ALLIANCE FOR HEALTH REFORM

Medicare 101: What You Need to Know
The Kaiser Family Foundation
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard. I am with the Alliance for Health Reform. I want to welcome you to today's program on behalf of Senator Cardin, Senator Blunt and our Board of Director's. The program is on the basics of Medicare. It is the third in a series of primers that the Alliance and the Kaiser Family Foundation are conducting. We do this near the beginning of each new Congress in recent years. We have done sessions on the Affordable Care Act, last week on Medicaid, next Wednesday we will be doing the final one in the series on the subject of healthcare costs. Watch your inbox for notices about that if you haven't gotten them already.

Today we are going to focus on Medicare- the federal government's largest healthcare program, at least in terms of federal costs. Before we go any further, I want to recognize our co-moderator for today's program, Tricia Neuman. She is the Senior Vice President of the Foundation and Director of both its program on Medicare policy and its project on Medicare's future. Tricia?

TRICIA NEUMAN: Thank you, Ed. It is great to be here today and it is great to be with my friends at the Alliance. They do such a great job in putting together these sessions to bring information to you and for today to our audience who are watching on C-SPAN. On behalf of the Kaiser Family Foundation, I want to welcome you all here to get your fill of Medicare. This is our Medicare 101 and it is an opportunity to get your questions answered and we have a great group of people who will be joining us to answer your questions.

We have a lot of ground to cover today, which we have gotten very good at doing very quickly. For those of you who are in the room, I am very pleased to be able to show you our primer…our Medicare primer…which you all can take home and for those of you who are watching, this will be on our website which you can download at KFF.org. This week, I imagine you all have heard a lot about Medicare with all that has been going on with the SGR and we will be talking about that. You may be hearing a lot about Medicare because of what has been going on in the budget resolution and we may be talking about that, but we talk about Medicare for important reasons. One…Medicare is very important to the lives of the 55,000,000 people it serves, mostly seniors but younger people with disabilities. Two…Medicare is a very important source of revenue to the nation's hospitals, physicians, home health providers and so I am sure you hear a lot from those who are in your boss' districts who come because they care about Medicare as well. And three…Medicare is 14% of the federal budget so when you all are working on issues related to the federal budget, invariably you are working on Medicare.

During today's sessions we are going to get through the A, B, C's and D's of Medicare…quite literally. We will also try to demystify some of the acronyms like ACO's and CMMI and the SGR and we hope this will be helpful to you. Before we get to our panel of experts, we are especially pleased to be able to show you a very short animated video on the history of Medicare and right before we get to this video, I just want to acknowledge three people in the room who worked very hard on this video and I hope you will, before you even see it, join me in giving them applause. Francis Ying who is over there [APPLAUSE], Christina Swoope who is right over there [APPLAUSE] and Shannon Griffin…who is also over there [APPLAUSE]. Thank you all for all of your hard work on this. I hope you will pretend that we have distributed popcorn and you will sit back and we'll dim the lights and watch the video.

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ED HOWARD: Thanks again to the folks who put that together. That was a tours de force. Did you get all that? Knowing Kaiser, there will be a quiz at some point that you're going to have to take on all the material.

TRICIA NEUMAN: Actually, there is a quiz on our website. We'll know if you watched carefully.

ED HOWARD: Okay. You are going to hear a lot more, not so much about Medicare's history, in the next hour and a half but its present and its future. We could ask our panel to join is if you could. In the interest of time, I am going to forego any further introductory remarks. We want to take full advantage of these folks. They are starts as well and we want to give you as much chance to ask questions as we possibly can. As I said, we are joined in this effort by the Kaiser Family Foundation. I just want to say a word. This video is not the only high quality resource on Medicare and other health policy topics that you can find by going to their website…KFF.org. We've got one of the country's foremost Medicare experts, as a matter of fact, right here in the fund's Senior Vice President, Tricia Neuman so she can do more than just referee the discussion, I can assure you.

A little bit of housekeeping. First of all, let me just say I am really happy that the Alliance and Kaiser are on the House side. We don't get back here very often. I do want to apologize for the sight lines that some of you folks in the corners might have but it is a limitation. If you can't get the Cannon Caucus Room then here you are so bear with us and we'll try to make the best of the shape of the room. The clarity of the conversation, I think, will make up for it. If you are in a Twitter mode, you can see the hashtag Medicare 101. If you need Wi-Fi there are instructions on how to connect. I think they are on your table and they are on the screens that you see there as well. Lots of important information in your packets including speaker biographical information more extensive than you'll hear from us. There is a materials list that has everything that is in your kit listed and all of that is on the Alliance website at allhealth.org so you can pass it along to some of your colleagues who may not have been able to get here today. Speaking of which, I should note the presence of C-SPAN. If you are watching on C-SPAN and you have access to a computer as well, you can go to allhealth.org and find all of the speaker slides and the background material so you can follow along even more closely. There will be a video recording of this briefing available on the Kaiser website…KFF.org probably Monday, if not Tuesday and a transcript a couple days later on the Alliance website at allhealth.org.

Two pieces of paper I want to call your attention to: the green question card you can use to ask a question at the appropriate time. There are some microphones you can use at the far corners of the room to ask your question orally. And then, a blue evaluation form that will help us improve these programs for you and get the subjects, and the speakers, and the treatments that you need to do your job. One final thing that all of you don't have in your hand is a yellow evaluation sheet that is more general about the briefings and activities that the Alliance puts on. We want to try to get particularly the opinions of Congressional staff so those of you who identified yourself as such when you checked in, I hope you got a yellow evaluation form. If you didn't, see one of the staff folks and we'll get you one. We'd very much appreciate you filling that out.

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So…enough of the preliminaries. We have a terrific panel and we're going to start with Juliette Cubanski. Juliette is the Associate Director of the Medicare Policy Program at Kaiser. She is one of the leading analysts of Medicare today and of the proposals to change it. Her task today is to sort of keep it simple and describe the basic structure of the program, who is in it, what is covered, what is not, how and by whom it is paid for and she can do all that in eight minutes, no problem. Juliette…thank you very much for being here.

JULIETTE CUBANSKI: Thank you, Ed. Thank you, Tricia. It is great to see all of you here to learn about Medicare and, as Ed said, I have a lot of ground to cover in a very short period of time so I am just going to jump right in. I will start at the beginning. Medicare was established 50 years ago to provide health insurance to people aged 65 and older back when most seniors had no or very inadequate insurance coverage. The program was expanded a few years later to cover people under 65 with permanent disabilities. Today, Medicare covers 55,000,000 people most age 65 and older, but also 9,000,000 people with disabilities who are under 65. Beneficiaries get the same benefits without regard to their income or their medical history. Medicare covers a comprehensive set of benefits including hospitalizations, physician visits, post-acute care and a prescription drug benefit which is delivered through private plans and private plans have been playing a larger role in the delivery of Medicare benefits in recent years, which I'll talk about briefly soon.

Medicare covers a population that is, on the whole, sicker and has greater health needs than people who are not covered by Medicare. For example, nearly half of beneficiaries have four or more chronic conditions and one third have one or more functional impairments. Many people on Medicare live on modest incomes primarily derived from Social Security. In 2013, half of all beneficiaries had annual income below $23,500 which is equivalent to 200% of poverty in 2015 for an individual.

Now let's look at what Medicare covers. Most people on Medicare get their benefits through their traditional Medicare program as distinct from the Medicare Advantage program which I'll discuss shortly. In traditional Medicare, beneficiaries can see pretty much any provider that participates in Medicare, which is the vast majority. Coverage of Medicare is divided into parts, which are funded differently and have different cost sharing structures.

Part A is the hospital insurance program, which helps pay for hospitalizations and post-acute care. In 2015, beneficiaries pay a deductible of about $1,200 before Medicare begins paying for hospital stays and they pay for each day of an extended stay in a facility. Most people become entitled to Part A after paying payroll taxes for 10 years and enrollment is automatic if you are receiving Social Security when you turn 65. There are some details about financing here but I'll come back to that shortly.

Part B is the supplementary medical insurance program, which helps pay for physician visits and other outpatient services. Most beneficiaries pay a monthly premium for Part B, which is about $105 in 2015, but this premium is income related meaning people with higher incomes pay a higher monthly Part B premium. Part B services are subject to a deductible and also a co-insurance of

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about 20%. Enrollment in Part B is voluntary but most people who are entitled to Part A also enroll in Part B.

Parts C and Part D are different from traditional Medicare because they involve the delivery of Medicare benefits through private plans. Part C is known as Medicare Advantage, which is an alternative to traditional Medicare where beneficiaries can sign up for a private plan such as an HMO or a PPO. These plans are paid by Medicare to provide enrollees with all Part A and Part B benefits and typically also provide the Part D drug benefit. They also often provide extra benefits that Medicare does not cover such as vision and dental services. Today, about 16,000,000 people or 30% of all people on Medicare are enrolled in Medicare Advantage plans.

Part D is Medicare's prescription drug benefit. Part D coverage is voluntary, meaning that people who want the prescription drug benefit must enroll in a private plan…either a standalone prescription drug plan to supplement traditional Medicare or a Medicare Advantage plan that covers prescription drugs. Plans can offer the standard drug benefit, which is illustrated here on this slide, or they can vary the design of the benefit as long as it is at least equal in value. Enrollees pay monthly premiums for their plan and they pay for their prescription drugs in terms of copayments and these costs vary from one plan to the next. If you have heard nothing else about Part D, you have probably heard about the Part D coverage gap, also known as the "doughnut hole", where beneficiaries had to pay 100% of their costs until they reached the catastrophic coverage level. As a result of a provision in the Affordable Care Act, however, the "doughnut hole" is gradually being phased out and will be phased out completely by 2020. Beneficiaries in Part D with low incomes get additional assistance with their premiums and cost sharing and in total, about 7/10 beneficiaries are now enrolled in Part D plans.

The money to pay for all of these benefits comes from several different sources. Part A is funded primarily through payroll taxes paid by workers and employers while Part B and Part D are financed primarily by general revenues and also monthly premiums paid by beneficiaries. Part C is not shown here because the Medicare Advantage program is not financed separately.

In 2014, Medicare spent about six hundred billion dollars on Medicare covered benefits. Payments to Medicare Advantage plans and spending on hospital inpatient services for beneficiaries in traditional Medicare accounted for about half of Medicare benefit spending, while payments for physician services and the drug benefit were about 10% each.

Despite the important benefits that Medicare helps pay for there are some missing pieces in its benefit package. Traditional Medicare doesn't cover vision or dental services or hearing aids and it doesn't pay for most long-term services and support such as extended stays in a nursing home. Medicare also places no limit on beneficiaries out of pocket spending each year unlike typical private insurance plans. To help with out of pocket cost and provide benefits that Medicare does not cover, most beneficiaries have some form of additional or supplemental insurance. A primary source is employer-sponsored retiree health benefits. Another source is private insurance policies known as Medigap, which help pay for Medicare's deductibles and coinsurance and for about 10,000,000 low income people on Medicare, Medicaid pays their Medicare premiums and cost

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sharing and for most of these so called dual eligible beneficiaries, Medicaid provides some benefits that Medicare does not cover, notably long-term care.

Even with Medicare and supplemental coverage, most beneficiaries face substantial out of pocket costs. In 2010, for example, beneficiaries spent close to $5,000 on average out of their own pockets both for premiums for Medicare and for supplemental coverage and for their costs for medical and long-term care.

Now I am going to take an abrupt turn and I am going to give you a quick overview of some of the major changes to Medicare that were included in the Affordable Care Act of 2010. There were benefit improvements including, as I mentioned, closing the "doughnut hole" and eliminating cost sharing for preventive services. There were provisions to improve the quality of care and lower costs through payment and delivery system reforms and there were also some explicit savings including reduced payments to hospitals and other providers and to Medicare Advantage plans and there were newer revenues…income relating premiums for the Part D program and a payroll tax increase for people with higher incomes. The Congressional Budget Office has estimated that the Affordable Care Act would reduce Medicare spending by four hundred twenty eight billion dollars over 10 years between 2010 and 2019…so the law was a big deal not just for the uninsured but also for Medicare.

The program does face some pretty big challenges so I think it is clear that Medicare will continue to undergo changes in the future perhaps even the very near future, as we are all kind of witnessing with the latest debate over the SGR. Medicare represents a growing share of the federal budget. With an aging population, beneficiaries themselves face rising healthcare costs and a more complex coverage landscape with a proliferation of private plans in the Medicare program and providers are navigating their way through new payment approaches and delivery system reforms. All of these factors could be a springboard for future changes to Medicare. With that, I'll turn it over to you Bob.

ED HOWARD: Let me just say who Bob is. Dr. Robert Berenson is an Institute Fellow at the Urban Institute. He was a practicing internist for 20 years. He has helped shape Medicare policy from the inside as a Senior Staffer at CMS and served on the Medicare Payment Advisory Commission…MedPAC…advising Congress on all thing Medicare. Today, we've asked him to describe the complicated world of Medicare payments. Bob, thanks for joining us.

ROBERT BERENSON: It is a pleasure to be here. It is a complicated topic. I'm going to try to start with just going over some terminology, which is au currant is what we say. Some of these terms are used, certainly in the media, but with serious policy analysts and researchers…are you going to set the timer for me, Ed?

ED HOWARD: You're out already.

ROBERT BERENSON: Exactly.

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[LAUGHER]

ROBERT BERENSON: It is important to understand some of this terminology. Underlying it are important concepts and some of the terms being used in some ways are misleading and I just want to point that out. Many people will continue to use them but at least it helps to understand what we're talking about.

The first one is fee for service. What fee for service really means is that payments are made for each individual service or item provided during an encounter or a hospital stay and actually it is not each service that is provided, it is individual services that actually are codified. They receive a designated code that they can be billed and paid for. The classic fee for service is the Medicare Physician Fee Schedule where you have over 6,000 individual services for which physicians can bill but even there, there are a lot of activities that physicians may perform that they don't get paid for because they don't have a separate reimbursement or a payment code. So that is fee for service.

"Fee for service Medicare" is a very commonly used term to just designate the part of Medicare that is not Medicare Advantage. Many people just refer to it as "fee for service Medicare." MedPAC does that and I spent a term on MedPAC and was unable to change that. I noticed that Kaiser correctly uses the term "traditional Medicare" rather than "fee for service Medicare" because, as I am going to point out in more detail in a couple of minutes…most of the payment that traditional Medicare uses is not fee for service. What it is, is the next bullet I have there. It is volume based payment.

By volume based payment I mean payments that increase as a function of the number of units of services performed and for which payment is requested. Most traditional Medicare payments are, in fact, volume based. I'll go over that in more detail. They are not classically fee for service. In fact, even volume based…in Europe they refer to the same concept as activity based. There is a little bit of a different connotation of doing services because you get high volume and doing services that involve activity for which you may get paid. I don't want to belabor this point. Let me go to the next one.

The alternative, as is being presented in most of the public dialogue around payment in Medicare is the alternative to volume based payment…value based payment. Here, payments include some level of financial rewards or penalties for measured quality and/or incentives for holding down costs with the view that under volume based payment the incentive is to generate more volume and get more payment. The idea here is to have some incentives for being more prudent with healthcare spending. One of the points I want to make, and I think it is important, is that value based payments as currently being implemented and Rahul will go over a lot of this in much more detail than I have time to do, are usually placed on top of volume based payments. It is not an either/or situation for the most part. What you have is current payment models, which we'll talk about, and then on top of that some new payment incentive or marginal reward or penalty related to an assessment of value.

Finally, a basic term to get out is what is now general described or called population based payment. These are payments that are made to a provider prospectively, meaning ahead of time, to a provider

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responsible for a population of individuals irrespective of the actual services provided. That is the key concept. Here, the payment goes for caring for an individual for a year. Usually the payments are made on a monthly basis and the incentive is completely different on the providers because if they do few services or lots of services they are basically getting the same payment. The notion here is the payment is based on the population for which the provider is responsible.

Now there are other terms and now we are getting more concrete about the units of payment, which is where all the action is. It can be at the individual service level which I described so in the fee schedule, there is…I don't know what the actual count is…I said 6,000 and here I put down more than 7,000…there are lots of individual services in the Medicare physician fee schedule. Those are for individual services that the physicians provide and request payment for.

There is a concept called packing, which isn't used very much in general discussion. It is when various services that are performed at the same time are not paid separately but are actually packed into a single payment. A simple example would be if you go to a doctor for an office visit and some of the incidental lab work like a urinalysis is not paid separately and is just part of the payment that goes for the visit.

Bundled is a term that is used a lot and there are actually two different meanings of bundled and you can get very confused. I have been very confused about what people were talking about. One is…it is used the same way packaging is used. A whole bunch of services are bundled together into a single payment and that is a term that is used a lot in the dialysis in the ESRD program…end stage renal disease, where there has been a recent reform that instead of paying separately for the dialysis and then the drugs that the individual receives, it has become a bundled payment or a packaged payment…a single payment with the drugs being included in that payment. It changes the incentive for how much drug you provide and that is a reason to package it or bundle it. The other meaning of bundled means putting different revenue streams together…money that goes to different providers. It can be a hospital and a doctor, for example. We are now bundling that into a single payment that goes to one of those entities as a bundled payment. That is the basic concept…it is bundling across providers.

An episode is payment for services extending over time. I'll give you examples. A case rate is one example of a payment to a hospital. The episode is the hospitalization. It is also called a case rate. Instead of paying for each service performed in the hospital or even for each day in the hospital, it is a case rate. It is a payment for the episode of the hospitalization and then a bundled episode is when you combine putting it out over time with putting different providers together into the same payment model.

Per diem is where you pay a packaged payment for service provided for each day of a hospital stay. You are not paying fee for service for each item. You are paying a fixed amount for the day in the hospital.

Diagnosis related groups is the term for the whole system of acute care hospitals of paying case rates.

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Capitation is a common form of population based payment.

We now have bonus and penalties so pay for performance in Medicare terminology is called value based purchasing. These are marginal payments that are made up or down based on the performance against specific metrics…usually quality of care or service use.

And then…shared savings is where there is an incentive for spending less than a targeted amount and if you achieve that, the provider and in this case Medicare will share in the savings.

I am not going to go through any detail. The point of this is to demonstrate there is a variety of payment methods in traditional Medicare. We still have lots of fee schedules but notice that some of these fee schedules have extensive or some packaging so it is not a payment for an individual item but it still is a payment for individual services provided under a fee schedule. There are per diems and under hospice and psychiatric hospitals and skilled nursing facility. There are episodes so in home health we have now moved to a system in which the home health agency receives a payment for a 60 day episode of care, not fee for service for each visit they make but a payment for 60 day episode. Finally, capitation which is the payment to Medicare Advantage and to Part D plans. It is a fixed amount per month and they are responsible.

Now very quickly… Rahul is going to go through this so I won't…is the HHS framework for evolution of payment models. I am going to finish with just two more minutes, if I can, with what was in this legislation. Some of you, I am sure, were working with it. Last year's bill title was *A Sustainable Growth Rate Repeal and Medicare Provider Payment Modernization Act*. I had to do my slides before a title was actually put on this year's legislation and this turned out to be the title for title of that act, which is called *Medicare Access and CHIP Reauthorization Act*. The point is, there is a repeal of this thing called the sustainable growth rate and, in addition, some notion of provider payment modernization which mostly means physician payment modernization.

Briefly, the background is that the sustainable growth rate, which was enacted in 1997 in the *Balanced Budget Act* was a formula which was passed in effort to control volume of services, which is the concern about a volume based payment method is that you get a lot of volume and what was called unsustainable growth in Medicare Part B spending. Spending targets were established and the theory here was if spending exceeded the target, the fees would be reduced…individual fees of the 6,000 or 7,000 services…so that spending would then revert back to the target and that the Treasury would not be out of pocket that extra spending.

In fact, since the early 2000's, actual spending has mostly exceeded the targets so that clinicians…and I use the term clinicians because the Medicare physician fee schedule applies to health professionals other than physicians…they should be subject to reductions. In fact, in 2002, they did receive a reduction of a little more than 4.5% and based on that experience, Congress decided we can't be cutting physician fees every year by 4.5% so each year there has been a "doc fix". There have been 17 of them. That means that instead of reducing the fees, which there is a cumulative factor here so the fees would not be reduced as 4.5% but in the 20% or 30% range was

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what the actuaries came up with…we have to do a "doc fix" every year. The original theory here behind this was…and I went back to 1989 when this was first talked about…this notion of putting a total cap on physician spending and then reducing fees…the theory was that somehow the profession itself would discipline itself. When it was exceeding this target, they would establish clinical practice guidelines, self-policing mechanisms so that there volume of services would come down. Well, that never happened and if you think about it…and many people thought about it…it wasn't a very good theory to begin with.

Now they are at the point, and here is my last slide, where the bill would repeal the sustainable growth rate specifying fee updates for…forget that five year thing in there…improve payment through what is called a consolidated, merit based, payment incentive system and under this basically is an expansion of the concept of pay for performance. As much as 9% reduction in payment of increase in payment would be applied to a physician based on their performance on measures of quality and resource use. There is a fee schedule which has specified updates, but that fee schedule to any physician can be adjusted by their performance and that is the notion of improving value.

Finally, the bill would set up alternative payment systems with 5% additional payment going to those physicians who actively participate with what is called alternative payment methods such as accountable care organizations, patient centered medical homes, bundled payments, if they are shown to be effective. There is an incentive in here to move away from fee for service…in this case it is fee for service…to alternative payment methods and that sets up Rahul for the next discussion.

ED HOWARD: Excellent. Let me pass the clicker to the distinguished Dr. Rajkumar. Rahul Rajkumar is, in fact, the Acting Deputy Director of the Center for Medicare and Medicaid Innovation…what Tricia referred to as CMMI…so you have one of the acronym-like things explained. He holds both medical and law degrees, completing a residency in internal medicine. He spent a good deal of his career helping leading hospitals and payers respond in this fast changing world of health reform. We have asked him to bring us up to speed about what CMMI, and CMS in general, are doing to identify and spread helpful innovation in healthcare delivery and payment. Rahul, thanks very much for being with us.

RAHUL RAJKUMAR: Thank you so much for having me here today. I just want to start first by thanking you, Ed and Tricia, for having me here today. It occurs to me that I see a lot of young Congressional staff in the room. Probably the most important thing you will learn here today from me…and you'll have a lot of fun with this fact in your careers…if you ever want to see a member of the Executive Branch sweat under the collar and squirm a little bit, invite them to the Rayburn Building and put them on C-SPAN and ask them a bunch of questions [laughter]. That is exactly what you are going to see here over the next 10 minutes.

This is an overview of the Center for Medicare and Medicaid Innovation and Delivery System Reform. I'll give it to you in three parts. Part one is…why is this important and what are our goals? What are we trying to do? Let's start with the patient. The way in which we pay for healthcare actually matters…that is my thesis. If you remember nothing else that I say today, it is all there in

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that one sentence. It matters because it signals to providers and to the market what it is that we value as a payer, as a society and as a nation. Fee for service sends one signal to providers. That, as Bob was saying, the more you do…the more volume you produce…the more we will pay you. The purpose for CMMI and payment delivery reform is to send a different signal to the market.

Here is a market in Southeastern Pennsylvania called Sama, and they are a participant in the CMMI model called the Comprehensive Primary Care Initiative. It is a medical home model. They do some things that are different than a traditional fee for service practice. They provide proactive, preventative care to their 19,000 patients. They use clinical decision support. When a patient has a missing lab or a screening, their electronic medical record and the embedded clinical decision support, alerts the provider. Then they risk stratify their patients to identify patients that are high cost or likely to be high cost and sick, and they take care of those patients in teams. The teams include a doctor, a nurse and often a care coordinator. It is a different way of practicing medicine. The question is, how do you move from a fee for service world to a world that looks more like this where physicians are practicing in teams and providing proactive, preventative care and risk stratifying their patients?

We are doing three things at a very high conceptual level. Number one…we are trying to change the way that we pay providers. Through the innovation center, testing new models of payment and if they work expanding them nationally. Number two…changing the way that providers delivery care…giving providers the tools that they need to manage population health, to help them learn from one another and to promote patient engagement through shared decision making. And thirdly…information. Being transparent about information, getting as much Medicare and Medicaid data out into the world as possible and promoting the uptake of electronic health records to make sure that both providers and patients have the information they need to make the right decisions about their care, at the right place, at the right time.

This is a basic taxonomy of patients and I'll spend most of my time talking about the first bucket of payments. This is the taxonomy that Bob eluded to of how you pay providers. This is my entire world. If you think of it, category one is fee for service as it existed say…20 years ago. Pure fee for service with no link to quality or value. Category two are fee for service payments…pay for performance…that have some link to quality or value. Think of programs like hospital value based purchasing or the hospital acquired conditions reduction program, hospital readmission reduction program or on the physician side, PQRS or the physician value modifier. It is a very broad bucket. Category three are alternative payment models. This is the work of the innovation center. These models are largely built on a fee for service architecture, as Bob described so thinks like accountable care organizations, bundled payments, advanced primary care medical homes. Category four is the future where payment is no longer tied to the delivery of a particular service but it is tied to taking care of entire populations.

These are the goals that Secretary Burwell announced this past January 26th. Really focus on the dark blue circle here on this page. The dark blue circle is percentage of Medicare fee for service payments in alternative payment models. In 2011, there were zero. No Medicare payments in alternative payment models. In 2014, at the end of 2014…they were about 20% of the three hundred

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sixty two billion dollars of Medicare fee for service payments. This is excluding Medicare Advantage. The numbers are similar on the MA side. About 20% were alternative payment models. The goal is that by the end of 2016, 30% of Medicare fee for service payments will be in new alternative payment models that work and 50% by the end of 2018.

This is the first time in the history of the Medicare program that we have set broad national goals. What is really critical to understand is that this is not just a Medicare project. This past Wednesday, at the White House, you may have seen that President Obama kicked off something called the *Healthcare Learning in Action Network*, where we have convened commercial payers…state Medicaid organizations and purchasers…to join us in matching or exceeding these national goals.

For the last five years, CMS through the innovation center, has been using a number of strategies to bring the private sector along in reaching these alterative payment model targets. In a number of our models we actually convened commercial payers and asked them to do models with us. In some of our models, like in the Pioneer ACO model, we give provides the incentives and we say…We are going to enter this ACO contract with you but by the end of your second year (Pioneer ACO's), we want you to enter into alternative payment models with other payers. Then thirdly, we partner with states in a number of our models. States have a lot of power to convene commercial payers and help us achieve targets.

So part two. What are we seeing in terms of result? At a very high level and taking a little bit of a risk here knowing who else is on this panel…so we can have a robust debate about this…one fact is absolutely true. Over the years 2010 through 2014, we have seen an unprecedented slowdown in per capita Medicare expenditure growth for Parts A and B. The reasons behind this are multifactorial but we think that at least part of the explanatory power here is changes in payment…changes in the way that we are paying providers. Similarly, we've seen significant reduction in Medicare all cause 30 day hospital readmissions. This means that from 2010 to 2013, about 150,000 fewer Medicare patients were readmitted to hospitals. Readmissions are a key measure of healthcare quality.

Pioneer ACO…just by a show of hands, how many of you have at least heard of the term accountable care organization in the room? So almost everyone in the room. I will give you a 30 second dramatic oversimplification of what an ACO is. An ACO is basically a group of providers that get together and they say…We are going to be accountable for these 10,000 or these 20,000 or these 30,000 patients. This can be in the commercial world or it can be in the Medicare world. In the Medicare world, what that means is that we look at these beneficiaries, we look at how much they cost over some historic period of time and that is the baseline. Then we use some formula to project out what we think they are going to cost over the performance year. That is the benchmark. An ACO contract is basically a deal between the group of providers (the ACO) and Medicare. We say…If you beat that benchmark, we'll share in the savings. If you exceed that benchmark, we'll share in the losses. And by the way…we're going to measure you on 33 measures of quality and we're going to adjust those payments based on your performance on those measures of quality. We have results from two years of the Pioneer ACO program. We are now in the fourth performance year but we have two years of public results. The Pioneers beat national benchmarks on 15/15 quality measures for which there are comparable national benchmarks and they beat the national

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benchmarks on 4/4 patient experience measures for which we have comparable national benchmarks and then they improved by a composite of 13 percentage points in the second year. For two years in a row they generated savings…cumulatively over two years of about $184,000,000 and the savings per ACO increased from $2,700,000 in the first year to $4,200,000 in the second year. Pioneers are organizations that are pretty advanced. They often have some experience in bearing risk and quite a bit of experience in delivering care in this new world of delivery system reform.

Another model, the Partnership for Patients, is part of a patchwork of programs including some of our pay for performance programs to improve care in the hospital. Partnership for Patients is a model where we invited about 75% of hospital CEO's in the country to join us in setting aggressive targets to reduce patient harm in hospitals. Three numbers for you over the years 2010 to 2013…50,000 lives saved, 1,300,000 patient harm events avoided and twelve billion dollars in all payer savings.

Very brief…just a couple of seconds on the CMS Innovation Center. This was created by the Affordable Care Act section 3021. It is one of the most inspired sections of the ACA. I love it [laughter]. I would think of it this way…we are scientists so we are testing models. If a model works we evaluate it. We have about 50 PhD level research scientists who work with us to evaluate these models. If they work…if they improve quality and cost remains neutral or option number two…if quality is neutral and cost is reduced or option number three…the one we all hope for- if quality goes up and costs comes down, the Secretary of Health and Human Services has the authority to expand these models nationally in their duration and scope.

This is a quick overview of our portfolio. We are testing about 25 different models. I could not talk about all of them today but it is in your package. This is a slide that just shows that innovation is happening pretty much everywhere in the country. This is a map that shows where our ACO's are. Nearly 8,000,000…7,800,000 Medicare beneficiaries are currently aligned or assigned to ACO's. We have more than 400 ACO's operating now.

Last slide…there is what I think you will see over the next couple of years. We are increasingly focused on integrating with the rest of CMS so really important point…CMMI is part of CMS. We could not function without the rest of CMS. Everything we do is to improve the programs that the agency runs. We are focused on evaluating results from our models, launching new models to round out the portfolio. I think you will see a steady drumbeat of results over the next few years and expanding models that work.

One very last thought. Tricia gave you three reasons why Medicare is important. I want to add one more to that list so here is reason number four. All of us, should we live long enough, will become Medicare beneficiaries. You could work on many other areas of domestic policy and it would never touch your personal life but if you live to the age of 65 or become an SRD patient or become disabled, God forbid, you will become a Medicare beneficiary and that is why delivery system reform actually matters. In the brief time I have been in government, I have been admitted to a hospital myself, I have taken my children to see the pediatrician. We will all be patients and so this

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matters not just as a matter of public policy, not just to your bosses…but to all of us as individuals. Again, thank you for inviting me here today. I look forward to your questions.

ED HOWARD: Thank you very much, Rahul. Our final panelist today is Sheila Burke. She is a faculty member at the Harvard Kennedy School. She is affiliated with Baker Donaldson, the public policy and law firm, spent a number of years on the hill many of you know…most prominently as Senator Bob Dole's Chief of Staff. She, too, was a member of MedPAC and serves on a number of non-profit corporate boards. Sheila is our designated visionary today. She is charged with identifying some of the major challenges facing Medicare as it enters its second half century. I am looking forward to hearing from you.

SHEILA BURKE: Thank you very much. I have to admit I've never been called a visionary but maybe it is my trifocals that are working in my interest [laughter], certainly reflecting my age. It is a great pleasure to be here again and to be with my colleagues on the panel and to talk about the Medicare program.

I am essentially going to start where Juliette left off and try to reflect looking forward on what some of my colleagues have commented on in terms of the challenges facing Medicare, but I wanted to begin by underscoring a point that Rahul made and that is that how we pay, who we pay, what we pay for makes an enormous difference. As we have seen since literally the passage of the program in '65, as Medicare goes so largely goes the healthcare delivery system. We saw it in how we transitioned the payment for end stage renal disease and where that occurred and really in a great many places Medicare has led the way. Obviously, the private sector has an enormous role as well but, again, the policies that we set, the collaboration that we put in place with respect to the private sector will in fact drive our delivery system going forward.

Again, let me start here Juliette began and really talk about these three sort of groupings of issue both spending, financing, beneficiaries and providers and again, reflect a little bit on what we might expect both short-term and long-term in terms of attempts to try and look at the program going forward. While much has been made about the slowdown in Medicare spending, it will continue to be an issue of tremendous concern to your colleagues and to your members. In part, obviously as you can see from the pie chart that Juliette gave us, it consumes a big piece of federal outlays and that piece is growing. It is an issue because a portion is financed by payroll taxes and the workforce is not expected to keep up with the number and the growth in beneficiaries. By 2030, we are looking at approximately 2.3 workers per retiree so that essentially is an underpinning of the financing of the program becomes an issue in terms of long-term stability.

At issue as well is because of the increasing percentage of funding that essentially is required out of general revenues, the other portion of the Medicare financing package Juliette pointed out, leaving far fewer resources available for other federal priorities. Again, if you look over time at the changes in Social Security, Medicare and Medicaid, they become an increasingly huge part of what it is that we spend on the federal side.

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Medicare costs have in fact slowed down and as is pointed out, they are expected to go from about 4% from about 2014 to 2023. Again, a smaller rate of increase than we have seen in the past certainly from the years I was on the hill and on MedPAC but, at that same time, the GDP is only projected to rise 3.5% and the CPI 2.2% so essentially, we continue to see the outpacing of costs generally by healthcare costs.

So again, all of this causes us to continue to concern ourselves with what Medicare is spending. And of course, the demographics are working against us. The baby boomers are arriving and while many of us are relatively healthy, notwithstanding my trifocals, at the outset and arguably less expensive for the near-term that changes. The good news is we are living longer. The bad news is we are more expensive as we get old, unless of course you live to 95 and then you become less expensive or you die [laughter].

In 2011, the average per capita Medicare spending tripled between the ages of 66 and 96. This is not entirely attributable to end of life care. We hear a great deal of what that contributes but that is, in fact, not the only factor. In many cases, there are individuals who are chronically ill and the management of these patients is enormously important. And of course, there are the sheer numbers of those who are going to be eligible. The first baby boomers began to arrive in 2011, when approximately 40,000,000 Americans were over the age of 65. By 2030, that number will have grown by 30,000,000 and by 2050 that number will have grown by 40,000,000. So, as you can see, the percentage of the old, old, old in the orange and yellow boxes in this chart, grows very quickly.

Again, if you think back to the chart in terms of the amount of per capita spending that increases as people age you see that we are looking at a growing number of individuals who, in fact, will be the most expensive portion of the Medicare program. At the same time, we have fewer young people coming in and we have fewer people that are paying payroll taxes to essentially support the program.

And of course, among those who are the most costly…and Juliette touched on this issue…are those who are dual eligible which we will talk about for a moment. Rising healthcare costs, in addition to an issue for us, is also an issue for the beneficiary as Juliette pointed out. As a population, they are not all living in Palm Beach. They are a relatively low income population in terms of looking at Medicare. Health status and chronic conditions are also significant drivers of healthcare costs and out of pocket spending, which becomes an issue and rises with the number of conditions that in fact you have. You recall some of the gaps in coverage that Juliette mentioned. Most significant among them, of course, is long-term care which is an issue we have successfully avoided really dealing with for a number of years but those are major contributors in terms of out of pocket costs that the elderly are facing as well as simply the program itself.

Now, of note, I would say women are disproportionately represented in this group with the highest out of pocket costs and they also tend to live longer. Women tend to be caregivers for their spouses for many years or for their parents. They tend to live longer, they tend to have more conditions and tend to confront these out of pocket costs and often, in fact, you see they become substantial at ages 75 to 84 and 85 and beyond.

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Then, as I noted and as Juliette pointed out, there are a unique population within the Medicare population that also concern us as we begin to think about the beneficiary challenges that we are confronting. The duals, as they are referred to, who are individuals who are both low income and eligible for both Medicare and Medicaid are disproportionately counted among the Medicare and Medicaid high spenders and they are a unique challenge in terms of managing this population. They are poorer, they generally have more medical needs than other beneficiaries, they are more likely to be frail with multiple chronic conditions and have functional and cognitive impairments. There are approximately 9,000,000 of these individuals and a particular concern not only to the federal government, as you look at the spending for the Medicare program and planning going forward, they are also a huge issue for the states who are also financing and they are, as this reflects, also a very high cost population for the states.

As we look at beneficiary issues and we look at the Medicare program going forward, looking at this unique population, one of the provisions in the ADA essentially begins to try to get the state Medicaid programs and the federal Medicare program to begin to coordinate with one another, which has not been the case in the past so that people often fell through the cracks, their services weren't coordinated, the payment systems weren't coordinated and again…many of them require things that fall outside of the traditional healthcare package. They require transportation services and often nutrition services and a variety of things that, as we manage this population and look at the beneficiary challenges going forward, this will be among the most unique populations that the two programs have to contend with.

Then finally, as part of the discussion with respect to providers, given the aging of the population, the increase in the number of beneficiaries increasing attention is now being paid to workforce which is something we've talked about in the past but have not made a great deal of progress on. Overall, access to physicians and other healthcare professions is adequate, MedPAC tells us. However, there are clear differences in their access to specialty care versus primary care with primary care being much more difficult to essentially identify and align with in terms of beneficiaries. This is in part a function and a result of the bias in Medicare payment historically towards specialty services and the financing models…the history of silos that we pay people to do things has essentially discouraged the development of primary care and the availability of primary care providers.

There is no question that our system of educating physicians and nurses is among the best in the world but, unfortunately, they are not fully aligned yet in the education system in the changes in the delivery system that Rahul has mentioned. It is quality measured, evidence based care, multi-disciplinary teamwork, a care coordination across essentially sites of care so that we begin to think about people in the context of the full continuum of care…not simply in silos…hospital based hospitalists, or the nursing home patient, or the home care patient…that we begin to think about and pay for as has been suggested looking across those systems, and the manpower workforce population has to begin to think in those terms as well. Medicare is the single largest payer for medical education. In 2009, we spent approximately 10 billion dollars a year in medical education. We pay far less with respect to nursing education but these are levers that we begin to look at in

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terms of how we incentivize the choice of specialty, the movement into primary care and all these payment models…ACO's and others that begin to think about team based care, which is something that our medical training programs, and nursing training, and other providers need to begin to think about going forward and begin to think about it in school…not simply when they go into practice so that we begin to get exposed. Certainly, when I was in school, we practiced and were trained in largely a silo based system rather than an inter-disciplinary way so that is one of the issues we are going to be looking at. Again, it is an important part about how we think about providers going forward.

Quickly, going forward and the issues that have been raised…first, there are the incremental kinds of changes. We spent a fair amount of time this afternoon talking about payment reform aimed at reducing costs and incentivizing changes in practice and specialty mix. The House passed SGR Bill is still pending in the Senate, again, is a movement…a clear movement in that direction and that is towards payment reform and movement away from fee for service and a link to quality. In the context of delivery system reform, again…the activities that were outlined by Rahul in terms of the push towards organized systems of care, the focus on quality, on coordination, on team based care are all steps in this direction and again, this unique population of high cost, high risk in the duals is going to be a particular focus of attention for people going forward. Eligibility…and these are all again, incremental kinds of changes based on the program and benefit restructuring.

Again, the confusing structure of the Medicare program that Juliette outlined A through D…suggestions about combining A and B so they look much more like traditional health insurance. It also helps to begin to organize and make sense of the cost sharing and potentially provide some limits on out of pocket or catastrophic costs incurred by people. The reform in Medigap…you began to see that in the SGR Bill…again, it is to get people skin in the game to essentially remove the first dollar coverage even for those under Medicare so they become more sensitive about the providers they choose. The eligibility issue is one that continues to come up and will no doubt come up again. You know…65 is not what it was in '65. People are living longer, they are staying in the workforce longer, we are largely healthier and so the question is…Is that the right age? It was a big issue for years because the people that fell through the cracks…would they have private insurance available to them that was affordable? That now has been less of an issue. The ability to purchase coverage through a network or through essentially an exchange rather than in the individual market but, again, this question of who ought to be eligible and at what point will no doubt come up.

And then there is, of course, the final note which is this attempt to sort of rethink the entirety of the Medicare program and move away from a guaranteed benefit to essentially a guaranteed contribution and that is whether we ought to get out of the business of essentially the program as we know it today and begin to essentially allow people to take the money we give them on a per capita basis and purchase coverage. It is really a step beyond Medicare Advantage as we know it today but Mr. Ryan and others have talked about premium support so all of these things are things that I think are going to be short-term priorities for us as well as long-term.

ED HOWARD: Terrific. Thank you, Sheila. Let me remind you, you now have the chance to enter into this conversation. There are microphones at the far corners of the room. There are green cards

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that you can write a question on. If you do go to the microphone, I would ask you to keep the question brief and to identify yourself so that we can get to as many questions as we can. I should remind you, this is a primer. There is no question that is too simple to ask because that is what we're here for. Yes, go right ahead.

AMY GRACE: Hi, Amy Grace from the Senate. I am just wondering what you think about the government Part D non-interference clause. I am hearing a lot about that…and whether you think the government will actually save costs if they were actually able to interfere with those negotiations. Thank you.

ED HOWARD: Whoever wants to take a crack at it, explain what it is we're talking about.

JULIETTE CUBANSKI: The Part D non-interference clause basically references the fact that, as part of the Medicare Modernization Act of 2003, which created the Part D drug benefit there is a provision that prohibits the government from interfering or doing any negotiating with pharmaceutical companies over prescription drug prices. There has been quite a fair amount of back and forth about this provision and the question about whether the government could actually get a better deal for Medicare beneficiaries who are enrolled in Part D plans than the plans themselves. I think the Congressional Budget Office has looked into this, I think MedPAC has looked into this and I think the prevailing view is that the plans are doing a pretty decent job of negotiating rebates and there is some question about whether the government could do a better job than the plans are doing for most prescription drugs. One of, I think, the sticking points about this issue though is drugs that are unique…that have no alternative, no generic substitute, no therapeutic equivalent. Is there a way for the government to intervene or perhaps try to come up with some alternative way of arranging pricing for these drugs where there is no equivalent…where there is basically the pharmaceutical company able to set whatever price it wants and I think there are various discussions…perhaps not official discussions, but there have been ideas proposed about ways to get a better deal for beneficiaries on drugs where there is no ability for the companies themselves to negotiate with the pharmaceutical companies. I think that is the issue where there could be a potential for Medicare to play an important role.

KEN SHARMA: My name is Ken Shama. I work with Northern Virginia Family Service. It is a non-profit. I have a question for Rahul Rajkumar. Quality and cost reduction seems to be pretty easily achieved in the first couple of years which assumes there is a lot of sloppiness in the system beforehand. Are these same innovative solutions being thought about for the rest of the healthcare systems like the ACA and the open programs as opposed to just Medicare?

RAHUL RAJKUMAR: That is a great point. A couple of things…we learn a lot from…in general, the approach that the Innovation Center has taken is to set the table for providers and give them incentives to innovate and care delivery and within any of our programs, whether it is Pioneer ACO's or comprehensive primary care initiative, or bundled payments…providers are using lots of different strategies and what we see is that different providers are able to find different pockets of savings in different parts of their systems. I don't think that there is a single universal theme that we see in terms of where there are savings to be had. I interpret your question as a question about

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multi-payer alignments and I think that is absolutely a critical success factor for payment and delivery system reform and it is a huge area of focus for us. All, or nearly all CMMI models, attempt to engage other payers because if you think about it from a business standpoint, if you are a provider you cannot succeed with one foot in fee for service and one foot in ACO or an alternative payment model because the fundamental operational strategy is different. If you are trying to keep patients out of the hospital for one population and then on the other side you are trying to maximize your hospital utilization…you can't manage two different goals.

As I said, we've tried a number of different strategies to engage other payers and so in some of our models, like the Comprehensive Primary Care Initiative, we actually went around the country in seven different markets and actively convened about 30 payers to do the model with us. So, CPPI…the Comprehensive Primary Care Initiative…actually, we engaged these 30 payers. In other models, we have relied on the participants to go out and get the other risk based contracts themselves. I think the other huge effort that you're seeing that was just announced this past week is we are now convening nationally payers, providers, and patient groups in a national healthcare payment learning in action network where our hope is that we will learn from one another about what the different factors for success are in alternative payment models and that the uptake of these models will spread and other payers will either match or exceed the pretty ambitious goals that we've set for the Medicare program.

SHEILA BURKE: I just wanted to add one cautionary note and that is the transparency of information. One of the things we hear about even with a single system is the inability to essentially easily access information across that system and one of the challenges, I think, is this is certainly true when you talk about multiple payers but even in the context of a single system…whether it is a Kaiser system or any other integrated system…the ability to convene in one place all the information for both the outpatient services, inpatient services and track and share that information…the learning that occurs by the ability to sort of report back on what is occurring across the system, and I think that is one of the things people struggle with is that ability because the systems don't necessarily match up.

KEN SHARMA: My other question is regarding Medicare eligibility because I encounter a lot of adults who have now brought their elderly parents into the country, who are now new citizens and new residents but will never have the 40 quarters that they need. What is the thought process for those elderly adults who are now living in our country but don't have the eligibility requirements for Medicare?

SHEILA BURKE: To be perfectly frank, it has not really been an area of attention. You correctly note that the 40 quarter issue is one that is fundamental to the eligibility program and the focus has really been on those who would otherwise qualify and the question about the time in which they enter into the system but not, frankly, a lot of attention to people who essentially don't qualify. You can imagine the unique set of circumstances…and Tricia will remind me if I am incorrect…but there were a unique set of circumstances early on with religious groups for example, who couldn't have 40 quarters. There was an accommodation for state based employees…so it is an issue that is not just unique to people that are coming into the country but people who have chosen, for example,

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to work at home…women who have chosen to work at home and didn't have essentially 40 quarters of traditional work behind them and contributed into the system. It is an issue that is broader than just that narrow population but it is not one that has been given a great deal of attention, to the best of my knowledge. I don't know that it's come up…to be perfectly frank…at least not in the recent discussions but it is certainly a good point and again, it would apply not only in the context of new citizens but it could well apply to people that don't traditionally transition into the system.

Unidentified Female: I had a question about incarceration…

ED HOWARD: Do you want to identify yourself?

EMMA: Hi, I'm Emma. I'm from the Senate side. As we have seen that there are the aging prison population is increasing, especially as we've seen issues of mandatory minimums and such like that we are keeping people in prisons longer and their care is becoming more challenging, especially as you develop chronic illnesses…I was wondering how does Medicare navigate what happens to that specific population so that people who do qualify while they are in incarceration, that cost may be redistributed to either states or other healthcare providers? I know that is kind of complicated with state and federal so any insight would be great.

SHEILA BURKE: I can be easily corrected by anyone here…as a general matter, it is considered outside of the Medicare program as it is outside of the Medicaid program in terms of the prison system and the healthcare funding that essentially occurs in the context of the federal and state prison systems. To the best of my knowledge…Bob may recall…I don't think we crossover in terms of Medicare coverage. I don't think they carry their benefits to prison.

ROBERT BERENSON: I don't believe so. One other topic that comes up in this eligibility item are those who have paid into Medicare but are living abroad don't get the Medicare coverage either and that becomes an issue for some as well but the coverage is not portable except for emergency situations.

JAVIER TREJO: My name is Javier Trejo and I'm with the office of Senator Johnny Isakson, Georgia. My question to you is…with regards to these problems that we're having with the SGR that are coming up this year, do you feel the problem is more so rooted in the SGR formula that is inherent to the program or is it more so Congress' inability to allow the cuts to go into place and now they have compounded to 21% or 22% as we are currently facing?

SHEILA BURKE: Yes.

[Laughter]

JAVIER TREJO: To both then?

SHEILA BURKE: Bob will comment on this…the fundamental structure of the…we were confronting at the time in the Part B program tremendous escalation in the cost of the program and

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this was thought to be a way to try and bring that under control. It was quickly realized that it was not going to be a system that worked and I think there has been…there are all the cost related issues. You've heard a lot of discussion about bargain basement price at the moment of 140 billion…so those issues have driven it but it is really a combination of both. One…it wasn't the right answer to the problem and secondly…there was a great deal of reluctance to allow 15% or 20% reductions in physician payments.

ROBERT BERENSON: I agree with that. What I'd emphasize just a couple of things…one is that it was some fanciful thinking that there would be a collective incentive that the medical profession somehow would come together and figure out how collectively they would live within this sort of target amount. If you think about it for more than two seconds, you realize that the incentive on each individual physician is to actually do more services if their fees are being cut rather than participate in the collective. At that time, we were really big on the notion of evidence based clinical practice guidelines and that everybody could follow them and that would keep volume down. There is a role for clinical practice guidelines but it got over emphasized at the time.

I do want to get one fact out, which is in the last decade…physician services were rising very rapidly. Imaging services sort of doubled in a five year period. That is all flat now. In addition to overall healthcare spending being pretty flat, and Medicare spending being pretty flat, even physician services now. The SGR seemed to…it became a political problem and a budget problem. It has never been a mechanism for actually restraining spending by physicians and so correctly, Congress is looking at ways of trying to get the incentive down to the individual physician level. I personally have some difficulties believing that what is passing is actually going to be for the good. We don't have, in my view, the ability to measure at the individual physician level their quality or their resource conservation…how good they are with efficiency. I think we can do that at a large group level. Congress is about to pass legislation that I don't think is going to achieve what its very nice goals are…this ability to measure at the individual physician level.

ED HOWARD: I should just point out we have five or six minutes left before the witching hour of 1:30 and I would ask you to pull out those evaluation forms and fill them out as we go through these last few questions. It looks like we have someone at a microphone.

MATTHEW: Hello, good afternoon. I'm Matthew from the Center for Medicare Advocacy. I have a question concerning the tuition assistance that is given to primary care physicians that practice care in urban areas and rural areas. There has been a little bit of doubt concerning the sustainability of helping these individuals.

ED HOWARD: I'm sorry…stay a little closer to the microphone if you would.

MATTHEW: There has been a little doubt about sustainability of funding these education grants…I've read this recently. What do you all think about that? Look into your crystal ball. What do you see about sustainability of those tuition grants?

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SHEILA BURKE: There clearly is a desire to incentivize a decision that increases the number of primary care providers. This is true both with respect to physicians as well as with respect to nurse practitioners. There is money in the ACA for an incentive program to create an opportunity for an increase in the number of nurse practitioners as well. The question is always going to be, are the incentives resulting in what you hope to achieve? The National Health Service Corps has a long history. The concern is that people tend to go into those areas and then they tend to leave and is that the right answer…although it has recently gotten additional funds and I think there is additional money in this last piece of legislation for both community health centers as well as for the Corps. It is clearly something we have done…Medicare has a strange history of not wanting to interfere in those issues through the GME program, although the reality is the way we pay has a direct influence on choices that are made in terms of specialties. I would put odds on continued efforts to increase the number of primary care providers. Certainly you have people, particularly in the Senate…and I am sure it is true in the House as well, I know the Senate far better…who have a commitment to maintaining rural healthcare and to the resources that are necessary in rural health communities and a real question about what does that mean? Does it mean having a hospital? I spent a lot of time in Kansas, as you might imagine, and at one point there 50% of the hospitals in the State of Kansas had fewer than 50 beds. When the hospital shut down, the doc left, the pharmacy left, the nursing home left and so…lots of questions about what do we need to support rural America. What is the right answer to that problem? I think there are enough people who care deeply about that, that there will be continued attempts to try to figure out what the right solution is in terms of mix of services and the availability of care.

ROBERT BERENSON: I want to follow up. This is my chance to make my one quibble with the CMS framework for categorizing payments to providers on this issue of how do we get more primary care, which I think we have all said…and Sheila in particular…is a need. Category one says there is no link to value. Now…my view would be that there is a fee schedule and there is a fee schedule. We have a fee schedule that is tilted far too much towards procedures and tests and research that we've actually done at the Urban Institute pretty well documents that Medicare compensation to specialists exceeds that to primary care by about 2.5 to 3:1 for every hour worked…at least for some specialties like radiology and cardiology. That is not sort of immutable. We are making choices to have a fee schedule that is tilted in that direction. We can have a fee schedule…and some of us have suggested it…that recognizes many more primary care activities and, in fact, CMS is moving in that direction by creating new codes for complex chronic care management, transition care. We could also change the relative values so that the time spent with a physician was given much more payment than just interpreting a test. To me, if we did that, we would have a different mix of services. We would have different signals to what specialty to go into and we would be improving value. I think, in some ways, we would be improving value more than by just adding a couple of quality measure which gets you to category two. The point I would make is that, while I absolutely agree with all the work that CMMI is doing to come up with good models of alternative payments, how we actually…what I call administer the legacy payment models…are real important to producing more or less value. Even in some of these legacy payment models that I put up in some of the slides, we have efficiency incentives. When a home health agency is paid for a 60 day episode of care rather than for each visit they make, they have an ability to use telemedicine, to use different personnel to do a number of things that presumably can improve efficiency. This

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division between category one and the rest strikes me as a little arbitrary and we in the policy world don't pay enough attention to that category one. There are people at CMS working really hard to improve that and the providers…the stakeholders in those systems are very involved with that but it somehow hasn't risen to the same level of policy attention so it is a quibble.

ED HOWARD: We have time for one more question.

JAMES CALDER: I am James Calder with the Advanced Medical Technology Association. My question is balancing of cost with innovation as we are going forth, especially with durable medical equipment. Items such as stairclimbing wheelchairs might allow a patient to stay in their house longer or a continuous glucose monitor that is paid for in Europe and not here. All these new innovations that might have upfront costs that are higher but long-term savings…how do we balance that with providing the high quality care and affordable cost?

TRICIA NEUMAN: It is a reasonable question and one of the issues…and anybody else obviously chime in…from time to time over the years there have been several proposals that have come forward and the CBO is a very skeptical organization and they look at these ideas of expanding coverage and they are very doubtful about cost offsets…savings. One of the opportunities that is out there with more people in capitated plans is there is nothing really to stop Medicare Advantage plans from testing whether some of the innovations you are talking about would improve care and lower costs and provide the care that people need in the most appropriate setting. That might be a real learning opportunity within Medicare Advantage in a capitated framework that could be translated into traditional Medicare and provide the evidence that is needed by the Congressional Budget Office.

ED HOWARD: That was a good answer. That was a good way to end the program, as a matter of fact. This has been a terrific session and I want to thank our panelists. Actually, I ask you to help me in thanking our panelists [APPLAUSE]. We didn't answer every question that everybody had but that is why we gave you the materials and the contacts where you can seek out more information. Next Wednesday we are going to do a primer on costs. If you can make it, we'd love to have you. Otherwise, thanks to our colleagues at the Kaiser Family Foundation and thank you for coming. We'll continue our mutual education next week.

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