppliers billing Medicare, claims volume and program spending, a review of program integrity issues raised in recent reports from the HHS

Office of Inspector General, assessment of what data are available to allow analysis of the costs and Medicare margins of ambulance providers and suppliers, and drafting possible recommendations, as appropriate.

This presentation and your mailing materials present the initial results of the first three elements of the work plan. In addition to our literature research and claims data analysis over the past six weeks, we have met with about a half-dozen ambulance services stakeholder groups, including representatives of ground and air ambulance providers, EMTs and paramedics, and state emergency medical services agencies.

In addition to getting your guidance today, we will, of course, continue to gather information and refine our analysis over the coming summer and fall.

Turning now to the payment basics portion of our presentation, I'll briefly summarize Medicare ambulance coverage policy and then Zach will walk you through how the fee schedule works and the results of our initial foray into utilization and spending trends.

Ambulance services for both emergency and non-emergency transports are covered under Medicare Part B,

subject to certain conditions of coverage. Like almost all other Part B services, Medicare reimburses the provider for 80 percent of the Medicare allowed amount for the covered service, and the beneficiary is liable for the remaining 20 percent.

In general, Part B covers ambulance services in cases where there is a physician certification of medical necessity. That is, when the patient's condition is such that the use of any other method of transportation is contraindicated. Other specific conditions for coverage are listed on the slide. In the interest of time, I won't go through them all, but we can discuss them later if needed.

Non-emergency ambulance transports that occur during a Part A covered hospital or SNF stay generally are not separately payable under Part B, but there are a few exceptions to this such as scheduled transports for a SNF inpatient with ESRD to and from a dialysis facility. Zach will now go over how the ambulance fee schedule works and the key results of our initial claims data analysis.

MR. GAUMER: In 2010, nearly 12,000 entities billed Medicare for ambulance services. 93 percent of these were non-institutional suppliers. This includes government

entities such as fire and police departments, county EMS agencies, and private commercial ambulance companies. The remaining 7 percent of entities that billed Medicare were institution-based providers. This group includes entities such as hospitals, critical access hospitals, skilled nursing facilities, and rehab facilities.

The number of non-institutional suppliers grew 4.3 percent from 2008 to 2010, while the number of institution-based providers declined approximately 9 percent. Now, starting with the smaller of these two groups, institution-based providers make up 7 percent of all entities and they account for a proportional share of overall Medicare ambulance spending.

Hospitals account for the majority of all institution-based providers. However, in 2010, just 18 percent of all hospitals offered ambulance services. Large urban hospitals, critical access hospitals, and government hospitals were more likely than other types of hospitals to offer ambulance services. And also, hospitals in Iowa, Wyoming, and Minnesota were more likely to offer these ambulance services than the national average of 18 percent.

Now, shifting to the larger of the two groups,

non-institutional suppliers are a large and diverse group. There are slightly more than 10,000 suppliers and they range in organizational structure from purely government, such as fire departments, to public/private partnerships such as counties that out-source their emergency medical service staff to a private entities alone such as two of the largest, which are American Medical Response and Rural/Metro Corporation. Collectively, these two maintain about 20 percent of the marketplace.

Data stratifying suppliers by organization type are extremely limited, however. Census data offers a little bit of insight, and we've learned from census data that slightly more than half of suppliers are government entities, slightly less than half are non-government entities, and among the non-government suppliers, 65 percent were for-profit. And it's this group, the for-profit, non-government suppliers that grew faster than other types of suppliers from 2008 to 2009, at about 2.4 percent.

Now we'll switch from supply to defining the ambulance payment system and how it works. The structure of the ambulance fee schedule system is similar to other fee schedules that you've seen within the Medicare program. The

ambulance fee schedule has two basic components, a base rate payment and a mileage payment.

The base rate payment consists of three distinct pieces, relative value units, weight -- the relative value unit weights are used to determine the relative severity of ambulance transports based on whether the transport is basic life support care or advanced life support care, and then emergency versus non-emergency.

A national standardized conversion factor is then used to convert the RVUs into monetary terms, and there are three conversion factors, one for ground and two for air. And the conversion factor is updated annually using the CPIU reduced by productivity.

The practice expense GPCI is the geographic adjustment factor that's used to adjust payment for geographic differences under the ambulance fee schedule. The mileage payment consists of the provider-reported mileage of the transport and the national standardized mileage rates for ground and air transports.

On the next slide, I'll show you how the fee schedule formula actually works. This is an example for a Level 1 advanced life support in Raleigh, North Carolina.

And keep in mind that this example does not include the add-on payments which might come to bear in the case in reality. The RVU for a ground ALS, advanced life support, emergency transport is 1.9. You can see that on the far left in the blue box. And it is multiplied by the 2012 national conversion factor of $214, and the GPCI from Raleigh is multiplied in there as well.

However, the complexity here is that only 70 percent of the base payment rate is adjusted by the GPCI amount. And altogether, this yields a base payment rate of about $386. That's also in the blue box there. The base payment is then added to the mileage payment, which is the product of a five-mile transport, in this case anyway, and the standard ground mileage rate of $6.89 per mile.

In this particular case, the fee schedule formula yields a total payment of $421, and again, this example does not include the add-on payments that are likely to apply.

Okay, add-on payments. There are five ambulance add-on payments active in current law. These add-ons are supplemental to the ambulance fee schedule formula. They increase the amount of total payments and are additive of one another where appropriate. Three of these policies are

specific to ground ambulance transports and two others are specific to air ambulance transports.

In addition, these policies are either temporary or permanent. The temporary add-ons are highlighted above in orange. These expire at the end of 2012 and it is these that Congress has asked MedPAC to examine more specifically. The permanent add-ons are in green and were implemented along with the ambulance fee schedule back in 2002.

The first ground add-on policy is permanent and referred to as a rural short-mile add-on policy. This add-on increases mileage rates by 50 percent if the distance of the rural transport is between one and 17 miles. The second ground add-on policy is temporary and it's referred to as the ground ambulance add-on. This add-on increases the base payment rate and the mileage rate by 3 percent for rural transports and by 2 percent for all urban transports.

The third ground add-on policy is also temporary and it's referred to as the super-rural add-on. The super-rural add-on increases the base rate payment by 22.6 percent for ground transports which originate in ZIP codes classified as super-rural. Now, super-rural ZIP codes are a measure of isolated areas and it's unique to the ambulance

fee schedule. They are defined as the lowest quartile of all rural ZIP codes by population density.

Now, the two air add-on policies are linked somewhat. The first, called the rural air add-on, is permanent and increases base rates and the mileage rate by 50 percent if the transport originates in a rural ZIP code. The second air add-on policy is temporary and extends the rural air add-on policy to a group of over 3,400 ZIP codes that were reclassified from rural to urban in 2006 when the Office of Management and Budget revised the definition of urban and rural.

As the result of this revision, these ZIP codes lost their rural status and were excluded from the rural air ambulance add-on policy. Through MIPPA of 2008, Congress essentially grandfathered rural status to these areas specifically for the air ambulance reimbursement policy.

One other key point about the add-on policies in general is that they are additive to one another. For example, using the same advance life support emergency case that we saw on the slide before, if the case had occurred in one of the super-rural ZIP codes outside of Raleigh, this case would have received the 3 percent add-on for ground

rural transports, the 22.6 percent add-on for being in a super-rural ZIP code, and the 50 percent add-on for having a travel distance of between 1 and 17 miles. Therefore, this would bring the total payment to approximately $542, which is a 29 percent increase over the version that we saw in the example on the slide before.

Now that we've covered the fee schedule and the add-on payments, I want to give you a sense for the average payment per claim for the various types of services here. The average payment per claim in 2010 was $314. Institution-based providers had higher average payments per claim than non-institutional providers. Air transports had significantly higher average payments than ground transports. Emergency transports had higher average payments than non-emergency transports. And finally, rural transports had higher average payments than urban transports.

In 2010, the Medicare program made $5.2 billion in payments to providers of ambulance services for about 16.6 million claims. This is a little over a third of the 13.9 billion in industry-wide ambulance revenue. On a per capita basis, ambulance payments per fee-for-service beneficiary

increased 19.1 percent from 2007 to 2010, and this was driven by three factors, a 10 percent increase in payments, a 4.5 percent increase in the number of ambulance users, and a 5 percent increase in claims.

In general, payments grew faster than claims from 2007 to 2010 due to a 3 to 5 percent increase in the ambulance inflation factor in 2008 and 2009, as well as the add-on policies which were implemented midway through 2008. Payments slowed from 2009 to 2010, increasing at less than half the annual rate in the previous two years. This was expected due to the ambulance inflation factor update of 0 percent in 2010.

Despite slowed spending growth, the number of users of ambulance services and claims per user continued to increase in 2010. In that year, 2010, 5.2 million individual beneficiaries, or 15 percent of all beneficiaries, used at least one ambulance transport. Individually, these users had used, on average, about three transports each in that year.

Three trends emerged from our analysis of ambulance claims data. First, non-emergency transports were more common among all urban transports than rural and super-

rural transports. Second, non-emergency transports were the fastest growing service type for urban transports, growing faster than rural and super-rural. Third, non-emergency transports were more commonly provided by non-institutional suppliers than institution-based providers.

Okay. And now John is going to walk you through a summary of our preliminary findings and next steps.

MR. RICHARDSON: All right. So there is a lot in here, but just to start the discussion, we've identified these four key take-away points from our initial analysis. First, as Zach mentioned, we've observed continued growth in total claims volume and the number of fee-for-service users per claim between 2009 and 2010, even as total and per-beneficiary spending growth slowed somewhat.

Second, the number of for-profit ambulance suppliers appears to be growing faster than the number of not-for-profit and public providers and suppliers over the period that we analyzed. Third, claims volume is growing the most rapidly for urban non-emergency transports. Fourth, we are concerned that there will be limited availability of provider cost data, which are essential to analyzing Medicare margins.

Medicare currently does not collect cost data from non-institutional ambulance suppliers, which as Zach said, comprise about 93 percent of the current Medicare volume. We have begun analyzing reports that the Government Accountability Office, or GAO, published in 2003 and 2007 on ground ambulance providers' costs and plan to report on those findings later this fall. The GAO also has been mandated by the Congress to update its 2007 report no later than October 1 of this year. And obviously the results of that study would be useful in our analysis.

We will continue to evaluate all available ambulance provider cost data as our work on this mandated report progresses. So I'll put back up the slide summarizing the mandate and look forward to your questions, discussion, guidance on how to proceed with this. Thank you.

MR. HACKBARTH: Thanks, John and Zach. I, before reading the chapter, didn't know much about the ambulance payment system. It's complicated. But you laid it out in a very clear fashion, so thanks for that. I have a question about the involvement of the private equity firms in the business. If I understood you correctly, the two firms now

owned by private equity represent about 20 percent of the total volume. Is that right?

MR. GAUMER: Yeah. AMR and Rural/Metro were both bought by private equity in 2011, two different private equity firms. There's another private equity transaction that I think is relevant. A company from -- a private equity firm from Europe who's the biggest supplier of ambulance in Europe came over and purchased two smaller regional ambulance companies and both of those are large for regional providers of ambulance services. So I think this all happened in 2011 and it's noticeable.

MR. HACKBARTH: So when I think of firms like these moving into a new industry, they usually have very specific reasons for doing it. This is smart money usually. So sometimes it will be that they will look at an industry and say, It's really inefficiently organized as it is, too many small firms, or something, and there might be economies of scale and if we move in and reorganize it in some fashion, there could be significant rewards, financial rewards.

In other cases, it may be because they envision that there's going to be significant sector growth, either

in price or volume or both and it's a good growing, expanding business to get into. A third, and this isn't a comprehensive list by any stretch, but third is they may see some sort of technology disruption on the horizon, you know, a real discontinuity that might create an opportunity for somebody that has some vision and some capital.

I think about all of the explanations that I can come up with and none of them quite seem to fit my limited understanding of the ambulance marketplace, and I'm really curious as to why these firms are moving into this business. Is there any way of learning more about that? I know that they are private firms, and so they're not necessarily doing the sort of statements that publicly-owned companies do.

MR. GAUMER: I think at this point, we've really just scraped the surface of that issue and we can look into doing some more. I'm not exactly sure what direction it will go, but --

MR. HACKBARTH: To the extent that we can sort of get a glimpse of how the ambulance world looks through their eyes, that might be interesting and informative.

MR. RICHARDSON: Yeah. I'll just add one point which has struck us as we've, as Zach said, just scraped the

surface which is this dichotomy between emergency and non-emergency transports. So I'm curious to look into that a little more deeply and see if there's a real difference in the way -- I mean, emergency is kind of what you think of when you think of ambulance services, but a lot of the growth seems to be in the scheduled non-emergency transports using basic life support as opposed to the more expensive advance life support.

So depending on how the provider costs, as you said, if there's a technology play or operational efficiencies that they can gain relative to what the payment rates are, they might be able to be looking at that. And then as far as the population growth, I would just -- we're all well-aware the Medicare population is going to get significantly larger over the next 10 to 15 years. So that could be a piece of it, too.

And I don't know if we said this, but Medicare currently is about one-third of the industry's revenue right now, so just another good framing point to have in mind. Private is about 40 percent, I think?

MR. GAUMER: Yeah, that's right, 40 percent.

MR. RICHARDSON: Privately-insured patients are

about 40 percent of the market. So that's another big area that these firms could be looking at.

MR. HACKBARTH: If one-third is Medicare and 40 percent is privately-insured, that means that the residual is paying out of pocket?

MR. RICHARDSON: Medicaid is --

MR. HACKBARTH: Oh, Medicaid, sure.

MR. RICHARDSON: -- a good bit of it.

MR. GAUMER: Yeah. Medicaid is about ten, then you've got tax subsidies, grants, that type of thing that are coming from local areas.

MR. RICHARDSON: Public agencies are supported by that, yes.

MR. GAUMER: Yeah. And then you've got out-of-pocket costs which are a small part.

MR. HACKBARTH: Okay. Let's see. Karen, do you want to lead off the questioning?

DR. BORMAN: I just wanted to commend you on Slide 10. The way you present the add-ons in this chart I found particularly helpful. And I would say that that kind of reproduction in the chapter would be very helpful. It was just a great, on-point go-to-it, and maybe I'm a visual

learner or something, but that was very helpful.

Also, I feel like I know tons more about this. Of course, that wouldn't be hard, but I found it a very nice rollout of that. And I'm still not smart enough to ask you any cogent questions.

MS. UCCELLO: I joined this session late, so if you talked about this in the beginning, just tell me and I'll look it up in the transcript.

[Laughter.]

MS. UCCELLO: And I didn't really mean that to be funny. I'm just trying to step back and understand better the rationale for these add-ons in the first place. It just seems like, you know, the super rural and the rural, there may be low volume concerns, but I don't know the urban and rural ground add-on, I don't know, you know, what prompted that.

MR. RICHARDSON: Good question. I think that the -- let me see if I can come up with a good answer. A couple of things.

As I mentioned earlier, the GAO has done a couple of studies of the industry's cost structure, and one of the challenges there that I alluded to is the industry is so

diverse that it's hard to get a handle on, you know, what is the average cost for a different kind of transport.

But based on what we know, at least at this point, about some of the GAO's work, I think there was some concern that as the ambulance fee schedule was put together through a negotiated rulemaking process and there was a budget neutrality requirement, that as it was fully implemented, payments were still falling a little bit short, and so the origin of the rural 3 percent and urban 2 percent came out of that sort of aggregate sense, that the payments needed to be bumped up.

MS. UCCELLO: So it was almost like a rebasing in a sense?

MR. RICHARDSON: A what?

MS. UCCELLO: Like a rebasing?

MR. RICHARDSON: More of a Band-aid, I think would be -- I guess you could call it a rebasing, give it more of a gloss, a sheen or something. So that's the urban and rural, the 2 and the 3 percent.

The other one, the super-rural pick-up, you'll notice is 22.6, which is a very specific number. CMS actually promulgated that through a rulemaking through a

process of looking at the cost structure of providers serving very rural areas, and so I think that they calibrated it a little more carefully -- or precisely, I should say, through the rulemaking process. Again, you also see reflected in the difference between, say, the rural 3 percent and the super rural 22.6, a recognition that if you have very low volume, you have such high fixed costs, per trip it's very difficult to cover those fixed costs. So super-rural area, very few trips, high fixed costs, you need to bump up the base payment considerably more than you would in the average rural area, so to speak. So we're definitely trying to work through these and see if -- part of the mandate is are these the right numbers, is this the right way to organize these, and, you know, we'll be certainly looking at that.

DR. MARK MILLER: Can I say -- because we were talking about this internally, too, and we're learning our way into this. It's not like we had this vast reservoir of ambulance knowledge prior to this. My sense of it is that it's a low volume that drives the argument, the point you were making there towards the end. It's kind of low volume that drives the argument. But my sense of how quantified

these numbers are is much more fluid, the 2 and 3 percent for sure; and even though the 22.6 kind of came out of a process, were we able to discover the estimated -- no. It was more -- yeah. And so what I don't want you left with is, for example, oh, so the 22.6 was estimated and here's the point estimate and here's the analysis. My sense is that it's driven by this concern of low volume and that there is some argument of fixed cost and that type of thing. And then you kind of find your way to the numbers, and that's what we're not able to answer very clearly, like how those come about. Is that fair? And maybe there is -- I don't want to rule out that there is actually some magic formula that brought all of this up, but to date we haven't run across it.

MS. UCCELLO: And just remind me, these are legislative add-ons and not regulatory add-ons.

MR. RICHARDSON: That's right. The 2 and the 3 percent are written into the statute. The 22.6 was developed by CMS through regulation, but with a congressional requirement to come up with an add-on payment for areas that met certain designations, that sort of language in the statute.

MR. ARMSTRONG: I'm just left wondering if there's any way of comparing this payment structure and these rates to the 40 percent of the private insurance market that's buying the same services and/or Medicare Advantage plans.

MR. GAUMER: That's something that we also scraped the surface of. A report recently came out in New Hampshire, the State of New Hampshire, looking at the variability of private rates, and it was wildly variable by municipality or county, and that's something we're also interested in.

DR. CHERNEW: So from what I know about the commercial sector, I think it's much higher than at least some of these rates, because I've been billed more than the rate. But in any case, I had a few just basic questions. The first one is: So there's this discussion in there about how this relates to an inpatient stay and what happens if it precedes an inpatient stay and when it gets bundled into the DRG. In those cases when it's bundled into the DRG, does that mean the hospitals have somehow negotiated with these companies for what the rate is, or do the companies still get paid this amount?

MR. GAUMER: So if the ambulance ride occurs in

the middle of a Part A stay, whether it's a hospital or a SNF --

DR. CHERNEW: In the middle? But what about the beginning of?

MR. GAUMER: No. So if an ambulance pulls up to an emergency department and brings with it a patient --

DR. MARK MILLER: Let's assume [off microphone].

[Laughter.]

MR. GAUMER: I'll assume that. I'm not going to leave anything on the table here. And it precedes a stay, prior to the stay that is a Part B billable service, that ambulance transport. It does not get lumped into the DRG payment, is my understanding. So if an ambulance transport occurs while that person is admitted to the hospital or SNF, it is generally lumped -- and I'm not going to use the right terminology. It's generally lumped in or bundled into the DRG payment unless there are a number of exceptions that are triggered.

DR. CHERNEW: And that could include a transfer or something like that.

MR. GAUMER: Correct.

DR. CHERNEW: I was looking at the nine -- you

list the nine categories there, and they sort of start with like basic you have diabetes and you need glucose to like something really bad happened to you and there's all kinds of bad things that they had to do for you. Are there other services that the ambulance company could bill that might not be actually in the ambulance fee schedule? Because they do a lot of -- they can do a lot of things in those ambulances now. So is everything captured in one -- everything the ambulance company gets is captured in one of those things and it's not like, oh, we also did the following lab work and you're billing that?

MR. GAUMER: No, it's all bundled together, and it's my understanding that the reason the fee schedule was put into place, partially the reason it was put into place in '02 was because of this problem, that there were a lot of different services and it was very complicated.

DR. HALL: If you go into any older hospital in the country, one that's been around for a century or so, invariably in the lobby there will be some old pictures or daguerreotypes, and one of them will always be a horse and buggy and a livery agent and a nurse or a doctor, and it became kind of the symbol of what the hospital would do for

the community. So that's where institutionalized ambulances came from, I think.

And then gradually they became sort of a public utility. The fire department took it over not because there were fires but because they were the kinds of people who were giving public services. You know, even Hemingway made a reputation for that in World War I working for one of these companies.

Then gradually the private sector took over, so now we have a very important and somewhat inexplicable part of this whole picture would be the non-emergent transfers. And you mentioned this, I think, in detail, that I had never known before, on page 6, where the exceptions are for a Part A Medicare stay when Part B does kick in. And a lot of this has to do in transport to and from SNFs, for example, for what are considered kind of specialized ambulatory services, which would be any large university hospital. Anytime an ambulance pulls up, that's certainly what it's going to be.

So I guess my question there is: Is there any way to look at whether there are any incentives at all for health systems to have some control over this? Does everybody who was delivered non-emergently to and from

hospitals or an SNF really need that level of intensity? Because you kind of get -- it's kind of a package deal. I mean, the ambulance pulls up, and they are equipped to do anything almost short of cardiac transplant right in the ambulance. It's like the inside of a nuclear submarine in terms of electronics.

One might think that some people who are just coming in for a look at a cough or a cold in the emergency room probably don't really need that level of service. But I don't think that that's ever parsed out.

I don't think there's much virtue in drilling down on the emergent services. I mean, I hope there are going to be ambulances around when I need one of those and that it has all that gear. But I'm not aware that anybody has any incentive whatsoever to look at alternative forms of transportation in a meaningful way. There are other ways to transfer. So that would be one kind of suggestion if we're going to look at these things.

MR. BUTLER: So having been involved with a private company, some of my speculation, in addition to the revenue opportunities that have been cited, is that the cost structure, not dissimilar from hospital-based versus non-

hospital-based or in some cases municipalities versus non, you've got costs and benefits and things in a hospital or a municipality that are probably higher than the cost structure in these private companies. And so they're living both with scale because they can cover multiple places and bring their technologies and systems. So some of these, you know, I think deliver at a cost that is lower than what a lot of the alternatives are and often do it pretty well. That would be a speculation.

On questions, the $5.2 billion, do we have any sense of how much of that total is wrapped into these add-ons? They're big percentages in some cases. I just don't know if this is like 10 percent of the total payments or we're only talking about a couple hundred million or something like that.

MR. GAUMER: I don't have an answer for that yet, but that's kind of on our list as well for something to put a number to.

MR. BUTLER: Okay,

MR. GAUMER: So we will have that.

MR. BUTLER: So I would think in our case, this is principally -- if we treat it like other issues, it's about

an access versus price issue, isn't it? I feel like, by the way, we're revisiting -- we're just putting rural health care to bed. Now we've brought a new issue back in, and we've got new words like "super rural."

[Laughter.]

MR. BUTLER: So I feel like, oh, my God, now we go all the way -- don't close up that chapter yet.

So I would think that our decision around the add-ons would have to be related to some expectation -- I'll used your earlier words, expectations not around quality but around an access standard that we're trying to serve, right, not a margin based on cost, but in the end what access is it that we're trying to make sure that is occurring and what is the price point that is the best guess at what that ought to be to make sure that that takes place? I don't know how else to really evaluate what the right payment level is in the end. That was my round two, so I won't comment on round two.

MR. HACKBARTH: Can I ask you about the first part where you were talking about institutional providers of the ambulance services? Were you saying that they may have high costs? They don't look at this as a broad business, but,

you know, filling a particular need of the institution, and so they're not looking for economies of scale necessarily, and they may have higher costs than one of these private firms would if they look at it from a different perspective? Is that what you were saying?

MR. BUTLER: I think so. The company that we use and that I'm involved with is at multiple sites. When we think could we do this, should we do this, would we want another municipality to do it on our behalf, we look to them and say, My God, they're at a lot of sites, I bet you they got a good, consistent product with a cost structure my guess is less than what the alternatives are that are out there, partly because they might pay benefits and things like that differently, but partly because they know how to consistently staff these things, and they've got a database and some scale to kind of say, okay, I think I can do this cheaper and better than others, and they look at the revenue size and know how to play that game to get the non-emergent, non-Medicare business to really make it lucrative.

DR. BERENSON: First, I want to just clarify, follow up on Scott and Mike's questioning about trying to get market prices as a comparison. Zach, your answer to

Mike about a Part A stay transfer, basically the hospital pays the transport, right? Is that basically what we're saying?

MR. GAUMER: Essentially, yeah, they eat the cost of the transport. If they have their own ambulances, it's an easy calculation. If they have to get a service, they probably contract with a service for --

DR. BERENSON: So basically we could look at both health plans and hospitals, the kinds of rates that they're negotiating as some guidance about what sort of market prices are looking like.

MR. GAUMER: Yeah.

DR. BERENSON: Okay. The other one, I think I'm following up on Bill's point. In the chapter you have a little part on some areas that the inspector general has expressed concerns about, and they go to non-emergency ambulances and apparently, in particular, around dialysis. Are you planning to do what we often do to find that there's a problem, which is a geographic variation analysis -- call it the "Miami-Dade test" -- to see if there's some consistency or whether -- I mean, that to me would be one of the kinds of ways we would look to see if there's at least

different behavior without explaining what's causing the different behavior.

MR. RICHARDSON: Yeah, we're going to look at the claims data like that and then also identify some Medicare administrative contractor, medical directors, that it would be worth talking to, more anecdotal but just to get a sense from them. Just looking at the IG's reports, there seemed to be certain areas that have attracted their attention at least, Houston and Dallas and places like that. So it's probably worth talking to the medical director of the MAC that covers that area and a couple other ones just to see if in their experience there's some variation across the different areas.

DR. BERENSON: Thanks.

MR. KUHN: A quick question about bad debt. Do we have a good sense or any kind of sense of how much bad debt ambulance companies are carrying?

MR. GAUMER: We can get back to you on that. We have some work on it. It's an issue. I know in our meetings with the ambulance community they've mentioned bad debt a couple different times as an issue. We should look deeper into that.

MR. RICHARDSON: Just one follow-up. I think, though, that that is more of an issue with private payers than Medicare. Is that right?

MR. GAUMER: Yeah.

MR. RICHARDSON: That's what I remember. We'll follow up on that specifically.

MR. KUHN: Okay. And I'm curious also with the super-rural payment and the dollar amounts you were giving, does the beneficiary co-payment -- is it off the base rate, or is it the base rate plus all the add-ons? Is the co-payment based on the maximum payment?

MR. GAUMER: I believe it's the whole thing.

MR. KUHN: Okay. Another question. I'm just curious if we could find out any information in this area, kind of a little bit what Peter was talking about, the institutional versus non-institutional providers of ambulance services. I know in some cases that I've seen -- and, again, I don't know how widespread this is, but where a lot of hospitals perhaps used to run the ambulance service, they don't know. It's either with a government entity or private entity. But in order to support that in the community, they make a payment to that entity to support it

beyond just the payment for the transport services, but, you know, I see this more predominantly in rural areas, but I suspect it goes on in urban areas.

Do we have a sense of how widespread that practice is across the country? I imagine it's probably more for the governmental entities, but do we have any kind of sense on that?

MR. RICHARDSON: No, not right now. We can certainly look into that and also see if the GAO did when they were trying to get a sense, because at least some of the -- we'll just have to see what they came up with to see if it made any difference in the cost structures because, you know, if there's that subsidy available, it may influence the providers' cost as well.

MR. KUHN: Thanks.

DR. DEAN: Like Peter, I was intrigued by this term "super rural." I've been involved in rural health issues for a long time, and this is the first time I've ever heard that term. So it would seem that we need some -- and I think you said in the chapter, we need to somehow standardize. I was particularly -- I couldn't understand -- you say that some of these are actually -- at least by the

urban influence codes, are actually metropolitan? That was a little hard to swallow.

MR. GAUMER: Yeah, we did find that, you know, comparing the super-rural classification to the UIC classification, which we've talked a bunch about, there are some cases. I think it was 27 percent of the super rurals were located in -- excuse me. It was 27 percent of the super rurals were located in frontier counties, and we expected the number to be significantly higher. And 10 percent were located in metro areas.

Part of that is because of the exception that's built into the system -- the Goldschmidt Rule it's called. This was also a new thing to me. So we would expect to see super-rural zip codes located in places within San Bernardino County, which had been, you know, exempted kind of or included specifically. But there's more there to look at, yeah.

DR. DEAN: And I guess the other issue is -- I mean, I think the issue probably is more related to volume than it is to location in terms of being able to run an efficient system. It would probably be useful to look at are there competing systems -- I mean, some of the same

issues that came up in the rural report about CAHs and so forth. At least in our area, we have two competing helicopter services, and I don't know their numbers, but my sense is that neither one of them are at a rate that fully utilizes the equipment. So I think the volume probably is the key issue in terms of maintaining really a viable and effective service, but I'm sure you'll look --

MR. RICHARDSON: Just a quick comment on that. It has been -- some of the folks we've met with have specifically mentioned this in regard to air ambulance services, that there's been rapid growth in the number of providers and overlap in their service areas, if you want to refer to it that way, and concerns about both the quality of the services being delivered and even just the safety of having multiple helicopters trying to -- and there were some accidents a few years ago which got some play in the media. So that's certainly one of the things we want to look at with regard to air ambulance.

DR. MARK MILLER: If this is any help -- and I'm trying to pull together what Peter, Bob, and you just said -- the way I'm trying -- I didn't quite have the elegant way you were talking about it, but I think the last thing I'm

going to say is what you're saying. The way I'm trying to organize this in my mind -- and I'm just kind of moving along here; I don't have it wired out -- is thinking about it, this issue is going to repeatedly come up and kind of vex the Congress, which is why it's in our lap, incidentally.

You know, one set of recommendations and thinking that we may want to do is about what data we want over time, because there is going to be a decided lack of information here.

A second box is sort of program integrity. Can you look at the claims data, whether geographically or otherwise, and identify patterns that look -- that may be -- in discussion with the industry or with medical directors, these are indications of aberrant behavior and could you begin to identify those types of things?

Then the third thing is really the most difficult and the real thing we really need to do, which is how should we be paying here, and I think you've hit on the points and you've hit on the points, Peter, of kind of low volume is decidedly an issue, but how do you work the isolation issue, particularly when we're talking about air flight, that type

of thing?

And so that's the kind of nut we're going to have to really think about how to crack, but you've indirectly touched on a lot of the different things we're going to have to pursue here.

MR. HACKBARTH: Ron.

DR. CASTELLANOS: I'm just curious, I looked at the critical dates. You are really going to have a tsunami effect December 31st, basically of, your report is due in June, but everything goes away December 31st, to include -- all of you should be aware the SGR will come up again.

Is there going to be any pressure to get this done before June?

MR. RICHARDSON: Yes, yes there will.

[Laughter.]

DR. CASTELLANOS: Okay, good.

MR. RICHARDSON: Yes. I mean, the point we were making is that the policies, the three add-on policies -- the mandate is very specific we need to look at and evaluate their current expiration is December 31st. Some of the language says they are no longer in effect as of January 1st, 2013. It means the same thing.

So, that is -- I should say, before that, the Congress is going to need to make a decision about -- as I put it, end, amend, or simply extend them again. So, that is what they are looking for us to help them make a decision there, by the end of the calendar year.

MR. HACKBARTH: So, even though the official report date is in 2013, what we would be looking at is trying to reach a conclusion in terms of recommendations by November. And so, that probably means in September certainly another discussion of this, October draft recommendations, November vote on a final, so that when they take up all of these issues at year end, they have got our input.

DR. CASTELLANOS: Second question is -- and I was asked to ask you this -- in the area I live, we have a lot of bridgeless islands, people that live on islands without bridges. And the only way you can get these people off on an acute basis is by helicopter.

On this super-rural, is there any exception for something like this? Most of these people that live on these islands are retired and in the Medicare age group.

MR. GAUMER: There are some super-rurals that are

classified through this add-on people that we are going to be discussing which essentially grandfathers in a bunch of places as rural.

I am not sure about Florida specifically, but it seems like they are in most states. So, yes.

MR. GRADISON: Most of my questions have been raised already. A couple of thoughts:

First of all, I seem to recall the National Transportation Safety Board did a study of helicopter accidents involving medical -- it might be interesting -- my recollection which, again, as I often say, I do not totally trust was that part of it was related to the frequency at which they actually flew and that the less frequent, the greater risk of accident, but that is -- well, the study will say, but it might be interesting to take a look at that.

I kind of wonder, listening to this discussion, whether there may be some major change around the corner that could substantially increase the use of these facilities in emergency, non-emergency situations where it is simply vital to provide certain treatments very, very quickly, more quickly than just driving them to the hospital

and letting them start to do the injections of whatever they are supposed to do. And we already have some information about that, I appreciate that, but maybe that is part of what is going on here, is an anticipation of newer medical treatments could greatly expand the market for this type of a service in the emergency field.

As far as the non-emergency, I would really like to better understand what is going on there and I know you are working on it.

I do have one question. This is actually a question asked me by one of the students I work with at Duke, and I was not able to, even with a lit search, to come up with an answer. I was asked, what is a mobile ICU? Have you run into that term at all?

MR. GEORGE MILLER: Oh, yes.

MR. GRADISON: Well, I will talk to you separately because I want to make sure -- well, I just want to make sure that I understand what is going on there. No point in taking more time now, but I am going to take advantage of -- later in the evening so that I can answer the student properly.

Thank you.

MR. GEORGE MILLER: Yes. I want to echo -- first of all, I just thought this is a fantastic and fascinating chapter to read.

Like the Chairman, I knew little about it before I read the chapter, and now I understand less, but it is just --

[Laughter.]

MR. GEORGE MILLER: It is still fascinating.

But one thing in the chapter -- I wanted to raise a question, and that deals with the rural area. You mentioned that the methodology to define remote areas and relate that to payments, there was a poor correlation between that. Do you have any recommendations on that issue or is that just an observations in general?

And then, the second part of my question -- I do not believe I read anything in the chapter about quality issues. Are quality issues and concerns going to be something that we are going to address? And over my career, we have had different levels of quality, including the -- depending on the patients and the critical necessity, we would call for a mobile ICU to transport a patient upstream to -- who is critical ill versus being in a very, very

remote area that was 70 miles from the nearest tertiary care facility, and all voluntary EMS -- all voluntary. So, the gamut runs the rapid -- so, is there a way for us to assess and measure the quality of EMS and are there going to be any recommendations or are we going to address the financial aspects, as this chapter so eloquently does?

MR. GAUMER: I will tackle the geographic question first.

MR. GEORGE MILLER: Yes, and you will let him take the hard question.

[Laughter.]

MR. GAUMER: He can have the tough one. He is our quality guy.

So, we, in learning about the ambulance fee schedule system, John and I were as surprised by the super-rural definition, as most of you were. It was new to us and felt that it was important to include an explanation of that in the mailing materials for all of you.

We just wanted to lay it out there and get your reaction to it. So, there was nothing implied or assumed.

MR. RICHARDSON: Quality, my favorite topic.

Yes, I think we will at least look at it. I think

in terms of other areas, this one is probably somewhat further behind than, say, hospital quality measurement or even physician quality.

There is one interesting thing which we started to look at, which is the quality of stroke care, which can be greatly affected by how rapidly the -- yes, cardiac, but also just the anti-thrombolytic, how quickly they are administered after the onset of symptoms and the ambulance can play a large role in that. And so, that is one -- there has been a very small study that I have learned about that was done in Chicago that looked at this and tried to compare between different ambulance services how -- looking at the outcomes from the stroke patients that were delivered to emergency departments.

So, there might be something there, a long way from something like value-based purchased, but consistent with how we have addressed other payment systems when we are trying to bring quality and value in it. I am certainly interested in looking at that.

MR. HACKBARTH: Okay. Rather than go around one by one, anybody have a second comment?

DR. BORMAN: In terms of looking at future data, I

would wonder if you could maybe give us top ten diagnoses perhaps -- for overall or perhaps by air versus ground or some other classification, because that might help us hone in a little bit on what is going on and where things might need to go in terms of where add-on payments are appropriate.

Second thing is I am struck in looking at this formula by its similarities in some way to the Medicare fee schedule for physicians and other eligible providers. It is a multipart formula, multipliers of multipliers of multipliers, and I think that one of the things that I know you will do a fabulous job of dissecting all the components, and I would just say let's also not lose sight of the whole, what the endgame is, as you have shown nicely here by your illustrative example of comparing the entire payment in the end that, while you do the analysis on the individual pieces and their propriety that we not lose sight of also the endgame payout there.

I was struck by what seemed to be a relatively small percentage of air transports compared to my own experience, but it may be different in the Medicare age group compared to an undifferentiated age group. But I

guess I would wonder about the contribution, particularly since air is growing and air rural is growing -- about the dollar percentages. Is there a trend that that dollar percentage could grow, because if you look at Page 11 at your table, the average payment per claim for an air transport is logarithmically greater -- or exponentially greater, and if that were to continue -- if that is what the trend is, then that could be a substantial expense issue that I think bears keeping in mind, looking into.

And then, finally, I think, given -- and you cannot do everything in terms of the time constraints, but the idea of extracting in a multipart -- extracting some principles as we did for so many things in the rural report to me may be something very important to be able to say here that -- particularly in the short timeframe. We may be able to come to principles more quickly than we may be able to come to something that, at the end of the day, might be micro management.

DR. CHERNEW: I think one of the challenges here is this is a high fixed-cost industry where you need to have some slack when people are waiting for something to happen, and that makes the economics of it particularly challenging,

because it is very hard to allocate the cost of various things.

So, I think the biggest challenge here is that, in other situations, I think our price the Medicare reimbursement could be higher and other payers might be taking advantage of that, and we have had some discussion about that with regards to Medicaid. This conceivably could be the opposite.

And so, I think, as we go through and think about what to do, the measures of entry by different types of firms, for example -- what you said in your very beginning remarks, Glenn, I think are going to be really important, at least to understand the overall profitability. And then, we are going to have to think a little bit about how we want to think about where Medicare payment rates should be relative to -- if others are paying a lot, do we want to take advantage of that and maybe pay a little and pay less of the fixed costs, and that is going to require some thought, because that is challenging in general.

MR. BUTLER: Okay. I guess I do have one more comment.

We really have not talked about the -- I think

drawing a little brighter line between true emergencies and non-emergencies is going to be important, because I think it is very different to make sure we can get people -- either individuals or communities that are under emergency situation requires a different kind of approach in thinking than the -- I would not call it "discretionary," but I would call it non-emergency, because a lot of these ambulances sit within EMS, for example, and I think it is a different kind of exercise.

And I cannot resist, then, one other comment on the trend towards privatization and outsourcing is that you can teach a turkey to climb a tree or you can hire a squirrel.

[Laughter.]

MR. BUTLER: So, there's some institutions where that is all they do, and that one thing is just kind of a big deal and I know it is a trend today in this.

MR. KUHN: Just two additional comments from me.

One is, on the quality issue that was raised earlier, I do think that is a good one, if we can pursue that. One opportunity to look at that is, I think, some ambulance services and states are working with patient

safety organizations in those states. So, that might be a good place to look for information in activities there.

And then, finally, picking up a little bit more where Bob left off on program integrity, it is kind of troubling that I think under the SNF PPS system, this kind of bundled payment has been in place for a decade now, and the fact that we are still having some difficulty ascertaining which one is Part B billable, which one is the bundle seems to be very problematic. So, any kind of further looking at that we can do I think would be useful.

MS. BEHROOZI: My concern is also on the program integrity side and separating the emergency from non-emergency and the fact that more of the inappropriate billing seems to be on the non-emergency side. But I just want to note for other work that the Commission will be continuing over the next few years that, on Slide 4, you note that non-emergency transports require physician certification of medical necessity which is, as I recall, something that we recommended be imported into some other payment system to avoid fraud and abuse. So, we probably need to look at some other ways to get a handle on that, at least in this program, and maybe some of it is education.

Maybe some of it is both provider and beneficiary education about what ambulances are really for.

DR. DEAN: Just maybe some context for all of this, and it relates to Bill's question about mobile ICU. Our reason, where I am at for using air transport has nothing to do with the speed. We can get somebody to our tertiary center faster if we just put them in an ambulance and send them down the road.

The difference is because our problem is the helicopter has to come an hour to get to our place and then another hour to go back, but the advantage -- the reason why that is worthwhile is that they are essentially a traveling ICU. And the safety -- our concern is putting that patient in a standard ambulance with a basically BLS crew who are very committed but do not really have the capabilities to handle big-time emergencies.

It has always been our judgment that it is better to keep the patient at our hospital until we can get the sophisticated team with all the monitoring equipment to come, and then use that equipment or that capability to make the transfer.

But like I say, in terms of speed, which is what

most people assume when you use air transport as an issue of time, it is not, at least in our case. So, it is another -- just for whatever that is worth.

The issue of -- there have been some nasty accidents and some very disturbing accidents. My understanding is that many of those had to do with weather issues rather than anything else, and attempts by helicopter crews to get to a place where they were clearly needed but were asked to fly in situations where it really was not safe, and they have really cut back on that enough so that it really creates a burden for us sometimes, because even though we need the service, they cannot fly. And so, we are stuck. But I understand it, that it is a safety issue that we cannot ignore.

Finally, at least in the area where I am at, the threat to our ambulance service is -- and I probably should not say this -- is not so much the payment but the ability of maintaining our volunteer EMT crews, which we are totally dependent on because it is a low-volume service in a small town.

We have a marvelous crew that really delivers a great service, but they constantly struggle with recruiting

and maintaining things because in our attempts to increase quality, we keep adding on more requirements and more additional training and so forth that they are supposed to have. And either they say, "I just cannot keep up with this," or their employer says, "I cannot keep up with this." And so, it is a threat, but we have been very fortunate. And even in times when we have had to face major emergencies with multiple injured people, it is our EMTs that have saved the day because they brought in extra people that could help to monitor these people when we only had a couple of nurses and one doc. And so, I have nothing but positive things to say about it, but I really am concerned with the additional burdens that we continue to lay on them in terms of raising quality, we cannot ignore. I mean, we do need to do that, but it is a question of the perfect driving out the good. So, whatever that is worth.

MR. HACKBARTH: Any comments on this side?

DR. NAYLOR: Briefly, I really like any focus on outcomes, here.

I am wondering, on the issue of physician certification, if there are issues that might be uncovered in terms of understanding of who does or does not meet

eligibility requirements, so, as you are pursuing that with medical directors.

And my third point -- oh, yes -- and I do not know if this is worth at all, but if you were to take the Goldsmith modification out, if you were to do an analysis of use of ambulance services based on how we have defined rural or uber-rural or super-rural and others. Would it look different? I don't know if that is worth pursuing, but I am wondering if it has implications for continued payment.

MR. GEORGE MILLER: Yes, just briefly. I want to echo what Tom said, especially in rural areas. There are three critical issues that I think, as we look at this information, particularly in those rural areas or remote areas where there are volunteers, and that is a whole different animal, and again, I want to highlight what Tom said.

There are three critical issues: You have a volunteer service, so there is recruitment, there is retention, and a continuing education, and these folks -- employers -- it is like the National Guard, the employers have to let them off for their recertification, their education, and then, when there is a multiple accident or

some major catastrophe, they supplement the rural hospitals and bring in extra hands. I do not know how the reimbursement deals with those issues, but they become a major impediment to keep a qualified, well-trained staff. And in this, the burnout -- because if you do not have a large population, the turnover becomes very tremendous as Tom indicated.

So, I think as we deal with outcomes and quality, we need to take a look at that and at least be cognizant of that issue.

And then, finally, on the issue Tom mentioned about using air versus ground and I want to echo that.

There are often times in rural areas where the quickest way is ground, but because of the medical ICU and the capabilities that that helicopter or fixed-wing provides is much more preferable over ground transportation, for the reasons I just illuminated about the volunteer services. I just wanted to echo that, as well.

MR. HACKBARTH: Okay. Thank you, John and Zach.

And our last session for today is on collecting data to improve relative values in the physician fee schedule.

DR. HAYES: Good afternoon. The specific type of data we want to talk about today is what's known as time data. These would be data that would be used to validated or even replace perhaps the estimates for the fee schedule on how long it takes for physicians and other professionals to furnish specific services.

For the Commission, issues of equity and accuracy of fee schedule payments have been longstanding concerns, as you know. Most recently, you made recommendations on improving payment accuracy in the Commission's October 2011 SGR letter.

What we can begin to talk about now is how CMS might implement one of those recommendations, a recommendation concerning collection of data on time.

The fee schedule relies on time estimates heavily. In the case of the relative value units for work, the statute defines work as time and intensity. But as you know from Commission analyses, for the most part the work RVUs are a function of time. The time estimate explain most of the variation in the work RVUs.

Karen has reminded us from time to time that time also is a factor in determining the fee schedule's practice

expense RVUs. So we have in certain cases what are known as the direct costs, some of which are a function of the time estimates. These are direct costs being costs attributable -- identifiable for specific services. But the time estimates also go into the formula in the practice expense methodology to allocate so-called indirect costs to services. These would be what you might think of as shared costs, items like administration and rent, things that are not readily identifiable as related to specific services.

There are any number of reasons why the time estimates might be inaccurate. Services can change. Factors such as technological advances, substitution of one type of input for another in the delivery of services, changes in patient severity -- there's all kinds of things, as you can imagine, that could go into changing the nature of a service and rendering its time estimate inaccurate.

The other thing that has come up has to do with the estimates themselves, their origins, and surveys conducted by specialty societies, and recognition that those societies in turn have a financial stake in the results, and does this introduce some potential for bias in the estimates.

Research has shown that there are -- has provided some evidence that there are errors in the time estimates. Research for CMS and for the HHS Assistant Secretary for Planning and Evaluation has shown this to be the case for some services that the estimates are too high.

Then the potentially misvalued services initiative that CMS has undertaken, that, too, has in a lot of cases shown that the RVUs and the time estimates for services need to be revised downward.

But just thinking about why all of this is important, we can recall that the inaccurate time estimates would have some implications. Obviously for the RVUs, if we think about the work RVUs accounting for close to half of fee schedule payments, the practice expense RVUs accounting for half of fee schedule payments, and two-thirds of that being indirects, we could stop right there and say that, you know, about 80 percent or more of fee schedule payments are either directly or indirectly influenced by the time estimates.

But it's not the case that this is just a fee schedule issue, of course. We know that private payers often use the fee schedule's RVUs in their payment systems.

They might have their own conversion factors, but in terms of just comparing their payments, one service relative to another, the extent to which they use the RVUs becomes important there as well.

And then there's the matter of physician compensation. You'll recall that we had work done by a contractor last year which shows that, for the most part, physician compensation is usually based on the work RVUs. We had another contractor report which compared compensation by specialty and found wide disparities. And so for the Commission this kind of thing, such disparities are where the concerns about equity come in.

And then just looking toward the future, you know, if that's not enough, we do know that as plans for new payment systems have emerged, they often retain some element of fee-for-service and may in some cases even be built off of fee-for-service. And so it appears that these kinds of issues will be -- issues having to do with the time estimates will remain salient for some time.

Just a quick reminder about the recommendations that you made on these matters. You've done so on a few occasions. If we think about going back to the March 2006

report, there were recommendations there just about the process for identifying overvalued services. But then more recently we've had the SGR letter, and there you had two recommendations. One I recall was collecting the data and doing so in a kind of targeted way, focusing on a cohort of efficient practices, remember all that. And then there was a second recommendation related to this having to do with the Secretary identifying overpriced services, reducing the RVUs, and in so doing achieving an annual numeric target for reductions equal to 1 percent of spending. That recommendation was -- the proposal there was that that activity would start in 2015 and kind of build off of the collection of the data that was in the preceding recommendation.

So that's where we've been on this, and now I want to shift gears a little bit and think about, you know, well, okay, the Commission has made recommendations in this area. What about, you know, ways to go about recommending -- or about actually collecting the data. And so we've given some thought to that, and we wanted to just kind of develop that idea a little bit here for the next few slides.

First of all, one way to think about collecting

the data would be kind of service by service, you know, sort of a bottom-up approach, if you will, and there are different ways to go about doing this. A good example would be direct observation or what some would call time and motion studies where you would actually go out and just try to figure out how long it takes to do a specific service. And then I'll have more to say in a minute about this idea of electronic systems, but that may have some potential, too.

But then the other approach is a more kind of top-down approach where you have the physician or other health professional as the unit of analysis, and there what you're trying to do is to take the actual hours worked for the professional and compare that to hours worked that would be derived from the fee schedule's estimates of time and just kind of compare the two and do a validation check that way.

So that's what we could think about in terms of a structure for this. We have since gone out and worked with a couple of contractors to try and learn more about these different approaches to collecting time data, and so in one case we worked with RTI on the service-by-service approach. And, you know, the key things that came out of that work

were, first, that it looks like some kind of -- you know, if you're going to go at this in a kind of service-by-service sort of way, that you're going to most likely have to do some kind of primary data collection. They looked at existing data sources, and with the possible exception of a database on surgical procedures, it doesn't seem that there are any existing data sources that would lend themselves to this purpose.

They then had phone interviews with representatives of multi-specialty group practices, integrated delivery systems, and such. These were places where the organizations had some reputation for having collected time data, say for efficiency studies or something, but the question was: Well, okay, do you have data, you know, at the CPT code level of a sort that could be used for the purposes that we have in mind here? And it just doesn't look like that such databases are out there, that the organizations don't have a reason for collecting such data, and they don't keep these kinds of data around.

So then the question was: Well, okay, if we're going to have to do some kind of primary data collection, what are the options here? And one idea explored was to use

electronic health record or other electronic systems. And I can talk in some detail if you want about how that would actually work, but the bottom line is that these systems may have some potential, but it would take some doing to actually get time data out of them. The thing is that those who have developed these systems just didn't design them with generating time data in mind, so it would just take some programming and perhaps some other kind of work to actually do that.

The other option that RTI explored was direct observation and here the finding was that, you know, this can be done, it is done in some places, but it's labor intensive, it is costly. And then there's the kind of overshadowing question about the old Hawthorne effect, that those who are observed may change their behavior and would that in turn affect the results. So, you know, a service-by-service approach seems like it's doable, but there's some challenges that would go with it.

Separately, we had a contract with the University of Minnesota -- this is still ongoing -- having to do with the more top-down approach to things, and here, you know, the project includes actual development of methods for

implementing such an approach and doing a field test. And I'll get to an example of this in just a second, but the key points here would be that, you know, the contractor has developed an instrument for collecting data on two things, essentially. One is number of units of service by billing code and, second, actual hours worked.

So they've got the instrument. They are doing field testing of this now with four practices in different specialties, and a follow-on project with this would involve doing the same kind of thing, use the lessons learned from this initial field test, but expand to more practices.

So now we just come to our example of how this top-down would work, and here the unit, you'll recall, is -- the unit of analysis is the physician, and so we would have here on the left side of this table the data that would come from the practice or integrated delivery system. So you know, for each billing code it would be number of units of service furnished during a specified period of time. In this case, we're looking at an example that involves just a work day, just to simplify things, but it could be, you know, a longer span of time of a week or month or whatever it would need to be.

So we have the data coming from the practice on the left side, and then on the right side would be the use of those data to do some calculations with the fee schedule's time estimates. And so you see there, you know, a column with time per service. Those are the fee schedule time estimates that I've been talking about, the kinds of numbers that the attempt would be made here to try to validate, and those numbers exist for, you know, all the services -- all the services in the fee schedule that involve some element of work by physicians or other health professionals.

So just to work through the example, the first step here would be to try to come up with an estimate of how much time was spent on a service. We'll take the first row here. We've got five units of service number 1, 20 minutes of -- a time estimate for that, 100 minutes total, or 1.7 hours.

The second step would be to just add up the hours in that far right column to get a total estimated hours worked based on actual units of service but using the fee schedule's time estimates to come up with the time. And then you've got, you know, in italics there, ten hours would

be compared to the actual hours of eight, and you can see all this. So, you know, we've got a difference of two hours.

Now, you know, just looking at this example, that kind of thing is what you'd want to go through to kind of -- procedures that you want to go through to validate time estimates. Just based on this one example, it suggests that maybe one or all of the time estimates here is off. But, you know, to really draw some kind of conclusions, you'd want to have this kind of data in sufficient quantity to do a statistical analysis and to essentially look for patterns. So do we see, you know, differences between actual hours worked and estimated hours worked? Do we see those kinds of differences appearing for some services but not others? Or is it the case that, well, all of the estimates seem to be off? So that's what, with a sufficient quantity of data, you could do a statistical analysis and try and reach conclusions like that.

Then the procedure from there would be to say, well, okay, it looks like we got a problem with some of these time estimates. We now want to go through a process, a more detailed review of them specifically, and see what we

can find there.

So that's kind of in a nutshell what all of this is about, and so it's a case where we've had some -- you know, the Commission has made some recommendations. We've now tried to go another step and see how the recommendations might actually be implemented, and the hope here today is that you would have a discussion of advantages and disadvantages of these different alternatives so that that could inform our work, staff work from here and further for the Commission itself, and then your discussion might also inform CMS decisions about how to collect the time data.

That's it.

MR. HACKBARTH: Thanks, Kevin. Could you put up the example for a second?

DR. HAYES: Yes.

MR. HACKBARTH: So in the example, you have actually hours working, eight.

DR. HAYES: Yes.

MR. HACKBARTH: It seems to that this mode of analysis is sensitive to the accuracy of the actual hours worked. The last I checked, most physicians aren't punching in and out of time clocks. Where does that kind of data

come from?

DR. HAYES: In the field test, it's coming in different forms. This is a matter of working with the practice to try to get the best available data that they have. The experience so far with the field tests that we've done is that in some cases you've got pretty well established schedules for when physicians are working. You know, in some part of the day they're in the office, and in some part of the day they're over at the hospital doing caths, or whatever it is. So there's a pretty -- but, yes, it's still going to be -- there's going to be potential for some noise to creep into the process at that stage, but that's the way -- that's a way -- from our experience so far, that's a way that this kind of information is generated. But it could be -- you could imagine other mechanisms, too, queries of physicians themselves and asking them, okay, well, you know, during this observation week, how many hours did you work? And it would be -- and the expectation here is that this would be a definition of hours worked that is consistent with how the fee schedule times are collected. So this is meant to capture not just the time spent with the patient but also the time spent on

activities like documenting services on the phone, communicating with other professionals. So there would be a need to specify with the practices, this is the kind of time that we're talking about here.

MR. HACKBARTH: Okay. George, do you want to start with questions?

MR. GEORGE MILLER: Again, I found this chapter interesting. I'll yield to my colleagues and say that I agree with Cori.

[Laughter.]

MR. GRADISON: It's hard to beat that recommendation. It would seem to me that you need to do, even if it's limited to one specialty or even one procedure, that you need to do both the bottom-up and top-down lest you miss significant variations that both methods would give you. Personally, I'd rather see you select a relatively limited number of studies but do it in both ways than to broaden it at the initial stage to more procedures and specialties. And maybe there are some which anecdotally seem to be way of out of line. There's nothing wrong with taking a look at those first, but being just informed by impressions. But I don't think that's mandatory.

DR. NAYLOR: We're just doing questions now?

MR. HACKBARTH: Yes.

DR. CASTELLANOS: Just clarifying questions?

MR. HACKBARTH: Yes. Clarifying questions?

DR. BERENSON: So on that same slide, I guess here's what I don't understand. By doing this analysis in your example, you can document that the time estimates are inflated by 25 percent, by two hours, but you don't know how to establish the correct times, I mean how to allocate into those three HCPCS codes. So I guess I don't see how you can avoid at least for one of those codes getting some actual time data, and then you have an anchor and you could use relativity, say, from the RUC estimates or not their absolutes, but, I mean, I guess I don't understand how you get to making an assignment of a new time when you've documented that in aggregate you've got 25 percent error. How do you actually get to assigning time to the individual codes?

DR. HAYES: There's a couple of options here, meant to be, you know, kind of a flexible way to go about this.

One would be to -- you know, if you have enough

data, you could do a statistical analysis of a type that would have as a dependent variable, if you will, hours worked, and then, you know, what the econometricians would call explanatory variables would be the codes, the various codes, say, that if a specialty typically, you know, bills for and the number of units for each, and all of that kind of stacked up one physician after the other. So you could then estimate -- in theory, you could then estimate the incremental effect on time, on hours worked, of a one-unit change in units of service. And so that could give you some kind of -- now, some people would say, well, no, you're going to take -- that's going to take a lot of data, maybe that won't work. Then the alternative is to say, well, this kind of an approach to things is a mechanism to complement what's already underway in terms of identifying misvalued services, where you would say, well, okay, it looks like when services A, B, and C are in the mix, that we tend to see more errors -- more differences between actual hours worked and estimated hours worked, and so those would be the kinds of services that you want to subject to a more detailed review of the type that's been occurring over the past few years.

DR. BERENSON: A more detailed review meaning?

DR. HAYES: Meaning what CMS has been doing in conjunction with the RUC over the past few years where you would say, okay, here's a set of codes where we have some concerns, where, you know, up until now the approach has been, well, there's rapid volume -- you know all this. There's been rapid volume growth. There's been shifts of the service from one setting to another. Well, this would be another way to identify the kinds of services that might be reviewed.

DR. BERENSON: Here's my problem then. My problem is the following, where they have been identifying services with revised definitions or where there's some suspicion that maybe there's time errors, and we're still dependent on the specialty societies' surveys, which then get massaged by the RUC and CMS. We don't have an independent source of objective data in that review, as I understand it, right? We're still sort of dependent on those surveys.

DR. HAYES: But with one --

MR. HACKBARTH: It's still the gold standard [off microphone].

DR. HAYES: Well, but with one additional sort of

accountability mechanism here, which is this: I mean, so the estimates are revised --

DR. BERENSON: I see. So you've now bounded those revised estimates -- I see. Okay. That helps me. Thank you.

MR. HACKBARTH: Can I go back to the first part. We've long since established that statistics is not a personal strength of mine. Is what I hear you saying, Kevin, is if we had enough data with different patterns, different combinations of services and the like, that through the magic of statistics --

DR. BAICKER: Multi --

MR. HACKBARTH: -- you could identify which services are most identified with errors in the time and how much they contribute? Help me out here, people that are -- Kate, Mike.

DR. CHERNEW: I don't think you need to know the adeptness of the estimated -- the ten. You just need to know basically the eight and then what was done and then you could figure out -- there's some other assumptions that have to go in and we won't have a fiscal discussion, but how you specify the model, and there are seven bazillion CPTs and

there's -- but in theory, you could, with a big regression, see if you knew the amount a person worked and the set of things that were done, you could figure out, on average, how much time something took under simple assumptions.

DR. BAICKER: So just to be clear, what you would need to know is the total hours worked, so you'd have to have that eight for everyone and you'd have to have the units of service in the codes, and as long as there was a mixture, as long as they weren't perfectly coded and every physician was doing the same bundle, as long as there's variety in the bundles, you could then attribute the minutes, on average, to each thing with no information from the bottom up if you didn't want it. There's obviously some value in supplementing that and you have to rely on people's report of the total time. But that alone is enough.

DR. MARK MILLER: And I think some of the thinking here is if you can't field or if the history of sort of fielding surveys, getting incomplete results or low response rates and then trying to build up and extrapolate missing cells, and then also time and motion, which is extremely expensive and kind of fraught, this strategy, if you pursued it alone, and I'm not saying that you pursue it alone, would

force a structure on the existing CMS RUC process where you come along, let's say you run this, and say, These are highly suspicious codes that consistently result in more time than the person seems to be working.

And then you could do one of two things, Please look at these, or, If you don't look at these, then the system is going to assume that they are over-priced and begin to move on them. And so, it's sort of a way to have a little bit more of a streamlined data collection process to kind of force the decision-making.

MR. HACKBARTH: But in that model, you've implicitly still left the RUC survey method as the gold standard for determining the final value.

DR. MARK MILLER: And the only thing I would say about that, in the description that I just went through, I said that because I would think that the appetite of the Commission to date has been to say, There is a role for the RUC. But arguably, depending on how robust and how much of this you collected and estimated and how comfortable you felt with the statistical results, you could have some fairly sharp indicators of where your problems are.

DR. BAICKER: So just along those lines, it seems

like we're interested in improving the accuracy and we're interested in having that be moving over time as we think that the time devoted to different things moves over time. So I wonder from a data intensity perspective which do you think is more costly, repeated measures of the things you'd need for this, the eight hours and the units of service if you had to do that every three or four years, versus the bottom-up approach every three or four years?

We might say that one dominates on point in time accuracy and another dominates on ability to update overtime or maybe one is best on both. But in thinking about the top-down versus the bottom-up, I want to know both of those. Which do you think is more accurate at a point in time and which do you think is more easily updated over time?

DR. HAYES: I would say that this is more easily updated over time. If we recall the Commission's recommendation of establishing a cohort of practices that are feeding data into a process here, you've got kind of a pretty well-established, one would hope, data collection process in place, uniform definitions. I mean, this is pretty straight-forward. It's unit of service by HCPCS codes and it's hours worked.

Whereas with a bottom-up approach, it is, of course, going to be code by code and there are 7,000 of those things. That's one thing. The other is that with each service, the specification of what you want varies. I mean, within the time estimates, there are three segments of time. There is what's known as pre-service, which is what happens before the doctor sees the patient. There's the intraservice part which is, what, you know. And then there's the post, the documentation and all that comes afterward.

So you've got to -- for each code then you've got to pretty well specify, Okay, this is what I want, you know, for each of those three segments and you've got to do it 7,000 -- so I -- that's -- right.

DR. MARK MILLER: Although I think Bob would say that if you did bottom-up for a smaller set and could extrapolate, you wouldn't be doing 7,00

DR. BERENSON: That's what I was going to say in Round 2.

DR. MARK MILLER: Sorry, Bob

DR. BERENSON: That's okay.

DR. CHERNEW: I just wanted to also ask about

this. So I think actually you'd need a lot more data than this and I want to ask, in part, because, for example, you might need to know -- what if you had, for example, other staff doing some of the paperwork. Right? Would you want to take away from the -- you know, you want to include that, it's not clear if you just want the physician hours. Do you care? For individual physicians, if they're doing multiple things or not multiple things? I mean, I'm just trying to figure out if this is all of the data.

DR. HAYES: Yes. Well, you'd want to be sensitive to a few things. One would be whether the physician, we'll say, is working with another professional, and essentially, you know, to use fee schedule terminology, whether this other professional is working incident to, is billing incident to the physician. And so, because that has -- potentially has the effect of kind of multiplying the amount of work, the number of units of service that the physician can produce in a given period of time.

The way that we are handling that kind of an issue with the field test is we're saying, Well, in those instances, we just are not going to include physicians who have, you know, with them working, you know, another

professional. However, you could imagine a situation where you would want to know that and you would want to allow that data into the process and to then make an appropriate adjustment and see what the effect is of having, you know -- right. And so, that's -- so yes, there is -- to answer your question, yes, there is a potential for additional data, but I would -- additional information to be used, but I wouldn't see that as necessarily, you know, kind of complicating the process necessarily.

DR. CHERNEW: And I guess the other question I had clarifying is, how were you selecting the respondents to the initial -- is it groups of volunteers, is it large practices, small practices?

DR. HAYES: You know, there's some thought that would need to be given to that. When we discussed it, and I'm not sure whether it was here or in the office about this in connection with the recommendation in the SGR letter, the point was that, you know -- hold on a second. I'm kind of losing the thought here. Now, I had it, but it's got to come back. It will.

[Laughter.]

DR. HAYES: There you go. Ask the question again.

DR. MARK MILLER: Actually, Kevin, maybe this will help jog your --

DR. HAYES: Yes.

DR. MARK MILLER: Remember where the Commission started on this. Meanwhile, you be thinking. Okay?

DR. HAYES: Yeah, I'm going to pull out all the -- I'm trying.

DR. MARK MILLER: Remember where the Commission went on this. It said, No, this isn't about trying to average and collect a representative sample. It was targeted to --

DR. HAYES: Ah.

DR. MARK MILLER: There you go.

DR. HAYES: So how would you --

DR. MARK MILLER: [Off microphone] -- do this everyday.

DR. HAYES: You've got the ESP working is what that is.

So anyway, it's a matter of one idea would -- the key thing here is how do you define what is an efficient practice, because that's the kind of practice that the Commission talked about in its recommendation. And so, you

know, there's been some research, not a lot, but some research on what constitutes, you know, efficient practices. There's some work on things like economies of scale and, you know, the extent to which a non-physician professionals are working in kind of a team kind of environment and all of that.

So there's going to need to be some thought given on the front end to what that cohort of practice is going to look like and how would you want to define what an efficient practice would be for that purpose.

DR. BORMAN: And I'm trying to do the mind-meld thing here. Okay? I'm actually very intrigued by this, and in a very naive way, I think I understand sort of how the statistics, in fact, play out and allow you to potentially come to this.

One of my questions and to clarify how you would come at this is, I can understand this for a discrete service that plays out from beginning to end in a day, or the intraservice part of it does. But for a service that extends over multiple days and on each day something different is delivered, that is for the major global surgical package, for example, I'd have to hear a lot more

about how you attribute those activities.

So I think that as you are going down this road, I think not -- I can understand going to the efficient practices, but I think you also have to select some very discrete services. And presumably, the power of this will also lie in the number of services -- in the volume of data that you have to bear. And so it would seem to me that the highest volume codes, as we all know, are the evaluation of management codes and that because of the way that health care has evolved, at least on the Medicare side, you have -- you know, because we're going to leave pediatrics and some of that out of it because we're interested in the Medicare part, we clearly have any number of physicians who are, in fact, hospitalists and we have any number of physicians who do, in fact, no longer go to the hospital.

So that, one, there should be a fairly substantial number of data points one could collect across the outpatient visit codes and there would be a substantial number of data points that one could collect from hospitalists that would be relatively clean in terms of, they'd only be this series of five or ten or 15 codes, but you could get a lot of it and potentially maximize the

potential of this approach to it.

So it would seem to me that's where you've got to start because there's going to be a huge issue with rolling out the global part unless there's something that you didn't have the ability to include in the chapter, that you can help me understand how you attribute per day the global piece.

DR. HAYES: And so, just to -- so we're all kind of together on this, when Karen speaks of global services global surgical services, recall that what she's speaking of there would be services, say that bundle -- the payment is a bundled payment for, say, the surgical procedure itself and any pre-op or post-op visits that occur within a 90-day window.

And so, the question then would be, Okay, so you're collecting data for one day, for one surgeon, let's say. What about -- so on that particular day, the doctor was doing surgical procedures and wasn't in the office at all. And then the next day they were -- you know. So we're dealing -- we have a surgical practice in the field test, and this is front and center, you know, the kind of issue that we want to deal with there.

The only way that I see to fully capture all that kind of activity is to run out the amount of time for which you're collecting the data. So you're not doing this for a day, for a week, but maybe it's for a month or it's a few months or something like that, to fully -- the other thing to do would be for whatever span of time you're looking at for which you do have data, you want to do a kind of a comparison to say, Well, okay, you know, we captured this kind of cross-section of the services that that particular surgeon furnished. How does that compare to everything for the whole year, you know, in terms of service mix.

So did we capture the right mix and a representative mix of the surgeon. So that's the kind of -- so the global services clearly are going to present, you know, the biggest challenge here in this kind of thing. I don't think it's totally unsolvable, but we're going to have to be sensitive to that if one were to use this kind of data.

DR. BORMAN: Because I can envision getting into a very complicated thing where, for example, just on the inpatient stay side, let's say I do a splenectomy, take out the spleen. So on this day, I've delivered the operative

service which is associated with pre- and post-time, and intra-time. Now, on post-op day one, in there underneath there is the equivalent of a 99X visit.

Do you break the global apart and attribute to me each day, which would seem to potentially be the fairest thing? There's a whole bunch of things. I just raise the point that I think that starting this analysis with things that are very discrete services over a day would help me to have a lot more confidence in its output of this kind of analysis as opposed to jumping into a rather complicated bundle to start with. But I understand you need to explore the feasibility of that.

The other clarifying question I would ask is, this is a contractor to the Commission. This is not a contractor to CMS. Is that right? So the University of Minnesota is doing this as a contractor to the Commission. And is there a point in that contractual process that will be sort of a sniff test on the preliminary data with some clinicians and not only my valued colleague economists and statisticians and actuaries, of course, so that just as an attempt to say, This kind of feels right, or understanding more about the methodology to just be able to bring something to bear at

some relatively early point in the process.

MR. HACKBARTH: Okay. Round 2.

DR. STUART: I just want to add to a point that Mike raised about how do you select these practices and how do you know whether it's efficient or not. And simply to note that if you had enough data, from a theoretic standpoint, you could use information about the practices, including the number and type of other ancillary providers who are there, the square footage. I mean, there are all kinds of things that if you knew enough about the practice and you had enough variation across the practices, then all of that information goes into the same large equation and you still get the right numbers, plus you may learn something about what actually is driving the efficiency.

Now, I want to emphasize that that's true in theory. When you're actually applying this in practice, you're going to have to make some pretty important restrictions in terms of your expectations here. But it still is something that I think is worth kind of laying out the theoretical basis for it because at some point, you may decide that this other kind of information is even more important than the time information that you're looking at.

DR. NAYLOR: So I think you've made a great case for how important this work is, and if I had to make a recommendation to CMS, I would say -- wait, I'm not sure I would put a ton of money into a time -- refining a system when we're -- a system is evolving. And so, I think about what are ACOs going to look like or whatever the future evolving -- or with bundled payments.

And the value of the work that's going on at Minnesota may be this template. But if I were to -- I would hope that we're thinking about templates that aren't looking at care delivery and the unit of analysis in the same way in the future as it is today, that maybe the patient becomes the unit of analysis or the work of a team becomes a unit of analysis.

So I'm just not sure that I would make recommendations that you would spend a huge amount of money today except to think about what could an assessment of efficient practices in terms of payment to whoever delivers that service -- what could it look like? What can you learn from the four sites that have ongoing that could inform and anticipate a changed care system. So that is mine.

DR. CASTELLANOS: I have several points. One is,

just a continuation of a point that Karen brought up last -- in the past and, Kevin, you acknowledge that she's done it. And when you look at practice expense, there's a direct and there's an indirect cost. And as we found out in the material that was sent out to us, the indirect costs account for two-thirds of the volume of the money.

We're focusing predominantly now into the direct costs. I don't want you to lose sight of that, that there's another source that we really need to look into. I think there's a lot of things that or some of the things that MedPAC can do to recommend some maybe administrative simplicity just to help with the administrative side.

One of them is, we've already recommended in the past just having a single insurance form. That would save millions and billions of dollars. I know that that's been discussed, but I think on the administrative side, let's not forget it because that's a bigger picture.

From Bob's viewpoint, you know, Bob, what you're saying is really you want an independent source. That's all you're asking for. And I think that's a good reason. What intrigues me is what Mike and Kate just said, that this may be available just by the hours that a physician works. That

intrigues me. I don't know anything about that model. I only can say that in my practice, there's no such thing as a normal day, and I don't think anybody sitting around here has a normal day.

You're kind of putting out fires, multiple interruptions, telephone calls, and not to include the work that you take home. So it's really intriguing, if we could look at that model, also. I think that would be something that we may want to consider. And maybe a middle of the road approach would be yes, the gold standard or what we use now as maybe the RUC data, but, you know, it really isn't.

It's probably the only standard we have, but perhaps the data we collect, whether it be by direct, by what you said, the up or down, perhaps we can use that data, or in the RUC process, for the time, also. You know, try to get a middle of the road thing. The RUC has, in my opinion, done a good job. It's totally volunteer. They don't get paid. There's no cost to that.

And for the most part, I think they do a fairly good job. There probably is some self-serving, as Bob suggested, but perhaps we can massage that process and make it work.

MS. BEHROOZI: I'm just thinking back, Kevin, to when you disabused me of the notion that a lot of the way the rates were set was sort of empirical and scientific and that, you know, a lot of it is very sort of subjective judgment. So I like the idea of introducing a little bit more empiricism to the task and recognizing that it's difficult to get, you know, very detailed empirical data without burdening people a lot.

So clearly it seems a lot better to get some empirical evidence without imposing such a burden that people would resist it. And if at least you can find the low-hanging fruit by using the top-down method for the places where a correction is most needed, that seems like a great advance.

MR. KUHN: When I got the agenda for this particular meeting, I went on CMS's website and went on the Medicare learning network and pulled down their brief on just the Medicare outpatient therapy billing. That's because obviously we talked about outpatient therapy last meeting. And I went through this thing and I won't bore people with details, but just going through the time codes, all the different issues here, I can just only imagine how

difficult and arduous the bottom-up, the service by service is, and I agree with all that you said, Kevin. I think just this one brief got me to that conclusion very fast that that's just not practical.

So when I looked at the top-down approach, I think that really is this whole conversation, but I think this one in particular is a good reality check for high volume procedures and services for us to get a better look at it. But it's kind of, I think, both Mary and Mike have kind of reflected on it a little bit. You know, what are we going to measure as we think about this?

And I don't really want us to be in a position where we're measuring current practices, I don't think, as we go forward. As I think a little bit about this, is that the policy objective is either current practices or something else, and the something else, I think, is all the various flavors of care coordination that we hope the program will go to and where we need to be in the future.

Because I don't think if we think about something else, then I think, in my opinion, and I could be wrong here, but that the primary care RVUs will continue to be held back if we discontinue to focus on current practices

out there. I don't think we'll see the real value of what's in the primary care area and I don't think we're going to see the opportunity to update them to their full potential of where we want them to be in the future and that's what worries me about this.

So I think this whole notion of defining an efficient practice and for us to be consistent in moving in that direction to encourage more efficiency and where we think the program ought to be, I think, is well-suited for some policy work for us as we go forward.

MR. HACKBARTH: So I think that's an important point. So are we defining the efficient practice as one that can churn out the maximum number of widgets, or are we defining efficient practice as one that produces the best total value, high quality, at the lowest total cost? And that's a very important definitional issue. Bo

DR. BERENSON: I'll try to be efficient here. First, I just have to disagree with Mary that this isn't something we should be asking CMS to get into in a big way, for all the reasons that Kevin put up on Slide 5. All the new payment models are based on these estimates, time being the key one. The only one that probably isn't is pure

capitation. But nobody's -- I mean, we're now talking about shared savings models that essentially continue fee-for-service spending.

So I just think -- and one other argument I would make here, in addition to what Kevin had listed, was that we are currently spending something like $65 billion, or something like that, on physician fee schedule and we're still basing those payments on, ultimately, what 30 specialists tell us is the time.

The RUC doesn't just accept that. I understand that. The RUC attempts to come up with something more reasonable when the times are wildly inflated, but they have no basis for knowing whether they should reduce the time by 5 percent or 25 percent or what I believe in some cases should be 99 percent.

And one of my concerns, and I agree with Ron that the RUC does a pretty good job, but I've seen some recent valuations and estimates of time and work which are just wrong. I mean, these are services I've performed. These are services I've had done as a patient or I've known people about. A lot of it has to do with recent automation of tests, the relatively recent introduction of PACs to the

reading of imaging, and those times are still just wrong.

And so, I think we need to be doing this. I'm very encouraged by what you've done. I hadn't understood the top-down, that you could use multi-variant regression to actually do that. I think there are certain kinds of services in which that is -- lends itself very good to top-down.

I can think of interpretations of imaging where that's largely what the radiologist is doing. They're not doing multiple things. They're doing a series of codes and they're doing a series of interpretations and I think it would be perfect. Or a cardiologist reading echocardiograms.

I guess what I want to preserve about the bottom-up is that there are some kinds of services where we actually have objective data. For OR services, we at least have intraservice work. I agree with Karen that dealing with post-service work is much more challenging, but we have intraservice work, pretty objective information from OR logs.

We've got appointment books that can tell us that a colonoscopy is scheduled every 30 minutes and doesn't take

115 minutes, which is the current estimate for a colonoscopy with polyp removal. And so -- and then one other that we didn't talk about, time stamps, which have become pretty standard now in EHRs.

I don't think they work well for, say, an office visit where the doctor is taking phone calls, seeing three patients at once, et cetera, but again, I've been asking everybody I know when they go in for a colonoscopy to find out how long it took, and now everybody's getting put to sleep so they can't do it. So the last person --

[Laughter.]

DR. BERENSON: The last person I asked to go sort of, Tell me how long it took, she said, Well, I went to sleep, but then they handed me my discharge paper and there was a time stamp that had beginning of procedure, end of procedure, it was 13 minutes. It's just what the New England Journal study sort of documented.

Now, that doesn't have all the pre- and the post- and so it's not perfect, but it does seem like there's an opportunity to merge top and bottom. And the point I would make, which Mark said in the first round, is, I don't think anybody, through the bottom-up, would venture to do 7,000

services. I think if you do 100 or 200 in families, you can then use extrapolation techniques.

I do actually think if you combine that with a top-down statistical approach, but anchor some of the services in, we can call it a time-motion study, I don't think it's all that complicated to observe. I'm a little skeptical of the Hawthorne effect, but we'd want to find out. I actually think we could -- I don't think the bottom-up should be given quite the negative view. I love the idea that this top-down through statistical techniques could take us a long way.

And in the end, I guess the final point I would make, is in the end, especially if we were sort of using different approaches to coming up with initial estimates of objective time, we would need a clinical panel to refine what those -- what we were getting to deal with rank order anomalies, to fill in for very infrequently performed services, et cetera, et cetera.

So it's not simple. I don't, in any way, want to say it's simple, but I just think it's worth taking on, as difficult as it is, for all the reasons, including the $65 billion just for pure program integrity. I think we owe it

to taxpayers to do a better job of these estimates. Good work.

MR. BUTLER: So directionally, I agree with Bob, but I would, starting with the importance, if we make the SGR recommendation that we've made, I don't know how we cannot provide some pretty -- this is a pretty important deal. It moves, potentially, a lot of money around in the right kind of way.

But I'd apply four criteria maybe a little bit more rigidly in my own mind. Cost, precision of the answer, the political sale-ability when the results come out, and the time required. So if look at the cost, I'd say, Well, it may cost a lot to do bottom-up, but how much in the big picture of all of the dollars at stake? I don't think that's really an issue.

Precision. I'm not sure. I assume bottom-up might be a more precise answer, but I don't know. I would think you would make that argument. The political sale-ability, I don't know. I think maybe the bottom-up might be better and more sellable. And then finally the timing, now there's one where it probably takes longer. And so, it's a question of how soon do you want the answer.

I'm not sure I made the right judgment on those criteria, but having the criteria against which we're evaluating the feasibility of going one way or another, I think, should be a little more explicitly in front of us so that we reach a conclusion on a little bit more careful thought than, maybe a little of this, maybe a little of that.

DR. MARK MILLER: The only thing I would say about the cost is that I think we think about cost. Well, in the scheme of things, in the $65 billion scheme, is it all that different? Whereas, the agency thinks about it as, is my budget going up or down? And that's -- I think your criteria is correct, which metric is [off microphone].

DR. BAICKER: Sticking with those criteria, which seem very reasonable based on what we've learned thus far, it seems to me that the top-down seems likely to be more accurate in that you can measure across more conditions and it's not subject to the same kind of -- gaming is too strong a word -- endogenous determination, perhaps, of the time associated given the problems in measuring those things objectively.

That said, people have raised a lot of caveats

that I think are important inputs into how you do that measuring well. You would want to measure not just the physician, but other staff around. You'd want to measure over a reasonable time period. You'd want to think carefully about the selection of the sample which you are measuring because, of course, it's going to be a sample and you want to think about whether it should be representative or whether it should be representative of the efficient providers and how you're going to figure that out.

So all those seem like complications, but from my very limited knowledge on this point, it seems like those are more easy to overcome in terms of logistics than the complications involved in the bottom-up. Which doesn't mean that the bottom-up is not useful as a supplement, but everything I've heard so far makes the top-down seem like the better baseline with the bottom-up being a supplement rather than the other way around.

DR. HALL: I was very much informed by seeing the value of time estimates. That came as a big surprise to me, I guess. But I guess one thing that hasn't really been said here and is rarely said in public is that there's a great deal of tension within the care provider community about

this whole thing of RVUs.

Sometimes -- and mostly it's silent, but sometimes it's fairly vocal. Proceduralists think they're worth more per minute than evaluation of management doctors. Evaluation of management doctors, primary care doctors feel that they're disadvantaged. There are practitioners who feel that they are disadvantaged by the system.

So this tension works its way out in funny ways, but one not so funny way is that there's no consensus here. And I think we are fooling ourselves if we think that we're going to somehow be able to all sit around and sing Kum Ba Yah over this kind of issue. It's not going to happen. The best we can do, it seems to me, and that doesn't mean we should give up, is that is to sort of parse this problem out.

For example, procedures are probably a lot easier to do, to look at, and you have some sort of concept. I think you mentioned a number of them, Bob, where a 13-minute colonoscopy shouldn't be billed as an hour-and-a-half of time or two or three hours of time. There are many, many, many procedures like that.

The payment for surgical procedures which assumes

a follow-up on a daily basis for some period of time, you can't identify that. But then if we're going to use time and look at it, I wouldn't just do it for the medical community in general, but I think go back to this theme that there are practices that do seem to be exemplars of best practices and that's where I would really try and add to the database, I think.

And as Mary said, you know, this will probably go away some day, but the problem is, it's not going to go away for a while yet and we're going to have to solve it. And people, I guess, are asking us to come up with some ideas. But the idea of saying that the paradigm is the physician sees the patient, does certain things that everybody knows they do, and then it's all over, that died somewhere around 1965, I think. We have to recognize some of these realities.

DR. CHERNEW: I'm going to agree with Mary, but really strongly agree with Mary. In fact, I think she was too nice about the entire thing. That's not to say that I disagree with Bob's basic comments, but let me sort of explain why. So first of all, I believe that we have some horribly mis-priced things and I believe we can do a lot

better and I believe it's really important that we do a lot better.

That said, if you do the top-down approach, it's going to be prone to huge amounts of air, and I'm incredibly skeptical that it's worth the effort. If you look at this across 7,000 things and do any econometrics, you're right on average, but you have a multiple comparison problem. So you're going to find some particular CPTs that just by chance say you should pay three times what you know the right thing is, and others are going to be, if you try to do a similar thing for allocating spending to disease, you find that certain diseases actually save you money.

They should pay you to have them. And it's just because of the way the statistics work because you're never going to get the specification right with anything, let alone specific things, and you have to measure all of them because you need all of the time. Otherwise you have variable problems and you're not going to measure all of them.

So you're going to end up -- and then the group that turned out the econometrics say you should pay five times what they are now, they're going to be standing at the

mic and you're going to be having a little button on stop and they're going to be telling you why the econometrics tell you that they need an extra three amounts of time, you know. And it's just going to delay any type of reform, in mine opinion, apart from all the effort of doing it.

You will not, and sometimes I rant, but I say this with great confidence. You will not get this right and you will -- because you have to get every one of the things right, it will almost surely be worse, in my opinion, for this thing. And if you try and put in all the other traits, which I agree was a good idea, then you're going to get people that have those traits. Oh, I look like this? I should get paid more because I have this trait in my regression.

And if you don't put them in, you're allocating all of that other time to the specific services. So recognizing the time of day, I will stop there, but we could have an entire seminar, and I think what will make this, the top-down approach a huge pitfall. So that said, so I agree with -- Herb said that the top-up -- the bottom-up approach is really impractical and I think that's right.

The odd thing about this is I think the situation

we find ourselves in is we know there's problems and we know -- the approach I would prefer, which is really cheap, would be an -- ask Bob. Bob knows that there are some that are wrong and the problem that we face is, we somehow seem unable to say we know this is wrong, let's fix it. We have to develop a systematic approach that we can apply to every of the 7,000 crazy services to then get it right because we're not willing to say that we know a colonoscopy, or whatever example you gave, Bob, is three times as highly priced.

For some reason, the system won't let us pick the ones where we know there's big problems or the five areas where there's problems. And so, I think it is folly to try and build a system that will get this right because you just won't. And it's entirely possible that not only will you spend a lot of money, you will end up with something that is simply worse.

For the top-down approach, which I think makes great sense in theory, I can almost guarantee you will not solve the problem. It might be informative in some areas, but then you'd have to have another committee to look at the results and decide what to do because the original results

won't have the right interactions and the bottom-up approach will have a bunch of people running around and arguing all the differences that we're going to have around the table.

DR. MARK MILLER: [Off microphone].

DR. CHERNEW: Thank you.

[Laughter.]

DR. CHERNEW: So I think the right -- if I had to pick the recommendation, I would echo everything that Bob said, although I do think we can move away from this as a basis, and then try and build through the RUC and some selected targeted areas. I'm not the one that knows. I actually was not joking when I said ask Bob.

There are areas where you know there are problems and there should be selected, targeted studies for those things where we can explain that this area is overpriced, and have a system to do a better job of getting the ones that I think a lot of people understand are overpaid, correctly paid, instead of spending our time trying to develop a comprehensive system that will allow us to now get every of the 7,000-plus ones right.

Because I just think we won't, which is why a system like the RUC, which I think has all the problems that

people have talked about, basically is able to handle just a vastly more complicated process than we're going to be able to do in either a top-up or bottom-down approach, and so targeting it to find the most egregious things, I do think is very important and I would spend time really trying to do that correctly, but not try and build a whole apparatus.

MR. ARMSTRONG: So remarkably, that made a lot of sense to me.

DR. CHERNEW: I hate it when I read the transcripts. I think Cori never believes the transcripts. But thank you.

[Laughter.]

MR. ARMSTRONG: I think we recognize that we're mispaying for a lot of these services. I think it's crazy to think that we can get the right answer through this process, but I feel resigned to do better than we're doing, particularly given our belief that there needs to be a real distribution in our payment. In the end, this is just symptomatic of trying to figure out how you pay on a fee-for-service basis the right amount, and what we want is we want to pay for those things that we get the best return on, but that's not where the system is at right now. So we

have to do this.

In terms of commenting on the advantages of the bottom-up or top-down, I also like Mike's conclusion. Let's just do what Bob says and I'll go with that

DR. BERENSON: Can I comment for a second?

DR. CHERNEW: [Off microphone].

DR. BERENSON: Point of personal privilege? I mean, I know some things, but my knowledge of 7,000 codes is limited. And so if I know a couple of smoking guns, who else -- I mean, there are others, is my point, and we can't -- I mean, I would be nice to just do outliers. We need somebody then who are the whistle blowers and maybe we could be thinking about a system of having -- of rewarding people to come forward with the wrong times or something like that.

DR. CHERNEW: I agree

DR. BERENSON: Okay. Maybe that's what has to happen.

DR. BORMAN: I'm just going to try and hit a couple of things. First off, I would say that I have some concern that just like the RUC process has to have some assumptions and some rules, that this will be very sensitive to that as well in terms of how we define an efficient

practice. The demographics that that practice treats could be very influential in determining the outcome if we happen to get to -- if there's an implied selection process in there that we don't entirely understand.

So just, there will be, I think -- I don't know that there will be as many, but there would need to be some careful analysis of what were the implied -- what were the assumptions that were made or what were the criteria in terms of getting the efficient practice. For example, the RUC valuation process is meant to describe the typical patient defined as 51 percent of the time. Okay?

So that -- and it also, the vignette for the process is not restricted to the Medicare age group. So that, in fact, there may be some things about the Medicare age group that do make the time higher than the vignette that was written for the service. The most frequent patient, for example, for cholecystectomy, is in their 30s probably, 30s, 40s, in there. And yet -- and that's what we're writing and giving to people to say, Tell me how long it takes you to take care of this patient, as opposed to, if we're really trying to talk about the Medicare patient, that, in fact, could be different.

So there is some flexibility and I would encourage flexible but not limp out there. There is fudge, if you will, in those estimates, some of which is probably legitimate in terms of the RUC is often giving best case scenarios as opposed to necessarily a spectrum of ages and diseases.

On the other hand, I would agree with Bob, probably that there is some systematic over-estimation just by virtue of the way the process is set up, and I would agree with Bob that there will be a need for some relative valuation going forward for quite some period of time. So I would support that this does, in fact -- is worthy of some attention, balancing it in the Commission agenda going forward.

I think, again, sensitive to the assumptions that are underneath it, I think that we need to acknowledge that there is some pressure when something is brought forward to the RUC, that it's a zero sum pie and that there is some pressure back in terms of sniff test and credibility -- you're saying what? And if every specialty gives each other a rise in minutes, that just kind of -- it doesn't really change any relativity, so I do think that there is -- there

is something of a break there, perhaps not enough of one.

I would agree with Bob that there probably are some key areas that in private could be identified as potential places to investigate or that bears study first. And I think, frankly, if you look at high volume services, that will lead you to many of them. If you look at high volume and high cost, getting back to sort of the Nick principle, I think that at the RUC, you're doing things like you often have a dichotomous thing.

So, for example, in my own practice, cholecystectomy is done open. That is not laproscopically. There are a number of patients that are already have an open abdominal operation for something else that legitimately should have their gall bladder out. Okay? So there's that.

But then a good bit more common, certainly equally as common if not more common, is somebody who started out have a laproscopic cholecystectomy and because of technical issues or difficulty just the stage of disease or other prior operations, whatever, gets converted to an open operation. That's a way different group captured under one code.

So I just think that there's -- I guess my short

answer is, I think there is probably some value. I find this intriguing. I think careful examination of the assumptions that we're making, that the researchers are using underlying it, the criteria for the selections of practices need to be very transparent and we'll need some post-hoc review when the results are available and that those need to be examined by a group of people that understand maybe both methodologies or some of both, and that it should focus on discrete services.

And there are some minor procedural services that are certainly discrete within the day that would lend themselves. But in addition, there are many E&M services that would lend themselves to starting with this analysis.

And then finally, sort of an editorial comment. Many of you believe that the biggest inappropriate valuations relate to the valuation management codes related to all procedural codes. If you want to view this as you think this is another way to maneuver that process, I would say to you I'm not sure that that's what it's going to be and you may want to spend more time on doing this through some other method that you define some of these other services that you find of value or other -- you proceed with

other care coordination models or things.

This will, I don't think, be the way that says that E&M services, by time, are hugely mistreated compared to non-E&M services. Just an editorial comment backed by no data other than some experience in working through the process.

DR. BERENSON: Just real quickly. My assumption, frankly, is that the major area that needs attention are in test interpretations where automation has really changed it, not in procedures. I think we know about a little bit about inflation of major procedures, but that, to me, isn't where I would expect redistribution to come from.

One basic thing we would have to demonstrate, I think, I know this is a view CMS has and I think some at the RUC have, is yes, there's probably time and place, but if it's across the board, then in a relative value scale it doesn't matter. I think it's not equal across the board, but I don't have the evidence to demonstrate that.

I think the real problem is not having kept up with automation related to what's involved with interpretations of things. And so, if I were picking an area to focus on, that's where I would be picking.

MR. HACKBARTH: Okay, thank you, Kevin. We will now have our public comment session.

MS. MCILRATH: It will be short, you don't have to hit the button.

I just wanted to say that one other piece that you could think about is that one of the ways that the RUC has sort of taken some of the -- put more objectivity into the time processes that they have packages. So that you have -- if you've done a particular surgical procedure, there is a standard package of what your gowning and all of that stuff is going to take.

And there are areas that you could think of doing that, maybe with automated tests -- there are areas where you could think of trying to get some kind of more objective time data that people could use as part of those packages.

MR. HACKBARTH: Okay, we are adjourned until 9:00 a.m. tomorrow.

[Whereupon, at 5:29 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, April 6, 2012.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 6, 2012
9:01 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:01 a.m.]

MR. HACKBARTH: Okay. Good morning. We have two sessions this morning, the first on variation in private sector payment rates and then one on care coordination.

Carlos, are you leading on private sector payment?

MR. ZARABOZO: Good morning. Julie and I are here to discuss some preliminary findings from an analysis in which we compared variation in private sector payment rates and Medicare Advantage bid data across geographic areas. We would like to thank Matlin Gilman and Jeff Stensland for their continuing assistance on this project.

MedPAC examines private sector payment rates and market conditions for a number of reasons. For example, we compare physician payment rates in the private sector to Medicare rates as part of our payment adequacy work in looking at access to physician care. We have also noted the connection between financial pressure in the private sector and the financial performance of hospitals. We have found that hospitals facing financial pressure from private payers have better Medicare margins. From the Medicare Advantage point of view, MA plans are private entities that enter into negotiations with physicians and hospitals to determine

payment rates. Those negotiated payment rates are not required to be the same as Medicare fee-for-service payment rates.

Last year we looked specifically at private sector prices and how they varied across geographic areas. We found extensive geographic variation across metropolitan areas, more so in prices paid for inpatient hospital services as compared to physician services. Looking at average per-stay payments for hospital services, we found almost a twofold difference across metropolitan areas when we compared the 90th percentile across areas to the 10th percentile of metropolitan payment rates. There was a narrower difference in the prices paid on average for physician services. For physician services, we found a ratio of 1.5 when comparing the 90th and 10th percentile of average payments.

In looking at physician services, there was variation in prices by type of service within a market and across markets. For example, with imaging we found that across markets there was a threefold level of variation, whereas for office visits for an established patient the ratio of the 90th to 10th percentile of average payments was

1.5.

We did not find a strong correlation between the level of prices for physician services in a given area and the prices for inpatient hospital services in the same area.

Finally, consistent with the literature on the topic, we found higher prices in specific markets with high levels of provider consolidation.

One of the points that we raised in our earlier work was the question of how much MA plans might be affected by the level of private payer prices when MA plans are negotiating with their providers. Within MA, the plans are free to negotiate rates with providers. As we've mentioned, in such negotiations neither the MA plan nor the providers are bound by Medicare fee schedules and other payment rates. In such circumstances, we hypothesize that private prices do, in fact, affect MA prices. We undertook the analysis we are reviewing today to examine whether this is true or the extent to which it is true. We look at relative prices in MA using MA bid data. However, using MA bid levels is an indirect way of determining how much influence private sector prices may have on MA. We use the bid data because we do not know information about the middle box in this

slide, which is the level of MA prices -- that is, how much MA plans pay their providers.

Although we hypothesize that private sector prices in an area affect MA bids, we also know that in the Medicare Advantage market there are other factors that are important determinants of plan bid levels.

One reason that we say that the MA bid is only an indirect measures of MA prices is that the MA bid is a bid for the total cost of care that a plan incurs for providing the Medicare Part A and Part B benefit package. The component parts are, therefore, the prices paid and the quantity and type of services provided. We hypothesize that other factors that also affect MA bid levels are the service use in an area and the MA benchmarks. Miami, for example, has very high service use in fee-for-service Medicare, giving MA plans the opportunity to reduce service use and have lower bids for providing the Medicare benefit. Another factor is the MA benchmark level for each county. The benchmarks are the maximum amount that Medicare pays an MA plan. If a county benchmark is well above fee-for-service Medicare expenditure levels, an MA plan can have a bid that is high relative to fee-for-service costs in an area while

still being able to use Medicare dollars to offer extra benefits and attract enrollment.

Now I'll discuss the data that we used for our analysis and our methodology.

Our analysis is based on the bids plans submitted in June of 2009 for the 2010 MA contract year. The comparison to fee-for-service expenditures, therefore, uses the 2010 fee-for-service rates. The service use data we are using is from the MedPAC analysis of geographic variation in service use, which averages three years of data, from 2006 to 2008; and, finally, we used private payer information from claims for the year 2008. The time frames are consistent with each other to a great extent in that the 2009 bids would have been based on plan claims experience in 2008, and the plans were preparing bids for the 2010 contract year and projecting enrollment for the 2010 contract year.

To determine an area-level bid for a metropolitan area, we looked at local PPO and HMO plans but excluded employer group plans, which can have very wide service areas, and special needs plans because of issues there with cost sharing in such plans. We excluded plans from Puerto

Rico, where benchmarks are well above fee-for-service rates, and we excluded Maryland because hospital rates there are all-payer rates. The term "local," as used by CMS, distinguishes HMO and local PPO plans from regional PPO plans, which we also excluded because they bid on a statewide or multi-state basis.

We then developed a metropolitan area weighted average bid for all the remaining participating plans. The weighting is by plan enrollment within each metropolitan area, but using only the enrollment in counties that are within the authorized service area of the plan. In order to develop an area-wide average bid for a metropolitan area, we made the assumption that the bid ratio for a particular multi-county plan as presented in the aggregate bid data was the ratio that could be applied to each county in the plan's service area. The reason we need to make an assumption about how to apply a plan-wide ratio across different counties is that the fee-for-service expenditure data that we are using are the county-level data that CMS publishes, which we combine with the actual county-level enrollment by plan that is also published by CMS. In the bid data, the ratio of the bid to fee-for-service is the ratio of the

total dollars the plan receives based on its single bid for its entire service area divided by the total fee-for-service dollars computed on a county-by-county basis. Because a plan's costs can vary from county to county, and plan fee-for-service rates vary from county to county, the bid ratio that we construct is our way of approximating an area-wide ratio that enables us to compare metropolitan areas across the country. It is not necessarily the case that the ratio that we construct is the actual ratio for a particular plan in a particular county.

In other words, we are making an important assumption, which is that for a given plan with a given benefit package in a particular multi-county service area, the plan bid is treated as uniform for all counties in terms of the ratio between county fee-for-service expenditures and the plan bid.

Here is an example to explain how we build the metropolitan-wide bid ratio for a multi-plan area where each plan is assumed to have an equal level of enrollment across the metropolitan area. And before I proceed, I should mention that, as a rule, examples are intended to clarify, illuminate, and simplify things, but as you can see from the

amount of text that goes with this example, this may be an exception to the rule.

In this example, we're dealing with a metropolitan area that consists of three counties, Counties X, Y and Z, which are served partly or fully by Plans A, B, and C. The second column, Column A, is what the bid data tell us about the relationship of the plans' bids to fee-for-service expenditures, which, again, is the total bid-based payment the plan receives for providing Medicare A and B services divided by our computed fee-for-service expenditures across one or more counties, using per capita fee-for-service expenditures for a county multiplied by the number of plan enrollees coming from that county.

In the example, Plan A covers only one county in the metropolitan area, County Z. Plan A's bid ratio shows that its bid is at 1.05 times the fee-for-service expenditure for all of its enrollees in the metropolitan area, which, again, come from only one county. If Plan A were the only plan covering this metropolitan area, we would say that the bid ratio for this area is 1.05, even though only one county is covered. Plan B, on the other hand, covers two counties in this three-county metropolitan area.

Its total bid ratio is 0.95, which is the total bid payment for Medicare covered services divided by the total fee-for-service expenditures for all its enrollees coming from two counties.

If Plan B were the only plan in this metro area, we would say the area bid ratio is 0.95, even though only two counties are covered, and even though, if we could disaggregate the plan's overall bid to come up with a county-specific bid, we would see that the ratio at the county level is different in each of the two counties. Because Plan B has an equal number of enrollees in each of the two counties, its area-level bid ratio is 0.95, which is equal to the sum of the two county-level ratios, County Y's 1.0 and County Z's 0.90, divided by two.

Plan C covers all three counties in the metro area, and here we again illustrate what we assume about the overall bid ratio. For our analysis, we determined Plan C's metro area bid ratio to be 1.0, but it could represent a combination of bid ratios that are different from 1.0 if we could disaggregate the overall bid to a county-by-county bid.

The final step shown in this example in the bottom

row shows how we computed the all-plan, area-wide enrollment-weighted average bid ratio. In this case, all three plans are assumed to have equal enrollment in the metro area; therefore, the area-wide bid ratio is the sum of the three plan-wide bid ratios shown in Column A -- 1.05, 0.95, and 1.0, divided by three, which ends up as 1.0.

And now we'll have a brief intermission.

[Laughter.]

MR. ZARABOZO: Turning now to our findings, for our initial analysis we examined the correlation between area bids as a percent of fee-for-service costs and the factors that we hypothesized as having an influence on the level of MA bids. With regard to private rates, we found only a weak correlation with MA bids. The more important factors were the Medicare-specific factors of service use and the MA benchmark levels.

This slide shows the correlation coefficients of the factors we looked at, indicating the extent to which they are correlated with the level of MA bids in a given metropolitan area. The closer the correlation coefficient is to 1 or -1, the higher the level of correlation. These numbers show that for both HMOs and local PPOs, the most

important factors were Medicare fee-for-service use levels and the MA benchmark levels. Lower bids were associated with high service use, and higher bids were associated with higher benchmarks. There is a weak positive relationship between private sector payment rates and MA bids, with higher private sector prices associated with higher bids.

We are having an intermission.

[Laughter.]

DR. MARK MILLER: Are we up to the last slide [off microphone]?

MR. ZARABOZO: We're up to the last slide. I'll just proceed with the last slide, which is our discussion slide.

Our findings are not surprising, but we did not fully answer the question of the extent to which private sector prices influence MA bids. We can continue to pursue our examination of bids and attempt to disaggregate price and utilization in MA plans. We also would probably want to consider other factors that may affect bid levels, such as the level of MA competition in a given market, and the absence in some markets of HMOs and PPOs. Because MA plans are able to segment markets and have different bids for

different parts of a metropolitan area, we also may be able to examine possible intra-market variation. Finally, we may wish to learn more about the actual negotiations that occur between MA plans and their contracted providers.

Thank you, and we're happy to take questions.

MR. HACKBARTH: Okay. Thank you, Carlos.

Mike, do you want to lead off?

DR. CHERNEW: I have just one clarifying question. So you were doing this for just the A-B parts of this. How was Part D treated? So they're bidding and they're getting money back from the Part D stuff, too, and there's benchmarks one way or another? So do you have the Part D bids and how that's playing -- because an MAPD plan is jointly doing both.

MR. ZARABOZO: Right

DR. CHERNEW: So is that assuming that the Part D program isn't really existing essentially for the purposes of this?

MR. ZARABOZO: Yeah, we did not look at Part D for this purpose. But as you point out -- we were just looking at the A and B bid in relation to fee-for-service.

DR. CHERNEW: Right, exactly. But my question is:

Do you think there's some strategy between the A-B bid and the D bid when the plans --

MR. ZARABOZO: Potentially, because, of course, it's a combined premium that you're looking at.

DR. CHERNEW: Exactly. That's what I'm trying to figure out.

MR. ZARABOZO: There is potentially an issue there, yeah.

MS. UCCELLO: So I want to continue on on this question about A-B. Were the extra benefits not included -- so that --

MR. ZARABOZO: That's right. Just the A-B package.

MS. UCCELLO: Okay.

MR. GRADISON: Perhaps this was covered, but I just want to make sure. Have you looked at the relationship to the extent of HMO market penetration in the private sector in these counties?

MR. ZARABOZO: We have not, and that's one of the things that we mentioned in the mailing material, that this is a slightly different market in terms of HMO predominates in Medicare Advantage; it does not in the private sector.

But in particular markets, HMOs may be highly penetrated, including in the private sector.

MR. GRADISON: The reason I was wondering, in terms of people aging into the program, what impact that might have on pricing. Okay. Thanks.

MR. ZARABOZO: Yeah.

DR. STUART: We had a discussion yesterday about using indirect methods for trying to determine important policy answers that you want to get, and this is another one of those cases where, if you really did have access to this final point of what the negotiations were between the private plans and the -- between the MA plans and the private providers, then you really wouldn't have to go to this extreme. And so I'm wondering where you are in that process and where one might be able to get access to that data while protecting the proprietary nature of the information itself.

MR. ZARABOZO: I think that we would probably approach it as talking to people as to what happens in these negotiations. I don't know that we would get data necessarily, but, you know, what is it in relation -- for example, do you pay Medicare rates? Do you pay X percent of

Medicare rates? Is it related to the private rates? Those kinds of things.

DR. STUART: I was just wondering, there's a group called the HMO Research Network that includes a number of the largest MA plans in the country as well, and they have experience -- and Scott can tell you about this. They have experience in terms of combining data across plans in ways that protect not just individual confidentiality but potentially plan confidentiality. And I'm wondering whether that might be a potential source of information for this.

MR. ZARABOZO: Also, I'm not sure if you're aware, but encounter data may help in this.

[Laughter.]

MR. HACKBARTH: Clarifying questions?

MR. KUHN: One quick question, Carlos. As you lay out here, the really high level of correlation with a high benchmark is a higher than -- as you said, higher bid as a percent of fee-for-service. As we know, CMS is running this quality program for MA plans which is boosting the benchmark even further. Would that also impact this? Would that add to that correlation, do you think, as well?

MR. ZARABOZO: Yes, because, you know, the

benchmark increases if it's a higher-quality plan, the number of stars that the plan has. So, presumably, because it would be a higher benchmark, you would see plans more likely to be entering particular markets, for example.

DR. BERENSON: Yeah, I have a question, but first I wanted to just put out some information around Bruce's question. As I think most of you know -- in fact, Paul Ginsburg did present here a couple of years ago -- the Center for Studying Health System Change over many years has been exploring the dynamics of negotiating leverage between providers and health plans. And this last round of site visits, we asked a whole series of questions, again, to explore this, and specifically asked in the 12 communities this very question of does this leverage apply to commercial products or do they apply to Medicare Advantage, and the specifically question was something like, Do you peg your Medicare Advantage prices off of Medicare or off of your commercial rates and get into a discussion? And it was pretty remarkably consistent that Medicare was the basis for the negotiation with hospitals? I'm not talking about docs at this moment. And we will be publishing that information in an article in the May Health Affairs, but it was pretty

consistent that -- you know, whether there's some variation based on Medicare Advantage penetration or commercial HMO penetration or whatever, it was pretty consistent that the -- it was either Medicare or more commonly Medicare plus a little. But that was sort of the basis.

My question has to do with the enrollment across counties and the methodology. You say you used actual enrollment files and not the projections from the plan's bids. How reliable are the projections from the plan bids? Do we know how that correlates with their actual enrollment?

MR. ZARABOZO: It's very close, usually, and looking at the overall numbers, what plans projected and what enrollment ended up being is very close.

DR. BERENSON: Okay. Is there an incentive for plans to suggest or to project that they're going to have more enrollment in high-benchmark counties and then --

MR. ZARABOZO: Well, the only difference would be in the rebate computation, and given that they are so close, I don't -- I mean, I would not perceive there to be an incentive.

DR. BERENSON: Okay. Good. Thank you.

MR. BUTLER: So my question was related to Bob's

comment, and that is, I mean, you looked at the correlation between the private -- between the rates and the bid levels. Why didn't you look at the correlation between the private rates versus -- I mean the rates themselves versus Medicare rates? Because isn't that what we're really trying to test, what is the market going to do by itself in a Medicare Advantage plan for these kinds of prices versus what happens otherwise?

MR. ZARABOZO: We actually -- is your question should we not have looked at the individual payment rates of Medicare versus the payment rates in the plans? Is that your question?

MR. BUTLER: Yeah, the comparison is what they would have gotten from Medicare versus what they're getting from the MA plan. Which one is higher?

MR. ZARABOZO: Yeah, see, that's what we don't know. We don't know what the MA plans are actually paying -- the prices, in other words.

DR. MARK MILLER: So the bid is P and Q. You're asking why not just look at P to P, and we're saying we don't have the price. And so we're using it as a proxy, and we know it's contaminated by whatever the influence of Q is.

DR. CHERNEW: When they say "mic," I get confused.

[Laughter.]

DR. CHERNEW: You're using this off of -- some of the stuff off the MedSTAT data, the Thomson Reuters data? Do you have the over-65 Thomson Reuters data? Because we do, and we've been looking -- you can look at the prices that the Medicare Advantage plans paid in the over-65 Thomson Reuters data.

MR. ZARABOZO: Yeah, we have not done that.

DR. MARK MILLER: Do we have that [off microphone]?

MR. ZARABOZO: I think we got the -- is that part of the normal MedSTAT --

DR. CHERNEW: They sell them in separate files --

MR. ZARABOZO: Yeah, I think we just got the private. We did not get the Medicare. We have that. We should talk.

DR. CHERNEW: Okay.

DR. MARK MILLER: We should talk [off microphone].

[Off-microphone discussion.]

DR. BAICKER: I'd hate to get in the middle of that, but should I be surprised at the strong negative

correlation between the fee-for-service use index and the bids? I am surprised, and what do you think the driving factors are in that strong negative relationship? And a corollary question is: What is the role of the number of plans and sort of competition between the plans within an area of play in driving these responses?

DR. LEE: So in terms just the correlation, we have not quite unpacked, but there are many different correlations that are going on. So what we are looking at is the fee-for-service -- so it's the ratio of the bid to fee-for-service. And the fee-for-service, per capita fee-for-service, is also highly correlated with the service use. So since it's the denominator, the service use is positively correlated with per capita fee-for-service, so it shows up as a negative correlation.

DR. BAICKER: So this is the ratio. This isn't the absolute bid, this is the ratio.

DR. LEE: Yes.

DR. BAICKER: Okay.

DR. LEE: So that's another -- that's one aspect of it, and now I lost track of what the second --

DR. BAICKER: Competition among plans.

DR. LEE: That would have been reflected only indirectly because, you know, to the extent that bids are going to reflect market characteristics. We have not looked at any other market characteristics in this set of variables that we were just looking for correlations in.

DR. MARK MILLER: Can I ask something of the two of you? Is it too simplistic to say that as utilization rates rise very high, the ability to bid under that increases?

DR. LEE: I think one could say that there is more potential for controlling utilization, so if in presumably a low utilization area, you know, even if you are very efficient and managing utilization, what's the room that you can maneuver in?

DR. MARK MILLER: Given that it was a ratio, I wasn't as surprised.

DR. BAICKER: Yeah, I would expect the levels to track together.

DR. MARK MILLER: Exactly.

DR. BAICKER: But I'm not as surprised that the wedge grows as --

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

DR. BAICKER: I'm with you on that. But it would be interesting to see the extent to which competition of number of plans in the area affects the ability or the strength of the bidding it down process.

DR. HALL: Just two clarifying questions. The bid process is an annual event, right? So how sure are we that taking a one-snapshot year tells us the real story? That is to say, among all the other variations, is there any evidence, even reason to think that there might be variations according to year?

MR. ZARABOZO: One thing that we could do is compare one year to another. So we could and we were thinking of doing that. Is there any change in the market circumstances, for example, that we might see.

DR. HALL: Okay. Then I guess the other question is, is there any evidence that any of the commercial underwriters, when they enter an MA market, might enter -- how shall we say this -- at a very competitive low bid only to disengage their consumers the next year and suggest they move to another MA plan that they have?

MR. ZARABOZO: Meaning that they would be the sole entrant initially and have a low --

DR. HALL: They would be the most competitive.

MR. ZARABOZO: Among many plans?

DR. HALL: Um-hmm.

MR. ZARABOZO: Well, how long you can do that for? I mean, you may do that as an entry thing, but whether you can sustain that level of premium is another thing.

DR. HALL: Okay.

MR. HACKBARTH: So could I just go back to the point that Bob raised about the weak correlation between private sector prices and MA bids? So Bob described findings from the health system change field work. Is there any way to look at whether the relationship between private sector prices and MA bids changes with MA penetration in the market?

MR. ZARABOZO: We could look at that, yes. And that is also -- I mean, especially if we're doing a multi-year thing. We could look specifically at that.

MR. HACKBARTH: My hypothesis would be that the way that a hospital executive thinks about the negotiation may change if it's a small piece of the hospital's business versus a really substantial growing share. They may be less willing to use Medicare rates as the benchmark, the bigger

the business involved.

MR. ZARABOZO: And we're also thinking that even in high penetration markets where maybe there's 50 percent MA enrollment, certain hospitals may not be contracting.

MR. HACKBARTH: True.

MR. ZARABOZO: And to increase the penetration to, let's say, 70 percent, the plans may have to yield more in the way of money.

MR. HACKBARTH: Yeah, true. Mike, Round 2.

DR. CHERNEW: So first of all, we have a lot of work going on in this area and we should talk about just generally what we found, because many of the questions that have come up we've been investigating in different ways. In response to Bill's point, in the Part D program, there's evidence that for a variety of reasons, plans will enter, get enrollees, but enrollees tend not to switch. So that over time, they can raise their prices.

And then the problem, of course, is you don't track new enrollees so then you have to have -- you can enter a new plan. So the dynamics of this market is very complicated because as you point out in the draft, what you mean by a plan isn't what is commonly considered a plan,

which say an insurer. It's really a benefit package. So insurers have multiple plans.

And the dynamics across those is important and they're coming and going in ways over time. They're difficult to explain. So there's a lot here. And I think you correctly point out that the connection between the MA market and the traditional Medicare market and between the MA market and the under-65 private market is really important to understand.

My comment is it's very hard in the analysis to understand what's causal, and so it's easy to think that Medicare is the first mover and then everybody responds to that. And there's no doubt that that direction of causality exists and that it's potentially strong. There's also, as we've done in other work, the other connection.

So we've had margin discussions, for example, when we've had margin debates which argue that the private plans are very strict. It affects how the providers respond and that affects what ends up happening to Medicare margin and stuff. So you could tell stories, I think, all of which are right to go in different directions and the challenge is going to be to figure out how to take the correlations you

find, whatever they are, and then translate them to some policy or causal conclusion.

And I think that's just going to take more work, but I think that doesn't mean that it's not a useful thing to do, because everyone is going to argue for a bunch of policies that we do that these connections, whatever we do in this market, is going to affect all these others. And the more we can know about those connections, the better able we'll be to respond to those types of comments.

MR. ARMSTRONG: So I would just say that even though I actually live in this world, I don't understand it nearly as well as Mike does. And to be frank, on this analysis, part of what I'm having a little bit of trouble understanding is, what are the policy implications of the work that we're doing? So what is the hypothesis we're testing or trying to disprove? I'm not really sure.

Is it the consolidation of providers is driving up Medicare costs? Is it an issue around limited access driving up costs? And so, I feel like, as we take this forward, it would be valuable to me for us just to be a little bit clearer, and maybe it's clear and I just don't get it, but a little bit clearer about, so what is it that

we really are trying to understand here?

The one other comment I would make would be, another variable -- and you were just starting to get at that. From our own experiences, which may or may not already be considered here, is that we actually, in order to influence the MA rates we pay to hospitals, consolidate our business to one hospital in different markets.

And our sense has been that that's far more influential than our overall volume or the competition in the market. But there again, I'm not really sure what the policy implication would be for us here at MedPAC.

DR. MARK MILLER: And I think that if it's not clear, I'm responsible for that. I think some of our thinking is -- and it's actually your first point. We've been looking a bit at what goes on in the private sector and how these two sectors influence one another.

A couple of years back, there was a long discussion that resulted in some work and some change in thinking about, there was the very simple cost-shifting argument. Medicare doesn't pay enough, the private sector has to pay more, and we looked at that much more aggressively and came to a different conclusion. And it's

sort of carrying that thought into this world and saying, How does that apply here? And that was the motivating question.

But it could also inform work down the road more generally as you think about managed care broadly and other ways of approaching, like how people are going to pay for plans over time. So that's kind of the way I see it anyway.

MR. HACKBARTH: Some of these questions could be very relevant if you're talking about a premium support model and what would be the dynamics under such a system.

MR. ARMSTRONG: But what you're saying is, in fact, there's not a specific problem we're trying to understand better or address right now? This is just a part of the overall Medicare program that we ought to be paying attention to because it could be relevant to issues we'll confront going forward, or it could become a problem?

DR. MARK MILLER: First of all, I hope it's absolutely clear that we are not trying to be very direct here. That's why we had Carlos go through that slide, so nobody understood what was happening here. And so, it was a very calculated attempt to be unclear.

[Laughter.]

DR. MARK MILLER: There are two things. In the short run, I think you're right. In the short run, there's not a lot. It may be this question of what influences the bids, and we've already gotten other ideas. What about penetration? What about this? So perhaps there's some application in the short run and understanding what's happening in MA.

But probably over the long run, this tension between the public and private sectors, both fee-for-service and in this world, is something that I think is going to rise repeatedly in our work and we're trying to understand the dynamics. So I think you're right. It's more down the road.

MS. UCCELLO: So I'm the third person and my points that I wrote down have already been made. So it's clearly a new day today. But I'm going to make them anyway. I just want to echo -- I'm going to keep trying. I think it is important to kind of explore the issue of whether these rates vary by MA penetration rates, and I think looking at that, as well as the level of competition in an area, are important because as Mark said, if down the road we do look at premium support, or Ron said this, at premium support

options, kind of the issue of whether fee-for-service Medicare is one of those options or not, I think these kinds of questions can answer what the implications of those approaches would be.

MR. GRADISON: Not really. I'm looking forward to your next step in this. I start with sort of a presumption, rebuttable, of course, that there may not be useful generalizations here that may be, as you say, in one market area, you see in one market area. I'm not sure of that at all, but I'm looking forward to what light you can shed on that possible explanation.

DR. STUART: Let me build on a point that Mike made about market skin. There is a database that's called the Medicare Supplementation and Coordination of Care database, and I'm not sure this is the one that you're referring to, but if it is, what it is, is that it strips all of the Medicare beneficiaries from the employer claims that you're using in your database and it puts it together in a separate file, and it's a big file. It includes a couple of million Medicare beneficiaries.

But they're all in retiree plans. And my understanding in discussions with Thomson Reuters is that

this reflects the secondary payer amount, and so it's not going to be particularly helpful, I think, in the MA market.

MR. ZARABOZO: That's very helpful. Thank you.

DR. CHERNEW: It does have the secondary payer amount, but like a lot of these, it has the total amount that they're paying a part of. So there are issues in the database because the biggest problem in the commercial stuff, you have to deal with this and I didn't ask it because I didn't understand the strategy in the first place, being unclear.

But the private payers don't always pay using the same fee schedule structure. They often do, but sometimes they don't. So just getting comparable prices, there's a lot of things you have to do, and in an MA market, it's more complicated because there's capitated claims, and just the concept of price is a little bit different.

But for a subset in there, they do have what they would claim would be the total amount paid per the claim that they're getting because the employer is paying the uncovered part.

MR. ZARABOZO: But can you identify payments by MA plans? Meaning it's not a Medicare payment. That is,

they're not wrapping around the Medicare amount.

DR. CHERNEW: Yeah. So you would have that they're in an HMO, for example. So that would make it an MA plan.

MR. ZARABOZO: Well, not always. You can be a cost to MA. But anyway.

DR. CHERNEW: We could have a discussion of that.

MR. HACKBARTH: Okay.

MS. BEHROOZI: Just briefly, given Scott's comments and things that other people have said, it seems like with all due respect to all of the quantitative people, it seems like there is an opportunity for some qualitative, not exactly focus grouping, but, you know, talking to different MA plans that operate in different markets or have high penetration in one market or, you know, operate in rural areas or urban areas, not just to get the data and the information, but to understand more about the right questions to ask and the right things to look for.

And I will also just take this opportunity, since I won't be here, if you ever talk about premium support to say that I find it very scary and, you know, it kind of goes in the opposite direction of what we were doing yesterday

with talking about the Secretary having more authority to design a good benefit plan. So that's my advance comment. Thank you

DR. BERENSON: I just would jump into the question that Scott asked. If we really understood more about the pricing of Medicare Advantage, we'd have a better understanding of the performance of Medicare Advantage in comparison to traditional Medicare in terms of its ability -- and if you're walking around with it, I've been walking around with this notion that, well, the plans have this major price disadvantage so they must be doing something pretty special on volume controls, and if it turns out they don't have a major price disadvantage, it changes that.

I also think there's implications for how to structure competition. If it turns out that this isn't just because it's a niche product that disappears as you get a higher volume of Medicare Advantage business, I've heard some people suggest that a reason for this difference has to do with the fact that it's individual choice of plans, that the beneficiaries are more price sensitive, there's more of an ability of the MA plans to offer products that exclude certain providers so there's a little more leverage.

I think we could understand more about some of those dynamics that result in this kind -- if, in fact, it is correct that the plans are basically paying prices off of Medicare with their larger sample. What does that tell us about structuring market competition? So I think there's some potential of values, in addition to what Mark talked about, in this area.

MR. BUTLER: So I actually think, Scott, there is a very specific policy question and we keep stating it. It's do MA plans extract a lower or a higher price than the Medicare fee-for-service fee schedule? And if they extract something much higher or lower, it has big implications if the percentage of enrollees increases in Medical Advantage plans -- Medicare Advantage plans over time. It's like half the equation. And so, we need to know how that behaves and we ought to be able to, I think, understand that better.

Now, from more of the qualitative side or how these things might end up, this is just my own observation being in the health system, is that when you go to negotiate with a plan, you're usually negotiating with all of their products at once, not one of their products. And you look at that portfolio and you look at the kind of yield, if you

will, off of the collective business. And sometimes you might even say, Well, I'll give a break on this one if you'll give me a little higher price on the other one. You look at the collective impact of the business. And that could be one reason why you're willing to give lower rates to Medicare versus higher -- you know, in exchange for higher rates from the private business.

But I think it's probably -- and again, this is just one man's opinion. It's probably -- you tend to get an all or nothing on a Medicare Advantage. They say, Well, thank you very -- because I think there's some understanding they need the kind of Medicare-like rates to be competitive, and I think some systems would say, Well, okay, no thanks, I'll take the rest of the business, but I'm really just not interested in Medicare Advantage.

So what's interesting about Medicare Advantage compared to even a lot of employer plans is that, in fact, there are networks that have not everybody in the market. And there aren't that many insurance products that are kind of still -- most insurance products have most players in the market. So what makes this one an interesting thing to look at is that, in fact, I think there are quite a few markets

where there are a lot of hospitals that are not in the given plan, which should begin to help us understand other dynamics.

And, Glenn, you made the comment, if you had a lot of -- I don't think it's just penetration of the plan in the market. It's how much of the business -- it really is institution-specific. So if you have a lot of that business now in your hospital for Medicare Advantage, in fact, they may be able to extract a higher -- or even better rate, rather than -- I think you suggested the hospital may be able to extract a higher rate.

I think it might work the other way around because if there's some evidence in the market that they're willing to exclude hospitals from a network, then there's leverage for the plan to say, Sorry, well, we'll just go somewhere else. So these are interesting dynamics to study and I think it is a little bit different than, as I said, other insurance products which still try to be all-inclusive when they provide their network to a market.

MR. HACKBARTH: Just to be clear, Peter, being a lawyer, I can argue either side without blinking.

[Laughter.]

DR. BAICKER: So this seems useful for all of these reasons to understand better the possibility for Medicare Advantage to drive higher quality care, more effective care and all that, but also then to provide more information about what we're doing in the main fee-for-service using -- we were always talking about trying to use mythical encounter data or other information from what's going on, on the private side, to gain information about how good a job we're doing on pricing, et cetera, on the fee-for-service side.

So I'd add that as yet another set of reasons that it's important to understand what's going on inside this black box.

DR. HALL: Well, let me just add briefly to answering Scott's question, you know, I think that we need to really know a lot more about the dynamics of MA nationally and regionally, and I think the discussion this morning shows that there are a lot of things we don't know. That is a bit of a black box. We can't even get provider rates.

And a very brief experience I've had in terms of surveillance of these plans is kind of a consumer watch

group. This information is very private because after all, a bid process, by definition, can't really be publicized. So you really -- until the bids are into the government agency, you really can't have any traction in terms of trying to understand them.

In our discussions over the last couple of days, one of the things we talked about and voted on was that med supplementation plans should probably have some form of payment by the consumer, first-dollar coverage or supplemental payment. So I guess all that says to me is that what we're going to see is a lot more interest in MA plans as time goes along.

We really do have to try to understand, explain some of this variability. As sort of an anecdote, the community in which I live has recently had the largest, in fact, the only large employer go belly-up after 100 years of being the major employer in this community. And one of their claims to fame was that they had an extraordinary retirement medical plan for their -- it was the best med supplementation plan you couldn't buy because it was sponsored by the company with -- it outdid Plan D.

And what has happened now with about 60,000 people

feeling, probably rightly, that they're going to lose their coverage, there's really only one major MA plan in the community and the papers are just absolutely full of information, in some cases, and misinformation in others that somehow the notion got out that they're all going to lose Medicare.

And now there are these elaborate explanations of why MA is the right choice and what can go on. And I can just see this being repeated. This is just a really microcosm in a relatively small area. So any time there's this kind of variability, I think we really have to keep track of it.

MR. ARMSTRONG: I just would add, if it's appropriate, and if there's a way that I can help bring -- I am in a relationship with a network of regional not-for-profit MA plans through the Alliance of Community Health Plans, and I'm sure I could -- to help on the qualitative side of this analysis, bring together several of them just to talk about how, in different markets around the country, these people engage in this kind of work. And so, if you and the staff want me to work with you on trying to do that, I'd be happy to try.

DR. MARK MILLER: Funny you say that because Glenn and I were writing a note back and forth, and I won't ask you unless you want to, and it could also be part of this larger thing. I wanted you to go back to the dynamic that you described at the outset because I thought there was kind of an interesting angle in there. But we could also take it offline and sort of talk with you and a network of plans, because I thought you had some particular insight here that I wanted to get at. So one way or the other, I'd like to pursue this.

MR. ARMSTRONG: Yeah. I think the point I was just trying to make was that I know very well one MA plan and how we negotiate and that our strategy is one thing, but that just exemplifies the fact there could be a lot of different variables that are in the minds of these leaders trying to make MA plans work and that it just might be nice to bring a group together to get a little bit more of an inventory of those different things.

Now, it's a subset of MA plans and it will only be useful to the degree you're getting not-for-profit regional plans together, but I would be happy to help with that.

MR. HACKBARTH: Okay. Thank you very much, Carlos

and Julie.

We'll now move on to care coordination.

[Pause.]

MS. BLONIARZ: Hello. Last month, we talked about care coordination in the Medicare fee-for-service system, including Medicare's experience with demonstrating a few different models of care coordination and disease management.

So this month's discussion will follow up on a couple of points that you asked us to tease out after last month's presentation. In your briefing materials, you have a full list of changes to the draft chapter, but we will focus on four today.

First, we'll review a definition of care coordination. Then we've looked more in depth at the Medicare demonstration programs that appear to reduce hospitalizations and summarize some messages from these case studies. And then we'll discuss communication frameworks to facilitate coordinated care and turn to quality measures. We'll conclude by asking for your questions, thoughts on the draft chapter, and next steps.

Last month, Karen and Mary had both made the point

that there are a number of different ideas included under the care coordination umbrella. So today I'll spend some time talking about that.

One starting point could be the AHRQ definition on this slide. It emphasizes the multiple entities involved in caring for a patient. And one could add in two additional ideas. The first is that care should beneficiary-centered and holistic, or not treating the beneficiary as a collection of illnesses. And, second, that it would focus on people with significant encounters with the health system -- because that's where the need for coordination is most acute. This description also implicates other concepts, such as primary care or team-based care.

The draft chapter describes different models that could fit under this description, and the slide lists some common models and their generally agreed upon definitions.

Overall, we've tried not to be too prescriptive with the care coordination definition because a lot of interventions include one or many of these elements, there's a lot of overlap, and the definitions evolve over time.

So moving to the Medicare demonstrations, Bob, you had referenced some work done by Randy Brown that teased out

some interesting findings from the care coordination demonstrations. And, Bill Hall, you had asked that we look more in depth at the demos because of the importance of this topic.

Using the data released to date, we looked at those programs that appeared to potentially reduce admissions, using a very generous significance threshold, because the demonstrations did not have a lot of statistical power to detect modest results.

Looking at the programs that achieved this level gives a couple of interesting case studies.

First, ensuring that the programs are sustainable is a concern. One promising program run by Georgetown University was unable to recruit enough participants, even though it showed early success in reducing hospitalizations. Furthermore, in Medicare Health Support, five out of eight programs dropped out early because they didn't foresee being financially viable.

Second, some interventions reduced hospitalizations, but this didn't mean that it reduced overall Medicare spending -- either with or without the care management fee. For example, the Care Level Management

program reduced hospitalizations but didn't reduce spending -- either because the enrollees used more ambulatory care or because the hospitalizations they did have were more costly. And that was before fees were included, which meant that overall it definitely cost the Medicare program.

Third, demonstrations findings can help shape future work. For example, Aetna used its experience in Medicare Health Support to implement their case management program for Medicare Advantage, where they train and embed care managers in medical practices.

And, fourth, some of the programs -- even the most effective one, which I'll talk about next -- changed the level of intensity of their intervention or design or changed their target population.

The most successful demonstration results to date have come from the Massachusetts General Hospital-Massachusetts General Physician's Organization program, which I'll refer to as Mass General for short.

The intervention was able to reduce hospitalizations, improve mortality, and reduce Medicare spending when fees were included, and there are four points I'd make.

First, the group ran a pilot project ahead of time to identify challenges and figure out the best ways to integrate the care managers into the medical practice.

Second, the beneficiaries enrolled in the program had to be regular users of the Massachusetts General Physicians Organization in the past.

Third, the care managers were paired with one physician's patients to facilitate that relationship. In addition to the care manager fee, the physicians were also paid for their time -- $150 per year for each enrollee.

Fourth, there was a strong linkage between the care manager, the hospital, and the medical practices. They all using an interoperable IT platform, which facilitated real-time updates when their patients were hospitalized. The care managers also had access to other supports in the hospital, such as mental health and pharmacy services.

Overall, the evaluation of the Mass General program attributed their success to deep institutional support for the program.

So there's a couple of points that I would draw out from the evaluations of the demonstrations.

First, program designs often seem quite similar;

for example, they emphasize patient education or transitions. But it's really the quality of these components that can make the difference between a successful intervention and an unsuccessful one. For example, a lot of programs sounded very similar to Mass General but were not able to achieve that level of success.

Second, the evidence base on which components are important, what environments they work in, and populations that they work for is still incomplete. The Randy Brown article pointed out that patient education, care coordination, and transitions models are promising, but there has not yet been a Medicare demonstration combining all three features.

And, third, demonstration programs where the system was not redesigned to accommodate the care coordination activities are unlikely to work well. This might also explain some of the cognitive dissonance between well-functioning systems that use telephone-based disease management with great success and the poor results from Medicare Health Support.

Also in last month's session, there was a discussion of the role of communication. In particular,

Bruce and Tom, you had pointed out that IT on its own is unlikely to improve communication.

There is widespread evidence in the literature that even when there's a formal communication mechanism, such as a discharge summary, these tools aren't well used or are incomplete.

Two situations in particular illustrate that not just information exchange but process changes to encourage the use of that information may be necessary.

First, when many providers are involved, there first needs to be a mechanical way of communicating important information across settings. This could entail using an information system with common elements or that are interoperable at some basic level.

Then, process changes need to occur so that the information the providers exchange actually shapes the beneficiary's care, and each provider is working in concert with each other. For example, if providers adopted a team approach to coordinating care, this would relieve the burden that currently falls on the beneficiary to aggregate all the different pieces of medical information.

The second situation is when a beneficiary starts

to feel worse and is considering whether to go to the hospital. One strategy is to have the beneficiary call the care manager to alert them that they are feeling unwell. But this also relies on systems changes so that the beneficiary can quickly schedule a doctor or clinic visit.

If this doesn't happen and the beneficiary does go to the hospital, then the care manager should be alerted. And one strategy is to assume that the care managers establish relationships with the hospital.

But there may be other ways for the Medicare program to help alert the care manager that their beneficiary was hospitalized. In this way, a number of safeguards would be in place so that any one of them could fail, without having the communications process between the beneficiary, their care manager, and the health care delivery system breakdown.

So I'm going to turn it over to Kelly to talk about quality measures.

MS. KELLY MILLER: Scott, last month you pointed out that care coordination is a characteristic of a well-functioning system, so we looked at how to measure whether systems are effectively coordinating care. The Commission

has historically focused on outcome measures; emergency department visits, preventable admissions, and readmissions are especially relevant for tracking care coordination.

Several measures have been developed specifically to evaluate whether a beneficiary's care is being coordinated. Two are survey based. The Hassles scale attempts to identify the difficulties patients encounter as they navigate the medical system, while the Care Transitions Measure evaluates whether a patient's preferences were taken into account during the transition from the hospital and whether they understood their care plan and how to safely take their medications.

Survey based measures could be incorporated into the Medicare Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey.

Other measures are based on information that can be culled from claims or medical records. The National Quality Forum, NQF, created a care coordination quality measures consensus report in 2010. NQF endorsed the care transitions measure, along with nine others that measure appropriate referrals and follow-ups, and evidence of medication reconciliation and discharge plans shared with

all appropriate parties.

The continuity of care index measures the number of providers a patients sees to gage the share of appointments with different types of providers.

MS. BLONIARZ: So, to conclude, we fleshed out a few of the items that you'd asked about and added them to the draft chapter. Are there further questions that you have or avenues you'd like us to pursue?

On next steps, we'd ask you to consider what direction we should take with this work in the next cycle.

To date, the evidence from the Medicare care coordination models has been at best uneven, showing modest improvements in quality and not a significant reduction in cost. One of the dilemmas is that there are some promising models, but it's unclear whether they can work widely in fee-for-service Medicare and whether the Medicare program can replicate these results in other areas.

So the next steps to pursue here are unclear, and there is ongoing work at the Innovation Center into some care coordination models, so maybe one path is to monitor that activity and express our views on the direction that work could take.

Overall, we welcome any thoughts you have on that. Thanks.

MR. HACKBARTH: Thanks, Kate and Kelly.

Mary, do you want to lead off round one clarifying questions?

DR. NAYLOR: Honestly, I don't have any questions. I thought you really, really were unbelievably responsive to all the issues and questions, and I will have comments, but I really don't have any questions.

MR. HACKBARTH: Okay. Clarifying questions?

DR. STUART: I agree and am frustrated by the lack of clarity in terms of clarity in terms of the results of these experiments because the reason you conduct experiments is that you'd like to learn from them, and not being able to generalize from them is a real frustration.

MR. GRADISON: There are a lot of apps out there marketed commercially to try to help individuals with wellness and care, and you commented briefly upon some instances in which the use of electronic connections with the beneficiary doesn't have apparently much of an influence on -- what? On outcomes, on costs, on hospitalization? I want to make sure I understand, and I may want to follow up

with you later to better understand exactly what that indicated to you.

MS. BLONIARZ: So we could look at some of the interventions used kind of real-time data feeds, you know, maybe it had a device at the beneficiary's house and the nurse or the care manager would check in with the beneficiary that morning and say, you know, "How are you feeling today?" Or sometimes they can even hook up and check pulse or blood pressure, things like that.

I think one of the challenges that the evaluations of these demos found is that even when there was an indication that the person was not feeling well, you know, the care manager may reach out to the physician's office and say, you know, this person's not feeling well, we should get them in, but the physician's office couldn't always pivot and get them into an appointment right away. And so, you know, overall the person may have continued to get worse and go to the hospital anyways. And so while the information flow was good between the beneficiary and the care manager, getting them into the health system quickly didn't always happen.

MR. GRADISON: Thank you

MR. GEORGE MILLER: Yes, please. First of all, Kate and Kelly, thank you. I really enjoyed reading the chapter, and I want to thank you particularly highlighting the disparity part in the chapter. I'll talk more about that in the second round, but this question: The Mass General demonstration that you talked about, do you know if they recognized any issues about disparity in any way and how they addressed that? I didn't hear anything mentioned about that in their experiment. Was that an issue that they should have addressed? Did they mention it at all? And although they had some success, did they have impact on the disparity issue at all, or was that even recognized so that they couldn't draw a conclusion?

MS. BLONIARZ: You know, I'd have to look into that. I'd have to look into that.

MR. GEORGE MILLER: Okay. I'll have some on round two.

DR. BORMAN: I just wanted to say I really appreciate you addressing the definitional piece, and I really thought that all the new material, like others have said, has really added great value to the chapter, and I appreciate you all doing that.

MS. UCCELLO: Do we have any more information on why the Georgetown program had such difficulty enrolling patients? The patients they did enroll seemed to be appropriate candidates because they saved money, so were they targeting too narrowly or were they approaching people that didn't want to participate? I mean, it seems like an important issue.

MS. BLONIARZ: It's a really good question. I've got to look into it. I think they did have a pretty narrow band of people they were targeting, but I'll flesh that out.

MS. UCCELLO: I guess then the question is, if there -- again, the people that they were targeting seemed quite appropriate for them to be including because they were, you know, getting a lot of gains from their efforts here. So my question would be, for other programs that maybe didn't target as narrowly, is this an issue of just the cost? You know, even though they were saving money, were there just other resource problems with this that made this a barrier to them continuing?

DR. CHERNEW: You mentioned that many of the programs looked similar but the results don't all seem to be similar, and I think explicitly that was with regards to the

Mass General program. These other programs that if you wouldn't have known the results and you just would have seen them on paper, you might have thought they were similar, but it appears not to have been the case. So do you have any sense as to what is different amongst them? Or do you think that there's some sort of really remarkably idiosyncratic, environmental, managerial things that account for that, or even randomness in just the way the world works?

MS. BLONIARZ: So the reason we started trying to categorize programs by, you know, what elements they had was we thought okay, well, then, maybe we would know which elements seemed to work, and that's where we ran into this problem that things sound very similar and they get very different results.

I think one thing about the Mass General model that I was struck by is just how much groundwork they had laid within the institution to develop the project. They had a lot of buy-in from the institution itself, and they kind of reorganized a lot of other external systems to wrap around the care manager function, making sure that the hospital knew to page the care managers, you know, right when one of their people walked through the door.

But, yeah, it does seem a little idiosyncratic or maybe operator-dependent in a lot of cases.

MR. HACKBARTH: So here's my hypothesis, and I think the Mass General experience may be consistent with it based on my limited knowledge about what they did. The Mass General project, the setting, you know, just looked at it from a distance, would not lead you to be very optimistic given the history and culture of the organization. This is a place that spends a lot of money and has a very intense style of care, and they've made a worldwide reputation on that. Yet they were successful in this intervention, and what I've heard about it in the presentations and discussions with them is exactly what Kate describes. They were meticulously careful in how not just dropping this intervention into a system but making important system connections and having some really high-level leadership, you know, all the way up to the top of the organization to make a cultural shift. And so it was a really surprising result from my perspective.

My hypothesis is that this whole approach to testing these innovations is based on a flawed premise, that you have these interventions that are like modules that you

can plug into a complex cultural and delivery system environment and you will get certain results. I don't think they're plug-in modules, and we can test until the cows come home, and we're not going to find things that work that way. Context is everything, and leadership and cultural variables.

So I'm never surprised when I hear that these interventions are so variable in the results and often fail. I think the basic model of testing is wrong. That's my hypothesis. I'll stop there.

DR. HALL: This is a terrific chapter. It really is. And I just was wondering: What are your primary data sources where you put this together? Where do you find out what's going on?

MS. BLONIARZ: So all of the evaluations that -- all of the demonstrations that CMS did, they had a formal external evaluator. It was either RTI or Mathmatica, and they've done very comprehensive evaluations. And then there's been a number of other synthesis reports about the demonstration findings. Those are the primary sources.

DR. HALL: So if we get into this in even further depth, it might be useful to kind of categorize the data as

it comes forward. Bob probably is the expert on this. That is to say, are these plug-in interventions truly just demonstrations and no data to suggest what happens when the money runs out for the demonstration? I think that's going to be important, because even with, you know, the publication bias that negative results are probably not going to be published as often as positive, there is a lot of negative data that has come out of this.

I think it's also very hard to catch what might be called local successes, institutions that are not banner institutions like Mass General, where I think we're probably going to really learn about this process because these are systems that are much more tractable if you really want to change them and they're less Titanic in nature. So I think that would be a useful next step. Maybe I should have saved that for round two. Sorry.

MR. BUTLER: So on Slide 7 you highlighted improving communications between providers and beneficiaries. But you said very little about communications among providers and particularly non-physicians, and I would think that that would be a real critical success factor in making these work. But I didn't

see as much evidence of that.

MS. BLONIARZ: Yeah, I'll flesh that out. We were trying to kind of get at -- you know, when a lot of providers are involved in one person's care, they kind of -- one way to think about it is they might have to adopt a team approach and think of each other as kind of their fellow team members, you know, and how do they communicate with each other, how does that information shape how they treat the beneficiary. There's a lot of evidence that that process doesn't work very well where people get repetitive tasks because a task may have been done in one setting and it's not communicated or the results aren't trusted between providers. So we'll flesh that out in the paper.

DR. BERENSON: Just a couple. The Mass General one, which is -- I would have thought they started from a very high base, and so I guess my question is: Do we know if their performance was a relative success to where they began? Or how does it stack up on a normative scale?

MS. BLONIARZ: Yeah, that's a really important point. It was relative to other medical practices within the Mass General Network, so, yeah, that's an extremely important point. The practice transformation models, which

this is one of, had to use kind of that matched comparison group instead of using like a randomized controlled trial, which a lot of the other demonstrations used.

DR. BERENSON: Is it being sustained now that the demo period is over, do you know?

MS. BLONIARZ: You know, I think it's actually still -- I think the demonstration is still ongoing. I think they received an extension.

DR. BERENSON: Oh, I see. The other question I had, I thought you said something -- and I may have heard it wrong, but I want to just clarify this -- that the Medicare Health Support demo wasn't successful, but that the model that had been used in other settings, like the private sector, was successful. It was trying to translate it into Medicare where the problem -- did I hear that right?

MS. BLONIARZ: So Medicare Health Support generally was commercial disease management companies coming in and applying their model to the Medicare program. I did have something in the draft chapter about how Aetna had run one of the Medicare Health Support programs, and, you know, they were basically doing telephone-based disease management. And in that process of going through the pilot,

they realized that they had to talk to the -- they had to go in and talk to the medical practices, and that's the only way they were getting any traction. And so they used kind of their experience with that for their case management program that they use for high-cost Medicare Advantage enrollees.

DR. BERENSON: Okay, because I think a number -- prior to Medicare Health Support, CBO and others had tried to do literature reviews of the success of disease management, and there really was no literature.

MS. BLONIARZ: That's right.

DR. BERENSON: So we don't really know what the experience was or wasn't. I mean, some in the Medicare Health Support -- I was actually on an advisory committee to one in Mississippi that was trying to do that, and it didn't work very well, and some point figures at Medicare, at CMS, to some extent, but it was probably the first actual trial of the approach. So that served some purpose, although, you know, was it the right demo I guess would still be a question.

MR. KUHN: First of all, Kate and Kelly, really nice work here, and I thought all the additions to the

chapter were terrific, particularly the case study examples really enhance the -- I think everybody's reading what we have here.

Just a couple quick questions. You talked before about the refresh populations in the Medicare Health Support and perhaps some of the others and the change in those populations. You know, maybe it was a 50-50 diabetes-CHF and then the refresh was then all CHF. Did they see any material difference? I mean, is there a particular set of population that the opportunity is greater, like CHF versus diabetes versus COPD? I mean, was there any kind of learnings out of that process in the refresh that we could see?

MS. BLONIARZ: You know what, let me check. I think there was a little bit of directional evidence out of some of them, but let me check that.

MR. KUHN: And I know also in running the demonstrations there was some real concern about Part D information, because, obviously, drug utilization is so key for managing this population, and the inability of Part D plans to get the information to those that are in these demonstrations. Has there been progress made in terms of

data feeds that, in the future, that this is going to be a better way to connect that information, because that is such a critical part on a go-forward basis.

MS. BLONIARZ: This is actually something I was thinking about this morning that I should have looked into. But I will check and see whether CMMI is planning on using Part D either for the evaluation or feeding it back to the projects.

MR. KUHN: And on that Part D information, I don't know if there's any kind of privacy thresholds that they're going to have to go over. I mean, one, there's a mechanical issue of kind of moving the information, but also if we could just check to see if there's any privacy issues that could create some barriers there, too. Thanks.

MS. BLONIARZ: Yes.

DR. MARK MILLER: I don't want to put too much weight on these things, but in discussions with various participants and with CMS following out of some of these things, there are at least a couple of things that I remember taking away. And so this is not so much evaluations as much as discussions with people after the fact who were involved.

One is this on the data feed, and I know you were asking a very Part D question, but just to hold that aside, a sense in designing these demonstrations, being more clear with the organizations that they have some ability to track information on the patient themselves coming into it, so that even from the claims stream, no matter how fast you can deliver it, there will always be a lag. If somebody goes into a hospital -- and I know that's not what you were just asking now -- when you get the claim, they've already been in the hospital. Do the actors have systems to know if somebody's hitting the hospital in their own right? And I know CMS has put some emphasis on actors in saying, well, how do you -- what kinds of systems separately from claims do you have to keep track of the patients?

And then I really don't want to put a lot of weight on this, but in the discussions that I was involved in, there was some sense that there were differences by disease categories and they seemed to get more traction on the CHF side of things and less on the diabetes in some ways for, you know, surprise, which was something of a surprise to a lot of people.

But again, I want to make sure that everybody

understands that this is people sitting around talking as opposed to like a science.

MR. KUHN: Yes, and the data in Part D, I thought, was such a powerful data set that was so important in terms of predictive of what was going on. But you're right. There were other data feeds that made it very difficult for the Medicare Health Support and other demo folks for if someone's hospitalized. They could get a data feed, I think, eight weeks later from the Medicare administrative contractors, but that was eight weeks later, and if someone was in the hospital or hit the ED, it would be nice to know within 24 hours. And I just don't know whether -- and much of that is contingent upon the provider filing the claim, which might not come for several days. So, again, it just goes back to the IT technology of really kind of managing -- you know, having the instantaneous information here is going to be real critical.

MS. BEHROOZI: This was so juicy. There was so much stuff in here. There's a lot, and I hesitate to ask you any more questions, but it makes me curious about some of the details.

One of the details is about the payments, the

demonstration payment for the Mass General demonstration. It says a risk-based administrative fee per beneficiary. Do you know any more about that, like how -- you know, was it an annual thing or per month, and what was the risk factor?

MS. BLONIARZ: So they were targeting -- I think Mass General actually targeted a very high-risk population, like an HCC score of three or above, I believe, and I think that -- they got a per member per month -- or they paid a per member -- Medicare paid a per member per month for that, and then in addition, Mass General also paid a per member per year amount to the participating physician offices, as well, to facilitate that.

But I'll look into how exactly it was risk adjusted. I don't remember how the payment varied by severity, so --

MS. BEHROOZI: Maybe that would be too much detail. I was just a little curious about that one.

And then the other question that I had was on the - you talk a lot about people establishing relationships with their care managers, and that's one of the more successful features. Did you learn anything about how they dealt with 24/7 availability or Friday discharges? As I

told Mary, as a recent experience with my Medicare beneficiary mother, not much coordination started happening until the new week started.

MS. BLONIARZ: I'm not thinking of anything off the top of my head, but I'll look at that. I'll look at that.

DR. DEAN: Yes. I would just echo what people have said. This is, at least in my view, really important stuff, and it's frustrating that we haven't made as much progress as we think we should.

But one of the questions, and I probably should know this because it's probably in the chapter somewhere, but I -- now, the time frame of these demos, because my perception is that so much of the success or failure of these kind of interventions depends on the relationship development, both the providers with the patient but also the providers with each other. And that doesn't happen overnight. It's like Glenn said. You can't just plug this in. This has to be -- this whole approach, at least in my view, in order -- if it is going to have any success, it's got to be really an integral part of the way the whole thing works, and that won't happen overnight. My recollection is

most of these went on maybe a couple of years or --

MS. BLONIARZ: Yes, on average. Yes.

MR. HACKBARTH: Could I just go back to Bob's important question about the comparison group for the Mass General project. So they had a comparison group that was within their system and probably --

MS. BLONIARZ: Yes.

MR. HACKBARTH: -- let's just say for the sake of argument, higher cost than the broader community. Is that typical of the comparison groups for these studies? Are there norms about how you establish an appropriate comparison group?

MS. BLONIARZ: So most of the programs used, like, a randomized trial model, and the reason they could do that is because the interventions did not -- were not practice transformation models. So, like, an outside entity was coming in and delivering care management services to a group of beneficiaries, and under that model you can do randomization. You can say, okay, every other beneficiary will get enrolled to receive these services and the others will not.

The problem with a care coordination model that

depends on a physician's office kind of changing the way they do their business practices is it's hard to randomize in that setting for, like, to select a group of people to receive the intervention and a group of people to not receive the intervention. So the way that they talk about it, those evaluations are randomized at the physician group level. They're not randomized at the individual beneficiary level. And there's only -- I believe there's four out of the 29 projects that we've talked about that use that matched comparison group. The rest of them are kind of classic randomized control trials.

MR. HACKBARTH: [Off microphone.] Thanks.

DR. NAYLOR: So, again, a fantastic chapter. But I would walk away with a better sense -- a better optimism about where we are, and I would think that this is really based on the fact that many of these projects have spanned multiple years and have actually very much influenced the kind of state of the knowledge today related to care coordination as you have defined it.

I think we know about the importance of being able to target the right risk population, about how to match a set of services that evolve and change over time as people's

needs change over time about the importance of -- and you've listed, actually, many of these -- patient and family caregiver engagement and attention to their goals and preferences as part of a model of care delivery, about managing symptoms and managing the complexity of the health and social issues.

We actually know about high-risk people's needs 24 hours after discharge and we know that they're at a functional deficit ten days after discharge. So I think the science has evolved a great deal, and today is different than even these demo projects because we've learned so much from them.

So we've been involved in a lot of systematic reviews, and one dimension of this work showed nine out of 21 RCTs were able to demonstrate -- and these were patient randomizations -- improvements in some measure of rehospitalization as well as some improvement in quality.

That said, I think the core issue is what is it that's going to -- and I do believe you can't plug in, but I do also believe you can make evidence available to organizations upon which they build something that matches their culture and values, and we've actually been involved

in a lot of these. We know that this is not cookbook stuff. This is multi-dimensional. This is -- someone said yesterday, you have to be both nimble and flexible in adapting to people's needs over time, et cetera, because this is managing complexity in complex systems that often people don't talk to each other within the system, let alone between one provider and the next.

So I think the core issue is, where are the care delivery incentives and/or payment incentives? What are the best combination of incentives or disincentives to get to the outcomes that people care about? And that, I think, is where we -- you know, CMMI, when they have launched these innovations, the Community-Based Care Transitions Innovation, for example, 3026, said it has to be targeting high-risk. It has to be an evidence-based approach, et cetera.

So how do we do the kind of evaluations that say, this is where we need to go? Is it by promoting the kind of care processes, like coding, or promoting Accountable Care Organizations that can garner these, or is it by the payment reforms, like bundled payments or whatever, or is it a combination of these transformative incentives and

disincentives? And I think that's really where we should hang our -- I mean, that's the end of your chapter and that's where we should hang all of our energy, on thinking about in these innovations going forward, what combination or what set of incentives seem to be getting the best outcomes for people and the things that they care about, their function and their quality of life and all of those things.

So I don't think we have that answer yet. I think we have -- and I think allowing a lot of flexibility in ways organizations use evidence to meet and respond to their specific mission and culture is great, but how do we create the incentives to allow that to happen?

MR. HACKBARTH: Thanks, Mary. That's a really important comment. So looking at the world as I often do through the prism of payment policy, I think about these innovations in very different ways. If we're talking about a capitated system, global payment, where the organization is at risk for the total expenditures and hopefully also for the quality of care, then the way I would think about these innovations is much the way you describe. You know, let's test things, or lessons to be learned. Lessons always have

to be adapted to the unique characteristics and culture of the organization, but they have all the right incentives to study the tests we do and draw the results and they're accountable for performance. So organizations like Scott's, I think that works very well.

If, on the other hand, we're talking about these things in the fee-for-service context and often where there's an additional payment involved, then you get into a very different mindset. Oh, it has to be proven that this additional payment is going to pay off for the Medicare program and its beneficiaries, and you're a lot less flexible about, well, let's let organizations adapt and learn over time. You know, there's this relentless fiscal pressure to see immediate payoffs.

I think much of our demonstration activity is geared to the second area. Oh, it's going to all be done in a fee-for-service context and so we need proven interventions. And I think, often, that search for proven interventions is going to be a futile one.

DR. NAYLOR: I think that there are proven care delivery models, but in a system, it's not as if everyone in that system needs it. The system has to be able to say, how

do I stratify whom I serve and adapt this best approach. So it's not as if there's a single solution to, you know, what a system offers. So what you need to do is an incentive that enables them to be able to apply multiple approaches, not one. So there are proven approaches. The challenge is, people need different things at different times and the best system is the one that's able to know, how do I apply to this high-risk population or this high-risk person today something that they may not need tomorrow because they've done that well today.

So I don't think the answer is we don't have the approaches. I think what we have are systems that need the flexibility and adaptability to make them work for a whole population.

DR. STUART: Yes. Let me add to that, because I think there are really two kind of overlapping issues here. One issue is do we have models that work, and then the second issue is how long does it take for us to figure out whether, in fact, they do work or don't. And one of the real frustrations with these demonstrations is that they went on for a long time and there were indications, process indications that maybe they weren't working very well, but

it just took forever for us to get any solid evidence.

My understanding is that the Innovation Center has taken that on as one of its major goals, is to try to reform the way in which it identifies both pilots and demos for testing so that the information about whether it's working gets back to the program faster. And so I think that's something that might be usefully explored a little more here.

And then the one other thing that I haven't heard anything about is PCORI and comparative effectiveness analysis. You know, we used to think of comparative effectiveness analysis as, well, does drug A work better than drug B in population C. But if you look at the agenda that PCORI has established, right at the top is organizational differences and which organization works best for, you know, which kind of treatment.

And so this is not something that I'm familiar with, so I really can't give you a lot of advice about this, but certainly it strikes me that it's something that if you haven't looked at it, you'd want to take a look at that.

DR. HALL: Yesterday, we were talking a little bit about some subjects for the retreat and I was particularly

trying to focus on beneficiary attitudes. And I'm kind of intrigued with the comment about Georgetown, but more generally about the question as to why might patients be reluctant to participant in the trials, because I think more generally, that raises, in my mind, at least, a question, is there arguably -- might there be a reluctance to participate as a patient in coordinated care? How does it change the relationship of the patient to the health care system, to their traditional provider? Are there barriers of culture or incentives, disincentives that might influence the actual -- not only the participation, but the behavior once somebody is in the program.

I think you've done an outstanding job. My only point is that I understand, for very good reasons, the emphasis here is on kind of the systems and the providers once somebody is in, and I'm wondering about the people -- two parts, those who for one reason or another aren't coming in, and then anything that might be learned about perhaps why the system is more successful in working with some patients who are in the group and some who are not -- and some -- as compared with others that are in the group and didn't come out as well, even though based upon

comorbidities and the organizational structure, it seems like if it works for A, it ought to work for B.

So I just want to mention that. I'm not sure that's a focus here. But I do sometimes get the impression, understandably, that the emphasis is on payment and on the full range of providers and so forth. But I suspect that there are some factors having to do with, frankly, with attitudes of patients. Maybe that's a gross oversimplification, but that may have some bearing -- significant bearing -- on outcomes. Thank you.

MR. GEORGE MILLER: Yes. Thank you. It is, again, a very written chapter, very rich discussion this morning, and so a follow-up on the path that Mary started on in talking about the overall care coordination. As I read this chapter, I thought this would be a perfect place to deal with the disparities issue, and again, I want to thank you for the issues you brought up.

One of the parts of the chapter talked about the consequences of poor coordination and dealing with the poor, lower-income, minorities, race, ethnic, and it would seem to me that one of the things, and we may want to consider going forward and taking with the lens that, Glenn, you just

talked about as far as the payment consideration, is for that small group -- or that group, I shouldn't say they're necessarily small -- but that group that we still see disparities even with the same type of insurance.

As we develop this chapter, we could, using the term "innovations" that Mary talked about, outline some of the parameters that should be dealt with when dealing with disparities to address the issue, not prescribe the solution, but to raise the consciousness level to deal with the question about communications and about education, so all the right questions are raised and asked in dealing with this vulnerable population, whether it's poor white Appalachians or minority groups or whatever the issue is, that we frame the questions so that when demonstration -- not only demonstration projects, but when care coordinators are dealing with this issue, those questions are raised and the fundamentals are put in the framework that would improve the outcomes going forward, still allow for innovations and for the community. They deal with the issue and talk with those communities that may be adversely affected to ask for their solutions and make sure they are addressed.

But in my mind, in care coordination, there should

be a set of principles and questions that are asked and raised to deal with that issue so we can turn that tide. Now, how to measure it, I'm not sure how to frame that question, but I think we should address it. And again, Mary teed that up correctly.

And then, finally, my comment on a payment, and we always look for quality, but part of that is making sure we get the right care. There's a lot of care going on and folks get a lot of care. That does not necessarily mean it is the right care. And, hopefully, care coordination will lead to the right care, the most appropriate care, instead of -- the ER is an example. A lot of money is spent in the ER. That is not necessarily the right care or most appropriate care.

MR. HACKBARTH: So on George's first point, has Medicare designed any demonstrations specifically targeted at reducing disparities? I would think that if you want to address that issue, you'd have to design the project very carefully in order to get the right population, comparison groups, and all that. Has that ever been the focal point of a Medicare project?

MS. BLONIARZ: I don't -- not that I can speak of.

I mean, there may have been demos that emphasized evaluating disparities and how the intervention affects differences in outcomes, but I don't know.

MR. KUHN: I don't know if there has -- I can't say there's been any specifically driven towards the minority population specifically, but there were some that dealt with, for example, chronic kidney disease to make sure they didn't go into full renal failure, to kind of manage that population. Obviously, that's a group that's more African American that have that problem. So there was kind of some that were focused on that area were probably the closest I can think of.

MR. GEORGE MILLER: I know after we met with Don Berwick last year, I talked with someone in CMS that was trying to design some things, and we talked a couple of times. I'm not sure where that fell out. And it was more than just end-stage renal disease. It was about the whole spectrum of health care, certainly around several cancer, cardiac, diabetes, hypertension, and obesity. They described those efforts being put in place, but I don't know where it has gone from there.

DR. MARK MILLER: My own experience is that it's

more aimed at larger interventions, and then in the evaluation they would examine how the impact occurred across different populations. But we can look into what -- CMMI's agenda and see if there is something more specific on that.

DR. BORMAN: As I try to think about this, and this, again, is a really well done chapter, it appears to me we have a number of services with something of a theme about what we're trying to accomplish for beneficiaries, particularly some of our most complex and vulnerable at times. Yet the package that is needed is different, essentially in the end, for virtually every one of them, despite the commonalities. And I think what we see in the demonstrations and pilots and so forth is a little bit that there's not a one-size-fits-all here. And it sort of begs the issue of while we certainly are affirming the value of the concept, that neither we nor anybody else has clearly come up with the magic bullet that really will do it all.

And I wonder if perhaps what, in the end, needs to happen is where can we consider introducing flexibility into the system to allow this to get done in the right way and whether that's at the State level through -- because there's 50 laboratories there, if you will -- or if this is perhaps

a piece of what we looked at yesterday in terms of encouraging flexibility for the Secretary, or perhaps at other levels in the system, at well, that maybe there's a way to set aside something per beneficiary, per county, whatever it may be, that the Secretary can allow in some sort of discretionary way to be applied toward care coordination services that seem to serve a better defined population.

I really despair of such precise descriptions that make them sort of abuse-proof and yet have meaning in the clinical application, and so I just wonder if we need to maybe move our thinking to something more like how can we do this in a targeted and discretionary way.

MS. UCCELLO: Well, I think Mary was very eloquent in talking about from like the 5 to 10,000 feet level, what the key kind of takaways and directions moving forward we should take on these issues. I'm going to take it up even higher to like 30,000 feet, but just think about, you know, in general, why do things not work? Well, there are really two reasons.

One is that we don't know what to do. And the other is, well, we know what to do, but we're not very good

at implementing it. So I suggest, as we move forward and monitor what's going on and think about all these things, that we explore a little more kind of what these barriers to successful implementation are. We've talked about cultural issues.

We've talked about not just having the IT systems, but having the processes that capitalize on these kinds of systems, but those kinds of things so we make sure that we're not discounting something just because it's not working, but it's not working because we're not doing it right, not because we don't know what works.

MR. ARMSTRONG: So I think you're correct with those comments because I want to build on that as well as the dialogue that Glenn and Mary were having, too. I think this chapter is really well done and goes as far as we can in the context of this chapter. But for our retreat this July and as we think about our agenda going forward, I think this is getting us into some topics that we really should be pushing much further.

To me, care coordination is not really something that you do -- I mean, this kind of module you'll plug in -- but rather, it's a symptom of a system that is designed

properly and that care coordination and the system itself gets designed around some of the things, Cori, you were just talking about, at least in my mind, of payment for outcomes, whether it's population outcomes or bundles, engaging patients and how we do that in a really constructive way.

That's a feature of a system that drives outcomes like good care coordination, information technology. And then, Mary, you were talking about system features have to include a culture and a care delivery process where providers are communicating with one another and engaging nimbly and quickly in adjustments to accommodate the specific requirements of the population of patients there.

So to me, that's just a beginning set of topics that we should have a conversation about. Through MedPAC, how do we try to advance and promote all those system features that in the end produce care coordination? And to me, the frustration is, we still, Glenn, as you were saying, we're still trying to plug in specific care coordination ideas, but all these other features of the system are keeping them from really getting the results I think that they're capable of achieving.

Then, of course, the real frustration is, we do it

in the context of a payment structure, fee-for-service, that itself is a real impediment to getting a lot of this stuff done.

The last point I would make is that sometimes in the context of what I just said, I do think that demonstration projects or initiatives like how do you just reduce readmission rates, you know, into hospitals? Could be a way of blunt, but rather, how do we do these things that we think are good coordination, rather than, how do we achieve this outcome, might be a better approach to some of these demonstrations.

For example, how do we reduce the unnecessary use of emergency rooms? I mean, if we could cut that by 50 percent, we would create enormous value to our system. And so, then to work backward, well, what kind of coordination would be required to reduce the emergency room -- unnecessary emergency room utilization? Anyway, those are the kind of topics I really hope we can spend some time in July on.

DR. CHERNEW: So I really enjoyed this as well, both the reading and the presentation, and what I took from it all was that the management, the environment, a lot of

idiosyncratic things are key and it's very hard to pick out, you need to do it this way or that way. And even if you did know that this place worked because they did it this way or that way, it's not clear that those exact things would go somewhere else, either because they don't fit that environment or, frankly, the people just don't do it as well. It's very hard.

And so, what that means and what I take from that is, it's very tempting to try and have a paradigm where we figure out what we think works and then and put in a bunch of managerial regulations or incentives or systems to make everybody kind of look that way.

And I really think what this told me was just the caution against that. For one, I don't think there actually is an answer to this is the best way and everyone should look this way because I know not everyone will look like Mass. General.

And two is that even if there was an answer, I'm not sure we would have the information and the ability to regulate to get everyone to be exactly there and we would get more and more micro. You need IT, but it has to be -- the meaningful -- if you tie this to the meaningful use

stuff and the article, we could say, Oh, we want it, IT will save us money in ten years.

But there's a little bit of hope there and I share that hope, but it's very easy to think that, Oh, this must work, it will work, we're going to make people do it this way, and then it turns out it doesn't and you haven't regulated it right and then you don't have the right, you know, measures to know exactly what they're doing. They have to get you a whole bunch of other data.

And then you have to segment the populations so you can figure out that they're doing it for these people but not those people, and you end up going down this huge, you know, morass that I think of as like a tar baby. You punch it once and you get stuck so you punch it again and you get stuck again. Then you kick it and then all of a sudden you're just stuck in muck and you haven't really made the system any better. Don't put that on the transcript.

[Laughter.]

MR. HACKBARTH: You should write a book, Mike.

DR. CHERNEW: But anyway, I worry that we're just going to -- we haven't started down that path and so I guess when I took this -- when I read this, I had this concern

that we might go down this path as we try and find all these things. So I want to be clear.

I do really fundamentally believe there's a problem. I really fundamentally believe that some places can do it better than other places. I do fundamentally believe that there are certain aspects of doing it well that involve IT and case managers and stuff, a bunch of things. But I think given the set of -- our task is not to figure out how to do this right.

Our task is to figure out how to set up the incentives and systems to encourage other people to do it right in their setting with their skills and their environment. And so, I think we really need to think how to be able to create the system to do it right, as opposed to figuring out how it should be done and then making sure that everyone's kind of managing it that way.

And I think that's hard to do, but I think we can get there. I think part of that is going to be focusing more of our effort on knowing what measures we want to demand, the outcomes we want, as opposed to trying to worry about the processes by which those things are generated, because I think a lot of different places will generate good

outcomes using a lot of different things based on their settings, what they can do, and a whole bunch of other things.

DR. HALL: Well, not to repeat what's already been said, I think I agree with Mike that it's not our job to design the system, obviously. But I would emphasize, I think we can learn a great deal from negative studies that do get published and are critically reviewed. Maybe we can learn more from those than we can from the positive studies. I wouldn't neglect them.

I'll bet you that a lot of the -- well, just one more point. There's not going to be one solution for every institution in the United States. There are going to be multiple solutions, but I think there are some principles that will emerge and one of them is probably going to be the leadership structure.

In a lot of parts of America in medicine, the power equation isn't very well-defined. There's the administrator, there's the doctor, and there's lots of other people, and silo structures even occur in very small places. But I think through looking at negative studies, we can see how people have overcome some of these barriers.

DR. BAICKER: I agree this was very informative about the potential for this kind of coordination to improve outcomes and our lack of knowledge about exactly which elements are doing the lifting, and especially our inability to predict that ahead of time. But hopefully we can predict one step back what program features we design that can enable the creative coordination that might manifest in many different ways, but we've set up an infrastructure that promotes that kind of coordination and rewards it, coming back to the payment system, without being prescriptive about what the particular manifestation might look like in different contexts.

MR. BUTLER: So I'm optimistic. I think the models are better than we think. I think the institutional leadership and culture on one hand and the payment systems still lag behind the models. And I think if those two things were present, you would see an acceleration.

I see a lot of my colleagues participating in many of the innovative solutions out there and it's subtle, but I see talent shifting to those kinds of organizations that are innovating. So I look at my own colleagues, I look at physician leaderships, and they're looking at what's going

on in the market and they're starting to say, I'm going to go with the ones that are kind of working on this stuff versus not.

I think you will subtly have an aggregation of the talent in the places that are thinking ahead and doing these kinds of things. That's a subtle thing, but I think it will reinforce itself with time and accelerate the adoption of the models.

Now, I get a little discouraged in the sense that -- not discouraged, but when we evaluate these, it's always what did it do to readmission rates, what did it do to overall spending. It's all about utilization and expenditures and it's less on maybe some subtle but important things like how about the satisfaction or the hassle factors in a physician's life or a case worker's life, or most importantly, the beneficiary.

What is the thing that makes the model feel like it's an easier thing and a better thing for all of those people, as opposed to simply looking at the outcome that's generated, because you have a lot of people that touch the process along the way, and it's almost like, what is the satisfaction level of all of those, including the

beneficiary in this process, would be part of what would make this successful and generate, in return, the outcomes that we're all looking for, because we know if it's coordinated better, we know it's going to be cheap

DR. BERENSON: First just a micro-point to pick up on Mitra's question earlier about the 24/7 access. My understanding, and this may not be correct, that Mass. General really spent a lot of attention on the physician on-call responsibilities, in particular, and communicating with the ED. It's an area that gets very little attention in Medical Home discussions or other things.

I think it's crucial and, you know, trying to find the balance between high quality on-call and a physician's natural desire to have a nice lifestyle and not be up all night, and trying to figure out how to do that. I think they may have some insights into that in that they did spend some attention.

But at the bigger picture, I won't go very far. I agree basically with a number of the comments that if you have a basic conflict between care coordination and the sort of fundamental engine of the business model of American medicine, what you've got, I think, in many situations are

some local champions who are trying to achieve something in care coordination which is sort of over there in the annex, while the whole sort of operation is moving over here. They're swimming uphill, or whatever that means.

MR. HACKBARTH: It sounds hard though

DR. BERENSON: It sounds hard.

[Laughter.]

DR. BERENSON: So I basically agree. That's why I'm more optimistic about ACOs, if we can support a population-based payment model with organizations who will organically then figure out how to do what's obviously a real important area, which is to do care coordination and care management well.

But having said that, I'm trying to be consistent with my yesterday's advocacy of Rube Goldberg approaches to getting time right. It would be hard for me to now argue that we shouldn't be trying to do what we can in the fee-for-service system to do some things. I'd be looking at, you know, I guess I wouldn't be expecting as comprehensive an approach in sort of the fee-for-service system. I'd be looking for real opportunities for making a difference like in transition care where we now know what works pretty well,

and some other specific areas, and would be giving it still a lot of attention.

I agree with -- I mean, I'm actually happy to hear from Mary that a lot of what we now know is based on these demonstrations, and even though they've sort of failed in some ways, there's a lot of learnings that have come out of them. So I think we need to try to change the business model for institutions and then the accompanying culture that would change, but at the same time continue, as frustrating as it is, in this area.

MR. KUHN: I was at CMS when most of these demonstrations were either started, run, or completed as part of the process, and while some of them had started before I began my work at CMS, a lot of them were spawned as a result of the Medicare Modernization Act, particularly the Medicare Health Support program as part of that process.

And I well remember the national meeting we had at CMS in the auditorium there in Baltimore where we brought all the interested parties together to begin explaining to them the Medicare Health Support program and what it was all about. And I well remember the hallway conversations during the meeting and then afterwards, days afterwards, not only

the sense of enthusiasm by all the organizations that came that wanted to participate in the program, but also the sense of bravado by a lot of the organizations out there.

Initially in that program, CMS set the savings threshold to 5 percent, and a lot of folks said, you know, You guys are being too namby pamby here. 5 percent? We can do 10 percent, we can do 15 percent. So to a degree, I think initially, there was a lot of very high expectations that care management was going to achieve enormous savings out there, and I think a lot of people set the bar way, way too high in terms of expectations going into that.

Having said that, I agree with Peter, that the enthusiasm -- while the bravado, I think, has abated somewhat, the enthusiasm is still there and I see a lot of talent, like he does, of people moving, continued to migrate into this space to try new methods to manage these difficult populations on a go forward basis.

But a couple learnings that I think as we think about this on a go forward basis worth looking at, first of all, we're always going to continue to suffer under the notion that the Medicare program is a national program and CMS has to have a set of business rules to run it as a

national program, and the ability to modulate the program in very small ways is very difficult.

So as we continue our work here continuing to look at payment incentives that permit that and that really focus on outcomes is going to be critical on a go forward basis.

The second thing is, I think as Glenn and I think others have shared this, is the notion of dropping in the silos of these programs. Again, Medicare -- and we've seen it in post-acute care and all the other work that we've done around here -- continues to be very silo-based, and these programs are no exception to that, and how we get better integration alone and payment systems to permit that on a go forward basis is going to be key.

The third takeaway I would just think a little bit about it something that Bill Gradison mentioned in his comments. But it always kind of troubled me a little bit about the beneficiary engagement on these programs. A couple of thoughts on that. First of all, if you're a beneficiary, you get a letter from Medicare and it says, Congratulations, you've been selected for this program. You're going to be hearing from this organization. And maybe a week later, you get a letter from some organization

that you have no idea who it is and they say, Boy, we've got this great deal for you, you know, time to sign up and get in this program.

It creates a lot of confusion for beneficiaries out there, and just think about some of the conversations we've had around this table in the past about the acute care episode or the ACE demo where beneficiaries are really kind of directed to those kind of high-performing organizations that are getting the bundle for cardiac or orthopedic services.

And in exchange for that, they get some remuneration. They get a check back for picking a low-cost provider. And they're even confused by that. They don't understand kind of what's going on out there. So I think in the future, this might be an area for us to look at, is beneficiary engagement in this area and better ways that we can do that, because I saw it then and I continue to see it now, that I think it's very confusing.

And also on the beneficiary side and something that Peter said that I think is so important is to really understand the socioeconomic factors in the evaluation and as CMS develops the evaluation contractors. It was quite

moving at CMS to hear some of the anecdotal stories you would hear back in terms of these organizations, particularly the ones in the Medicare that all support the telephonic engagement with beneficiaries and what a difference it was making in some of these people's lives.

It wasn't saving a lot of money, but it was really helping them get through day-to-day on some really critical things that they were facing, and you just can't discount that. That's pretty powerful stuff and it was always good to see. In fact, some people almost described it, some of those beneficiaries, that like an angel appeared, you know, to help them in these areas. This is how powerful it was to some of those folks that were really in distress and in need at the time. It would be nice to be able to cashier that in the future somehow.

But finally, I would wrap up kind of where Mary took us and many people have commented about that, is that how do we take this kind of basic set of demonstrations, 30-some demonstrations that all kind of look the same and take that kind of into the Phase 2 to get us -- what are the learnings from that, what are the refinements? How do we take all that to kind of move it in a direction that's going

to be very powerful that we can learn more and get better at this and keep the enthusiasm going, dampen down the bravado a little bit, but hopefully make some progress.

MS. BEHROOZI: So as much as I love this chapter, before I listened to Mary, I was really disappointed that I didn't get the answer that as a payer I need, because people keep saying to me, So what are the funds doing about care coordination and care management and what do you do? And my answer has been, We're just the payer, we're not the provider.

So we're trying to figure out what the best way to do that and hopefully I'll get the answer really soon from Kate and Kelly. No, I don't say that to them. So I was a little disappointed. I think there was only one and it was a hospital that our members don't go to because we're in New York and not in Boston.

But Mary cheered me up and I think that it's true that there is a lot of information in here about what works, but also as a payer it is that much clearer to me that there's not a lot that we can do that is specific, that drives toward the plug-in. I love that imagery, Glenn, that we can't buy something that, you know, inserts into all our

providers across the board and that makes our program now -- I mean, our health care coverage now a coordinated care health care coverage product.

I mean, that's not what you get out of this. What you get out of this, and as Mary said, is trying to figure out how to pay that gives the most flexibility for providers to do the right thing, which, you know, kind of naturally drives towards ACOs and bundling and, you know, risk arrangements with providers.

Of course then the problem is how do you set the price in the bundle and all of that, but that's, you know, that's a different presentation. I'm not going to ask you to explain all of that.

So as a payer, it does seem to me that the two main issues -- and this is in my world and there are some analogies for Medicare is how we pay, but the other thing is also who and how do we steer patients or beneficiaries toward these interventions? And Herb just spent some time talking about that. Bill had raised it.

You know, you see in the descriptions that it's not only high-cost beneficiaries, and I think, Mark, you were talking about this, that certain conditions are more

amenable to certain kinds of interventions and certain results. And I think also, again going to points that Bill and Herb talked about, you described in the chapter that -- you say, one key difference about the Mass. General program was what they called a loyalty component, that the beneficiaries had to be regular users of that physician group in the past.

And that's really hard to replicate. And, you know, when you're starting out with beneficiaries who can go to any willing provider, who have gone to whomever they wanted to in the past, whether they were getting good care or not, they believed that their choice was more important than their outcomes, it's hard to make that transition.

So how do you get people to transition over? You can try to use economic incentives. I mean, that's about all you can do. Or you can use rules that say you can't get care unless you get it this way. I don't think the Medicare program can get there any time quick. I don't know exactly how we would.

So, Kate, I think I told you at the retreat last year about this little experiment that we're doing not very scientifically, but kind of out of necessity. Our home care

workers were in a joint public/private partnership thing for a couple of years. Didn't work very well. And now they're back under self-insurance and self-administration and we've offered them a choice of Plan A or Plan B.

Plan B is comprised of -- all the primary care services must be obtained at a network comprised of all the FQHCs and PCMH Level 3s in our service area. We didn't like go to each one and make our own judgments about them. We figured if the NCQA and CMS had given them those designations, they had to meet standards, you know, of care coordination and, you know, EHR and all of that.

And then they don't have to pay any co-payments, those members. But if they would like to stay in our broad provider network, any willing provider, they have to continue to pay the co-payments that they were paying under the public program, which are fairly small and maybe some providers don't collect them, but they do have like three and six-dollar payments for drugs and things like that.

Surprisingly, only 25 percent of those low-income members chose Plan A, about 7,000, I guess, out of the 28,000. More surprisingly, and this really goes to Bill's point, we are seeing a couple of hundred switch over out of

Plan A, out of the free, narrower network into the open network. We're seeing a couple of hundred per month switching out, which really surprises us.

So we are going to be surveying them and we'd be happy to share that survey data. And we're very disappointed because the very early, very, very early results are -- you know, we don't have a whole lot in the way of claims data yet, but just drug data -- shows about an 80 percent or something ratio for the people in Plan A. They're costing about 80 percent what the people in the open network are costing for drugs.

And you'd be surprised about the high utilization of drugs. It's not because they're so much sicker, apparently, in Plan B and they wanted to stay with their providers. It's like osteoporosis drugs. So whatever we learn from that we're happy to share.

DR. DEAN: Yeah, maybe a couple of smaller points to begin with. Herb mentioned that there was a difference in the conditions of this one program; they shifted more towards heart failure than diabetes. I think that's understandable, especially if we're looking at a short-term analysis, because heart failure is inherently more unstable

than diabetes. If you're going to get benefits from good management of diabetes, you're looking at a time frame of years. Oftentimes with heart failure, it's a period of weeks to months, so I think that makes sense. It's unfortunate because over the long run I think that the proper management of diabetes has major payoffs, but, unfortunately, they're down the road a ways. And we tend to have too short a time frame as we look at these things.

I think also some of this discussion relates back to some of the stuff we talked about with EHRs yesterday and brings up the dilemma that some of us face, and I was lamenting our particular situation with multiple systems that don't relate to each other and how hard it is for the information we need to move between the various places it needs to be. But even when it does move, Bill and I were complaining about how much information at least we find valuable that never appears in the EHR. I mean, they record blood pressure and they record the list of drugs and they record the heart sounds and they record those sorts of things. But very often it says nothing about what that patient's values are, what their idiosyncrasies are, what things have angered them in the past, and these are

fundamental things in terms of our ability to make a care plan that's going to be useful and going to be effective.

And so, again, it's a frustration. I don't have an answer, but I think it speaks to the fact that we have a ways to go in terms of developing these systems in ways that really communicate the information that at least I believe will make a difference over the long run.

Finally, I think that -- and probably this reiterates what Glenn just said. I think we just can't look at care coordination as a separate entity. It has got to be integrated. And I guess if you want the most stimulating testament to that that I've seen, it's actually the analysis of Group Health experience with their medical home over the first two years, which, if you haven't read it, you certainly should. It was in Health Affairs May of '10 -- or '09? '11? I can't remember.

PARTICIPANT: Two years ago.

DR. DEAN: Two years ago, which goes through in great detail the many steps along the way that the Group Health folks have integrated this into the care that they give and the payoff that it produces. And so it's just -- I think it's not surprising that these programs have not

delivered what we had hoped because to really do it properly, it has to be -- it's not a separate service. It just has to be completely integrated into every step of the care.

DR. CASTELLANOS: This is the first time I've been last, but this is fine. I really appreciate -- what I really appreciate is listening to all of your comments because you all come from different points of view, and you're all right. Kate and Kelly, you did a great job, you know, stimulating us, working together, and you really see the benefit of what the MedPAC Commission is.

My points are going to be very simple. Mary, I think you're right, and Cori. But you guys are looking at it from 10,000 feet and, Cori, you from 30,000 feet. Urologists live right where they're down in the nitty-gritty, okay?

[Laughter.]

DR. CASTELLANOS: So I'm going to get down to the nitty-gritty, okay? I think the science is here. I really think we know what we need to do, and all of us, we know there are programs that look great on paper. What's the difference? Well, you know, I was asking myself that. We

do this in our office, and I have a strong feeling that it's really the person, the individual, the care, who's providing it, sort of what Glenn said. You just can't plug it in, or what Tom said. It's a developmental process. It's a relationship.

I have one partner who's an excellent surgeon, an excellent guy, but he's arrogant and nobody wants to talk to him and he doesn't want to talk to anybody. I don't know how to change that, but --

[Laughter.]

DR. CASTELLANOS: Anybody have suggestions? Don't say, "Throw money at him." Whatever you do, don't say that.

But, you know, really the point is that I think we're really dealing with a very vital part of the practice of medicine, and I appreciate all of your efforts and your ideas, but I think a lot of it is going to come down where the tire hits the road, the individual relationships that are important, not just the physician and care providers but the beneficiary.

Thank you.

MR. HACKBARTH: This has been therapeutic for me. I actually --

[Laughter.]

MR. HACKBARTH: I actually feel better at the end than I thought I would when we started. This is a topic that always frustrates me because we have this seemingly poor track record of success in these interventions. I hadn't been able to articulate what Mary and Peter and some other people did for me. There is reason to be if not optimistic, not be entirely pessimistic about what's going on. Even though we're not producing a certain type of positive results, I think we are learning things. And these issues are becoming more prominent in health care delivery. More people are focused on them. As Peter says, more talent is moving in these directions, and I think that is encouraging.

You know, for reasons I've already said, I don't think that we're likely to get where we want to go looking at how we can in a fee-for-service context do plug-in modules for X, Y, Z activities. I think that's going to continue to be a fruitless search. But that is not the same as being pessimistic that, oh, we're not learning anything and we're not figuring out how we can do better than we have in the past.

I think the key thing for MedPAC, given our focus on payment policy, is how can we use payment policy to best support, facilitate, permit the innovation that will improve care for patients. And, generally speaking -- you know, this is a regular theme for us, and generally speaking, I think there's broad agreement here that more flexible payments systems, moving away from fee-for-service, broader bundles not only create better incentives, but they also give providers the flexibility to allocate resources and be accountable for the use of those resources. And, you know, to me that's the key message, and if we have that payment context, we've got a lot of really smart people in health care, and they will figure it out. And as Mary says, there's information here that we're learning. So I feel good.

Thank you, Kate and Kelly. Nice work on this chapter.

We'll now have our public comment period. Seeing -- oh, Sharon's on the way.

[Laughter.]

MS. MCILRATH: I just wanted to pick up on what Dr. Berenson said. Before you sort of totally rule out

doing anything in fee-for-service, it is going to be here for a while, and there are ways that you could potentially finance some of the infrastructure that you need to do some of these other programs. And, you know, we do have a group within CPT and RUC that have been working on putting something together that would sort of more go in the direction of the areas, such as Bob said, of transitions and taking care of -- identifying some really complex patients and some things that you would really want to see happen with those patients and then allowing there to be a fee that would cover part of the cost of some of the infrastructure you'd want in the office, such as the case managers, to deal with those patients.

So I would hope we wouldn't just rule that possibility out, that at least we could look and see if we couldn't, you know, complete that work, and maybe people would see that there was something there.

MR. HACKBARTH: Okay. We are adjourned.

[Whereupon, at 11:23 a.m., the meeting was adjourned.]