MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 12, 2012
9:33 a.m.

COMMISSIONERS PRESENT:
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ROBERT BERENSON, MD, FACP, Vice Chair
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KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
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AGENDA PAGE

P R O C E E D I N G S [9:33 a.m.]

MR. HACKBARTH: Okay. Good morning. Our agenda today consists primarily of recommendations on update factors for inclusion in our March report. We discussed each of these at some length in our December meeting, and so the discussions we will be having today will be a shortened version. We are not going to review all of the same information that was presented in December in the interest of time because, in addition to our update recommendations, we have some other issues that we want to get into the agenda for the meeting today and tomorrow.

So for those of you in the audience who did not attend the December session and are just entering the conversation at this point, I want to emphasize that there have been extensive discussions of these issues already in the Commission.

I want to say a word about the legislative context for the update recommendations this year. As everybody knows, as part of the debt ceiling legislation, a committee, a congressional special committee, was created to develop a deficit reduction package to hit a particular target. They did not succeed in doing that, and so under the terms of the

debt ceiling legislation, the alternative is a 2 percent sequester in payment rates in Medicare to take effect in February 2013. In formal legal terms, that sequester has not yet been formally triggered. That would happen at a later point, but the common assumption is that the sequester seems likely.

Of course, there is the possibility that Congress could pass new legislation between now and February that would alter that. But, again, many observers are assuming that the sequester will take effect in February 2013. So that raises the question of what are the implications of that sequester for MedPAC's update recommendations that we will be voting on today.

We think of our update recommendations as recommendations for a percentage increase in the existing base rates in the various payment systems for physicians, hospitals, nursing homes, home health agencies, and the like. So each of those payment systems has a schedule. There is a base rate, and then off of that base rate, various adjustments are made for differences in wages, differences in case mix, and the like to calculate the rate for a particular service that is paid to a provider.

When we make update recommendations, they are recommendations for a percentage change in that base rate. And so just for the sake of illustration, if you think of the base rate for a provider category as $100 and we recommend a 1 percent update, what we're saying is we think the base rate for that category of providers should go to $101 for the fiscal year in question, and we are making recommendations now for fiscal year 2013.

The sequester, if it were to occur, also would affect those base rates. If the sequester were to reduce the base rate below our $101 recommendation in the example, that would be contrary, lower than what MedPAC recommended. And so we're not going to make a sequester adjustment. We simply will recommend what we think the appropriate base rates are. Then Congress will make its judgment on our recommendations, whether to allow the sequester to continue, whether to make any modifications. So the sequester is out there, but you won't hear us referring to it in each of our discussions. We will make recommendations on how the existing base rates should be adjusted in percentage terms.

With that preface, let's turn to our first session on hospital inpatient and outpatient services.

DR. STENSLAND: All right. Good morning. This session will address issues regarding Medicare payments to hospitals. As Glenn said, we're going to be concise. These topics were covered in December, and the details are all in your mailing materials.

First, we will recap how our payment adequacy findings have led to the draft update recommendation for inpatient and outpatient hospital payments, and then Dan will discuss the rationale behind the draft recommendation to adjust E&M payment rates.

To evaluate payment adequacy, we use a common framework across all sectors. When data is available, we examine capacity, service volume, quality of care, access to capital, as well as providers' costs and payments for Medicare services.

This is the first set of payment adequacy discussions you will hear today. The analysts discussing payment adequacy for the other sectors later today will use this same set of indicators when the data is available.

Recall that we have discussed how capacity was increasing and how access to capital is adequate. We see strong volume growth in outpatient services and a slight

decline in inpatient volume. These capacity and volume measures, particularly the growth in outpatient volumes, point to adequate payments.

All quality-of-care indicators are either improving or stable. We monitor improvements in 30-day mortality and see improvements in all the conditions we monitor. We also see patient satisfaction has also improved slightly. However, readmission rates have not improved. Hospitals will have a stronger incentive to reduce readmissions when a new readmission penalty starts in 2013.

As we discussed last month, margins improved from 2008 to 2010, and this was due to two factors:

First, with the introduction of the MS-DRGs, documentation and coding changes resulted in increased Medicare payments;

Second, with the downturn in the economy at the end of 2008, hospitals responded by tightening expense control. The result was slower cost growth in 2009 and 2010.

The combination of higher payment growth and slower cost growth led to the better margins you see on this slide.

We estimate that overall Medicare margins will go from negative 4.5 percent in 2010 to negative 7 percent in 2012, which is about where margins were in 2008 prior to the full effect of the documentation and coding on revenues.

The drop is primarily due to reductions in inpatient updates that occurred in fiscal years 2011 and 2012 to partially offset changes in hospitals' documentation and coding. These documentation and coding adjustments to the update resulted in inpatient payments increasing by only 1 percent from 2010 to 2012.

We also expect cost growth to increase from roughly 2 percent to 3 percent per year. We expect input prices and hospital costs to increase due to an improving economy and a reduction in hospitals' pressure to constrain costs after achieving high all-payer margins in 2010. We expect the net result will be slower payment growth and faster cost growth, causing approximately a 2 or 3 percent decline in margins over the two-year period from 2010 to 2012.

It's important to note that the 2010 margin of negative 4.5 percent is for the average hospital. There is a subset of relatively efficient hospitals that on average

kept their 2010 costs down below Medicare payment rates.

As you recall from last month, we showed you that this group of relatively efficient hospitals has been able to keep its costs roughly 10 percent below average while having better patient outcomes on average. Lower costs allowed them to generate a 4 percent positive Medicare margin on hospital services.

At the December meeting, Mike asked what was driving their 10 percent lower costs. He was wondering whether it was fixed or variable costs, and I want to say that each individual hospital has its own story and there is a wide variation in costs. I wouldn't read too much into this. However, on average, there are two tendencies amongst the more efficient group:

The first tendency is higher occupancy. Due to higher occupancy, the median efficient hospital has 10 percent more discharges for every bed than the average hospital, and this could explain why they have roughly 10 percent lower building and 10 percent lower equipment costs per discharge than the average hospital. They benefit from spreading their fixed costs over more cases.

The second difference is in the distribution of

labor costs. Labor costs are also about 10 percent lower for the efficient group, meaning the whole labor cost pie is about 10 percent smaller. However, the relatively efficient hospitals tend to spend a little bit larger share of their labor costs on direct patient care. In contrast, the less efficient hospitals tend to spend a little bit larger share of their costs on indirect costs such as administrative and general expenses.

Given the data presented on payment adequacy and the need to recover past overpayments due to documentation and coding, the draft recommendation now reads: that Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2013 by 1 percent. For inpatient services, the Congress should also require the Secretary, beginning in 2013, to use the difference between the increase under current law and MedPAC's recommended update to gradually recover past overpayments due to documentation and coding changes.

The spending implication for 2013 is that it would decrease spending by roughly between $750 million and $2 billion over one year -- probably close to $2 billion -- and by over $10 billion over five years. These are our

preliminary estimates, and they are subject to change. We see no adverse impacts on beneficiaries from this recommendation.

Just to recap the rationale behind the update recommendation, adjustments for documentation and coding are needed to recover overpayments from 2010, 2011, and 2012. CMS needs new authority from Congress to make these recoveries. However, we do not want the magnitude of the recoveries to cause a financial shock to hospitals. Given the payment adequacy indicators, a 1 percent update is sufficient to preserve payment adequacy for reasonably efficient hospitals. The difference between current law and the 1 percent update could be applied to fully recover all overpayments due to documentation and coding changes.

The 1 percent increase on the outpatient side is appropriate for two reasons: First, we see outpatient volume growth of 4 percent. Given this volume growth, the projected update under current law of is probably too high. However, a 0 percent update may be too low given the current profitability of outpatient services. Therefore, a 1 percent update appears reasonable.

Part of the rapid growth in outpatient services is

due to a shift in the site of services from physician offices for evaluation and management visits to hospital-based offices. Dan will now discuss that concern.

DR. ZABINSKI: In the December meeting, we discussed the issue of increased hospital employment of physicians. Data suggests that this has caused the billing of services to shift from free-standing practices to OPDs and that this shift has been accelerating.

For example, for E&M office visits provided in OPDs or in free-standing physician practices, the percentage that is provided in OPDs has increased at an annual rate of 3.5 percent per year over 2004 through 2008, but by 9.9 percent in 2009 and by 12.9 percent in 2010. Moreover, incentives are present for this acceleration to continue.

A problem related to this shift is that payment rates for the same service are typically much higher in the outpatient prospective payment system than in the Physician Fee Schedule. For example, Medicare payment for a mid-level office visit is about 80 percent higher in the OPD than in a free-standing practice. Consequently, the result of services shifting from free-standing practices to OPDs is increased program spending and beneficiary cost sharing even

though the care received by the patient may not change at all. For example, beneficiary cost sharing for a 15-minute office visit is $15 if provided in the free-standing physician practice but $25 if provided in an OPD.

So how should the Medicare program address this issue of higher payment rates when the services are provided in an OPD compared to a free-standing practice?

A simple approach would be to set the payment rates in the outpatient PPS so that payment rates for all services are the same whether provided in an OPD or a free-standing practice. However, for some services we need to consider the following questions for services provided in OPDs:

Do OPDs have more complex patients?

Do OPDs maintain standby capacity for that service?

And does the outpatient PPS have greater packaging of ancillary services than the Physician Fee Schedule?

For E&M office visits indicated by CPT codes 99201 through 99215, we have found that patient complexity is addressed through the CPT codes for these services; the costs of standby capacity are generally allocated to other

areas of the hospital; and the cost of packaged ancillaries is small when these services are provided in OPDs, about two dollars of the total cost for these services. Therefore, we believe it is reasonable to have equal payment rates across these two sectors for E&M office visits.

If this policy is fully phased in, it would reduce hospitals' overall Medicare revenue by 0.6 percent and outpatient Medicare revenue by 2.8 percent.

I bring up the term "phase-in" because in December there was general agreement on this policy in principle, but there was concern that it could adversely affect some hospitals that are longstanding institutions that provide access to primary care for low-income patients in their community.

To ease that transition, a three-year phase-in was suggested. Under a phase-in, we found this policy would reduce Medicare revenue by about 0.2 percent for each year of the phase-in. Also, for most hospitals, the effect of a fully phased-in policy is relatively small, as 78 percent of hospitals would have their overall Medicare revenue reduced by less than 0.5 percent.

However, the effect on hospital revenue differs by

hospital group. We estimate that Medicare revenue would decline by 1.1 percent among major teaching hospitals but by 0.4 percent among other teaching hospitals and non-teaching hospitals.

In addition, last month we were asked the effect of this policy on efficient providers. The answer is that it would reduce their Medicare revenue by 0.7 percent and drop their overall Medicare margin from just under 4 percent to just over 3 percent.

Finally, there is wide variation of the effect on Medicare revenue of this policy as 10 percent of hospitals would see no effect on their Medicare revenue and 10 percent would have Medicare revenue decrease by at least 1.2 percent.

As I mentioned on the previous slide, there was agreement among Commissioners about the general principle of this policy, but some were concerned about the transition to the policy for hospitals that are a critical source of primary care to low-income patients. To ease the transition, a three-year phase-in was suggested.

Features of the phase-in include that the impact of this policy would be limited to 2 percent of overall

Medicare revenue for hospitals with disproportionate share percentages of 0.25 or higher, where 0.25 is the median DSH percentage among all hospitals and the DSH percentage is the sum of the percentage of Medicare inpatient days that are for patients who are eligible for SSI plus the percentage of total inpatient days that are for patients who have Medicaid. In the final year of the phase-in, this policy would affect about 4 percent of all hospitals or about 120 hospitals.

At the December meeting, Peter wanted to know the profile of the hospitals that would be most affected by this policy, so we analyzed the 4 percent of hospitals that would have their losses limited during the phase-in.

We found that there is a broad mix of hospitals in this group, but as the first column in this table indicates, these hospitals do have some different characteristics from other hospitals. In particular, they are more likely to be government-owned and have major teaching status; they have a higher percentage of Medicaid patients; and they have a lower all-payer margin.

However, these hospitals also have a better Medicare margin than other hospitals, probably because of

the relatively high payments for their DSH and teaching status.

So based on a goal of making payment rates for office visits equal across free-standing practices and OPDs, we have the following draft recommendation: The Congress should direct the Secretary of Health and Human Services to reduce payment rates for evaluation and management office visits provided in outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician's office. These changes should be phased in over three years. During the phase-in, payment reductions to hospitals with a disproportionate share patient percentage at or above the median should be limited to 2 percent of overall payments.

That is long enough to deserve a copyright, I think.

[Laughter.]

DR. ZABINSKI: Okay. The spending implication is that it is expected to decrease spending for 2013 and over five years because of lower payment rates in the outpatient PPS. For beneficiaries and providers, this policy may slow

or stop the shift of services from free-standing practices to OPDs; it will reduce beneficiary cost sharing; and because of the lower OPD payment rates, we may need to monitor beneficiaries' access to these services.

In addition, it may be prudent to have a study that evaluates how this policy affects access to ambulatory physician services among vulnerable populations, so we have this additional draft recommendation.

The Secretary of Health and Human Services should conduct a study by January 2015 to examine whether access to ambulatory physician services for low-income patients would be impaired by setting outpatient evaluation and management payment rates equal to those paid in physician offices. If access will be impaired, the Secretary should recommend actions to protect access.

This recommendation should have no effect on program spending, and for beneficiaries and providers, it may help identify problems beneficiaries are having in regard to access to ambulatory physician services.

The rationale behind this draft recommendation is to determine if there is a set of hospitals that serve as the vital source of clinic-based services for low-income

patients in the community.

The purpose of the study is identify any financial difficulties these hospitals face due to this policy that may affect low-income patients' access to primary care. And if low-income patients are found to be at risk, the Secretary could recommend appropriate policy changes.

Now I'll turn things over to the Commission for discussion and questions.

MR. HACKBARTH: Thank you.

What I'm going to propose is that we separate the discussions on the update factors for inpatient and outpatient services, recommendation 1, from the discussion of the payment for E&M services in outpatient departments, the later recommendations. So let's just now begin with recommendation 1, the update recommendation, and what I propose we do in this discussion and all day is just have one round of comments from Commissioners inasmuch as we have discussed each of these issues in December.

Scott, let me begin with you on recommendation 1. Any comments or questions?

MR. ARMSTRONG: No questions. I would just tell you that I'm prepared to support this recommendation.

DR. BAICKER: I support the recommendation.

MR. BUTLER: I will support the recommendation, but I would make one comment. We have said several places in the chapter that the payments for outpatient are okay because there has been growth in the last ten years and so they must be decent. I'd take issue with that because the fact is there have been many incentives for outpatient care. We take who comes in the door for outpatient care, and I don't think people celebrate the payment that you receive for it. That's the business we're in. So I'm not sure that that's the rationale, but I do support the recommendation.

DR. CHERNEW: I also support the recommendation and just would like to note that this is the place for the discussion about all the issues about hospitals not being paid well enough or hospitals having financial problems or a whole series of things because this is the part of the discussion that's fundamentally related to the hospital fiscal health overall as opposed to other places where one might have that discussion.

DR. HALL: I support this.

DR. BERENSON: I am supportive.

DR. NAYLOR: I support the recommendation, but I

just have a question in terms of the relatively efficient providers. I know you left out the highest -- the top 10 percent of Medicaid share hospitals, but do you have the statistic on where they fall with respect to DSH? What's the profile, the DSH profile of the relatively efficient versus all other? And if you don't have it now, maybe if you could share it --

DR. STENSLAND: I don't have it now, but I'll get back to you.

MR. GEORGE MILLER: In light of Peter's comment about outpatient payments across the system and my colleague Michael's statement that this is the place where we should deal with all the other issues, I do not support the recommendation because I believe we should update the outpatient piece here to deal with the other recommendations you said not to talk about here, so I want -- the other two recommendations, you want to separate them. I think Michael is correct. We should deal with the inadequacy of the payment on the outpatient side and this recommendation here, and so I do not support the recommendation until we address the outpatient payment adequacy. We've got negative margins for outpatient payments, and I agree with Michael, this is

where we should fix those problems versus bringing it up in addressing the third -- the second recommendation. And I think the third recommendation should be done before the second recommendation as well.

MR. HACKBARTH: We'll come to that. Comments on recommendation 1?

DR. STUART: I support the recommendation.

DR. CASTELLANOS: I support the recommendation. I do have a question. On Slide 5, you mention that the overall medical margin for 2011 was going to be minus 7 percent. Do you have any guesstimate for the outpatient margin for 2011?

DR. STENSLAND: Usually when we make our projections, we just make a projection of the aggregate total of the two together.

DR. CASTELLANOS: I understand that, but that's why I used the word "guesstimate."

DR. STENSLAND: Well, the outpatient margin now is what, negative 9.6, Dan?

DR. ZABINSKI: Yeah.

DR. STENSLAND: And basically the outpatient margin probably will not fall as much as the inpatient

margin. The outpatient margin, you know, may be somewhat -- the guesstimate might be somewhat close to where it is, because part of the reason we're seeing this decline in the inpatient margin is they're doing some adjustments to the updates to recover some of the documentation and coding increases in payments, and those adjustments only affect the inpatient side. So the bottom line is the outpatient update will be bigger -- was bigger than the inpatient update, so we won't see as much of a decline in the outpatient margin.

DR. CASTELLANOS: Thank you.

MR. LISK: And, in fact, you might actually see it increase slightly because of volume growth and stuff like that, you know, if you had the continued volume growth, because we have seen the margin improving on the outpatient side.

MR. GRADISON: I support this package. My thinking is heavily influenced by the importance that I give to trying to have the payment related to the service, regardless of where the service is actually provided. And I think this is kind of a classic example, but hardly the only one. It would seem to me that one of the high-priority concerns of the Commission over the next couple of years

ought to be looking to see whether there are other situations in which similar questions could be raised and should be examined. And I also would encourage those on the outside to think about this, too. We emphasize, or at least the people who contact us -- or the losers, as they see it. It's kind of interesting to me, at least my own experience in the last couple of weeks is I haven't been hearing from the ostensible winners, the ones who would get paid more. I don't know the significance of that, but it would seem to me that in looking at differential payment rates beyond this one, other situations that might arise, that there may be groups out there that monitor our activities, if you will, the possible winners in future changes that ought to speak up if they see distortions that they think we ought to examine.

MR. HACKBARTH: Other questions or comments on recommendation 1?

DR. BORMAN: I support the recommendation.

MR. HACKBARTH: Okay. Why don't we also go ahead and do the official vote on 1 before we turn to recommendations 2 and 3. All in favor of recommendation 1, please raise your hand.

Opposed to recommendation 1?

Abstentions?

Okay. Thank you.

So now we will turn to the recommendations related to payment for evaluation and management services in the outpatient department, and I wanted to kick off that discussion by saying a little bit about how I have thought about this issue.

To me, the principle here is that, over time, Medicare needs to move towards paying the same amount for the same service regardless of the provider type. In the current siloed payment systems, we have rates that differ based on the type of provider even if they are providing the same service to the same type of patient. We often lament the existence of these payment silos in the Medicare program and say that that makes sense neither from a financial nor a clinical perspective.

There are a couple different approaches for breaking through the existing silos. The one that we most often have discussed in the past is developing new payment methods that span the existing provider groupings, for example, bundling around hospital admissions whereby there

would be a single payment that would cover the services provided not just by the hospital, but also by physicians and post-acute providers. That is one approach to breaking down the silos and moving forward. Another example, of course, is Accountable Care Organizations, where there is a payment to an ACO for the full range of services and the organization assumes both clinical and financial responsibility for a defined population.

Over time, I strongly believe that these are the preferred ways to deal with the silo problem. However, I think realistically, those changes in payment methods which in turn require changes in the organization of the delivery of care, will only come into Medicare gradually. Significant reorganization of care is required under these new payment methods. New legal and structural arrangements, not to mention new clinical relationships, are required. And so this will be a gradual process of instituting payment reform and care delivery reform.

As far as I can see into the future, we will continue to have a traditional fee-for-service Medicare program, so I believe it's also important to, within the context of traditional Medicare, look at ways to start

bridging the existing siloed payment systems, and I think one of our guiding principles should be to try to pay the same amount for the same service regardless of provider type.

I see this instance of evaluation and management services provided by both hospital outpatient departments and physician offices as but one example of that. We have often, for example, in talking about post-acute care, noted that we have very different payment rates based on type of provider, even though in some instances they are providing services to the same type of patients and we need to, in post-acute care and other parts of the Medicare program, begin bridging these silos, breaking down the payment silos, and moving towards the goal of payment the same amount for the same service regardless of provider type. It will be challenging to do this.

This discussion of payment for hospital outpatient services often comes up in the context of hospitals acquiring existing physician practices or physicians electing salaried or other financial arrangements under the employment of hospitals. Everywhere I go, in talking to both physicians and the hospital people, there is talk about

a shift in how care is organized, where more physicians are seeking new relationships, often employment relationships, with hospitals.

It is not clear to me, nor is it, I think, clear to anybody how far and how fast that evolution will occur, but we are seeing -- beginning to see signs of that in Medicare data and other data that we see.

I want to be clear, though, that I don't see this payment recommendation, recommendation two, of moving towards equal payment, as motivated by trying to stop acquisition of physician practices by hospitals. I think that there are a lot of good reasons for both physicians and hospitals to rethink their traditional relationships and perhaps join together in new relationships. Our goal should not be to discourage that.

Having said that, it's clear that, to the extent that the shift occurs, it has important implications for both the Medicare program and for Medicare beneficiaries. If there is a significant shift of evaluation and management services from physician offices paid under the Physician Fee Schedule to hospital outpatient departments paid under the hospital outpatient system, that will increase costs both

for Medicare and for Medicare beneficiaries. The increase for Medicare beneficiaries will come in the form of both increased copayments at the time of services and increases in their Part B premiums.

So I think it's important to be aware of that potential shift in the cost increases and adjust our payment system so that there is not an adverse effect on either the program or Medicare beneficiaries.

As I say, this is new ground, in a sense. What we are saying is that no longer are we going to benchmark the payment for OPD services within an OPD hospital-based payment structure. We're going to look for benchmarks outside of the hospital system, and that raises a number of complicated issues, sensitive issues, that have been called to our attention. We've all heard a lot about this in the last month or so.

There are two issues that are of particular concern to me. First is that we have often noted that payments under the Physician Fee Schedule for evaluation and management services are, we think, too low and have made over the years a series of recommendations aimed at increasing payment for E&M services, some of which have gone

into effect, and, in fact, in recent years, there has been a significant increase in the relative values for E&M services. As we have made clear, however, as recently as our October letter on SGR and the recommendations therein, we don't think that that has run its course yet. We think there is still further room for improving the accuracy of pricing in the Medicare Fee Schedule, which we believe will, among other things, increase the relative prices for E&M services.

One of the advantages of having the transition that's described in draft recommendation two is that it does allow some time for that work to continue and increase payment for E&M within the Physician Fee Schedule.

The other issue that has struck me as particularly important is the potential effect of this recommendation on hospitals that are a critical source of care for communities, where there may not be private practice alternatives. There are parts of the country where the hospital outpatient department is an essential provider of services to all patients, but in particular to low-income patients. And, of course, it is not our intent to damage those institutions, so we're proposing to take two steps in

that regard.

The first is to have what we've referred to as a "stop loss" for institutions that experience a greater-than-2 percent loss in their total Medicare revenues and, in addition to that, have at the median or a higher ratio of disproportionate share patients, namely, low-income Medicare or Medicaid patients, and that stop loss protection would be in effect for the first three years.

Before the end of that period, we also recommend in draft recommendation 3 that the Secretary do a study of the potential impact of this change in payment for E&M services on providers that are a critical source of ambulatory physician services and, A, determine whether this proposal would adversely affect access, and for those institutions where it would adversely affect access in communities, propose an approach for dealing with that issue directly.

So, with that, I will pause and, Scott, we're open. Again, we're going to have just one round here for comments or questions on recommendations 2 and 3.

MR. ARMSTRONG: So just a brief question, and then I'll make a couple of comments.

With respect to this three-year transition period, just to make sure I get this, this means that we would not be applying these new rates to the hospital outpatient services until the end of that three-year period? How does that actually happen?

DR. ZABINSKI: I'll just start. It goes in a three-step -- you know, a third of the way. I mean, there's a -- you got your whole difference, and a third of the way the first year --

MR. ARMSTRONG: Okay, okay. I get it.

DR. ZABINSKI: Two-thirds the second year.

MR. ARMSTRONG: So we do start with 30 percent of the impact of this in the first year and then --

DR. ZABINSKI: Right.

MR. ARMSTRONG: Okay, got it. Okay, great.

So, Glenn, the points you just made are points to a great degree that I agree with. I just would want to reiterate a couple of them.

One, we have affirmed, I think actually quite a few times, that we believe the principles that you just laid out, and whether they are the principles about paying comparable rates for comparable services or Medicare's

responsibility not necessarily to subsidize for losses through Medicaid or through other programs. And I think one more time we should be affirming that those principles are our responsibility to uphold as Commissioners on MedPAC.

Second, I really like the point that you made that we've discussed at length that one more time we are dealing with a symptom of a payment structure that's highly fragmented and that it's a lot of what we do, and it sometimes simply doesn't make sense, and there's real compromises that we make. But this is not unusual in that we are trying to deal with what is indeed a symptom of a payment structure that pays in a highly fragmented way.

I'd also just have to say that I think most people agree -- at least people I speak with, even people who run hospital systems dependent upon this payment structure agree -- this payment structure doesn't necessarily make sense. The issue we're dealing with is that they have come to rely on the revenues that have been supporting their financial structure, and I think that just reinforces the fact that it is time for us to deal with the symptom and apply these principles and come up with some other way of dealing with the consequences on the financial performance.

And then, finally, I know there has been a concern about whether we have studied this enough to move forward with our recommendations today. I think we have studied this more than enough. I think that, in fact, the influence of organizations that want to study this more is problematic in many ways and keeps our industry from moving forward with changes that are long overdue, and I think this is, again, one of those cases where we know more than what we need to know to move forward with this recommendation. And I will support it.

DR. BAICKER: I support the recommendation and, again, agree with the principle that we need to harmonize payments across silos, and this seems like a great first step in that direction because of the well-defined nature of the service and the well-defined nature of the patients.

I think it's important that we're being cognizant of the effects on access for particular populations that may primarily access these services through these venues, but I think the transition period is a great way to address that and that in the long run we don't want to preserve access for populations to critical services through the mechanism of introducing a wedge in payments between services

delivered in one venue versus services delivered in another. It's a very inefficient way to promote access to care to preserve the wedge for that purpose. So I think moving to a broader look at how can we preserve access in geographic locations where it may be limited is a good endpoint for that transition, but I'm glad that we're not keeping the wedge as a permanent mechanism for guaranteeing that access.

MS. UCCELLO: I agree with all the comments made thus far and strongly support the recommendations. Our goal is to get a good value for Medicare expenditures, and we're trying to balance payment adequacy, beneficiary access, along with affordability to taxpayers and beneficiaries. And I think the way that the E&M payments are currently structured doesn't provide good value. It just doesn't make sense to pay a lot more for pretty much the same service in the hospital setting than the free-standing physician setting.

And agreeing with Scott on this, I think we need to continue to explore whether there are similar recommendations we can make for other types of services that are provided in different settings by different providers.

There is one thing that I am somewhat bothered by,

and that is, because of this stop loss, the reductions in beneficiary co-pays for those hospitals that are subject to the stop loss are actually going to be higher than the co-pays in the hospitals that are not subject to the stop loss. So some of those -- or even many Medicare beneficiaries in those stop loss settings, they're still going to pay less than they would under current law, and many of them are already going to have their cost sharing paid through other sources, in particular Medicaid. However, for those people who are low-income yet don't qualify for Medicaid, they're still going to have to pay more, and so there's an equity issue here. But because this is a temporary stop loss program, I think that it's fine, and so we'll eventually get to where there's equity in cost sharing across people.

So, again, I strongly support these recommendations.

MR. BUTLER: Okay. I think this is one of those occasions that what we say and capture on the transcript is as important as our votes, because I think there are a lot of messages that need to be carried forward for sure.

If we could turn to Slide 13, I just wanted to make a couple of points and questions on this. I've been

concerned all along that we presented these numbers in overall Medicare revenue versus outpatient and also the way we display them by percentile. So let me just both ask a question and try to make a point.

So if we look at the 95th percentile, for example, and we say that 2.6 percent impact on those organizations in overall revenue, first of all, you've already identified that that top 5 percentile tends to be large public teaching hospitals. So it may be 5 percent of the hospitals. If they're four times the size of other institutions, it could be 20 percent of the dollars. Right?

DR. ZABINSKI: Potentially, yeah, sure.

MR. BUTLER: Well, not potentially. It probably is certainly skewed that way. I don't know what the number is.

Secondly, if you were to say, and arbitrarily but not totally randomly, that 25 percent might be outpatient and 75 percent inpatient, that 2.6 percent is more like a 10 percent reduction in outpatient payments. And so we kind of -- in other sectors where we've displayed things, at least we've shown the impact -- and one other point along those lines. We've highlighted 9.6 percent loss on outpatient

overall. So if you were to apply a 10 percent reduction to outpatient, that would, all other things being equal, be a 20 percent loss for those institutions in that last 5th percentile.

The point I'm trying to make is the impact on the outpatient side, when you isolate that, is really, really significant. And the way we -- I fear that as these numbers go forward that Congress, they look at, well, 0.6 or 2.6, this isn't a big deal. But when you isolate those that are impacted and you isolate the outpatient, it is a very significant percentage of the outpatient money.

MR. HACKBARTH: I follow your logic and agree with that, with the proviso that this doesn't include the stop loss effect.

MR. BUTLER: Right. This is just today's world.

MR. HACKBARTH: Okay. Yes.

MR. BUTLER: This is today's world. And, by the way, I very much appreciate the staff's effort to try to identify where the impact is and where it is skewed. Okay. So that's my comments on just how we portray this. I would encourage us -- or more than encourage us, would like to see something in the chapter that shows the percentage impact on

the outpatient per se versus just overall revenue. I understand we're trying to look at the overall financial health of the institution, and that's why it's displayed this way. But I think we need to -- we run our outpatient business a little different than the inpatient businesses, and you need to understand the impact on the outpatient revenue. Okay.

So the more I have learned about these groups of institutions -- and I still don't have a great appreciation for them -- my support for this initially was in no small part due to the fact that I saw a lot of sites off of academic medical centers in the suburban communities that were converting and making money off of this -- or at least making the conversion easy, with no apparent value added to the Medicare program and at greater expense. And I still do and strongly believe that those things should not be permitted to occur.

There's a second group that are kind of the multispecialty group practices -- some are in urban areas, some are in rural areas -- that have been in this business for a long time.

And then the third is not just teaching hospitals

but principally the ones that are the primary affiliates of a medical school. They sit in urban areas. And those are the ones I'm most familiar with, not just in my experience at Rush in Chicago but Henry Ford Health System in Detroit, so I'm going to speak to those because I don't pretend or I don't want to suggest my expertise is all that thorough in the other areas.

So what do these buildings -- and they're not just buildings, they're services -- look like? Because I think sometimes a qualitative description is as useful as a quantitative description. We have previously talked about the requirements, the regulatory requirements, or conditions of participation or Joint Commission or standby capacity. I think it's a little bit more or different than that.

For those of us that have been in these settings, they're often one or more large buildings that house a large faculty that is employed and has been employed for a long time. In our case, we probably have half a million visits in these buildings. So it's a big operation.

They also tend to be, I think, disproportionately supported by electronic health records compared to other settings. I don't have all the data on that, but I have

read literature that these settings are also more advanced in terms of having electronic support.

It's also where a lot of the ambulatory training occurs that we want to encourage and support as we try to move to a new system. We don't want to discourage that.

But from a patient standpoint, what you see come in the door of these places is an unusual population, often. They're often in wheelchairs. They often need social services. They often need interpreter services. None of those things are regulatory issues, but these are often complicated patients coming to specialty clinics, and these things aren't captured in E&M codes as much as E&M codes capture complexity. But it's a support system that, you know what? The free-standing practices, they don't -- even if they're insured, they often do not really want these patients because they're a heck of a lot of work.

What kinds of diseases are treated? Well, you look to academic medical centers, and sometimes you think that these are -- they are things like comprehensive cancer clinics that provide supportive care and team care and are doing wonderful things, and they do -- beyond provide care, we, for example, look at a lot of disparities in breast

cancer, and there's research associated with these. They're things like movement disorders clinics that treat Parkinson's. There's Alzheimer's clinics. And in our case we even have NCQA-designated medical homes that are in geriatric care. So it's not just specialty care. So it gives you a little sense of the kind of environment that it's in, and I think we need to protect it, I think particularly those that are serving the poor.

We need to think, too, about an ACO world, however you want to bundle payments and bring them together. These kind of enterprises aren't going to go away, and we need to find ways to partner and make sure that, you know, further integration is accelerated, not, you know, picked away at one step at a time. And I think Ron articulated the physician, you know, needs to be partners in the reform of the system. I think that these big academic medical centers do, too. As archaic as they can be, we need to find ways to kind of get these environments flipped where needed, have teaching in them, have them do the kinds of models and convert these kinds of clinics into ways that are really managing care in a cost-effective, highly service-oriented way, and can continue to serve the poor.

I know I'm making a lot of statements on these, but I think this environment is a very important one, and we can criticize each part of the system, but I think all of us need to be partners and find ways to kind of make this occur as expeditiously as we can. Culture are hard to change for sure.

So when all of that is said and done, the problem is these provider-based clinics are bad policy. I mean, it's a bad technical policy. It really is. And as much as I believe that the academic medical centers and others desperately need this support, this mechanism is probably not the way to do it. And coupled with the fact that I think we need to stop these conversions where they're not appropriate, where they're occurring remotely, is time sensitive and should be addressed.

So in the end, with great angst for sure, you know, while I would prefer a moratorium, while I would prefer something to be done, you know, that is more off campus than on campus from what I know about particularly academic medical centers, and while I would prefer actually the -- and I understand the problems with using DSH and inpatient versus outpatient, I think we should convey that

MedPAC is not in the business of cooking up formulas, and it is better to use ones that exist. It's a proxy, though, for serving the poor, and I do think that the access is in the end the key issue along with the support of, as I said, some of these environments that are contributing to the future reform of the system.

So when all is said and done, not with great enthusiasm, I can support this, particularly with the knowledge that the Secretary will closely monitor this and that it has a three-year phase-in.

DR. CHERNEW: So I support the recommendation and would just like to say that the challenge here is, I think, to get the structure of payment right and then worry about the level one way or the other. And there has been a lot of criticism of various things, and I think Peter's comments were eloquent, and I understand about some of the unique and different things. The concern that I have sort of about a lot of the arguments that we've received in letters and other people who have spoken with me is, despite what I think is the truth behind a lot of those arguments, I just find the magnitudes that were presented before so large that you simply can't argue that they're taken into account by

any of some of these other arguments. And so I think it is certainly a fruitful exercise to figure out which of those particular things are concerning and what the right magnitudes should be, but I think to a first order we would never, if we thought there were problems in the hospital and the payment rates were equal, say we should solve those problems by raising the E&M fees. I think we'd deal with it some other way. And so I think that this basic approach and the basic principle is an important first step towards moving us forward, and we can try and get the actual levels that we're moving payments to right and make adjustments where we can.

DR. DEAN: I certainly -- I do support the recommendation with some of the same hesitations that Peter mentioned. I think as we have said many times, we have a deeply flawed payment structure that is poorly targeted, it's filled with perverse incentives, and it clearly needs to be changed. But change clearly brings with it some very difficult things and creates some pain that all of us would prefer to avoid.

At the same time, if we're going to move toward a system that more rationally uses the resources that we have,

I think these changes are the direction that we need to go.

Having said that, you know, I'm concerned about a lot of the questions that have been raised about this proposal and the impact it will have. I'm concerned -- well, to support it, I'm concerned right now about the differential in beneficiary co-payments, which I think is a significant concern, a number of sort of not very well tied together concerns.

We've been told a number of times that outpatient departments are the most poorly supported, most poorly reimbursed section of hospital services, but I have asked several times: Is that because of Medicare payments? And I've never really gotten a straight answer to that, and I tend to think it's not because of Medicare payments. I'm much more -- I believe it's most likely because of inadequate Medicaid reimbursement plus uninsured folks and all that. And that's a real problem, and we want to try to be sure that we don't too seriously limit the facilities that are willing to try to tackle these challenges and still try to provide the care.

At the same time, I think these kind of movements hopefully will refocus some attention on those problems and

hopefully help to move the overall system in a more logical way, and that Medicare really is not the solution to the overall payment system for the rest of the population.

There are lots of concerns, but I guess rather than ramble on, I think that this is a movement in the right direction, even though it clearly has some impacts that are going to be a real concern.

DR. HALL: I'm speaking in favor of the recommendation as well, and I'd like to just say a few words particularly concentrating on the beneficiaries and access to care for present beneficiaries and for the burgeoning number that are coming down the chronological pipe.

I was very much impressed by the letters and calls from a variety of interested parties, mostly health systems, that we've received, and they were respectful and they were passionate. And I think if I had to break it down to the two themes that I saw in all of these institutions, it was: How do we preserve care to the most disadvantaged in the population? And how do we preserve the basic function of many of these centers, which is the education of the next generation of care providers? So what does this do in terms of addressing those concerns?

Well, I guess I'm persuaded to believe that this is just one additional step to start to rectify, as many people have said here, some of the difficult discrepancies in payment systems that we deal with, not only in Medicare but indirectly through all the other payment systems. And I think it has to be looked at in the context if it's not -- it is one decision, but it's a decision that fits into a much larger plan of really aligning our interests, which as a new member of the Commission, I've come to really respect, and that is that we really do care about access to care for beneficiaries and we do really care about the educational function of some of our premier institutions. So this is one of a number of steps, and I think we could see some positive things flowing from that.

I'm also reminded that our primary responsibility is to the beneficiaries, and as others have said, it's not to continue to perpetuate and extend the life of the system that is taking money from one pot and putting it into another, and inevitably these kinds of conflicts arise.

I believe that from the educational standpoint, although we're not directly talking about medical education, it makes little sense to continue to foster education,

particularly in teaching people about evaluative and management services, in a broken system. The better thing for us to do is to fix the system and then the education will follow from that. So this I think will also move us forward into a continued improvement of our educational system.

And I think as we'll see in recommendation 3, we put in some safeguards here that I think are going to allow us to really think through this problem a little more deeply as it becomes implemented over 36 months.

Thank you.

DR. BERENSON: Yeah, I also thought the letters and phone calls were important, laid out a number of concerns, and did raise the issue of why are we moving so far on a complicated issue. And I guess I had to think a lot about that and generally came up with the counterview that, in fact, the provider-based payment policy has been festering for many years. I became aware of the distortions it creates in the discussions around changing oncology payment -- Herb was living through that time -- in which one of the arguments made for not moving from the previous system, which provided substantial profits to oncologists

based on getting paid AWP, the argument was, well, we'll just refer the patients to the hospital and Medicare is going to wind up paying a lot more money, so why would you do this?

More dramatically, 18 to 24 months ago, when the fee schedule reduced overpayments, substantial overpayments for some cardiac studies, nuclear studies and all, the response was, similarly, you're penny-wise and pound-foolish, we're just going to refer these patients to the hospital outpatient department and you're going to wind up spending a lot more money.

It actually got worse than that. The cardiologists went to the hospital, not just their patients. And, indeed, I've seen marketing materials suggesting to cardiologists how valuable they were because the hospital was going to be able to use provider-based payments to generate substantial revenues. I heard just the other day of an academic health center buying a cardiology practice and raising the prices for echocardiograms by 400 percent. Medicare won't pay all of that, but Medicare policy ripples through the entire health care system. So we actually have a broken payment system here, and to take more time to study

it I don't think is appropriate. And I think we do want to move towards a system, as the Chairman suggested, of pay equivalence or differentials that can be empirically justified. We will later on in the day talk about ASCs, and there is a lot of pretty good data there suggesting that the case mix is really very different between an ASC and an outpatient department, and we would not want to recommend going to payment equivalence there.

I think on E&M it is a simpler case because, as staff have made the case -- and I think it's largely correct, not 100 percent correct -- that the levels of E&M services are in a sense a case mix adjuster. Whether or not the hospitals appropriately code, I think they'll have a greater interest right now since the profits will be much less to actually get the coding right.

I do have a regret that we are starting with E&M services. The examples I used are not largely around E&M services, and I've been, I guess, one of the leading protagonists in arguing that we have distortions in the Physician Fee Schedule with overpayment for tests and imaging largely and underpayment for E&M services. There has been some correction of that in recent years. It's

especially a problem because there's a growing recognition -- and this was reflected in the physician payment rule this year -- that we actually have to do fundamental rethinking of even the code definitions of E&M services. CMS basically is deferring to an ASPE study which is looking at how we can better capture the work of E&M services, especially in primary care, because it is not well captured in the current code definition.

So I'm not happy that we've started with E&M. There are reasons why we started with E&M. I do think we want to move very quickly and send a clear signal that for other services where there really is no empirically justified differential, we would adopt the same recommendations for those such as echocardiograms, where I have trouble imagining that there is a patient severity of illness difference in how we would pay.

So I'm in favor of the policy. I guess what I would want to iterate or reiterate is that we have a lot of work to do in adopting this policy, we and CMS and ideally the RUC, and one of the perhaps unintended consequences of this policy would be to bring a new party to the table of trying to work through the correct coding for E&M services

and the correct payment for E&M services, that those would be hospitals, and I would actually welcome some chief medical officers of hospitals to the kinds of meetings that are being held, need to be held, to try to rationalize the Physician Fee Schedule coding and payment.

So with that, I'm in favor of the policy, although I did want to point to one concern that was raised in some of the letters which I was not sympathetic with. I am sympathetic to some of those that were raised about time and impact on the kinds of hospitals we're concerned about. The argument that basically said MedPAC is in favor of ACOs, of more integration, and now you're reducing payment for E&M services to hospitals that's going to make it difficult for us to integrate. I'm not sympathetic with the argument that says we need lots of extra money so we can entice docs to come to our place so that we can become more efficient. It doesn't work for me. And that's one model of integration, hospitals owning doctors and being integrated systems. There are certainly other models around multispecialty group practices and IPAs, and I don't think we need to -- in a sense, the implication was we need to sort of subsidize the hospitals for a while so they can develop their integrated

systems with the promise that they are then going to be much more efficient. That one didn't convince me.

So I'm in favor of the policy.

MR. KUHN: Thank you, Glenn, and I want to join Bill and Bob in expressing my appreciation to all the groups that sent in letters and comments through the system that Glenn shares with everybody at every meeting. I thought it worked very well, and people have supplied us with some good information to help us work through this issue.

Let me state at the outset that I'm going to oppose this recommendation, and I want to make three general comments about that.

I agree with, as Glenn laid out at the beginning, and others, the same price for the same service, and I think that's an important principle to be on. But I'm just a little bit concerned that are we comparing the same service in the two different settings. We've got packaging issues, although I don't think they're as great as some folks would think they are, but there is a bit of a differential there. We have standby capacity issues. We have life safety code issues. And I think as some have expressed, we have some case mix issues. I think we recognize that the acuity level

of some of the patients presenting themselves to some of these hospital-based clinics are far greater than others. And so I just don't know if it's a true apples-to-apples comparison in my mind.

The second issue -- and both Peter and Glenn talked a lot about this -- was the clinic system that exists out there now, and I think Glenn did a nice job of saying, well, what if there is no private practice alternative? And I do want to compliment Glenn and all the other Commissioners who raised these issues because I think the changes that are in this draft recommendation 2 recognize that issue and do a lot to try to get us to that place. With the three-year phase-in, the stop loss, the retargeting of dollars back to those organizations that are actually doing the work, not supporting others who are doing the things that we've heard about that are probably inappropriate behaviors that are out there, and recommendation 3 for the Secretary to come back and look at these issues, I think are all good improvements, and I appreciate those being in there. But for me, I'm still a little concerned that when we look at 2014 and we know all the new individuals that are going to have coverage as a

result of the expansions of PPACA, are we going to continue to have that robust clinic system for those that can't get care elsewhere? And I just have a bit of a nagging concern in the back of my mind for that as we go forward.

And then the final issue -- and it's one I raised at the last meeting, among others -- is the issue of the changes that this will bring about in the APC payment system. It is a charge-based system that's put in place with the cost-to-charge ratio, and if we move down this direction of reducing charges for E&M codes, that means that other codes will change dramatically, particularly device-dependent codes, and will we see a skewing of the system in the future with more payment being driven to device-dependent codes, does that create even more access issues for us for E&Ms in the future for these clinic systems, and particularly in rural areas, is a concern of mine.

So, again, Glenn, I want to thank you for bringing this issue forward. I think it's an important one for us to look at. I think the principle of what you're trying to do is sound. I think the changes you've made are good. But I still have some nagging concerns here, so I will oppose recommendation 2, but I believe I'll be able to support

recommendation 3.

DR. NAYLOR: So I would like to acknowledge my support of recommendations 2 and 3. I think that we have -- and everyone here has talked about the critical principles that we've outlined that should guide everything that we do, our decisionmaking, and the notion of accelerating accessible, affordable, equitable services for those in the Medicare program is who we are and what we are supposed to do, and the opportunities to align our payment across sites and services to make sure that everyone gets that access and we all benefit from the affordability of the program is critically important. So let me just highlight a couple related to each of these principles.

Under access, the higher co-pays experienced by Medicare beneficiaries who are seeking and receiving services in OPDs in many ways can serve as disincentives for them to access those services, and I think that this is really, in addition to the fact that I don't know how you can justify a $10 differential for a mid-level or a mid-range visit, 15 minutes in one setting versus another, the very fact that that exists can serve and other evidence suggests might be a disincentive for them accessing it. And

I certainly agree with all the transition plan, with the attention that needs to be paid on assuring that hospital OPDs both continue the critical services that Peter described and particularly where they are in communities that they are the critical access point.

I also think that we need to be really accelerating and supporting other types of provisions of these services in other contexts: independence at home, patient-centered medical homes, nurse-managed clinics. We have numbers of provisions already in play that are providing and adding bonuses to providers in health profession shortage areas. So we have a lot of change ongoing to promote access, and I think that we want to have the kind of policies that support and align and accelerate those efficient providers.

On the issue of equity I keep coming back to, it's so difficult to justify paying differences and justifying an issue of affordability and equity for the system, Medicare's use of increasingly finite resources for a growing population of people and not using them as wisely as we can. So really taking into consideration all that Peter and others have said about the critical role that outpatient

departments play and will continue to play in the future, we also need to recognize that we've got big challenges out there, we've got to consistently apply these principles.

I don't know if we -- two minor points. On the studies that will go forward, I think it's really important to look at access to primary care or E&M services broadly. In other work, we know that many Medicare beneficiaries are not just accessing their care in physicians' offices or by physicians -- 11 percent by NPs and PAs, and 33 percent getting care elsewhere. So as we think about studies to look at access, I hope we'll include those individuals as well.

MS. BEHROOZI: Can I just ask a question first on Slide 13? The margin in the 95th percentile, the per transition year hit to the margin is 0.9 percent in the lower right corner, right? So that's for each of the three years. And so I'm trying to figure out the relationship between that and the 2 percent, the protection with respect to the 2 percent. So then on Slide 14 you say that about 4 percent of hospitals would end up being protected, I guess, in the final year. Does that differ in the first and second years?

DR. ZABINSKI: Yes.

MS. BEHROOZI: Okay. Do you have those figures?

DR. ZABINSKI: It's a lot fewer in the first year. It's like 17 the first year, 44 the second year, 120 in the third.

MS. BEHROOZI: Thanks. Okay. So I'm going to try to go back to something you asked us to do in prior times, just to say what you like first before you say what you don't like. If you don't mind going back to the recommendation, please, Jeff? Thank you.

I like the principle, I absolutely do like the principle of paying the same for the same service in different settings, and that's why I was one of those people whom Dan referred to, I guess, when we discussed this previously, the appeal of the principle is undeniable. And where it doesn't make a difference as applied -- you know, the principle is absolutely correct, and when as applied it turns out the way the principle should make it turn out, then it's fine, like when I take my kid to the pediatrician to one office on Tuesday and pay one rate and then take him to a different office on Thursday for the same service and pay a different rate because, you know, it's affiliated with

a hospital, it doesn't make a difference. I can keep seeing him at the first place, at the physician office, and my access is not impaired. And, you know, the principle absolutely then should be applied.

But where it does make a difference, I think, is where I feel a responsibility to say that I don't think that I can support the recommendation as written, and where it makes a difference is in low-income communities. And like all others, I heard a lot of, you know, some rhetorical and some very, very persuasive and important information presented by hospitals in response to this potential recommendation.

But of all of that stuff that was deliberately presented to all of us, I don't think any of it had quite as much impact on me as listening to a hospital CEO who runs an independent safety net hospital in Brooklyn talking about when another hospital in Brooklyn in a different neighborhood had closed -- part of the unfortunate trend in New York City of the Catholic Church getting out of the business of running hospitals at a loss -- and that hospital closed, and that community would then be unserved by not only the hospital but the clinics that provide primary and

other care. And so her hospital took over those clinics and sought to run them, but then ultimately -- and it's not just the fault of Medicare. This was before New York State did the opposite, I think, of what we're considering here. New York State has moved via the Medicaid program more money into the outpatient side of hospitals. By the way, we're talking about outpatient departments versus physicians, but, you know, I think it would be helpful to put it more within the context of inpatient versus outpatient and the incentives to shift site of service within the hospital. But, anyway, that's a whole other discussion. So she talked about trying to run these outpatient clinics and that they were just losing too much money and threatened to drag the rest of the hospital down, so she ended up having to close them. So it's not about, you know, the threat -- it's not about the fact that the hospital would close, but those neighborhoods then lost their access to the services, the primary services provided by those clinics.

So it's the fact that they're already losing money, can the hospitals sustain the additional hit, and what choices will they make based on that additional hit. And in the slide after the recommendation where it talks

about what the potential impacts are, I think it doesn't sufficiently acknowledge that there is a potential for outpatient clinics to close. That's what it means when we say there will be an impairment of access.

So I like that in the second part of the recommendation there is a recognition of the potential for that access impairment, but I really don't think it's sufficient. I mean, I think to protect 17 hospitals in the first year from, you know, a hit and to take 2 percent out of their overall Medicare revenues based on the fact that they're running these outpatient clinics could very well mean that they're not going to run those outpatient clinics. And I think that it's just not protective enough.

Another concern that I have with the recommendation as written is that it doesn't sufficiently -- it's not sufficiently tied, it's not sort of sufficiently conditional on getting E&M codes right, which isn't just about E&M as a whole area, you know, a big lump, but I think kind of goes to Herb's point as to being able to differentiate better within the scope of E&M services and the patients' accessing those services, and then it kind of gets into is there a difference between at least some of the

services, the E&M services provided in hospitals and those provided in doctors' offices based in large part on the different characteristics of the beneficiaries. I mean, 68 percent of those accessing outpatient services in hospitals in New York City are Medicaid and uninsured, and I kind of doubt it's that high a percentage in doctors' offices. So the extent to which the patient mix is different, are there at least some differences in the types of E&M services provided in hospitals?

So I love the third recommendation, and I think that it should be more tied to the second recommendation, or more conditional. So because of those reservations, while I like overall the principle and the protection of those who could be harmed, I don't think the principle is sufficiently tied to other principles we hold dear, and I don't think the protection is strong enough.

MR. GEORGE MILLER: I, too, do not support the recommendation, and much of what I will say has been said before, so I'll try to be brief. But my concern -- and, again, like Mitra, I'll start with the things that I like. I certainly support and understand the issues of the structure of the business of paying the same price for the

same service and certainly support that in theory and hope -- and know this Commission will move to that point. And I certainly understand the desire to move to reform the very broken payment system, and we're addressing that.

But I guess the problem that I have is that we're picking one silo to fix that versus doing a comprehensive program to fix everything at one time. And that then causes me angst because, again, I'll make the point -- I think Peter made it very eloquently earlier -- that the outpatient department is a different structure, particularly for those vulnerable populations in the areas where private physicians would not go and provide those services. And in some rural areas, I think it's the same thing. The rural hospitals provide these services because those patients would not have primary care services if they did not go to the hospital-based physicians.

I realize we want to try to get the structure of payments right, and, again, I support that and that's the right thing to do, as Mitra just illuminated. But, again, I'll go back to my example, what Dr. Ron Anderson at Parkland has put together. That network of clinics, which has been built over a long period of time, they've made an

investment -- and, again, because of certificates of participation, like safety code issues, EMTALA, the Joint Commission, that clinic structure has to be vast and has EMR and has to be put together right. And we will dismantle by this recommendation -- at least in my opinion, this recommendation will dismantle that infrastructure, again, which is an access issue for the very poor, for minority populations, and I would say part of the disparity problem in America can be tied to this issue as well. So, again, philosophically, I support the method. I don't think this recommendation is the way to go.

And like Mitra, I can support recommendation number 3, but I think it should be tied closer to recommendation 2 so it has less of an impact. I think we all agree that E&M services are too low, but the recommendation doesn't address that issue. But what it does is, I think, harm safety net hospitals in America. I think I mentioned earlier, and I'll say it again, Grady would take currently as proposed a $20 million hit with this proposal, which they can ill afford to take, a safety net hospital in Atlanta, Georgia.

DR. STUART: I support both recommendations, and I

support the order of the recommendations. In other words, I do not believe that we should have a moratorium on this until we study it further.

I also believe that we should make a very strong case for the philosophic underpinning of equal pay for equal service, regardless of the provider setting.

I happen to think that focusing on E&M first is appropriate, particularly given the volume of services that are provided, much more volume than you're going to have with specific tests or specialty procedures. And I'm convinced by the need to do this to prevent even more erosion in the value of these services being provided in hospitals that are taking up physician practices in order to increase their bottom line. So I thoroughly agree with that.

I think, following up on Bob's point, that we should take this opportunity to perhaps in the first chapter, the introductory chapter, to say, look, this is the first time that the Commission has really forcefully moved in this direction, and we recognize that this is just the first of other areas in which we really need to look at this, and so to put us on record as saying this is a first

step in an ongoing process that needs to be given some -- needs to be continually addressed by the Commission.

I do have one technical question regarding Slide 13, and it gets to the eloquent point that Peter was raising about the impact on specific facilities, and that is, do these numbers, both by transition year and when fully phased in, take account of the stop loss?

DR. ZABINSKI: They don't. Let's see. You know, it's not -- I have something. It's buried in here somewhere. You know, stop loss, for example, the overall effect would drop from 0.6 percent to 0.5 percent. It would have a small effect on each number.

DR. STUART: Well, it strikes me that it could very well have a very large effect on a specific institution. In other words, if there is a cap of 2 percent, then for the facilities that Peter was referring to, presumably it would be a lot less. And so I think that's important, particularly in light of recommendation 3, because the way I read recommendation 3, if somehow we've really screwed up and there is going to be some particular harm done, this will provide a mechanism by which we can address that. And so I don't necessarily see the stop loss

disappearing after the third year. I mean, it might be there, but we just don't know. So I think that's the reason that I support having the study following the implementation of this so that we have some experience with it, so we see where it's headed.

DR. CASTELLANOS: I'll be as brief as I can.

First of all, I support both recommendations very strongly. In a previous discussion, a discussion with Peter and his comments, he made a very astute comment. If we were going to pay the E&M charges for physicians in their office higher or more appropriately, we wouldn't be having this discussion. We would not be having this discussion today. But because we're on MedPAC and we're the prudent spenders of the taxpayers' money, I think it's very appropriate that we're making the decisions and the comments that we're making.

I strongly recommend going forth both with the payment and delivery reforms as discussed. The only thing I would like to -- two things.

One, can you go back to Slide 16? We had a lot of discussion earlier about some of the definitions, and I'm not sure what I'm voting for unless we clearly state the

outpatient department and the physician's office, a clarification on those issues. So perhaps we could clarify that before we vote.

And the second thing is, within the text, I would like it to be stated where this dollars and savings is going to be applied to, not the general revenue but where we intend to have this savings applied to. In our previous discussion, there was strong recommendations for applying to the SGR and that issue.

MR. GRADISON: I've already expressed my support for all three recommendations and am delighted that the transition, which I and others were talking about in our previous meetings a month or so ago, is included here.

I want to hit head on a concern I have about the argument that basically says leave things alone. I'm not talking about the things that have been expressed around this table so much as some of the things that we've heard from outside, because I think the argument in favor of the status quo is a pretty hard argument to square with the notion that the payment should be equivalent for substantially equivalent services. And if you buy the notion that they should be equivalent for substantially

equivalent services, then there are basically two ways to do it: increase the payment to the level of the hospital outpatient departments to the physicians that provide the services outside the hospital structure; or what is here, which is the other way around.

I frankly would be a lot more comfortable with the recommendations of the critics if their real feeling is let's increase -- do it the other way around, although I would prefer this recommendation, than to say, well, let's just stick with the status quo. It isn't usually expressed that way, but that's really what it comes down to, in my opinion.

DR. BORMAN: I support these two recommendations. I've had some internal conflicts in thinking through this, having practiced in hospital-based clinics as well as in other settings and recognizing the large amount of good that can be done through these practices and the populations that in the best of all possible worlds that they target.

At the end of the day, we are obligated to advise the Congress about the best investment of dollars into the program and to make sure that the beneficiaries are being best served and that their precious dollars are going to

best effect. And because of that, I think that we need to move down this road.

I would make a couple comments about the study. We usually talk about cost, access, and quality. We have not talked a lot about quality in this conversation. I'd like to hope that in the study that we make sure that we include the appropriate quality evaluations because that may, in fact, also help us understand where better to target these dollars in the future. And I think that needs to -- building on one of Mary's point, it needs to include all the things that are going on in terms of the EMR use, the quality bonus program already set up and so forth that, surprisingly, populations of hospitals may or may not be eligible for and will figure into this conversation about where the dollars are best spent.

And the last thing I would mention is that -- it's not something that we can deal with here today, but in one of those rather peculiar quirks of the program, the specific coding of the visit by the physician is not required to match the coding by the facility. And there's a lot of history there, and I would submit that perhaps part of the study going forward would be to also include looking at the

underpinnings of that so that this becomes more transparent and more appropriate and more easily valuable, because I think that probably confounds a little bit some of the analysis that underpins our recommendation today. But overall I support the two recommendations.

DR. MARK MILLER: So the language point that Ron raised for everybody is what we're trying to do here is equalize the rates for an E&M visit that occurs in the OPD and make it comparable to what happens in the physician's office under the Physician Fee Schedule. This is laid out -- - one thing before we just discuss language, I just want to remind the Commissioners and the rest of the world, in the report that we've put in front of the Commission and ultimately would be published, this is laid out in a fair amount of detail as to how these rates are actually arrived at. In your current drafts, it's around pages 50, 51, 53, in there.

So there's a fair amount of detail that explains what we actually mean when we say this, but the actual words in question is in the sixth line down in that recommendation. You see the phrase that says "outpatient department or physician's office." And the question is

whether the "physician's office" is enough clarity.

So one thing we could do is stick with this and make sure in the text we say this is what we mean by it. Alternatively, there is another construction that -- you know, because we knew this was an issue that a couple Commissioners had -- that we could go to, Jeff -- and you'll see also in the sixth line "non-facility setting paid under the Physician Fee Schedule." It's a little bit more complicated. Either way the text would explain what we meant by these words.

I could go either way, but I'm not voting. So the attempt is just to make sure that we're linking the payment rate to the right level. It's laid out in the chapter in some detail how we got, you know, where we got. And the question is which of these kind of captures the concept more clearly.

MR. HACKBARTH: We are substantially behind schedule here, and so I propose what we do is go with the original language and amplify in the text. I think this language is a little awkward. It almost sort of screams out, "Explain me." And so I'd rather go with the simpler, more commonplace English, and then address the issue in the

text, if that's okay with you, Ron.

DR. CASTELLANOS: [off microphone] Okay. And Mary.

MR. HACKBARTH: And Mary.

DR. NAYLOR: It's totally okay.

MR. HACKBARTH: Okay. It's time to vote on recommendation number 2. All in favor of recommendation 2, please raise your hand.

All opposed?

Abstentions?

Okay. On recommendation number 3, all in favor?

Opposed?

Abstentions?

Okay. Thank you. I'd like to thank the staff in particular this time. This is a complicated issue and done in a relatively short time frame, and so they made heroic efforts. Thank you very much. It's much appreciated.

Okay. We are now moving ahead to physician and other health professional payment adequacy and update.

In fact, as our staff get in place here, let me just say a word about this for the audience. Most of you are familiar with the fact that in October, we sent a letter

to the Congress about the sustainable growth rate system in the Physician Payment System and included in that letter several recommendations, including a recommendation to repeal SGR, and then we presented in the letter options for how that might be financed if Congress were to decide that SGR repeal must be financed fully out of the Medicare program. That letter still stands as MedPAC's statement of policy on the Physician Payment System, so we will not be having separate update recommendations on physician payment.

Cristina, are you --

MS. BOCCUTI: Actually, we're going to start with the ASC group.

DR. ZABINSKI: Okay. Today, Ariel and I will present our payment adequacy analysis for ASCs and evaluate the purchasing program for ASCs and Cristina will discuss the payment adequacy analysis for the Physician Fee Schedule that she and Kevin Hayes have done.

Before getting into the presentation itself, I want to address the specific question that Mary asked in December about how cost data could be collected for ASCs. And as we discussed in the paper that the Commissioners have, we see two possible mechanisms. First, CMS could use

annual surveys of a random sample of ASCs each year with mandatory response to them. Alternatively, CMS could require all ASCs to submit cost reports that are more streamlined than what you, say, have with hospital cost reports. All in all, the intent is to obtain data that is still sufficient to assess the payment adequacy while minimizing the burden on CMS and ASCs.

Okay. On to the payment adequacy. Important facts about ASCs in 2010 include that Medicare payments to ASCs were about $3.4 billion. The number of fee-for-service beneficiaries served in ASCs was 3.3 million. And the number of Medicare certified ASCs was 5,316.

In addition, about 90 percent of ASCs have some degree of physician ownership. Because of this ownership status, physician owners may furnish more surgical services in ASCs than they would if they had to furnish their ambulatory surgeries in hospital outpatient departments, which is the sector with the greatest overlap of surgical services with ASCs.

And finally, ASC payment rates will receive an update of 1.6 percent in 2012.

At the December meeting, we discussed measures of

payment adequacy in detail and we also provide detailed discussion in the Commissioners' papers. But in the interest of time, today, we will cover measures of payment adequacy more briefly. In particular, our measures of payment adequacy for ASCs were all positive in 2010. That is, access to and supply of ASC services was adequate as the number of beneficiaries served, the volume of services per fee-for-service beneficiary, and the number of ASCs all increased in 2010. Also, the increase in the number of ASCs indicates that access to capital has been at least adequate.

Finally, Medicare payments per fee-for-service beneficiary increased in 2010. However, we are unable to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS, even though the Commission has recommended submitting cost data in 2009, 2010, and 2011. In addition, we cannot assess quality of care because ASCs do not yet submit quality data, but they are slated to begin doing so in October of this year.

So for the Commission's consideration, we have the following draft recommendation. The Congress should update the payment rates for ambulatory surgical centers by 0.5 percent for calendar year for 2013. The Congress should

also require ambulatory surgical centers to submit cost data.

In regard to the first part of this recommendation, given our findings of payment adequacy and our stated goals, a moderate update is warranted. However, this is a lower update than the one percent that we just recommended for outpatient departments. The purpose is to provide motivation to satisfy the second part of the recommendation, submitting cost data, which could be used to better evaluate payment adequacy and help develop a market basket for ASCs.

Spending implications of this recommendation are that ASCs are poised to receive an update in 2013 of 1.2 percent. Therefore, this recommendation would produce a small budget savings. For beneficiaries and providers, we found growth in the number of ASCs and the number of beneficiaries treated in ASCs as well as providers being willing and able to furnish services under the ASC payment system. Therefore, we anticipate this recommendation having no impact on beneficiaries' access to ASC services or providers' willingness or ability to furnish them. However, ASCs would incur some administrative costs to submit the

cost data.

Now let me turn things to Ariel, who will discuss a value-based purchasing program for ASCs.

MR. WINTER: So, as Dan was saying, CMS has adopted a quality reporting program for ASCs for 2012 and ASCs will begin reporting five claims-based measures in October. ASCs that do not report data on these measures will receive a lower payment update in 2014 and thereafter. However, payments to ASCs will not be affected by how well they perform on these measures. In fact, CMS does not currently have statutory authority to establish a value-based purchasing program for ASCs that would rewards high-performing facilities and penalize low-performing facilities.

The Commission has outlined general criteria for performance measures that should apply to any VBP program. In the interest of time, I won't mention them here, but they do appear on the slide and they're discussed in more detail in your draft chapter.

Based on these criteria, the VBP program for ASCs should include a small set of measures to reduce the burden on ASCs and on CMS. We discuss several potential measures

in more detail in the draft chapter. Most of these indicators are focused on outcomes, including patient safety measures, such as patient fall or patient burn, hospital transfer after an ASC procedure, and surgical site infection. The measure set should also include some process, structural, and patient experience measures. Several measures are already part of the ASC quality reporting program, but others would need to be developed.

I also want to mention some other key design principles. First, it is important to reward providers who attain certain thresholds of quality as well as lower performing providers who improve their quality over time.

And second, funding for the pool of VBP payments should come from existing ASC spending.

So the second draft recommendation reads, the Congress should direct the Secretary to implement a value-based purchasing program for ASC services no later than 2016. Given the need to develop additional measures and gain experience with reporting them, we think that 2016 is a reasonable time frame for starting this program.

With regards to spending implications, because funding for VBP payments should come from existing ASC

spending, this recommendation will not increase Medicare spending. However, the Congress or CMS could design the program to create small savings.

With regards to beneficiary-provider impacts, this should increase the quality of care provided to beneficiaries. ASCs will incur some administrative costs to submit quality data, and high-performing or consistently improving ASCs would receive higher payments than under current law, while low-performing ASCs would receive lower payments.

And now I will hand things over to Cristina.

MS. BOCCUTI: So this final slide provides just a brief summary of the issues and results that we discussed at last month's meeting and also in your draft chapters, particularly on the SGR. And, of course, you have the chapter draft and I'll start here at the top.

Drawing on our patient survey and other national studies, we found that most Medicare beneficiaries are able to get timely appointments with physicians and can find a new one when needed. Although only a small share of patients look for a new physician in a year, we continue to find that among those seeking a new physician, finding one

in primary care is more difficult than finding other ones in other specialties. We also found that about a third of patients reported receiving some or all of their primary care from nurse practitioners or physician assistants.

Also in our analysis, we found that growth in the volume of services provided, that is on a per beneficiary basis, slowed in 2010, which is after about a decade of rapid increases.

On claims-based measures of ambulatory quality designed specifically for the elderly, we saw that most indicators either improved or did not change significantly.

Looking at payments, we found that the ratio of Medicare payments to private PPO rates remained steady, but some payment factors are not included, like performance bonuses, for example, that Bob and Peter have raised in the last meeting.

As in previous years, the vast majority of services are paid on assignment, meaning that physicians accept the Medicare Fee Schedule rate as payment in full.

And the final bullet here on the slide calls attention to the letter that MedPAC submitted to the Congress this past October. That letter included four

recommendations, one of which was to repeal the SGR and replace it with a ten-year path of specified updates. In this recommendation, updates for primary care are higher than those for other fee schedule services in the first three years.

Okay. I think we can open it up for questions now.

MR. HACKBARTH: Thank you. Let me kick off the discussion by saying a little bit more about physician payment and our October recommendations. We took up again the issue of SGR and recommended repeal in October. Of course, MedPAC has a long history with the SGR issue, having first recommended repeal of SGR in 2001. As we began discussing the SGR issue again last spring, it was prompted by a concern that continuing the SGR was posing an increasing threat to the Medicare program, a threat of destabilizing the program by undermining both physician and beneficiary confidence in Medicare. So that concern, which has for me, at least, and other Commissioners can speak for themselves, has only grown since the spring, prompted us to delve into what is a very difficult area, and it's difficult because of the fiscal situation and the concern that is

widespread, if not universal, in Congress that we cannot repeal SGR without having a way to pay for it.

So as I talked to people on the Hill back in the spring about our taking up this issue, really, there was bipartisan support for MedPAC delving into the SGR issue again, but also a caution that if we are to do that and we're to be effective, we need to also address the cost of SGR repeal. Just another recommendation, repeal SGR without any notion of how to pay for it, would not be seen as particularly helpful to the Congress. That's the barrier they've got. There's widespread agreement that they want to get rid of it. The problem is, they don't know how to pay for it.

In addition to that, at least some key people on the Hill made it clear that we are the Medicare Payment Advisory Commission and, therefore, our ideas about how to pay for SGR ought to be from within the Medicare program. To be blunt about it, our views on tax policy or on how big the deficit should be or whether we ought to be funding wars, not a war in Afghanistan, our views on those topics are not of much interest to the Congress. So if we want to talk about repeal and how to finance it, we ought to focus

within our domain, our area of expertise, the Medicare program.

So the question that we faced as we addressed this issue in September and October was did we think we wanted to recommend repeal of SGR even if it had to be financed out of Medicare, and we made the recommendation for repeal again and suggested options within Medicare for how repeal might be financed if Congress determined that it had to be fully financed out of the Medicare program.

I want to be clear about that. We were not recommending that SGR repeal should be fully financed out of Medicare. There are other options. Those are beyond our purview. The question for us is did we recommend repeal even if it had to be financed out of Medicare, and if so, what were the options for financing that, and that's what was in our October letter.

At the end of our discussion in October, I made a point that I will reiterate here. There are two, actually, very important messages in the fact that we went through what we did in October to recommend repeal. Message number one is that if Congress elects to fund SGR repeal solely out of Medicare, it's going to be difficult and painful and it's

going to have an effect on a lot of different parties -- physicians, hospitals, Medicare Advantage plans, drug companies, home health agencies, skilled nursing facilities, really across the board. So if that's the path that Congress elects, it will be a difficult one and painful one for some people.

The other message in the fact that we went ahead and recommended repeal anyhow is how urgently we feel that it's time to get rid of the SGR system and that the threat that it poses to the Medicare program and the beneficiaries it serves is growing and just kicking the can down the road is increasingly problematic.

So with those comments, I will open up the general discussion, beginning with Karen. In this case, we have both the ASC -- well, really, we only have the ASC recommendation to vote on, but feel free to address either ASCs or the physician issues.

DR. BORMAN: Yes. I support the ASC recommendations and I think we've been over the issue sufficiently while I don't have much to add.

Relative to the SGR, I think I imagine we have all been hugely disappointed at the current two-month short-term

temporary stopgap and that how all the things come into play about how demoralizing, how destabilizing, how unfortunate, inappropriate, any adjective or adverb will apply about right now. I think that we certainly outlined a lot of options for change and a pathway to do that. I continue to disagree with differential payment based upon specialty, but still endorse the notion of repeal of the SGR.

MR. GRADISON: I support the recommendation.

DR. CASTELLANOS: I support the recommendations on the ASCs.

I just have one question on the ASCs and it's just a clarification question. Once we get a cost report from the ASCs, has there ever been any consideration to have a single market basket for both the hospital outpatient and the ASCs?

MR. WINTER: Yes. In prior reports, we talked about that. Our concerns with the current market basket use for ASCs, which is the CPIU, and we actually used some older cost data collected by GAO to look at whether the hospital market basket or the Physician Medicare Economic Index would be a better proxy of ASC input costs and found that ASCs -- their cost structure in some ways resembled hospitals. In

other ways, they resembled physicians' offices. And so we left that decision about whether one of those market baskets should be used or a completely new market basket should be developed to the Secretary, once they collect the cost data and analyze it. So that's certainly a possibility.

DR. CASTELLANOS: Talking about physician pay, I don't have to recapture the whole argument. Both, as you remember, Karen and myself were very opposed to the October recommendations for some very good reasons. Needless to say, it was voted on as positive. Like Karen, I am extremely concerned over these short-term fixes. It is extremely disruptive to a physician who's trying to run a practice, to CMS, and to the Medicare beneficiary. In the present Congress, I don't see that Congress is very likely to make a good recommendation and I think we're going to continue to have these temporary patches with bigger budget deficits and costs.

Within the medical community, there's a strong ongoing feeling that we hope maybe Congress will enact the 27.4 percent cut. What that will do, if it is put in, it'll make the Medicare beneficiary and the physician community and the hospital community really seriously thinking about

this issue, and we really believe -- a lot of the doctors believe that Congress will finally do something.

I've been on this Commission now five-and-a-half years and we bring up the same issue. Glenn, you and I have talked about it. In fact, in the September meeting when we were talking about our recommendations, I said to you, Glenn, what are we going to do in January when we have another fix? You know, we both hope we haven't. We can't have this. We need an answer. And I don't know how to stress this more passionately, to say there needs to be a message from MedPAC that this is just totally unacceptable. We really need to consider going ahead and making -- getting this -- so I can go ahead. I'm not abandoning my patients. I'm trying to be able to provide care for them not just today but in the future. We just need some -- there's no other business, and I'm sure the hospitals, if they were in my situation and running a practice, they would feel exactly like I do.

It's just totally, totally unacceptable. I don't know how to get that message across any better. I don't think we -- you know, I don't like the idea of letting the cut go into effect, but certainly if that happens, I think

we'd get an answer.

I just am a little concerned. You know, we're talking about payment reforms and we're talking about equal payments across different sectors. If we go ahead and continue that argument and continue that philosophy, especially with the issues of some payment cuts, I think we're going to see some significant differences in payments, especially in the ASCs and the hospital HOPDs for the physicians.

I would like to only suggest that we seriously consider some discussion on the same philosophy we've had about appropriately paying for the same service across all areas.

DR. STUART: I agree with Ron on that. I'd like to see that recommended, as well.

I support the recommendation. the only thing that I thought about when I looked at this in terms of one of the rationales for only offering 0.5 is because we don't have any information, and one might take this as to say, well, we know that asking ASCs to provide cost information is going to be cost increasing. So one way to think about this would be to say, well, maybe we should give them a one percent

increase if they provide cost information and a zero percent increase if they don't. I'm not suggesting that we change the language on that because that's going to take more time than we have today, but something to that effect, that to the extent that the costs rise because of this, that should be considered as part of the activity that MedPAC goes through in terms of recommending payment updates.

MR. GEORGE MILLER: Yes, I support the recommendation and I kind of like what Bruce just said to get the cost data. But I am struck in reading the chapter previously concerning the demographic information that ASCs, and I don't think it's improved over the year as far as minorities and low-income and Medicaid patients. Their proportion is very small compared to, like, the hospital outpatient departments. Is that still correct?

DR. ZABINSKI: Yes, that's correct.

MR. GEORGE MILLER: Okay. All right. So those patients probably go to the hospital outpatient departments to get their care, but they don't get them at the ASCs.

DR. ZABINSKI: That is right.

MR. GEORGE MILLER: Okay. Thank you.

MS. BEHROOZI: I support the recommendations, and

just a comment. Rather than messing with the words of recommendations, perhaps it's just something to note for the text, you note in the principles for the ASC reporting, or for any reporting -- I'm sorry, quality-based program that the Commission would support that it should be aligned across similar settings, in this case, including OPDs and physician offices, but then the rest of the text just talks about an ASC quality program and it might be worth kind of reiterating that that should be aligned and where, in particular, the obvious alignments are.

DR. NAYLOR: I support the recommendations. I think recommendation two, in particular, highlights the critical importance the Commission is placing on consistent sets of expectations regarding reporting quality and cost data, but then goes to the next step of a value-based purchasing recommendation that rewards high performers. So I think that this is very consistent with what we do.

MR. KUHN: I support both recommendations.

DR. BERENSON: Yes. I just want to ask, since it was an important part of the last conversation, you've added some text to our chapter which talks about the severity of illness, more complexity of patients in the OPD rather than

the ASC. Could you give me a little more about that? What's that based on? And is the sort of the measure of the complexity -- I mean, the burden of that complexity manifest in longer OR times? Do we have anything else to be able to demonstrate that, in fact, that there are increased costs that support such a differential?

MR. WINTER: Okay. So the language about how ASCs -- how OPDs serve patients who are more medically complex than ASCs is based on primarily two sources of information. One was a study that the Commission staff did that was published in the 2003 Report to Congress that looked at differences in average HCC risk scores for ASC patients versus OPD patients and found that they were consistently higher for OPD patients, recognizing that HCC risk scores are an imperfect proxy for patient complexity and higher cost.

In addition to that, the Commission funded a study by RAND published in 2006 where they looked at specific comorbidities -- presence of specific comorbidities for ASC patients and OPD patients for two common outpatient procedures, colonoscopy and cataract surgery, found that the OPD patients were more likely to have these comorbidities

than ASC patients. But that report was not able to quantify the impact of those differences on cost or on surgical time.

Separately from the RAND study we funded, RAND did a study for ASPE which was published, I think, last year, where they looked at differences in surgical time for ASCs and OPDs using data from a CDC NCHS survey and found that ASC procedures were about 40 percent less time than OPD procedures. The question is, is that because OPDs are treating sicker patients or they're less efficient or have greater demands because they provide emergency care? We don't know, and the study didn't get into that and I don't think the data are in the NCHS survey to be able to disentangle those factors. So it is -- unfortunately, we just can't quantify the impacts.

DR. BERENSON: Do we know if there's any more coming, any more in this area?

DR. ZABINSKI: I don't know of any --

DR. BERENSON: Okay.

DR. ZABINSKI: -- further research, but we can take another look at what we can do with the data we have.

DR. HALL: I'm in support of the recommendations.

DR. DEAN: I support the recommendations. I would

just, for the sake of time, say I absolutely support in as strong a possible way as we can the concerns that Ron raised about the SGR. It just is so immensely frustrating that Congress refuses to deal with this, and the fact that the whole system suffers because they refuse to deal with it. We've stated it about as strong as we can, but we just need to keep doing it because it is a huge failure on the part of our political system to deal with a major problem.

So -- and I also support the concerns that George raised about the apparent cherry picking that goes on in terms of selecting patients. That also is something we need to look at and we need to respond to. It's beyond the scope of what we can do right now.

DR. CHERNEW: I support the recommendations and the concern about the SGR.

MR. BUTLER: I'll repeat the SGR, too. It doesn't hurt, particularly in light of the conversation we just had, where we offer up yet another reduction in hospital outpatient which is out of the same pot, in effect. Can you imagine another 27 percent on top of that for some of these institutions? It just makes no sense.

MS. UCCELLO: I support the recommendations and

the comments made, and I just want to clarify something. The issue with respect to minority patients in ASCs, is it -- - not that this necessarily makes it right, but is it because of the physical location of the ASC, or is there -- I think that's what it is, as opposed to something else --

MR. GEORGE MILLER: Cherry picking.

[Laughter.]

DR. ZABINSKI: There's probably some of that, but I look at this a little bit -- I haven't had a lot of time to do it. Some of it's probably due to the location. I just looked at, you know, for example, in the Washington, D.C. area where the ASCs are and it's probably some location issue. It also might be some factors of type of insurance, and this probably gets into a little bit of the cherry picking. The minorities that were likely to be on Medicaid, they're more likely to lack supplemental coverage for their Medicare, things like that. And so that probably plays a part in it, as well. But I've definitely got to do a little more digging to make a real definitive answer to that.

DR. DEAN: I would say that the location is a version of cherry picking.

DR. BAICKER: I support the recommendations.

MR. ARMSTRONG: Yes, same.

MR. HACKBARTH: Just a few concluding comments, one on ASCs and one on physician payment. I just want to be clear that for my part, I see ASCs as serving an important role in the system. Having run a large group that did surgery both in the hospital outpatient department and in ASCs, I know from working with our surgeons that they often preferred working in the ASC. It allowed them to be more productive, give a better experience for their patients. Through no fault of the hospital, often working in the outpatient department, ambulatory surgery suites, you're subject to disruption because of the emergency department and the management of the scheduling and the case flow is just different.

And so in our group, we split our cases between ASCs not owned by our group but by others and the hospital outpatient department, the Brigham, in recognition of -- and then we distributed the patients between those largely based on the severity of risk. Some patients were more likely to experience complications and need the back-up that was in the hospital and so they were directed to the hospital outpatient department and, frankly, the easier cases, less

risky cases, were directed to the ASCs. And I think that was clinically the appropriate thing to do, and through our payment, we recognized that selection of patients by paying lower rates, significantly lower rates at the ASC than we paid at Brigham for the hospital outpatient department.

I think ASCs are an important part of the care delivery system. That said, we need to pay them accurately just as we need to do so for hospital outpatient departments.

On the physician issue, my concluding thought about the urgency of SGR repeal is this. We noted in October that there were three reasons that we thought it was important to deal with this now as opposed to later. One is that repeal of SGR will only get more expensive. Those numbers will go up, not down.

Second is that given the fiscal challenges that the Congress is grappling with, the likelihood that they're just going to forgive all this seems to me, and this is just my opinion, the likelihood that they're going to forgive it and write off the SGR debt is going down, not up.

And then third is that Medicare savings that could be used to finance SGR repeal are being snapped up for other

purposes, whether it be deficit reduction or for funding the Affordable Care Act. Those are both legitimate purposes, let me be clear. But to say that we can't repeal SGR without it being offset and then take the Medicare savings for other purposes and leave this destabilizing element at the heart of the Medicare program is problematic.

And it was for those three reasons that I felt a real sense of urgency about making the recommendation to repeal SGR.

Thank you. Good work.

We will now move on to outpatient dialysis.

DR. MARK MILLER: Wait a second. We've got to take the vote.

MR. HACKBARTH: Oh, I forgot the votes. A little detail.

[Laughter.]

MR. HACKBARTH: Okay. So we have two recommendations on ASCs. Would you put those up?

MS. BOCCUTI: I've got to find it.

MR. HACKBARTH: I led Cristina astray, too.

Okay. On recommendation one, all in favor, please raise your hand.

Opposed?

Abstentions?

Okay. And number two, all in favor?

Opposed?

Abstentions?

Now I think we're done. Thank you.

[Pause.]

Nancy, you can start whenever you are ready.

MS. RAY: Good morning. During today's presentation, I am going to summarize information about the adequacy of Medicare's payments for outpatient dialysis services. Nearly all of the payment adequacy information was presented in detail at the December meeting. During my presentation, I will be addressing specific questions that Commissioners raised. I will present a draft recommendation for you to consider about updating the payment rate for calendar year 2013. This is the last presentation before the March report.

So here is a snapshot of the dialysis sector in terms of beneficiaries, facilities, and total Medicare spending. You saw this last month and it is also in your briefing paper.

Overall, the dialysis payment adequacy indicators are positive. Dialysis facilities appear to have the capacity to meet demand. There has been a net increase in the number of facilities and dialysis stations.

Looking at the volumes of services furnished by dialysis facilities, growth in the number of dialysis treatments continues to match beneficiary growth. However, use of erythropoietin, the leading drug in the ESA drug class, declined in 2010. Looking at patients who received erythropoietin in January and December, we see a seven percent decline in mean units furnished per month.

Mitra, you asked for us to look at this by ownership type. For the two large dialysis chains, the decline was six percent. For all other freestanding facilities, the decline was nine percent.

There was also a question about changes in the use of other dialysis drugs. Between 2009 and 2010, the total volume of iron agents increased by one percent. And between 2009 and 2010, the total volume of Vitamin D analogs decreased by two percent.

Beneficiary access appears to be generally good. There were few facility closures in 2010, and it did not

disproportionately affect any beneficiary group, including African Americans, the elderly, and duals.

Quality is mixed. Some measures are high or improving and others still need improvement. One of the improving measures is the use of AV fistulas. Karen, in reference to your question that not all -- well, in reference to your comment that not all patients may be candidates for AV fistulas, in the draft chapter, we have referred to CMS's quality initiative goal that 66 percent of hemodialysis patients have an AV fistula and noted some of the reasons why patients may not have one.

Glenn, in response to your question about international AV fistula use, in 2010, seven out of ten Western countries had higher rates of AV fistulas.

Mike, in response to your question about the effect of the decline in ESA use, between 2009 and 2010, the proportion of patients with hemoglobin levels less than ten that might be suggestive of undertreatment of anemia increased slightly, from 6.2 to 6.6 percent. That being said, the FDA has not specified a lower bound for the hemoglobin level. This spring, we will begin looking at Medicaid outcomes, including changes in the use of blood

transfusions, and we will baseline blood transfusion use in 2009 and 2010, and once 2011 data become available, we will make the comparison.

Bill Gradison, the draft chapter includes rates of hospitalization and mortality by age, the decrease in rates over time that we see overall and by race, we see the similar changes by age.

Herb, you referred to the PPACA 3014 provision that requires the Secretary to establish a Federal pre-rulemaking process for the selection of quality and efficiency measures. There are five ESRD measures, one on vascular access infection, adequacy, hypercalcemia, which has to do with the bone and mineral drugs, dialysis drugs, and bloodstream infections. None of the measures relate to anemia.

George, among the PPACA 3014 measures that I thought you would be interested is the one in the Physician Quality Reporting System that would measure the percentage of patients age 18 years and older on dialysis for 90 days or longer who are referred to a transplant center for a kidney transplant evaluation within a 12-month period.

Access to capital appears to be good. Merger and

acquisition data suggests that access is available for the two large dialysis chains and other freestanding chains.

Glenn, we are still in the process of following up with the FTC and we will get back to you about that.

Scott, you asked about the cost growth by provider type. In 2010, the cost per treatment for the two LDOs was four percent lower than other freestanding facilities. Between 2005 and 2010, cost growth was 2.6 percent per year for the two large dialysis chains and two percent for all other freestanding facilities.

The 2010 margin here includes composite rates -- the 2010 margin for composite rate services and drugs is 2.3 percent. As in previous years, the Medicare margin varies across the different provider types.

Mitra, in response to your inquiry, I have also included in this table the 25th and 75th percentile.

We are concerned about the direction of margins for rural facilities. Tomorrow morning, Jeff and Adaeze will address the dialysis low volume adjustor that began in 2011 under the new payment method and that this low volume adjustor is anticipated to disproportionately benefit rural facilities. Recall that 2010, the year that the margin is

for, is the last year of the old payment system for most facilities.

So the projected Medicare margin for 2010 is 2.6 percent. This includes all of the 2011 and 2012 policies noted on the slide. It also includes a conservative behavioral offset to account for efficiencies in drug delivery expected under the new payment method.

So this leads us to the draft recommendation, which attempts to balance being cost conscious and ensuring that providers can handle cost growth, and it reads, the Congress should update the outpatient dialysis payment rate by one percent for calendar year 2013. This recommendation would decrease spending relative to current law. Currently, CMS's ESRD marketbasket projects providers' costs would increase by 2.8 percent in 2013, and under current law the update is marketbasket minus a productivity factor. No adverse impact on beneficiaries is expected. The draft recommendation would decrease beneficiary copayment relative to current law. The draft recommendation might increase financial pressure on some providers, but overall, a minimal effect on providers' willingness and ability to care for beneficiaries is expected.

And I look forward to your questions.

MR. HACKBARTH: Okay. Thank you, Nancy. Well done.

For anybody in the audience who just joined us, the presentations today on most of the update recommendations are short, concise, as well, exemplified by Nancy's presentation. I asked the staff to do that so that we could allow some more time in our schedule for some of the more complex issues that we are wrestling with. I want people to rest assured that we discussed these issues in detail at the December meeting and this is a summary focused, as Nancy did, on questions that came up in the December meeting.

So, let's see. Scott, I think it's your turn to lead off. Again, one round, comments or questions.

MR. ARMSTRONG: Nancy has addressed all of my questions and I'm inclined to support this recommendation.

DR. BAICKER: I support the recommendation, as well.

MS. UCCELLO: I support the recommendation, but I want to revisit an issue I raised in the December meeting where I asked -- the chapter made note that facilities were

having difficulty documenting certain comorbidities and one of the public comments was that they were unaware of the existence of certain comorbidities. So that suggests that those comorbidities are not related to the costs of providing care for those patients. So I hope that this is something that we can look into more moving forward and perhaps provide insights on whether the current comorbidity factors are appropriate.

MS. RAY: Just two follow-up points. Once we begin to get 2011 data, we will, of course, examine the extent to which facilities -- you know, how facilities are billing in terms of the case mix adjustments and so forth.

In terms of where these comorbidity adjustments came from, they were based -- CMS's contractor conducted an analysis of claims data and cost reports, and it was through the use of claims data that these predictors in these conditions were found to have some sort of effect on providers' costs and payments. But I can add that into the text.

MR. BUTLER: I support.

DR. CHERNEW: I support.

DR. DEAN: I made a mess.

[Laughter.]

DR. DEAN: I support the recommendation. I would just say, I appreciated the concise report and I especially appreciate the addition of the variation in margins that exists, because one of the frustrations I think I've expressed before is that, too often, we look at facilities that really may differ immensely in their location, their challenges, their settings, all those things, and we sort of lump them all together, and I think looking at the variation in margins is a first step to doing a better job of targeting the resources we have.

DR. HALL: I am in favor of the recommendations.

DR. BERENSON: As am I.

MR. KUHN: I support the recommendation.

DR. NAYLOR: As do I.

MS. BEHROOZI: Same, and thanks for the answers.

MR. GEORGE MILLER: Yes, I support the recommendations. However, at some point in the future, I'd like to make one quality standard that we would support dealing with the kidney transfer issue, as I've raised before. I'm concerned about the disparities about that issue, but I appreciate the information.

DR. STUART: I support the recommendation.

DR. CASTELLANOS: I support the recommendation.

MR. GRADISON: I do, too. I have a quick question, looking forward. I've heard some concerns that some folks are initiating treatment through dialysis where the treatment is rather marginal in terms of whether it's actually needed at that point in time, but are doing so arguably in order to get some priority in terms of kidney transplants. I'm not asking for -- this is not related to this recommendation, it's a chance to ask you to take a look at it if you haven't already done so. Thank you.

DR. BORMAN: I appreciate the answer to my question and I support the recommendation. I would, however, leave a couple of thoughts for the next time we address this particular sector.

One would be that, as noted in the chapter, that the biggest chunk of increasing costs was general and administrative costs. In a time when we're trying to press for efficiency, I think that that worries me a bit and that we should continue that line of analysis and perhaps not be so generous going forward if that persists.

A second piece is that I'm troubled a bit by some

of what appear to be behavioral adjustments in prescribing patterns that have been documented through this, and obviously we need to keep an eye on that. It's counterweighted by -- you know, it becomes very difficult. We start setting some of these targets -- it starts to wander dangerously into individual medical practice. And so, for example, while there's not a guideline about how low can you go, it's a very individual judgment based on a particular patient about what they will tolerate in terms of anemia. And so it may, in fact, be appropriate that there's not a lower bound. That doesn't mean that anemia is not an important issue, but it just means that we need to be a bit cautious about thinking we can have these specific things for so many different kinds of things. We need to stick to the things that are relevant, that we can measure, and that are less subject to that individual variation.

The flip side of that is I would encourage us to push for things that assess bone disease management. I see this in my -- I have seen this in my own personal practice related to the fact that I operate on hyperparathyroidism and secondary hyperparathyroidism is a result of end stage renal disease. Management of these patients, particularly

the -- well, not even particularly in the young ones -- relative to their bone disease can make a dramatic difference in their functionality. I've operated on patients for their hyperparathyroidism who have had ruptured Achilles and patellar tendons, so at their knee and their ankle, tremendous morbidity because of relatively poor management and sometimes non-compliance with that management, which is key, about that. And that kind of disability and so forth is something that I think bears looking at, because we have already seen some variation in the prescribing patterns of those drugs already, and I would worry that we put people at risk for a lot of bone disease that will lead to additional disability that in a very crass kind of way will cost the program more, much less the human cost. So I would think we should look at that.

And then, finally, as I mentioned last time, I don't perceive that we've subjected the relationships among the elements of this system to the same scrutiny that perhaps we have, for example, with ambulatory surgical centers, the use of radiologic imaging, high-end imaging and things that people own and refer to and so forth. And while I think we nicely summarize it actually in the appendix -- I

thought that was a wonderful outlay of the current state of the market -- are there data that we can come to relative to appropriateness of some of those relationships in ways that they may have unintended consequences. Particularly if the data continue to mount that more aggressive times per week hemodialysis leads to a better outcome, we want to make absolutely sure that we're getting exactly these relationships in the services appropriately targeted to our best ability.

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

Opposed.

Abstentions.

Okay. Thank you, Nancy.

Our next session is on hospice.

MS. NEUMAN: Good morning. Today I'm going to review our indicators of payment adequacy for hospice. We discussed these data in detail at the December meeting, and your paper has more detail as well. Before I do that, though, I'll give a brief overview of hospice and respond to questions from the December meeting.

This slide provides a snapshot of Medicare hospice

services in 2010. Over 1.1 million beneficiaries received services from over 3,500 providers, and Medicare spent about $13 billion.

At the December meeting there were several questions. First, on the hospice aggregate cap, George, you asked about the process for repaying cap overpayments. Generally, how it works is CMS and the hospice work out a repayment plan. Hospices have at most 5 years to repay the overpayments, and interest is charged. Due to the court challenges, the collection of cap overpayments was put on hold in 2010 and for some hospices in earlier years. Now that CMS has issued a regulation establishing an alternate cap methodology, we expect overpayment collections will restart soon, and we'll have to wait and see how that goes.

Bruce, you asked about the characteristics of above-cap hospices. About 87 percent are for-profit, more than 90 percent are free-standing, and they have smaller caseloads than below-cap hospices.

Herb, you asked about the impact of the original cap methodology versus the new methodology. We've added to the mailing materials the results of some modeling of the two approaches and pointed out that the impact depends in

part on how the formulas are implemented operationally.

Mitra, you asked about the trend in live discharge rates. Between 2008 and 2009, overall the live discharge rate was were stable.

Kate, you asked about how much of the increase in length of stay that we've seen over the last decade is due to the changing diagnosis profile of the hospice population versus growth in length of stay within diagnosis categories, so we have a slide on that. This shows the components of length-of-stay growth.

In the chart on the left, we see the changing diagnosis profile of the hospice population. For example, in 2010, cancer patients account for a smaller share of the hospice population than they did in 2000, whereas patients with neurological conditions and debility account for a larger share. In the chart on the right, we see the growth in length of stay within diagnosis categories. And if you decompose the overall growth in length of stay into these two components, it's the growth in length of stay within diagnosis categories rather than the changing profile of the hospice population that accounts for most of the growth in overall length of stay.

So now to review our payment adequacy indicators. First, our indicators of access to care are positive. The supply of hospices continues to grow, increasing more than 50 percent since 2000 and almost 3 percent in the most recent year. For-profits account for most of that growth.

The percent of Medicare decedents using hospice continues to grow, and hospice use grew in 2010 among all beneficiary groups examined. Average length of stay among decedents also increased in 2010.

In terms of quality, we do not have any data on which to evaluate trends in hospice quality. However, in 2013 per PPACA, hospices will begin reporting quality data. Those that do not report that data will face a 2 percent reduction in the update beginning in 2014.

As we discussed in September, MedPAC convened a technical panel on hospice quality in November. Information has been added to your mailing materials on that, and I'd be happy to discuss on question.

As far as access to capital, hospice is less capital intensive than some other provider types. For free-standing hospices, we continue to see entry of for-profit providers and modest entry by nonprofits. Publicly traded

chains have generally reported positive financial results and adequate access to capital. Provider-based hospices have access through their parent institutions, so overall access to capital appears adequate.

Now, in terms of margins, the aggregate margin is 7.1 percent in 2009, up from 5.1 percent in 2008. You'll recall this estimate does not count cap overpayments as revenues and excludes nonreimbursable bereavement and volunteer costs.

Looking at margins by type of hospice, freestanding hospices have more favorable margins than provider-based; for-profits have higher margins than nonprofits; and below-cap hospices have margins that are slightly above the industry-wide average, while above-cap hospices have high margin before the return of overpayments but low margins assuming full return of overpayments.

As we've noted before, margins are higher for providers with longer stays and for providers with more patients in nursing and assisted living facilities.

In terms of urban and rural, margins are higher for hospices serving urban areas. Some of the difference appears to be driven by volume. Higher-volume hospices have

higher margins. And although it might seem counterintuitive, looking at hospices that serve rural counties, margins aren't lower for hospices serving more remote counties as defined by our typology.

So this brings us to our 2012 margin projection, and our assumptions are shown on the slide. In 2012, we project a margin of 5.1 percent, And then one policy to note for 2013 is that there will be the continued phase-out of the wage index budget neutrality adjustment, which will be an additional 0.6 percent reduction in payments that year.

So this brings us to the draft recommendation. It reads: The Congress should update the payment rates for hospice for fiscal year 2013 by 0.5 percent. And preliminary estimates of the spending implications are that it would decrease spending by between $50 million and $250 million over one year and less than $1 billion over five years. And we do not expect any adverse impact on beneficiaries or providers' willingness to serve them.

We also, in addition to an update recommendation, plan to reprint two of the Commission's prior recommendations on hospice in the March report. We are

reprinting these recommendations because action has not been taken yet in these areas.

The first is the payment reform recommendation. This is the U-shaped curve. It would increase the per diem payments at the beginning of the episode and at the end of the episode and lower them in the middle, and this would better align payments with the service intensity of care and has the potential to make the payment system neutral toward length of stay rather than favoring long stays as it currently does.

The second recommendation is for focused medical review of claims exceeding 180 days for hospices with unusually high percentages of long-stay patients. This recommendation was in response to concerns we heard from the hospice community about the need to target regulatory scrutiny toward those providers where it is most warranted.

So that concludes the presentation. I look forward to your discussion and any questions.

MR. HACKBARTH: Okay. Thank you, Kim.

Prepare yourselves for this. Herb, we're going to start with you. We're going to change the order here. No, this is a big change.

DR. MARK MILLER: [off microphone] Wait, wait. We didn't --

MR. KUHN: You are making sure everybody is staying awake today, aren't you?

I support the recommendation.

DR. BERENSON: I support the recommendation.

DR. HALL: As do I. I support it.

DR. DEAN: I support the recommendation.

DR. CHERNEW: As do I.

MR. HACKBARTH: People are speechless.

MR. BUTLER: Not so easy.

[Laughter.]

MR. BUTLER: I have an observation on Slide 4 that I would -- I support the recommendation, but it did start piquing my interest that this shows obviously the dramatic decrease in the percent that are cancer, and then in the text it shows there are about a little more than double the number of users over the same time frame, which suggests that cancer has increased but not much, which is kind of surprising to me.

But the other thing that it triggered is that I wonder in all these per diem payments, we're almost starting

to get into a case mix thing. Is the palliative care provided for these -- I'm just speculating that some of these areas require less care than others on a per diem basis in terms of the challenge of the disease.

MS. NEUMAN: So in our look at sort of service intensity, what we've seen -- and this is all based on the number of visits. What we've seen is that it's really length of stay that is the biggest determinant of sort of the average number of visits you get per week over your episode rather than diagnosis, but diagnosis is highly correlated with length of stay.

We do see secondary effects of different types of service mix. Cancer patients tend to have more nurse visits as a share and less aide visits, and so there's potentially those kinds of differences, also duration differences which we will look at. So we're continuing to investigate that, but our sort of first look at this has found that length of stay is much more of a driver than diagnosis.

MR. BUTLER: Even the nature of a nurse's visit for a cancer patient with certain kinds of pain could be very different from a nursing visit for something -- for one of the other neurological diseases, for example, right?

MS. NEUMAN: Yeah, that's true.

MR. BUTLER: Okay.

MS. UCCELLO: I support the recommendation.

DR. BAICKER: I think that extra detail on decomposition of length of stay by type is really helpful, and I support the recommendation.

MR. ARMSTRONG: So do I. You've heard me say before I'm glad to see that the utilization of hospice services is going up, but I think it's really smart the way that we've pulled together a recommendation to adjust payments to neutralize the financial benefits of long-length-of-stay patients. So I think the balance between our different recommendations here is a very nice one, so I will support this, too.

DR. BORMAN: I support the recommendation.

MR. GRADISON: As do I.

DR. CASTELLANOS: I have a couple of clarifications. I've been traveling. I've been out of the country, actually, but I saw something about the OIG just completed a report or a study against a few of the hospices, and I'm just curious what that was about and whether that explains any of the data we've seen in the past. Are you

familiar with that?

MS. NEUMAN: Are you talking about the OIG study of hospices that heavily focus on nursing homes?

DR. CASTELLANOS: I think so, yeah.

MS. NEUMAN: Yeah, so there's some discussion in the chapter about that, and they found some results consistent with what we found, that patients who are in nursing homes tend to have longer stays, diagnoses that tend to require a mix of care, more aide services, less nurse services, those kinds of things, and they recommended that CMS monitor this and also to lower the payment rates for hospice and nursing homes.

DR. CASTELLANOS: Just another clarification. On Slide 2 there's about $1.1 million and we spend over $13 billion. Like Scott, I'm a big supporter of hospices. How does that fit into other terminal care costs per patient?

MR. HACKBARTH: Are you asking, Ron, whether costs for terminal patients are higher in hospice or lower in hospice than --

DR. CASTELLANOS: I just don't know where we stand. I'm just asking. I don't know.

DR. MARK MILLER: Yeah, we've gone through this.

I'm just going to trigger you to start talking about it. I think the way I would answer this question is the studies that say is hospice more or less expensive than staying in the acute-care system is highly dependent on when the patient hits the system and how long they stay. You could pick it up here if you wanted to.

MS. NEUMAN: Yeah, and also diagnosis is a factor. Most of the research shows that it saves for cancer, generally; it's more mixed for the other diagnoses. Some studies say yes, other studies say no.

DR. MARK MILLER: Ron, the reason we kind of went through a lot of this, and also to Kate's question about the increase in the length of stay, we were seeing all these increases in lengths of stay, and some people were asserting, well, this is just a shift in the diagnoses. But we were also documenting financial incentives to increase the length of stay that I think was just mentioned over here, and that kind of got us into some of the questions that you were asking about, and it's highly dependent on whether -- when people say hospice saves money, it's highly dependent on sort of where that experience occurs. If people bring them in very early and keep them for long

periods of time, then it doesn't save money.

DR. CASTELLANOS: I guess you're digging down to each individual or individual category. I'm just looking at it in bulk and wondering if -- how do those numbers match up to other terminal-care care? Do we have any idea? If we don't, you know, maybe you can get back or something.

MR. HACKBARTH: You need to dig down to particular situations as opposed to think about it in the aggregate. And I think we talked about this some in December, I believe, and I think Mike reminded us that whether it costs less or more, that's not the only issue at stake here. If it's the care that the patients need at the end of life, it's a good thing to do, and it shouldn't be solely evaluated on whether it saves money or not. But having said that, there has been research trying to assess whether the hospices save money, and Kim gave you the brief summary of that.

DR. CASTELLANOS: I appreciate your answer, and I totally agree. I'm a supporter of hospice. I was just looking at those numbers.

MR. HACKBARTH: Okay.

DR. STUART: I support the recommendations, Kim.

Thanks for answering my question. And, Glenn, thank you for putting in the previous recommendations.

MR. GEORGE MILLER: Support, and thanks for the answer to the questions and the previous recommendations as well.

MS. BEHROOZI: Yes, I support the recommendations, but, you know, especially with the reiteration of the prior recommendations, and I'm just going to use my last opportunity to emphasize the point on volunteers. You know, it just struck me. We were talking about for-profits having almost twice the margins of not-for-profits, and, you know, we're worrying about spending money unwisely in the program. It just seems like if for-profits want to enter the field that was when it was established an all-voluntary field, an all not-for-profit field, they should have to enter it like any other market where they have to hire people and provide all the services that their patients will want in order to feel satisfied. The fact that places that use volunteers or the services for which they use volunteers have higher patient satisfaction, well, that's what, you know, providers spend money on in other contexts. They spend money on doing the things that will make their patients satisfied. And so

certainly on the for-profit side, they should have to do that in hospice, and maybe we'll -- and so if the requirement to have volunteers as part of the mix is eliminated, volunteers certainly can still participate. They will still find their way to the not-for-profits. Maybe the for-profits will find they still have to keep providing those services, but they'll have to pay to provide them in order to retain patients, but their margins will come down, and we'll know better what the money is being spent on and not just going into profit.

DR. NAYLOR: I support the recommendations. I also hope that as we go forward -- because I think the Commission has really encouraged the shared responsibility and accountability for reporting of quality measures, and I think the expert panel that you brought and the recommendations that came from that both pointed to challenges in the existing measures, especially measurement of pain among the growing population of neurological -- those who have neurological conditions. So I hope that we can continue the conversation about advancing expectations around quality reporting measures, building on the expert panel's idea.

MR. HACKBARTH: Okay. It's time to vote on the recommendation. All in favor of the recommendation, please raise your hand.

Opposed to the recommendation?

Abstentions?

Okay. Thank you, Kim.

MR. HACKBARTH: Next up is public comment. And I would ask people to keep their comments to no more than two minutes. Begin by identifying yourself and your organization. When the red light comes on, that signifies the end of your time.

I would also remind people that this isn't your only or even your best opportunity to provide input into the Commission's work. As people could see from the discussion this morning, Commissioners are eager to get input from various sources and various mechanisms and pay close attention to it, so please avail yourself of all of the alternatives, most importantly working with the MedPAC staff.

Sharon.

MS. McILRATH: Sharon McIlrath, AMA. I just was looking for a clarification. If the Congress were to enact

your proposed changes on physician payment, i.e. a freeze for the primary care and 5.9 percent a year cuts for the other physicians who are providing those services, does that then transfer over to the visits that are done in the hospital clinics or not? And either way, it seems like the answer is problematic. If the answer is no, then how is it consistent? But if it does, then it even expands the problem that they have with the reductions that they're getting.

MR. HACKBARTH: Consider that a rhetorical question, Sharon. You --

MS. McILRATH: Well, honestly --

MR. HACKBARTH: You know the ground rules here. We don't engage in dialogue. If you want to talk at another time, we can talk about that, but for now, we'll go on to the next speaker.

MS. BAER: Okay. My name's Ivy Baer. I'm with the Association of American Medical Colleges and I just want to go on the record as saying that we're very disappointed that the Commission voted to reduce payments in outpatient departments. We have very serious concerns that this will adversely affect access, as a number of the Commissioners

noted. And although there is a study, we feel that by 2015, it may be too late, that a lot of these clinics may have either closed or already reduced the services that they're providing and we don't really think that it will be helpful to not look at this until 2015.

And finally, we certainly regret that we didn't have information about the stop losses. We were unable to model that and did not include anything in the letter that we've already submitted to you about that, but we will be returning back to our offices and taking a look at that to see what the actual impact would be on our members. Thank you.

MS. UPCHURCH: Hi. My name is Linda Upchurch and I work with NxStage Medical. I was very encouraged in the December meeting to hear a great deal of discussion around more frequent dialysis and the benefits of more frequent dialysis, and so I was discouraged to not hear that continued in conversation, particularly in this meeting.

I want to put a challenge out for you to continue to look at the mountain of clinical evidence showing the benefits of more frequent dialysis in survival, in morbidity, in transplantation. The list goes on and on --

in bone disease. It's important that you focus on that. It's important that you continue to look at it. I know you asked for additional follow-up from Nancy, and Nancy does a great job in providing that follow-up. So I can only assume and hope that that discussion will continue.

But to point out again that the disparities in access to more frequent dialysis are evident with Medicare beneficiaries routinely being discriminated against if you look at the population on more frequent dialysis versus traditional thrice-weekly. Again, the transplant status of these patients has improved. Survival and cardiac outcomes are improved. Health-related quality of life and employment status are improved. It's certainly worthy of time and attention in the March report and in meetings subsequent to this to focus on the benefits of more frequent dialysis. Thank you.

MS. HUANG: Hi. My name is Xiaoyi Huang with the National Association of Public Hospitals and Health Systems, and our members are two percent of hospitals but provide 20 percent of all hospital uncompensated care.

The impact of reducing payment for E&M services would disproportionately impact these hospitals. They're

estimated to absorb some 15 percent of MedPAC's annual estimated impact of $1 billion. We are also disappointed that the recommendation number two doesn't adequately protect these hospitals and that the third recommendation isn't strong enough and may come a little too late. These safety net hospitals serve critical roles for vulnerable populations. They provide primary care and serve as medical homes for these patients. And these patients also have multiple chronic illnesses and mental and behavioral health issues and require more comprehensive services in the outpatient setting that's not available in the freestanding physician office. Thank you.

MR. MAY: Thank you. I'm Don May with the American Hospital Association. I'll try not to repeat what my colleagues at the AAMC and NAPH have said.

We are very disappointed with this recommendation and we think this will lead to access concerns. And while the transition is helpful and an improvement over the last recommendation that was here in December, it's simply not enough.

We also think it's misleading that the impact is being shown overall and not at the outpatient PPS system.

We would encourage you to show that in the chapter. When we look at this, we're looking at taking assistance from 90 cents on the dollar down to 87 cents on the dollar when the transition is over, and then don't forget the two percent sequester. So we're really talking about 85 cents on the dollar of costs.

Our objections are really not about keeping the status quo. Hospitals are doing a lot to coordinate care, improve quality, and lower costs. But simply making this cut is not a first step, it's a misstep, and that makes a broken system even more broken.

Finally, one of the most concerning parts of this recommendation is ignoring the costs of the very system you are trying to pay, the outpatient system, and taking away that link to the hospital-level costs. If the system is going to move away from what is adequate for a payment system, MedPAC really needs to look at how are stand-by capacity going to be covered. If we're not going to look at stand-by costs and we're going to pay site neutral, how do we then ensure that hospitals have the funding to keep an emergency room open 24/7, to be able to be in communities where private physicians aren't practicing, and to be able

to have those services available that we can improve care.

We want to move forward. Taking us two steps backwards isn't the right way. Thank you.

MR. HACKBARTH: Okay. We're adjourned for lunch and we'll reconvene at 1:30.

[Whereupon, at 12:36 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:33 p.m.]

MR. HACKBARTH: Okay. It is time to begin our afternoon session with skilled nursing facility payment. Carol?

DR. CARTER: Okay. Before I get started, I wanted to follow up on a couple of questions from the December meeting.

Cori, you asked about how much variation there is in Medicare and Medicaid days across SNFs, and I added that information to the chapter.

Bill Hall, you asked about hospice use in nursing facilities, and the association reports that about 6 percent of nursing home residents receive hospice services.

I'll start with a thumbnail sketch of the industry, and on this slide you can see the numbers of providers and users and spending and the Medicare shares. We went over a lot of this, the next set of information, at the December meeting, and all the detail is in the chapter, and so I'm going to go through the update very quickly.

MR. HACKBARTH: Carol, could I just interrupt?

DR. CARTER: Yes, sure.

MR. HACKBARTH: It occurs to me that for purposes

of people who weren't here this morning, I ought to say that I have asked the staff to keep the presentations today as concise as possible so they will not be reviewing in detail material that was discussed at the December meeting when we talked about the draft recommendations for updates. And I've asked Carol and the others to focus on what questions came up in December, and as I say, keep it to the point.

So, Carol, thank you.

DR. CARTER: So, in summary, access appears stable for most beneficiaries. Supply is about the same as last year. There was no change in bed days or in occupancy rates. Covered days and admissions decreased slightly between 2009 and 2010, and that reflects the lower hospital use which is required for Medicare coverage.

In terms of quality, risk-adjusted rates of community discharge and rehospitalization showed almost no change between 2008 and 2009. In terms of access to capital, capital was adequate this year, and lending and borrowing is expected to be slow in 2012, reflecting uncertainties about state and Medicare policies.

Comparing payments and costs, the aggregate Medicare margin for free-standing SNFs was 18.5 percent in

2010. There is quite a bit of variation, as you can see on this slide, and in part this reflects cost differences across facilities. For example, nonprofit facilities have costs per day that are 7 percent higher than other facilities, after adjusting for differences in wages and case mix. The variation also reflects the biases in the PPS that raise payments for high therapy care above these patients' costs.

We use consistent performance over three years to define a group of SNFs that are relatively efficient, and relatively efficient SNFs had costs that were 10 percent lower, community discharge rates that were 38 percent higher, and rehospitalization rates that were 17 percent lower compared to other SNFs.

To project margins for 2012, we model revenues and costs using the assumptions on this slide. We did not model any behavioral responses to current policies, and we project the average margin in 2012 to be 14.6 percent.

The projected margin for 2012 continues the trend of double digit margins in this sector since 2000, indicating that the PPS has exerted too little fiscal pressure on providers. Several other facts support the need

to rebase payments:

The variation in Medicare margins is not explained by differences in patient mix;

Cost differences are not explained by differences in wage levels, case mix, or beneficiary demographics;

Some SNFs have both low costs and high quality;

And some MA payments are considerably lower than fee-for-service payments.

Three key concerns have been raised about rebasing Medicare payments. First, Medicare's payments were already reduced by 11 percent in 2012. But remember that this reduction was made to correct unintended overpayments in 2011 that we estimate resulted in margins in the 24 percent range. Even after the reductions, we estimate margins will be over 14 percent in 2012.

A second concern is that some argue that facilities need high payments from Medicare to finance low payments from Medicaid. However, using Medicare payments to subsidize Medicaid payments is poor policy for a number of reasons that we went through in December and are summarized on the slide. If Congress wishes to help nursing facilities with high Medicaid mix, then a separately financed, targeted

program should be established to do this.

A third concern is that the variation in Medicare margins could mean that some SNFs would fare poorly with rebased payments. We appreciate that the financial performance under Medicare partly reflects the shortcomings of the PPS. Your recommendations back in 2008 to revise the PPS would correct these known shortcomings and would shift payments from SNFs with high shares of patients receiving intensive therapy to those with high shares of medically complex patients. By improving the equity of payments across different types of patients, the differences in Medicare margins would be narrower. Payments would increase for hospital-based facilities, nonprofit facilities, and SNFs that treat high shares of medically complex patients, and these are facilities that have, on average, lower Medicare margins than other SNFs.

While the empirical basis and policy rationale for rebasing are sound, we recognize the need to proceed cautiously but deliberately to help ensure that there are no unintended disruptions caused by rebasing. The draft recommendation includes several elements that reflect this caution. It states that the PPS should be revised first so

that payments are redistributed before reductions occur. Rebasing would not occur until the following year, in 2014. It also acknowledges that a transition is important. The reductions would be taken in steps, with the reduction in 2014 seen as the first step in aligning payments and costs. And we will be monitoring industry performance each year as rebasing is implemented.

The draft recommendation reads: The Congress should eliminate the market basket and direct the Secretary to revise the prospective payment system for skilled nursing facilities for 2013. Rebasing should begin in 2014, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare payments are better aligned with provider costs.

Last month, we talked about how both revising and rebasing are necessary to reform the PPS. The first corrects the distortions in the payment system, and the second brings payments closer to costs.

This recommendation would decrease program spending relative to current law. For 2013, the preliminary projection is that spending would be lowered by $250 to 750 million lower, and over 5 years it would be between $5 to 10

billion lower. For beneficiaries, fairer payments across all types of care may result in better access for beneficiaries. Provider payments will be lower, but the differences in Medicare margins across facilities will be smaller. Impacts on individual providers will be a function of their mix of patients and their current practice patterns. The recommendation would not eliminate all of the differences in Medicare margins due to the large variation in costs.

Last month, we also talked about a policy to discourage unnecessary rehospitalizations. The goals of such a policy are to improve the care beneficiaries receive in SNFs, improve the transition care, and to lower program spending on rehospitalizations that could have been averted. Because not all factors that influence rehospitalization are within a provider's control, it is important that a policy accommodate the variation across patients and their changing circumstances, but still encourage SNFs to improve the care that they furnish.

This slide shows the wide variation in rehospitalization rates for five potentially avoidable conditions across facilities and suggests that there is

ample opportunity for some SNFs to lower their rehospitalization rates.

Last month, you discussed the key parameters of a rehospitalization policy: the definition of the measure, the time period covered by the policy, and the importance of using a rate to gauge performance to avoid evaluating how individual cases were handled. Looking at rates over multiple years ensures that providers are not being penalized for having one "bad" year.

Mary, you asked about the alignment of the hospital and SNF incentives if a SNF rehospitalization policy was implemented. This chart shows which providers are at risk under a rehospitalization policy that would include a 30-day window after discharge from the SNF. The hospital stay is shown in the first bar and the SNF stay is in the second bar. If a rehospitalization occurred within 30 days of discharge from the hospital, both the hospital and the SNF would be at risk, helping to ensure good transitions between these providers. That's the overlapping red bars.

If the rehospitalization occurred on day 31, however, only the SNF would be at risk. Some asymmetry in

risk may make sense since at some point the hospital is less accountable for care provided considerably after a beneficiary is discharged from it. Looking at the risks after the beneficiary is discharged from the SNF, the SNF would be at risk for rehospitalizations that occurred within 30 days, helping to ensure adequate transitions after the SNF stay.

And with that summary of the policy, here is the draft recommendation: The Congress should direct the Secretary to reduce payments to skilled nursing facilities with relatively high risk-adjusted rehospitalization rates for their Medicare-covered stays.

The recommendation language is purposefully general to indicate flexibility about the measure and time periods covered by a policy. In the chapter, the text below the recommendation outlines a phased approach that would allow CMS to move forward with a policy with a risk-adjusted measure that is readily available. Over time, the measure could be expanded to include a time period after discharge from the SNF and could include all causes for the rehospitalization once risk-adjusted measures become available. The key point is to put a policy in place so

that providers have an incentive to lower their rehospitalizations.

In terms of implications, it would lower spending relative to current law due to fewer hospital stays and payments would be lower for those SNFs with high rates. Fewer beneficiaries would be hospitalized unnecessarily, and more beneficiaries would receive better transition care. Payments to providers with patterns of high rates would be lower.

As required by PPACA, we include information on Medicaid trends in spending, utilization, and financial performance for nursing homes. The details are in the chapter, but here are the highlights. Service use increased between 2009 and 2010, and while spending decreased slightly, since 2002 spending has increased 16 percent. Average daily payments vary twofold across states. Both non-Medicare and total margins improved between 2009 and 2010. In 2010, non-Medicare margins were slightly negative while total margins were positive.

And with that, I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Carol.

Since these recommendations sort of fit together

as a group, I think we should discuss them all in one round, and Bill is going to lead off.

DR. HALL: I'll speak in favor of the recommendation. One thing I have been kind of puzzling about are some of the discrepancies between the for-profit and nonprofit nursing homes and whether there are some unintended consequences of our recommendations. Specifically, right now in many parts of the country Medicare patients are considered really excellent patients for SNFs. The payment is good -- it flows -- relative to the alternative payment, which is almost invariably Medicaid.

The other way that costs can vary is the sort of subtle quality of the experience that people are given. There aren't very many ways to cut overhead in an SNF facility. Usually there are state laws about staffing. There are fairly stringent requirements that tabulate kind of the daily activities of staffing. But it's sort of the human part of it that gets this into trouble, and at least some people feel that the nonprofit homes are the ones that have some kind of an institutional affiliation, seem to do a better job of that.

So I guess I'm saying I think that we should do this, but I think we also have to watch very carefully as to whether we exacerbate these kind of discrepancies between the for-profit and nonprofit facilities.

DR. CARTER: There are two factors that are going to influence how facilities fare under the rebasing and the revised PPS, and those are: What is their cost structure? And the second is: What's their mix of patients and how much therapy are they currently furnishing? Because the revised PPS really does move money away from therapy.

So if you're a nursing home that has a high cost structure and is really in the high therapy business, you're going to be the most affected by this.

DR. HALL: Right.

DR. CARTER: But there's a lot of institutions that really didn't get into the therapy game, and so the impact on them is much less. And so it's really those two factors that affect kind of the distribution of the impacts.

DR. HALL: Yeah. Well, the data you presented on the margins really gives me confidence that we should proceed with this.

DR. DEAN: I support the recommendations. I guess

I don't have any other questions.

DR. CHERNEW: Me, too.

MR. BUTLER: Just a thought. I support the recommendations, and I think it's a very important step to get the SNFs involved in the rehospitalization efforts. They're not equipped in general with the data or with kind of the infrastructure and the case management typically that the hospitals have in this. And I don't know what to suggest in terms of anything in the chapter, but I think just as we had kind of the QIO discussion and things like that, I'm wondering whether we need to think ahead and how to support kind of the effort that it will take to do this correctly and not just put the recommendation on the table, because I think it will be an important part of the partnership.

MR. HACKBARTH: Would you say a little bit more, Peter, about what kind of data you're referring to?

MR. BUTLER: Well, let me contrast the hospital side, which there is much electronic information available, there's discharge planners, there's a whole army of people that has analytical tools that already know where patients are being discharged to and with which diagnosis and where

to zero in on the focus. I think that the nursing homes on their side are sitting with paper records, are sitting with a gut sense of where they're sending people, under what conditions, but they don't have kind of the same information to kind of understand where they are falling short now and where the opportunities are for improvement.

MR. HACKBARTH: So, Carol, would you put up your bar graphs where you showed the responsibility? Within the hospital readmission window, where there's a shared responsibility, that's not the part you're worrying about. You're more focused on the discharge from the SNF issue where they may be discharging into the community and not know as much as hospitals know about their patients.

MR. BUTLER: Well, and also sometimes the discharge is back to the hospital as well, and --

MR. HACKBARTH: Well, yeah.

MR. BUTLER: Wherever that discharge is going I think is -- you're right, it's -- I don't think they have the same information, and, yeah, you're right, they get out into the home, and they don't -- if they don't have the information, you can imagine what sits out in the home, almost nothing sometimes once they're discharged.

MR. HACKBARTH: Okay.

MS. UCCELLO: I support the recommendations. I think taken together they're a really good, important set of recommendations. It's clear that the levels of payments are too high, they're distributed poorly, and there's not enough that's targeting quality. So, taken together, this moves us more toward value.

And thank you in particular for adding in the distribution of shares. I think it helps more explicitly show that Medicare would not -- using Medicare payments to help offset low Medicaid rates is not well targeted.

DR. BAICKER: I support the recommendations, and I think it makes a lot of sense to be flexible in recommendation 2 about the manner in which rehospitalizations would be incorporated into payments, especially because we think we're going to be getting better information over time.

MR. ARMSTRONG: Yeah, I do, too. I think just to build on a couple points already made, I like how we are thinking about within a section of our payment structure we're organizing payments that actually extend beyond it as a mechanism for sort of slowly working our way toward

something that just kind of holds together a little bit better. So it is, I think, just good to point that out.

Was this recommendation in the packet of our SGR proposals?

MR. HACKBARTH: The rebasing?

MR. ARMSTRONG: Yeah.

MR. HACKBARTH: Yes.

MR. ARMSTRONG: Was it? Okay.

DR. MARK MILLER: And the rehospitalization.

MR. ARMSTRONG: I just couldn't remember. And then another point, and it's not specific to Carol or this but more broad. It seems that we're approving more recommendations that in the next couple of years make some payment structure change, and we're saying at the same time let's monitor the impact of this and, if we need to, let's make adjustments to that. My question is: Have we ever actually felt like we over-rebased and had to make an adjustment?

MR. HACKBARTH: Rebasing, the first provider group for which we recommended rebasing was home health, and that is -- remind me, Mark, the schedule for the home health rebasing.

DR. MARK MILLER: 2013

MR. HACKBARTH: Yeah, so it begins in 2013. So there isn't a case where it's actually happened and we've had a chance to evaluate the impact.

MR. ARMSTRONG: Maybe my question shouldn't be so specific to just rebasing, but it seems like when we're making what seems like fairly significant adjustments to our payment structure or the payment rates themselves, we often talk about, well, and let's monitor this over the next couple of years and make adjustments if we feel like it didn't really turn out the way we thought it might. And I'm just wondering whether actually it ever turned out differently than we thought it might, or whether we're just inherently just very conservative about this and that -- I'm just interested.

MR. HACKBARTH: Yes, do you have some thoughts?

DR. MARK MILLER: The only thing I would say, actually I've never thought about that question, so I actually -- and I wouldn't want to answer it on the fly. It is an interesting question.

What I would say, though, is more of a looking -- an evolution in thinking looking forward where people -- you

know, and thinking about my experience, which has been several years now, where people are like these payment rates and these margins, for example, just don't make sense, and people would talk about payment rates. But then that was unsatisfactory, and we started driving down into the underlying payment systems and finding things like, look, this is therapy and medically complex. I realize this is not a very scientific statement, but you see what I'm saying. You know, this type of thing. And also beginning to build around that things like -- and, you know, hospice is a good example of this, looking at patterns that aren't fraud but appear to be abuse.

And so the evolution of thinking is you can't just push down on this rate. You've got to start thinking about the underlying guts and the world that it's operating, and I've seen that kind of evolution as opposed to what you've said where we start something and then we go, Wait a second, stop it. It's more as we've been going forward we've been getting a little more detailed about it.

But I'm going to think about your question directly.

MR. ARMSTRONG: The reason why I ask it is that my

sense is that we are inherently so conservative and that we're cautious and we make recommendations and then we sort of mitigate the potential impact by saying we're going to monitor the impact. I just think if we reflected on that a little bit, it might free us to be a little less conservative about some of these things. But I don't really know that for sure.

MR. HACKBARTH: It's a good question, Scott, and worthy of more thought. My initial reaction to it was, you know, our update recommendations, other than the rebasing, again, they're always incremental, and so you wouldn't expect huge effects.

The area that occurs to me where there was a more significant change was in the case mix change in the hospital where we've moved around a fair amount of money based on recommendations for changing how the weights are derived. And, you know, I don't know if we've looked at, for example, the effect of that on the development of physician-owned specialty hospitals.

Now, there are some confounding factors like the moratorium and the like. In fact, this was an issue that George and I talked about on the phone the other day. So,

you know, that would be an opportunity to look at a significant policy change that we made and what effect did it have in the real world. Did it have the sort of effect that we anticipated or a different one?

So a good question. More thought on that.

DR. BORMAN: I support the recommendations.

MR. GRADISON: I do as well.

DR. CASTELLANOS: So do I.

DR. STUART: I support the recommendations. I do have a question about the rehospitalization, and that is, whether there has been an effort to determine whether this might have unintended consequences for certain patients in the sense that the SNF would have an incentive not to accept patients with a higher risk of rehospitalization independent of what they might be able to do about it. Is this something that you've looked at?

DR. CARTER: No, I haven't, but I understand where your question is coming from. If a patient has something like CHF where those patients typically, if they're not well managed, do get rehospitalized, but, I mean, part of this recommendation -- and at least starting with potentially avoidable, those are in theory conditions that not for every

patient but in general one can manage the care to try to lower rehospitalization.

DR. STUART: I'm less worried about the avoidable hospitalizations than those that might not be avoidable.

DR. CARTER: Well, some of those are not predictable.

DR. STUART: Then the question is whether this policy would make a distinction between rehospitalizations for CHF or COPD or others that might be managed well in a well-run SNF from others over which the facility really has no control

DR. CARTER: Well, and I think that we've left this recommendation general. There's a lot of debate about how you define the measure and whether -- I mean, we've talked about potentially avoidable because those are risk adjusted. Some of the industries think that they like all cause, but they want to throw out or not include things that are scheduled, planned readmissions, like in chemotherapy or something. And so that I think in how you define the measure could maybe address some of your concerns.

DR. MARK MILLER: I would say it's actually, I think, somewhat striking to both Carol and me that we

thought, in part from some of our previous conversations a few years ago, that the industry's general posture would be potentially avoidable. Let's make sure that we define this down to places where there are cases that can be avoided. Remember, this is a rate-based thing, not specific cases. But we've been having conversations with the SNFs on this, and they've come in and had a lot of interesting ideas about how to approach this, and they're not taking a position yet or anything, but some discussion about wanting, some of them, all-cause measures. And just because it means that the effect and the organization is more broad based instead of focused on specific either activities or patients and some argument that that's a more effective way of going at things.

And so I think what Carol and you are trying to do in this conversation right now is leave some flexibility to approach this from a couple of different direction. It was at least somewhat surprising for us that they said those things.

MR. GEORGE MILLER: I support the recommendations.

MS. BEHROOZI: I support the recommendations, particularly because of the -- I think you used the word

"caution," Carol, with which it proceeds. It's not just about protecting those that are providing services that we want them to keep providing them for the patients that do, but, in fact, rewarding them, you know, shifting the balance to make it easier for them to do that and not lose money. And so it's an improvement of access policy, recommendation 1, so I think that's great.

DR. NAYLOR: I support the recommendation, as I chop myself and need a rehospitalization. I was --

[Laughter.]

DR. NAYLOR: But I do want to highlight how building on Peter's comment, you know, the industry, a lot of attention has been paid in the last decade to rehospitalizations focused on hospitals and technical assistance, starting with the QIOs and building through CMS efforts, including CMMI's Partnership for Patients, community-based care transitions, a lot of attention on getting better data, data flow, getting better competencies in the workforce to be able to really manage people in those 24 hours after hospital discharge. So I think if we could stress whatever opportunities might exist to help in this plan to build the technical assistance and support that's

needed.

The second thing, I would totally like the rehospitalization, Slide 18, the policy, and I would also stress the flexibility. I mean, there may be a reason, for example, why I think your data show about 12 percent of the SNF beneficiaries have a length of stay 0 to 5 days. Now, I don't know how many of them are going back to the hospital, but there might be a reason why something that happens within 0 to 3 days is the hospital's accountability, not the SNF's, or something in 24 hours. So the notion of flexibility in this policy as we monitor what is actually the experience of people and who should be accountable might be important to include.

MR. KUHN: I support the recommendations, and like many others, I'm particularly appreciative of the work on the rehospitalization. I think better alignment, particularly in the post-acute care provider setting, is going to be very critical in order to be successful across the board here.

In particular, I know in the draft chapter and I think in a chart that was distributed at the last meeting, where you looked at state by state in terms of the great

variation out there, there is remarkable variation around the country; and I think anything we can do to get some better alignment and move that forward will be great.

Then speaking of the chart that you have up here on page 18 slide, I think that's a very good chart to show about the shared risk. But in the chapter you have another horizontal bar on there that talks about home health, so that if a person is discharged from the SNF into home health, and, you know, maybe for future conversation we may want to think about rehospitalization policies for home health in the future as we think about that. And I think that's a nice set-up in this chapter. Maybe that was by design, but I think this would be the next part in terms of making sure all post-acute care settings are pulling in the same direction as we look at this policy.

DR. MARK MILLER: And that is the thinking, and we just simplified the chart to make the SNF-hospital point here. But the more complex one is there, and that is what we'll be back to you eventually to talk about.

DR. BERENSON: I support the recommendations. I would reiterate that I am a big supporter of recommendation 2 to try to figure out how to provide incentives for SNFs to

address -- to reduce rehospitalizations not only for the SNF patients but, as we talked about at the last meeting, as developing some skills that would apply more broadly to their larger nursing home population.

To Bruce's issue, it's not clear that -- depending on how this is constructed, the nursing home might still be better off accepting a penalty on a high readmission and not forgo the patient. And so the details of how this is constructed and all need to be flexible. We can't be overspecific here.

I like very much the idea that we will align the incentives of the nursing home and the hospital while separately there will be experiments in bundling the payment, that actually bundling the payment is much more complicated and involves other design features than simply aligning incentives. So it will be nice to know which turns out -- whether we can be successful with this kind of parallel strategy as opposed to the bundled payment, which also deserves good testing.

So I'm all in favor. This has been very good, and I think we're in a good place. Thank you.

MR. HACKBARTH: Okay, Carol, would you put up the

first recommendation? All in favor of recommendation 1, please raise your hand.

Okay. All opposed to recommendation 1?

Abstentions?

Okay. Recommendation 2, please. All in favor of number 2?

Opposed?

Abstentions?

Okay. Number 3.

[Comment off microphone.]

MR. HACKBARTH: Oh, that's right. That's right.

DR. NAYLOR: [off microphone] You're on a roll.

MR. HACKBARTH: Yeah, right. I'm trying to make up for the fact that I didn't ask for a vote --

[Laughter.]

DR. MARK MILLER: [off microphone] You okay, everybody?

MR. HACKBARTH: Well, I'll leave others to judge whether I'm okay or not, but thank you, Carol. Good job.

Okay. So where are we here? This is MedPAC, isn't it? Inpatient rehab facility services.

MS. AGUIAR: Thank you. Our analysis was

presented in detail in December and the Commissioners have a paper with the details of the analysis in their mailing materials. During today's session, I will briefly review the analysis and the draft recommendations.

First, to address Commissioner questions from December. George, you asked for a map with the distribution of IRFs and that is included in the mailing materials.

Herb asked for more information on studies comparing outcomes for hip and knee patients across post-acute care settings. In general, research studies do not conclusively identify one setting as having better outcomes for rehabilitation patients.

Peter asked for more information on the differences in case mix between hospital-based and freestanding IRFs and tables showing the top ten cases and distribution of cases by tier are included in the mailing materials. In general, hospital-based and freestanding IRFs have relatively similar patient populations.

As a reminder, this slide presents some key characteristics of IRFs. The details of these characteristics are included in your mailing materials.

As a quick reminder, we use the same framework for

payment adequacy as the other sectors.

We will begin with access to care measures and supply. In 2010, there were close to 1,180 IRFs with at least one IRF located in every State. Changes in supply in 2010 vary by IRF category, but the overall picture suggests that supply is adequate.

The number of rehabilitation beds and occupancy rates are measures of IRF capacity. As you can see on the top half of this slide, in 2010, there was a decrease of hospital-based IRF beds and an increase in freestanding IRF beds. As you can see on the bottom half of the slide, occupancy rates in 2010 were higher for freestanding IRFs than for hospital-based IRFs. However, total industry occupancy rates remains above 62 percent. Overall, both the number of beds and occupancy rates indicate the IRF capacity is adequate to handle current demand.

This chart presents our measures of volume and fee-for-service spending. As you can see, IRF volume remained relatively stable in 2010. Fee-for-service spending increased by close to five percent, and payment per case increased by three percent. This spending increase is likely due to a 2.25 percent update to the base rates in

2010, an increase in outlier payments, and an increase in patient severity.

Turning now to quality of care, we worked with researchers at RAND to develop preliminary risk adjustment models. As you can see, there was incremental improvement between 2004 and 2009 across five quality indicators. However, as you can see on the last row of the final two columns, more than nine percent of IRF patients that were initially discharged home were subsequently readmitted to the hospital, and almost three percent of IRF patients that were initially discharged home were admitted to a SNF. These represent areas for improvement in IRF quality of care.

Turning to access of capital, hospital-based units have access to capital through their parent institution and their access to capital appears adequate. In addition, although the cost of accessing the debt and equity markets increased in 2011 for one major national chain of freestanding IRFs, this chain is still able to access the capital markets because of positive revenue growth.

In terms of Medicare margins, as you can see, margins increased from 8.4 percent in 2009 to 8.8 percent in

2010. There is also a relationship between volume and margins, with margins increasing as bed size increases. Margins vary substantially between freestanding and hospital-based IRFs. Freestanding IRFs, which account for almost 42 percent of total IRF spending, had over 21 percent margins in 2010. In comparison, hospital-based IRFs, which account for 58 percent of total IRF spending, had lower margins of negative 0.2 percent.

It is likely the hospital-based IRFs have lower margins because they tend to have lower occupancy rates, as we saw on Slide 4, and have lower volume and higher costs. More than half of hospital-based IRFs have less than 21 beds, and as we saw on the previous slide, margins for IRFs with fewer than 21 beds are negative. Hospital-based IRFs also have higher direct, indirect, and standardized costs per case than freestanding IRFs. However, even though hospital-based IRFs have negative Medicare margins, on average, they have margins of 34 percent on their direct costs. We also see that margins for acute hospitals with an IRF unit are 1.6 percentage points higher than acute hospitals without an IRF unit. Therefore, we see that IRF units are able to cover their direct costs and financially

contribute to their parent hospital.

As we discussed, aggregate Medicare margins for IRFs in 2010 were 8.8 percent. To project the aggregate Medicare margin for 2012, we modeled the policy changes indicated on the slide for 2011 and 2012. We estimate that Medicare margins for 2012 will be eight percent.

In summary, our indicators of Medicare payment adequacy for IRFs are positive. Supply and capacity are stable and adequate to meet demand, and volume is relatively stable. Preliminary risk-adjusted quality of care estimates indicate that quality incrementally improved since 2004 and that there are still areas for quality improvement. In addition, access to credit appears adequate for both hospital-based and freestanding IRFs. Finally, we project that 2012 aggregate Medicare margins will be about eight percent.

The draft recommendation for your review is, the Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2013. On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the payment in 2013. We estimate that

this recommendation would decrease Federal program spending relative to current law by between $50 million and $250 million in 2013 and by less than $1 billion over five years. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressure on some providers, but overall, a minimal effect on providers' willingness and ability to care for Medicare beneficiaries is expected.

This concludes the presentation and Craig and I welcome your questions.

MR. HACKBARTH: Thanks, Christine.

George, why don't you lead off this time.

MR. GEORGE MILLER: [Off microphone.] First of all, I support the recommendation.

MR. HACKBARTH: Microphone.

MR. GEORGE MILLER: I support the recommendation. But in the chapter, could you spend a little bit of time, and you did an excellent job in the chapter differentiating between freestanding and hospital-based, but I was struck by where there's a difference in pattern of different reasons for patients being in the hospital. Could you draw any conclusions, or could you expound on that analysis? One

was, for example, in the chapter, stroke patients were more likely to be in a hospital basis much more than in a freestanding, and the neurological patients were more apt to be in a freestanding than in a hospital. I'm just curious why that difference.

MS. AGUIAR: Right. So I think you're referring to the Table 7 --

MR. GEORGE MILLER: Yes.

MS. AGUIAR: -- that has the distribution --

MR. GEORGE MILLER: Yes.

MS. AGUIAR: You know, we have to still look more into that. Unfortunately, we don't know exactly why it is the differential. I mean, it could have to do with referral sources. But, again, we're not sure, and that is something that we've been thinking to look more into, to try to understand -- and again, that study did not include that table on the slide, so for those who are not familiar with it --

MR. GEORGE MILLER: Right. Yes. It's in the chapter.

MS. AGUIAR: As that said, the sort of main take-away from that was that the top ten diagnoses are the same

for both hospital-based and freestanding IRFs.

MR. GEORGE MILLER: Right.

MS. AGUIAR: Five of those ten are not conditions that count towards the threshold --

MR. GEORGE MILLER: Right.

MS. AGUIAR: -- the compliance threshold. But again, that there were some differences, and like you said, stroke was one of them --

MR. GEORGE MILLER: Yes.

MS. AGUIAR: -- with hospital-based having about 22 percent of their patients with stroke and freestanding it's about 16 percent.

MR. GEORGE MILLER: Yes.

MS. AGUIAR: So, I mean, in short, that is something that we need to find out more about.

MR. GEORGE MILLER: Thank you.

DR. STUART: Actually, I have a similar question regarding the differences between freestanding and hospital-based. I'm familiar with one system that purchased one of these facilities that had been freestanding. Now, is that now hospital-based or is it continuing to be freestanding? In other words, does hospital-based mean a financial

relationship with a hospital or does it mean a physical relationship with a hospital?

MR. LISK: I don't know what the specific facility you're talking about would be, so it might depend upon how the financial arrangement is made. I mean, usually, these facilities are part of the hospital, but there could be a financial relationship where it's not exactly attached to the facility, too, where it could be considered hospital-based in some circumstances. So it depends upon kind of both things. I'm not sure what actually happened in the transaction there that you're talking about.

DR. STUART: Yes. Well, I guess this actually cuts across not just this particular segment, but other segments, as well, and I guess I just leave that as a question without asking for an answer now to the extent that it might have an implication for other providers.

DR. CASTELLANOS: First of all, I support the recommendations. Could you show Chart 8, please, or page eight? Again, you explained it, but that's such a big swing among the margins, from minus-two percent and minus-zero-point-two percent to 21.4 percent. That's a -- you mentioned something about size of hospital beds, they're a

little smaller than units, but that really seems high.

MS. AGUIAR: Sure. So I'll try to go into a little bit more detail, and again, we did have more in the December presentation. I apologize for not having included that here.

The reason that we think may account for some of the differences is really one of the issues is on economies of scale. Freestanding IRFs, I believe about 50 percent of them have 22 or more beds. As you can see when you look at bed size, those 22-plus tend to have positive margins, whereas hospital-based IRFs, I believe it's about -- I think it's half of them -- and so, yes, more than half of hospital-based IRFs have less than 21 beds, and as you can see, they tend to have negative margins. So there is an economies of scale at play, as well. We think, also, as on Slide 4, hospital-based IRFs also tend to have lower occupancy rates, as well.

So we subsequently did an analysis which is included in the paper, but again, I apologize, not in the presentation, trying to look at the differences in direct cost per case and direct cost per case. And just to throw some numbers out for you, hospital-based IRFs have about 30

percent higher direct cost per case than freestanding IRFs, almost 11 percent higher indirect costs per case than freestanding IRFs. And freestanding, their standardized costs per case are about 24 percent lower. So we think it's a mix of economies of scale due to low volume, higher costs, direct and indirect costs and costs per case, standardized costs per case, but then also lower occupancy rates. So that's sort of our hypothesis about why that is.

MR. LISK: There's also one other factor on the freestanding, too, is there is a kind of, you might say, a corporate efficiency, as half of the freestanding are in one chain. So there may be a corporate efficiency in terms of broad scale efficiency that's gathered there because that group has a higher margin than the other freestanding -- all of the freestandings have higher margins, but there's that that may come into play, too.

DR. CASTELLANOS: It's just a big swing, that's all.

MR. GRADISON: I'm in support of the recommendation.

DR. BORMAN: I support the recommendation.

MR. ARMSTRONG: Yes, same. My questions have been

answered.

DR. BAICKER: I support the recommendation.

MS. UCCELLO: Me, too.

MR. BUTLER: So one observation is we're midway through our three-facility post-acute facility provider -- that I'd support the recommendation, but it's a reminder of in truly an ACO world, all this stuff would be rationalized. These more expensive IRFs which we think are doing a pretty good job and we've got this 60 percent threshold and all these, it would take care of itself if we were managing in an ACO world and putting them all in the right place at the right time.

DR. CHERNEW: I also support the recommendation, and in the spirit of what Peter said, thinking about these in terms of cohorts of patients, because some of them are getting cared for in different places is much more productive than cutting them up the way we cut them up here, but that said, since we have to do it, I support the recommendation.

DR. DEAN: I support the recommendations, and I would agree entirely with what Peter just said, that if we had a more sensitive way to get people to the services they

really need, I suspect we would do a much better job.

DR. HALL: I support the recommendation.

DR. BERENSON: And I support the recommendation.

MR. HACKBARTH: I'm waiting for a piece of information here. Actually, we can go ahead and vote while we wait for that.

DR. CASTELLANOS: [Off microphone.] You've got these people down here --

MR. HACKBARTH: Oh, right.

[Laughter.]

[Discussion off microphone.]

MR. HACKBARTH: Yes, right. Right. If I had a gavel, I'd be giving it to Bob at this point.

[Laughter.]

MR. HACKBARTH: Herb.

MR. KUHN: I support the recommendation.

MR. HACKBARTH: Mary.

DR. NAYLOR: One question. I support the recommendation. Have we as a Commission, because I know you mentioned in the report the emphasis we want to place on pay-for-performance versus pay-for-reporting, and have we ever made a recommendation directly related to moving from

P4R to P4P?

MS. AGUIAR: To my knowledge, no, and I'm just looking because there were things that happened before I started working here, so no --

DR. MARK MILLER: Do you mean for this sector or more broadly?

DR. NAYLOR: For this sector.

DR. MARK MILLER: For this sector, we have not, but we have pursued it in other sectors, and I think what's going on here is we're trying to develop the quality measures --

MS. AGUIAR: Exactly.

DR. MARK MILLER: -- so that we can begin to move in that direction, and I think that's some of the work that you're doing with the RAND folks.

MS. AGUIAR: Yes, exactly.

DR. NAYLOR: Thank you. I support it.

MS. BEHROOZI: I also support with concerns raised by my colleagues over there where I used to sit.

MR. HACKBARTH: Okay.

[Laughter.]

MR. HACKBARTH: So one of the issues that came up

at the December meeting, I think it was Bruce that raised it, and that is wouldn't it be good to have an introduction to the post-acute providers that talks about -- puts the whole post-acute sector in context and the fact that often they're treating the same patients in different facilities at different rates and we need to move towards a more integrated approach to post-acute care. And so we are planning to include something along those lines in the report. And we did that, I think it was -- was it two years ago we had that kind of a prelude to the post-acute? It might have been three, but we'll do something similar again this year.

Okay. Now, I think we're ready to vote, right? So on the recommendation that's on the screen, all in favor, please raise your hand.

Opposed?

Abstentions? Are you stretching, Bill, or are you --

DR. HALL: [Off microphone.] No, no. Aggressively voting.

MR. HACKBARTH: Aggressively voting yes? Okay.

And abstentions? No hands? Okay.

Thank you very much. I appreciate it, Christine and Craig.

So next, Dana is going to present on long-term care hospital services, and this will be the last of the update recommendations.

MS. KELLEY: Last month, we discussed in detail our update analysis and the Chairman's draft recommendation for long-term care hospitals, and you have the chapter and the recommendation in your mailing materials. So today, I'll review our findings on payment adequacy for LTCHs and then you'll vote on the draft recommendation.

You'll recall, of course, that LTCHs furnish care to patients with clinically complex problems who need hospital-level care for extended periods. In 2010, about 118,000 Medicare beneficiaries had almost 135,000 LTCH stays. Medicare spent $5.2 billion on this care. About 412 LTCHs filed Medicare cost reports in 2010, and Medicare's payments to LTCHs are made on a per discharge basis based on the MS-LTC-DRGs, which are the same groups that are used in the acute care hospital PPS but with weights that are specific to LTCHs.

Before I go on with the update summary, I wanted

to answer a few questions that were raised last month. First, Mary, you asked about the use of hospice care following discharge from an LTCH. In 2010, 3.3 percent of LTCH discharges were directly to hospice care, and about 60 percent of those discharges were to hospice facilities as opposed to hospice within a home setting. What we don't know is how many LTCH patients who are discharged to other post-acute care facilities eventually are discharged to hospice and that's something we might be able to answer in the future with some linked -- analysis of claims that are linked together to see an entire episode of care.

Herb, you asked whether the LTCH quality measures to be collected in the forthcoming pay-for-reporting program will be available online on Hospital Compare. Under PPACA, the Secretary is required to establish procedures for making the measures available to the public and CMS is currently developing procedures that will allow LTCHs an opportunity to review the information before it is posted online.

Glenn, who's not here, asked about the effect, if any, of LTCHs on SNF margins in an area, and in her work on SNF margins, Carol found little relationship between the presence of an LTCH in a county and a SNF's margins.

Bill Hall and Mary, again, you asked what we know about LTCH outcomes and how they compare with those for medically complex patients in other settings. I've included a text box in the chapter that summarizes recent studies on the issue, and generally speaking, researchers have been unable to clearly distinguish LTCH patients from the medically complex patients that are served in other settings, acute-care hospitals and some SNFs. As we discussed last time, I think lack of assessment data does limit what can be said about outcomes, but in several analyses performed for CMS, RTI has shown that outcomes that can be measured for medically complex beneficiaries who receive care in LTCHs are comparable to those for similar patients who don't have an LTCH stay.

And finally, Tom, you asked about the distribution of length of stay in LTCHs, and you can see here that there is a long tail of the distribution showing that some cases really are quite lengthy. The mean length of stay over -- this is for all MS-LTC-DRGs combined, as you can see up top there. The mean length of stay is 27 days and the median is 24.

So turning now to our update framework, our first

consideration, as you know, is access to care. We have no direct indicators of beneficiaries' access to LTCH services, so we focus on changes in capacity and use. But it's important to keep in mind with this service, in particular, that the product here is not very well defined. There are no established criteria for an admission to an LTCH, so it's not clear when patients treated there require that level of care. And remember, too, that many Medicare beneficiaries live in areas without LTCHs and so receive similar services in other facilities.

To gauge access to services, we first looked at available capacity. This slide shows the number of LTCHs nationwide. A moratorium on new LTCHs has slowed the growth in facilities. There was a net increase of one LTCH between 2009 and 2010. The line representing the number of LTCH beds looks very similar to this one, so we're seeing the same pattern there. Between 2009 and 2010, the number of beds remained steady, as well.

And looking at growth in the number of cases per 10,000 fee-for-service beneficiaries, we see an increase of 3.5 percent between 2009 and 2010. So taken together, these trends suggest to us that access to care has been maintained

during the period.

Turning now to quality, as you know, LTCHs don't submit quality data to CMS, so we rely on claims data to examine trends and in-facility mortality, mortality within 30 days of discharge, and readmission to acute care, and we use these to assess more high-level changes in quality of care in LTCHs. In 2010, these rates were stable or declining for most of the top ten diagnoses, or most of the top diagnoses, rather.

And, of course, we've long been concerned about this lack of quality data in LTCHs, and you'll recall that last year, we convened a panel, an expert panel, to elicit information on how best to measure LTCH quality. As I mentioned, CMS is implementing an LTCH pay-for-reporting program beginning October 2013 with data collection beginning October 2012.

We also look at facilities' access to capital. The moratorium, of course, limited opportunities for expansion, but in 2010, the two largest LTCH chains, which together own slightly more than half of all LTCHs, acquired other LTCHs and other post-acute care providers. According to the chains' filings with the SEC, they have access to

revolving credit that they've tapped to finance these acquisitions. These two LTCH companies are increasingly diversified both horizontally and vertically, which may improve their ability to control costs and better position the companies for payment policy changes. But smaller chains and nonprofits probably do not have the same level of access to capital.

As you can see in the top row here, the aggregate Medicare margin for 2010 was 6.4 percent. There's wide spread in the margin, similar to what you've seen in other settings, with a quarter of LTCHs having 2010 margins of minus-2.9 percent or less and another quarter having margins that are 14.6 percent or more.

For purposes of projecting 2012 margins, we modeled a number of policy changes. We included updates in 2011 and 2012 and also, of course, the PPACA mandated reductions. This resulted in an update of minus-half-a-percent in 2011 and an increase of 1.8 percent in 2012.

Altogether, we estimate that the effects will result in somewhat slower growth in provider payments relative to costs over the next year, so we've projected a margin of 4.8 percent in 2012, assuming providers' costs go

up at projected market basket levels.

Before I put up the draft recommendation, I'll just remind you of some policy changes that are expected in fiscal year 2013 that will have an impact on both LTCH payments and provider behavior. We'll see changes in the 25 percent rule and the short-stay outlier policy and the moratorium on new LTCHs will end. These are discussed in full in your paper, but I can take any questions that you might have about that.

We make our recommendation to the Secretary because there's no legislated update to the LTCH PPS. The draft recommendation reads, the Secretary should eliminate the update to payment rates for long-term care hospitals for fiscal year 2013. CMS historically has used the market basket as a starting point for establishing updates to LTCH payments, so eliminating the update for 2013 will produce savings relative to a market basket, even assuming the PPACA mandated reductions. We don't anticipate any adverse impact on beneficiaries or on providers' willingness to care for beneficiaries.

So with that, I will turn it over to you.

MR. HACKBARTH: So when the Secretary has

discretion on the update, what is the baseline that we use for determining savings?

DR. MARK MILLER: Market basket.

MS. KELLEY: Market basket.

MR. HACKBARTH: Okay. Cori, you're starting this time, please.

MS. UCCELLO: I support the recommendation.

MR. HACKBARTH: Kate.

DR. BAICKER: As do I.

DR. BORMAN: I'm fine.

MR. GRADISON: [Off microphone.] As I.

DR. CASTELLANOS: Same here.

[Members around table shaking heads.]

MR. HACKBARTH: Herb.

MR. KUHN: I support the recommendation, but I'd like to come back to Glenn's question because I had the same thought in my mind as you were putting the information up there. So the Secretary has complete discretion on the update, so in the CBO OMB baseline, they use just regular market basket to move each and every year accordingly. Okay. Thank you.

DR. BERENSON: I support the recommendation.

DR. HALL: I support the recommendation.

DR. DEAN: I support the recommendation. I think we're still struggling to figure out where does this model fit within the overall scope of things, and I think -- I would hope that gradually some of these changes, we will begin to get the information that will help us to answer that question.

MR. HACKBARTH: Mike. Peter.

MR. BUTLER: Support, but this is our last update, right?

MR. HACKBARTH: Yes.

MR. BUTLER: So collectively, how much have we contributed off the baseline here? It's also an interesting question to -- we never kind of revisit that --

MR. HACKBARTH: Yes.

MR. BUTLER: -- in terms of what the law says versus what damage we've done.

DR. MARK MILLER: And we could do -- I don't happen to have that accumulated across them. And remember, as an institution or a Commission, we don't say that. We do this whole bucket approach because CBO in the end does kind of the final statement to the Hill as to how much all this

stuff saves. So we go through this process of estimating ranges because we aren't in the estimation business. We could put together a back-of-the-envelope and let you guys know in general what happens across these updates, but I don't happen to have it on me.

MR. HACKBARTH: Okay. The draft recommendation is on the screen,. It's time for our vote. All in favor of the recommendation, please raise your hand.

Opposed to the recommendation?

Abstentions?

Okay. Thank you, Dana.

MR. HACKBARTH: So our next discussion is on encouraging the use of lower-cost medications by beneficiaries in the LIS program.

MS. SUZUKI: Good afternoon. Last year, we spent several meetings discussing the issues related to the different patterns of drug use we've observed for beneficiaries receiving the low-income subsidy compared to those who don't. In this session, I'll briefly review some of the key points from the previous presentations and present a draft recommendation to increase the use of generics by LIS beneficiaries. Additional detail on this

issue was included with your mailing material.

As you recall from the previous sessions, there are some notable differences in drug use patterns for Part D enrollees who receive the LIS compared to those who don't. Specifically, we found that: LIS enrollees tend to fill more prescriptions, and the cost of each prescription was higher, on average, compared to non-LIS enrollees; and we also found that the use of more brand name medications by LIS enrollees was contributing to the higher per prescription cost for this population.

We also discussed how we might change the LIS cost-sharing structure to encourage the use of lower-cost medications, when clinically appropriate, through generic substitution and therapeutic substitution, which involves switching to a different drug in the same therapeutic class.

Generic drugs cost significantly less than their brand counterparts, so a policy that encourages generic substitution has the potential to reduce Part D's program spending without limiting access to medications. A switch to lower-cost drugs can also reduce what beneficiaries pay out-of-pocket.

In the example we gave in December, which I'll

come back to in a minute, the generic co-pay was lowered to widen the spread between brand and generic drugs. Under that scenario, in addition to those who switch from brand to generic drugs, beneficiaries who are already on generic medications would also see a drop in their out-of-pocket costs. Studies have shown that lower costs can improve adherence to their medication therapy.

Here are the two key features of the policy we discussed in December:

First, the policy would modify co-pays for LIS beneficiaries to encourage the use of lower-cost drugs when available in a given therapeutic class. Many plan sponsors already use tiered cost sharing for their non-LIS enrollees to encourage the use of lower-cost drugs. But for their LIS enrollees, plans have limited ability to do this because the co-pays are set by law, and the amounts in the statute provides weaker financial incentives to choose the lower-cost drugs compared to the incentives faced by non-LIS enrollees.

So the policy would change the co-pays for LIS enrollees to increase the spread between generic and brand name drugs so that generic drugs become relatively more

attractive. Depending on the drug class, this policy could increase generic substitution or, in some cases, increase both generic and therapeutic substitution.

The policy would not apply to classes with no generic substitutes, meaning that the cost-sharing amounts for brand name drugs in classes with no generic substitutes would remain unchanged. This is because we wanted to ensure that beneficiaries continue to have access to medications they need.

The policy would only apply to those LIS beneficiaries currently subject to co-pays, so it would not apply to dual eligibles residing in institutions, where in many cases beneficiaries are not the ones making the decisions about the choice of brand versus generic drugs.

The second key feature of the policy is that the Secretary would review the therapeutic classes to determine the appropriate classifications for the policy. The Secretary could define a drug class broadly or narrowly depending on the appropriateness of therapeutic substitution, and the Secretary may exclude certain classes for clinical reasons.

There's been some concerns raised about this

policy, so I wanted to explicitly review protections that would be in place under the policy.

First, the draft recommendation directs the Congress to provide broad authority and flexibility to the Secretary to determine appropriate therapeutic classifications for the policy. As I mentioned on the previous slide, this would allow the Secretary to: define a class narrowly or broadly, depending on the clinical appropriateness of therapeutic substitution, and exclude certain classes of drugs from the policy.

Our intent here is to encourage substitution only when it is clinically appropriate. However, for some classes, therapeutic or generic substitution may not be clinically appropriate for all individuals.

We would maintain the current exceptions and appeals process under the policy to ensure those individuals have access to the brand name drugs when clinical reasons prevent them from substituting to a lower-cost medication in the same therapeutic class. In the future, we plan to monitor this process to ensure that beneficiaries continue to have access to medications they need.

Finally, the same out-of-pocket limit will

continue to apply. As you recall, Part D is structured to limit the out-of-pocket spending for beneficiaries who incur very high drug spending. For these LIS beneficiaries, that means that once they reach the catastrophic phase of the benefit, they no longer pay cost sharing for their medications.

Here is an example that should look familiar to all of you. This illustrates how one might change the co-pays to make generic drugs relatively more attractive. The example shows co-pays under current law and under the policy for LIS enrollees with incomes at or below 100 percent of poverty. Currently these LIS enrollees pay a little over $1 for generics and $3.30 for all brand name drugs.

Instead of this $1/$3, we eliminate the cost sharing for generic drugs and increase the cost-sharing amounts to $6 for brand name drugs when there are generics. This is shown in red.

For brand name drugs in classes with no generic substitutes, cost-sharing amounts would not change so that beneficiaries would have the same access to those drugs as under current law.

There are many ways to do this. For example, many

plans have separate non-preferred tiers for generic and/or brand name drugs. For those plans, the Secretary may want to allow some flexibility in setting the co-pays for LIS enrollees to encourage the use of drugs that are placed on preferred tiers.

Here's the draft recommendation. It reads: The Congress should modify the LIS Part D co-payments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs when available in selected therapeutic classes. The Congress should direct the Secretary to develop a co-pay structure giving special consideration to eliminating the cost sharing for generic drugs. The Congress should also direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years.

We expect this policy to decrease Medicare spending relative to current law. For beneficiaries, on the one hand, a lower generic co-pay could lower beneficiaries' out-of-pocket costs and increase access to medications. On the other hand, a higher brand co-pay could negatively

affect access if beneficiaries aren't able to effectively use the exceptions and appeals process to obtain the medications they need.

Some plan sponsors may experience a decrease in the costs of providing the benefit, which would tend to lower the premiums for all beneficiaries and the subsidy payments Medicare makes to Part D plans.

Finally, some pharmacies may experience an increase in profits from dispensing more generic drugs.

So, with that, I'll turn it over to you.

MR. HACKBARTH: Thank you, Shinobu.

DR. STUART: Thank you. I had some additional suggested language on this draft recommendation, and part of it comes about because the chapter actually does not include the graphic that you had a couple pages earlier about the changes that might include both not just a zero co-pay for generics but also higher co-pays for preferred and non-preferred drugs. And that's not reflected in the -- that language is not reflected in the recommendation, and so I thought just to be honest about this, we really should say that we're giving the Secretary the authority to recommend or to increase co-pays for these selected therapeutic

categories for brand drugs.

My own thinking on this is that if the only effect of this was to reduce the generic co-pay to zero, that could very well increase total cost rather than decrease total cost. I really think that you need both the carrot of lower cost for the generic side as well as the potential stick of higher costs on the brand side, recognizing, as we all do, that you have to be very careful in terms of targeting this. That would be the other part, is to make sure that that's really ironclad, not just in terms of the recommendation but in the language in the chapter as well.

MR. HACKBARTH: So, Bruce, your comments suggest two possible paths. One is to amend the language of the recommendation. A second would be to change the text to incorporate the table, whatever slide that is. Shinobu, could you put up the slide that has the table with the example of the different -- yes. So we could put this back into the text and explain, leave the recommendation language the same.

DR. STUART: That would be my recommendation.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: I support the recommendation.

MS. BEHROOZI: I share Bruce's concern, so I support -- I actually support the recommendation as written, but, Shinobu, would you mind turning to Slide 7 where you discuss the implications? Because I guess that maybe shows up a little more boldly than the rest of the text. I feel like the second sentence in the first bullet, "A higher brand co-pay could negatively" -- I feel like that's a little too cautious because we're already giving -- we want the Secretary to have the authority to decide in which classes any of these rules should apply and then to say, "A higher brand co-pay could negatively affect" if they can't "effectively use the exceptions," well, what does that mean, if they can't get an exception anytime they wanted? You know, I think by saying that the Secretary should decide the appropriate drug classes first, that we're being quite cautious. We're saying that the exceptions and appeals process should stay in place. But I think there's really -- this is one of those things we know a lot about already, as we were talking about earlier, and all the evidence that you cite of what private plans do, that there's still suspicion and whatever distrust of generics over brands, but we really do know a lot clinically -- not me, but, you know,

clinicians know a lot about the fact that you don't really need the brand when the generic is exactly the same. So I feel like the way that second sentence reads, it kind of undermines too much, you know, what Bruce said, that the Secretary really ought to have the ability to set a co-pay structure that maximally encourages generic utilization, and we wanted to emphasize the zero, but I think we shouldn't sort of de-emphasize or take away the ability to add additional cost if she finds it appropriate.

DR. MARK MILLER: Well, you're looking at me, right? Yeah, I knew it.

I made this more cautious because, you know, there were people who commented after the last session saying that we weren't being enough -- and I see your point, and I agree, and I think there are -- we've designed the policy to have safeguards. But I asked them to amp up the concern a little bit, and so we'll go back to the other way.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: So I just want you to know I was responsible for that notching up.

[Laughter.]

MR. HACKBARTH: Mitra, since this isn't in the

formal recommendation, if you want to suggest language, that would be welcome.

DR. NAYLOR: I support the recommendation.

MR. KUHN: I support the recommendation.

DR. BERENSON: I support the recommendation.

DR. HALL: Support.

DR. DEAN: A question. The statement that there should be no change in cost-sharing amounts for drugs in a class with no generic substitutes, does that mean that for a preferred brand drug it would stay at $3.30? Is that what it would be?

MS. SUZUKI: Yes.

DR. DEAN: Okay. And a broader comment that really isn't addressed here, I think this is partly a beneficiary issue, but it's also a prescriber issue. And I think some of this, the use brand name drugs really relates to what the prescribers choose and what they tell their patients. And it would seem that we're very limited in terms of the amount of leverage we have in terms of how much we can adjust these co-pays given the population that we're dealing with. And I guess the thing that occurs to me -- and I don't exactly know how to merge it in with this, but

some kind of requirement for, say, a step care approach or, for instance, in the statin family, you know, there's a couple of very widely known drugs that everybody knows about and there are some lesser-known ones that are every bit as effective and have just as much science behind them and sell for, you know, a quarter or a fifth as much. We need in those selected situations to somehow develop policies that would encourage that use. And that probably is a prescriber issue, not a beneficiary issue.

MS. SUZUKI: So I guess we're trying to balance a plan's -- plans have the ability to use step therapy and other prior auth. or other tools to manage the use. They apply that to both LIS and non-LIS equally. One place where we saw the difference was in maybe the financial incentives that they face, and part of it is that plans create their formulary structure individually. So how much you want the Secretary to determine versus plans making decisions about how to structure and how to encourage use of lower-cost drugs -- we were trying to add a little bit more leverage by increasing the spread between generics and drugs, and maybe that would prompt beneficiaries themselves to ask about maybe cheaper alternatives, which we've seen happen for the

non-LIS population, especially when they hit the doughnut hole.

DR. DEAN: I support the recommendation and the direction we've gone. I'm just saying that -- and maybe what you've just said answers my concern, that maybe the incentive is there for the plans to put these things in place rather than Medicare. If that's the case, then maybe we don't need to worry about it.

DR. CHERNEW: Yeah, I'm sorry for being a little confused in that the recommendation is relatively vague with broad authority the way the recommendation is written, but some of the discussion and some of the implications, we're assuming something that seemed a little bit different. Like the recommendation really was just the Secretary having the authority to develop a co-pay structure with consideration for eliminating the cost sharing for generic drugs, but it doesn't say a lot about the increasing part -- although they would have the authority there, but the implications seem to flow a little bit from that. And so it's hard -- which is the comment that --

MR. HACKBARTH: [off microphone] That was Bruce's.

DR. CHERNEW: Right. And I think that it's

important to think through what that is. My general sense is, although I'm supportive of the recommendation as written, one of the things that's not in this whole process is something that was analogous to the discussion we were having when we were talking about the outpatient department E&M codes, which is some process to measure the impact. So depending on how the co-pay structure -- if you're just lowering generics, that's -- you know, I don't have a problem with that one. When you start raising branded, which I think you can make a rationale to do, but a lot of complicated things happen when you do that because a lot of times people don't substitute the way they want. Remember, we're talking about people switching drugs most of the time in a therapeutic class, but still switching drugs. A lot of people may drop. I'm a little skeptical of this population, for example, using the appeals process for a whole bunch of reasons. So I think some monitoring about what's happening to adherence in some of these areas, particularly the chronic care areas and other areas, I think would be very important if you were going to start having a more aggressive interpretation of our recommendation than the text of the recommendation actually implies.

DR. MARK MILLER: So I think, you know, just to draw a couple of points together, some of the comments and concerns that you see that we built in there derive from this kind of perspective. You obviously have tracked very carefully on the fact that the implications that we've put in here sort of presume the policy more in the chart that we put up than the language.

DR. CHERNEW: [off microphone] Right.

DR. MARK MILLER: But I just want you to understand why the language is a little bit more open-ended, is because we don't know whether it's, you know, $0 and $6 or $0 and $5.50. You know, we didn't want to start writing numbers in. And in this area, there is still some feeling around, and we've talked to plans and gotten some sense.

So my question to you, although this is really a Glenn question, would be: Would you be satisfied to make the statement that you made in the text? Or are you calling for something to change in the recommendation? But you have tracked through the thought process correctly.

DR. CHERNEW: So the recommendation right now relatively vaguely says the Secretary shall have the authority to think about a better co-pay structure for drugs

for low-income subsidies, right?

DR. MARK MILLER: [off microphone] And then the table, not --

DR. CHERNEW: Right, but the table is --

DR. MARK MILLER: [off microphone] Illustrative.

DR. CHERNEW: So in terms of the recommendation, I'm a supporter of that. I think there's a lot of improvements one could do to the co-pay structures just in general. That said, as you just pointed out, you don't know what the actual changes are going to be, so it's hard to figure out -- it really has a lot more to do with your trust in the Secretary than it has to do with particular changes that are going on. So I'm fine with the recommendation, and I'm fine with the discussion. I think some concern -- there are things the Secretary could conceivably do that I would have concerns over. We aren't recommending she do them. The recommendation is vague than that.

So I think the easy answer to your question is I am fine with the recommendation. I think the text is reasonable. I did have a concern about the implication part of the stuff was inferring something a little bit more than just what's in the recommendation, and I would be a little

happier one way or another if we had some lip service to the text is fine to having to monitor whatever the changes the Secretary does do, which we don't know what they will be. We should monitor that for utilization changes. And I think at our -- we should caution about assuming that all the substitution patterns work the way that you would think in a perfectly rationale world -- I think it's pretty well known -- Bruce can comment -- that if you take people on a branded medication and raise their co-pays, you might think they would just substitute to the generic equivalent. Many of them just stop taking the medications. And I think depending on the classes that were done, adherence to the medications turns out to be very important.

I would just add, because I like to say these things, the merit of whatever the Secretary does shouldn't be judged based on the cost. The whole point is to balance out the cost with the quality of care. So if it turned out that there was some change like the reduction in generics increased to zero, if that's all they did, and that increased spending, we should not view that as a bad thing. That could be a good thing. Getting people to keep their medications in many of these classes is really our goal if

we can do it in a cost-effective way, and in many cases I think these drugs -- the ones at least I have in the back of my mind -- are very cost-effective ways of treating illness, not necessarily cost savings but at least very cost-effective ways of treating the illnesses, and people should be encouraged to take medications for chronic diseases.

MR. HACKBARTH: I certainly don't disagree with anything that you've said, and I think based on previous discussions, I think your statement reflects a consensus among the Commissioners. What I would suggest is that we include language along those lines in the text discussing the recommendation as opposed to amending the recommendation itself. And that language in the text can also say that we think it's important for the Secretary to monitor the impact of these changes.

I don't want to set the precedent that every time we recommend a change there's a formal recommendation to monitor the effects. I think after awhile that gets a little old. But your points are well taken, and I think they ought to be included in the text.

MR. BUTLER: A question. We dumb this down in our example so that we have this $6 co-pay example, and in

reading the text, it says the high-cost beneficiaries have an average of 111 prescriptions per year and that 83 percent of the LIS people fit into that category, which means to me there may be nine or ten prescriptions -- these are 30-day prescriptions, so they're holding basically nine or ten prescriptions, most of these. So it's really like a $60-a-month -- if they went all to preferred, in the example it's like -- I'm trying to get a sense of what the real financial burden is here for the co-pays, not just on an individual drug but on, you know, the total out-of-pocket. Do you follow me?

DR. MARK MILLER: I think so. Shinobu, if you [off microphone].

MS. SUZUKI: So one thing that we were trying to make clear is that Part D limits the out-of-pocket spending by using true out-of-pocket calculation. So plans track how much you've spent in gross spending, not just your out-of-pocket spending but gross spending, and your actual out-of-pocket spending and see how much it is, and once you hit that limit, then you're in this catastrophic phase where, for these LIS beneficiaries, their cost sharing would be waived once they hit that limit.

For LIS beneficiaries, their cost sharing is right now $103 if you're under 100 percent of poverty, but the LIS subsidy also counts towards these troops. So if they are, for example, taking the $6 drug but that $6 drug turns out that the cost sharing on plan formulary is $80 because it's a non-preferred brand, then the whole $80 plus the $6 counts toward the troop limit. So it gets you to that limit much quicker in some ways, and so relative to someone who takes a lower-cost medication, it's possible that they get to that limit much quicker.

And so I guess you were trying to compare current law versus under the policy if their out-of-pocket amount would be much greater, and our sense is that it's still going to be pretty limited. Even if they take the brand version, that just gets you much quicker to the catastrophic phase. Does that make sense to you?

MR. BUTLER: I understand how you get credit for the $80, and that's a lot towards getting towards your limit, even if you're only paying 6 bucks. I can't do the math to figure out, you know, what is the true -- what are they really going to pay out-of-pocket. That's what I --

MR. HACKBARTH: So Peter gave an example that he

derived from the averages and how many prescriptions these people are taking, or at least a sub-group of the population are taking. Can we answer his question in terms of that example? That person who's taking nine or ten brand name drugs, how quickly are they going to hit the out-of-pocket limit, as you describe it?

MS. SUZUKI: I guess that would depend on the mix of drugs.

DR. MARK MILLER: Right.

MS. SUZUKI: It's a case-by-case sort of calculation, so it's hard to say whether someone who's taking 111 drugs under current law with a different mix of brand and generics gets to the catastrophic limit under the policy more quickly or not, it just depends on how they change their behavior. I mean, we can try to work up an example where it's less under the policy, maybe it's more under the policy in some cases where they change behavior, if that's helpful. But I think it just depends.

MR. HACKBARTH: Bruce, do you have --

DR. STUART: I guess I'm a little confused. The LIS are not subject to the benefit thresholds, so the out-of-pocket limit wouldn't come into play, would it?

MS. SUZUKI: It applies because after their gross spending gets to a certain limit -- so assuming they have no supplemental coverage, they count out-of-pocket, they count the low-income subsidy, and they tally that up to figure out whether they reach the true out-of-pocket limit that's applied to non-LIS people. So say $3,600 per year is the limit. From non-LIS that would be a true out-of-pocket, but for LIS it's the out-of-pocket co-pays plus the subsidy, and you get to that limit. Above that limit you don't pay any cost sharing.

MS. UCCELLO: I'm sorry, but I think the issue here is that after you reach that cap, Medicare is paying for the reinsurance portion of things.

MS. SUZUKI: Mm-hmm.

MS. UCCELLO: And that's why it matters in this case. It seems like -- you know --

MS. SUZUKI: That and --

MS. UCCELLO: It's not necessarily out-of-pocket for the LIS enrollee, but it has financial implications for the program.

MS. SUZUKI: It definitely does have financial implications. It also changes what -- so the law defines

those co-pays, but those co-pays only apply until they hit that catastrophic limit, and that's what I was trying to bring up.

MR. HACKBARTH: I agree that it has implications. The way I understood Peter's question, though, he was focused on the financial impact for these low-income people, and if the brand name co-pay goes up to, say $6 and you're taking nine or ten prescriptions, he's trying to assess the implications of that for their out-of-pocket costs.

DR. MARK MILLER: And I think --

MR. BUTLER: Exactly. And when you just look at, oh, one drug, 6 bucks, what's the big deal, anybody can come up with 72 bucks in a year. But if you're taking ten of these, is it -- and that's just an example, anyway. It's not even the recommendation. It says the discretion, the Secretary is going to do it. But it's a little bit like this morning. You get in these numbers, and suddenly you multiply them together, and it might be -- I just want to make sure it's not as big a financial burden as we're -- our portrayal of it is an understatement of what the real financial burden might be.

MS. BEHROOZI: But, you know, it's about driving

behavior. The idea is to get people to take the same effectiveness drug -- and it's only for those cases where it's the same effectiveness -- for free. So now they could be paying $33 a month for the ten brand name drugs, but then they could be going to zero, getting the same effectiveness, because they would be helped to make that choice. Only same clinical effectiveness for that patient, I want to [off microphone].

DR. CHERNEW: But I think the thing is it's actually not written for only the same clinical effectiveness, because it's all done within a therapeutic class. And within a therapeutic class, particularly for some of these, like some of the mental health drugs, the effectiveness of drugs in a class could be very different. So you could see an implementation of this that it isn't substituting branded Drug X for the generic version of X. It's substituting branded Drug Y for a generic version of Drug X in that class, and that in many cases could be a bigger deal, and that's the way the recommendation --

MS. BEHROOZI: But that's what the appeals and exceptions would be for, and that's the cases they would be applied to. That's the way I understand --

DR. MARK MILLER: [off microphone].

DR. CHERNEW: [off microphone].

MS. BEHROOZI: As well as how the Secretary -- exactly. So there are all those protections to prevent that. As I understand this and what I'm supporting is not a situation where people would have to pay more for the drug they need, that they clinically need based on them as an individual and the drug -- the spread of the effectiveness of the drug within the class. That's not the intention. It's only where it for them is the clinically effective equivalent.

DR. CHERNEW: And I think the issue is how much you think this appeals process and all those safeguards that were just discussed, how effective would they be? And I think there's reasons in certain areas to worry about that, but as a general principle, given the Secretary the authority to do a better job on co-pays is probably a good thing, but they have to be careful of [off microphone].

DR. STUART: [off microphone] -- it's not the appeals process here that we're going to. It's the selection of the appropriate therapeutic classes so that you don't say that you're going to have high co-pays and expect

to have therapeutic substitution in classes where there is evidence that, in fact, they're not substitutable.

MR. HACKBARTH: So --

DR. MARK MILLER: [off microphone] didn't answer your --

MR. HACKBARTH: Yeah. Before we leave Peter's question -- and I don't know how feasible this is to do, Shinobu, but if we -- I don't recall this being addressed in the text. If we could add something to the text that addresses Peter's core question of how much of a financial burden would this represent for LIS beneficiaries, I think that would be helpful.

DR. MARK MILLER: I know you want to move on. The only thing I want to say is we may have to end up doing a few illustrative examples, because the clutch of drugs that the person has could say this one's going to stay under current law, this one's going to move to zero, this one's going to move to 6, assuming 6 is the number. So it may be that we have to show you hypothetically how ten prescriptions in a month could be affected by this up or down, is my sense, unless you're sitting on some data and can move through it faster than I'm thinking.

MS. UCCELLO: I support the recommendation, and I especially support the way it is worded now. Last month, it was more vague in terms of giving the Secretary authority to change the co-pays to encourage more generics, and Mitra and I and maybe some others with some confirmation from staff thought that, you know, one of the -- the bigger driver was moving to zero versus raising the branded co-pay. And so I like the way that that has been incorporated into this recommendation, and the text itself, especially if that table is included, with examples or not, can show the potential to also increase the brand co-pay without necessarily having to be explicit in this. We're trying to strike the right balance here.

In a total topic change, in the text it kind of highlights the need for to have this be a competitive market where people are choosing plans in part based on premiums, they have to be willing to switch using the price signals, but there seems to be a low frequency of switching in general, and in particular for those low-income subsidy folks who may now have to actually pay a premium if they don't switch, but they still choose to stay.

So I'm just wondering what kind of information is

provided to the LIS beneficiary kind of every year notifying them of choices, and even more generally to all beneficiaries, you know, making it clear that they can change plans if they want.

MS. SUZUKI: I may have to get back to you on the details, but for LIS beneficiaries, they do provide a lot of information about, well, your plan is no longer qualifying for the zero dollar premium. I vaguely remember some conversation about maybe providing information about, you know, switching to other plans in your area, but I can definitely look into that and get back to you.

DR. BAICKER: I think this is moving in a very good direction of promoting higher-value use as we do across all things, and we have a reasonably well-ground idea that people are underusing generic drugs and underadhering in general. And so this promotes that kind of use. All of the things that people are worried about, the methods that we're using to address seem good but are never going to be perfect, and I think we just have to acknowledge that, that there isn't a world in which for some patients there are perfect substitutes and for others there aren't. It's a continuum where, you know, it's going to work almost as

well, for some people it will work exactly as well, but for a lot of people there are going to be these small differences, and we have to acknowledge that by introducing a price wedge, some people are going to have to pay a little bit more for some drugs that work a little bit better, and we're not going to be able to perfectly separate and no appeals process is going to be able to perfectly separate that because it's a continuum.

By the same token, I think we're never going to be able to say that there are certain -- I'll stop there, with the overall idea that it's worthwhile to move people towards more use of generics and that some people will inevitably have to pay more than they would have otherwise to achieve the same therapeutic outcome.

MR. ARMSTRONG: I support the recommendation. Actually, I think building in a way on Kate's points, first, I think it's so admirable the accountability that we feel as Commissioners to the beneficiaries of our program and the kinds of concerns we've been expressing. I also am just -- part of what makes me proud to be a Commissioner is the degree to which we're looking for ways of safeguarding any potential negative implications of some of these policy

changes.

But I just feel like this is an area that is so five years ago, I mean, these kinds of -- there are experts and this kind of benefit design has been going on now for a long time. So, anyway, I think we should move forward with the recommendation.

DR. BORMAN: I support the recommendation.

MR. GRADISON: I do, too. I have a quick question. My recollection is that in the new health act, 133 percent is the cut-off point for mandatory Medicaid coverage. This is 135. Is that statutory?

MS. SUZUKI: Yes

MR. GRADISON: So there's a 2 percent difference. In other words a dual eligible is up to 133. Is that correct? But LIS is at 135? I'm just -- later. I just want to make sure I understand that because -- it's just a factual question, and I'm confused.

DR. CASTELLANOS: I support this. Could you go to Slide 4 for a second? I just want to bring out a real-world problem. You talk about the current exception and appeals process that should remain in effect. Then during your excellent presentation and in the chapter that you give us,

you said the Commission had planned to monitor the exception and appeals process for its effectiveness. As a physician -- and I'm sure Tom and Bill and Karen will say this, too -- if you go through this process, it is a difficult process to go through, not just for the Medicare beneficiary but for the physician. And it's such a mishmash of things. I'm not quite sure how you're going to monitor that, and I'm really not quite sure what you plan to do with that. But that would help us significantly trying to ease the burden of especially the primary care doctor who's doing this work and it's uncompensated.

So I really would like you to -- I know I'm talking about something that's probably not the biggest thing on the agenda, but it's something that in the real world it would help.

MR. HACKBARTH: Okay. Would you put up the draft recommendation, Shinobu? All in favor of the draft recommendation, please raise your hand.

Opposed?

Abstentions?

Okay. Thank you.

And our final session is on Medicare Advantage.

Each year in the March report, we provide a status report on Medicare Advantage even though there is not an update, payment update involved. Scott.

DR. HARRISON: Good afternoon. We are here to report the current status of the Medicare Advantage, or MA, program in terms of enrollment in the program, the availability of plans for 2012, projected Medicare payments, and quality indicators for those plans.

Our March chapter is a view of the landscape of the program and contains no formal recommendations. There is more detail in the chapter than we are presenting here today just to keep things short, but we invite your questions and comments on all the material in the draft chapter.

Let me begin by describing the MA program and payment system. The Medicare Advantage program allows Medicare beneficiaries to receive their Medicare Parts A and B benefits through a private plan rather than through the traditional fee-for-service Medicare program. A beneficiary who enrolls in a plan continues to pay the Part B premium and any additional premium that the MA plan charges. The Medicare program plays the MA plan a monthly capitated

amount that is adjusted for the health risk of the individual beneficiary. The plan then provides coverage for the Medicare A and B benefits and usually provides coverage for additional benefits. In 2011, about 25 percent of Medicare beneficiaries were enrolled in MA plans.

In some of the analyses, I will differentiate by plan types and other plan characteristics and I just want to define some of them for you here. Coordinated Care Plans, or CCPs, are either HMOs or PPOs. CCPs have provider networks and various tools to coordinate or manage care. Under the MA program, there are local PPOs and regional PPOs. The difference is that the local PPOs can serve individual counties while regional PPOs are required to serve entire regions, which are made up of one or more complete States.

The MA program also includes private fee-for-service plans which historically had no provider networks and paid providers' Medicare fee-for-service rates. Recent legislation changed the plan requirements, and as of last year, these plans must either have networks or can only be offered in areas where there are fewer than two network plans.

We sometimes make other distinctions. Special Needs Plans, or SNPs, limit their enrollment to either Medicare-Medicaid dual eligibles or to those beneficiaries who have either certain chronic or disabling conditions or who require institutionalization. And there are plans not available to individual beneficiaries but only to employer or union groups. Our availability numbers that you will see do not include these so-called employer group plans or SNPs because these plans are not available to all beneficiaries. But our enrollment and payment numbers generally include them.

Plans submit bids each year for the amount they think it will cost them to provide Parts A and B benefits. There is a separate bid for Part D drugs, but the MA plans just get paid for Part D as if they were stand-alone Part D plans.

CMS actuaries review the bids to make sure they are reasonable. Each plan's bid is compared to a benchmark, which is a dollar amount set for each county. Benchmarks are administratively set based on historical payment rates for each county. A plan's benchmark is based on the benchmarks of the counties it serves, and beginning in 2012,

on the plan's quality rating. Carlos will discuss the plan quality ratings shortly.

If a plan bids above the benchmark, Medicare pays the benchmark and beneficiaries make up the difference with a premium. If a plan bids below the benchmark, Medicare pays the bid plus a rebate calculated as a percentage of the difference between the bid and the benchmark. The rebate must be used by the plan to provide extra benefits to the beneficiaries. These extra benefits can take the form of reduced cost sharing for A-B services, additional non-Medicare benefits, such as dental, vision, hearing, or gym memberships. They could also take the form of improved Part D benefits, including lower Part D premiums.

There has been growth in Medicare Advantage enrollment each year since 2003. From November 2010 to November 2011, enrollment grew by about six percent, or 700,000 enrollees, up to 12.1 million beneficiaries.

Among plan types, HMOs, at eight million, continued to enroll the most beneficiaries, and as a result, 16 percent of all Medicare beneficiaries were in HMOs in 2011. Private fee-for-service enrollment shrank from about 1.7 million to about 600,000, with enrollment shifting to

network plans. PPOs exhibited rapid enrollment growth, with local PPO increasing about 65 percent and regional PPO enrollment increasing about 34 percent.

Going forward, plan bids project overall enrollment growth in the seven to eight percent range for 2012, but almost all of the projected growth is in HMOs.

Enrollment patterns differ in urban and rural areas. About 26 percent of urban Medicare beneficiaries are enrolled in Medicare Advantage, compared with about 14 percent of beneficiaries residing in rural counties. What's not shown here is that urban MA enrollees are much more likely to be in HMOs and rural enrollees are much more likely to be in non-HMO plans.

So let's look at plan availability. Medicare beneficiaries have a large number of plans from which to choose. MA plans are available to almost all beneficiaries. Zero-point-three percent of beneficiaries do not have a plan available.

Looking at the top line here, in 2012, 93 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county, up from 92 percent in 2011 and 67 percent back in 2005. And if you combine the local CCPs

with the regional PPOs, you would find that 99 percent of beneficiaries have a Coordinated Care Plan available in 2012, but don't look too hard at the chart because that number is not on there. Regional PPOs are available to 76 percent of beneficiaries in 2012, down from 86 percent in 2011 due to the withdrawal of the only California regional PPO for 2012. Access to private fee-for-service plans decreased from 63 percent to 60 percent of beneficiaries.

In most counties, a large number of MA plans are available to beneficiaries, although the number varies by county. At the high end, beneficiaries in Miami and New York City can choose from more than 50 plans in 2012. On average, 12 plans, including eight Coordinated Care Plans, are offered in each county in 2012, and that's the same as was in 2011.

And in 2012, 80 percent of beneficiaries have access to at least one MA plan that includes Part D drug coverage and charges no premium beyond the Medicare Part B premium, and that's compared with 90 percent in 2011.

So we use the plan bid projections to compare projected MA spending with projected fee-for-service spending on a like set of fee-for-service beneficiaries.

Because we are comparing fee-for-service expenditures with plan bids and the resulting MA payments, we are using a growth factor for 2012 similar to what the plans use to develop their bids. Plans generally assume costs will grow modestly and discount the likelihood that physician services would be cut by the SGR. We also used this assumption, as we have done for the previous two years. The numbers here assume no SGR cut during 2012.

So looking at the top row, we estimate that, on average, 2012 MA benchmarks, bids, and payments will be 112 percent, 98 percent, and 107 percent of fee-for-service spending, respectively. For 2012, the county benchmarks average approximately three percent less than the benchmarks for 2011 before you took into account any of the quality bonuses that are starting this year. However, almost all 2012 plan enrollment is projected to be in plans that will receive add-ons to their benchmarks for quality. The quality demonstration in effect offset most of the PPACA benchmark reductions that were scheduled for 2012.

The pre-quality benchmark reductions, however, may have encouraged plans to tighten costs and lower their bids for 2012. The average bid is now 98 percent of the

projected fee-for-service spending for similar beneficiaries, and the HMO bids average 95 percent of fee-for-service. Now, the bids of the other plan types are generally above fee-for-service, but they are closer to fee-for-service than they were last year.

As a result, we project that plan payments in 2012 will move closer to fee-for-service spending. And with the exception of employer group plans, the payments for all plan types are projected to be closer to fee-for-service levels in 2012 than they were in 2011.

Before we go on to quality, let me make a few summary observations about the direction of some areas of MA. Enrollment continues to grow in the more tightly managed care plans, namely HMOs, which we think have the potential to increase the quality and efficiency of Medicare services. Over each of the past four years, HMO enrollment has grown by seven percent and plans project similar growth for 2012.

Led by the HMOs, the plans have responded to the tighter benchmarks by lowering their bids relative to fee-for-service spending. The average bid is now lower than fee-for-service spending.

Payments, even after including the quality bonuses, have moved closer to fee-for-service spending levels, and at the same time, the benefit packages offered by MA plans have not eroded in terms of the dollar values of the extra benefits offered.

Now, as promised, Carlos will present findings on quality and the quality bonuses.

MR. ZARABOZO: I'll give you a quick overview of the most recent quality indicators in the Medicare Advantage program, which are discussed in detail -- in fact, in excruciating detail -- in your mailing material.

Looking at the clinical process and intermediate outcome measures that plans report, we find that between last year and this year, there's been improvement in those measures. Among HMOs, for example, 14 of the 45 measures that we track showed improvement between 2010 and 2011 among plans reporting in both years. For local PPOs, nine measures improved. For the other two types of plans, private fee-for-service and regional PPOs, their results are generally not as good for HMOs and local PPOs. We did not see major improvement between this year and last to the extent that we can evaluate results for the small number of

these plans that report quality measures.

For some measures, we're able to compare the performance of Medicare Advantage plans with the performance of fee-for-service Medicare. For example, a beneficiary survey administered in both sectors tracks vaccination rates for influenza and pneumonia. For the most recent time period, the surveys show that vaccination rates are about the same in each sector and have improved in each sector compared to last year's rates.

As we found in the past, newer plans tend to have lower levels of performance on quality measures than more established plans. And this year, we attempted to look at Special Needs Plans in particular, sometimes using a proxy method to identify those plans in the broader data. We find, in general, that the Special Needs Plans are lower performers than other types of plans, albeit with major exceptions.

Beginning this current year, 2012, Medicare Advantage plans will receive bonus payments based on their performance on quality indicators. Plans are awarded a star rating, between one and five stars, based on their performance on clinical measures, patient experience

measures, and contract performance measures. The 2012 bonuses are based on the year 2011 star ratings that were announced at the end of 2010.

Although the statute established the manner in which the bonus system was to be implemented, CMS is using a program-wide demonstration project to determine bonus payment amounts. While under the statute only plans with a rating of four stars or higher would have been eligible for bonuses, in the demonstration, bonuses begin at the three-star level, meaning that based on the bids that we saw and the projected enrollment, 93 percent of enrollees are expected to be in plans that will receive quality bonuses in 2012 versus 25 percent of enrollees that would have received bonuses under the statute because they're in four- to five-star plans. As a result of this and because CMS has set higher payment amounts to the bonuses themselves, the demonstration is expected to result in an additional cost of $2.8 billion in 2012.

The Commission sent a letter to CMS expressing its concern over the use of demonstration authority for this purpose, that is, to do a program-wide demonstration, and over the cost of the demonstration, the resulting cost.

Another concern that we raised regarding the star system is the actual method for determining the stars of plans. The concern that we raised last year was that the stars placed too great an emphasis on contract performance measures, that is, things like how responsive the call centers were and whether or not they had foreign language interpreters versus clinical measures such as outcome measures, intermediate outcome measures, and patient experience measures that are from the CAHPS regarding patients' perceptions of their care.

CMS did address this concern and they are now, for the bonuses that will be effective in 2013, they are using a weighting system to assign different weights to different types of measures, resulting in a system where contract performance measures are not as heavily weighted. Higher weights are now attached to outcome measures and patient experience measures with less weight given to process measures and contract performance measures. And again, the new system will be the basis of bonus payments in 2013.

This concludes our presentation. We look forward to any comments you may have on the draft chapter, any additional information you would like to see included in the

chapter, and any questions you may have on the draft chapter or on the material that we've just presented. Thank you.

MR. HACKBARTH: Okay. Thank you.

Scott, could you put up the slide that has the comparison of the bids and payments, Slide 7. Could you give just a brief reminder of what the recent trend has been on the bids to fee-for-service ratio? My recollection is that over the last several years, that has been trending down.

DR. HARRISON: The payments -- yes, it seems to me they were a high of about 114, maybe, a few years ago.

MR. HACKBARTH: Yes.

DR. HARRISON: Last year, the payments were 110.

MR. HACKBARTH: Yes, and I'm focused in particular on the bids to fee-for-service ratio.

DR. HARRISON: The bids last year were 100 percent --

MR. HACKBARTH: Yes.

DR. HARRISON: -- with the HMOs being 97 and everybody else above. And before that, they had been -- they'd sort of hovered there a little bit, but they may have been a little bit over fee-for-service for a few years.

MR. HACKBARTH: Yes. Yes. That's my recollection, also. So one hypothesis is that this downward trend, especially this year, is consistent with what we've seen in other sectors, so when there's pressure on rates, the providers, in this case plans, respond to that by reducing costs. And here, they want to reduce costs so that they can have money to provide added benefits, which is their mechanism of attracting customers. Now, so this strikes me as good news and consistent with past MedPAC thinking about the Medicare Advantage program.

What I wanted to ask about, though, is there any way that this could be confounded by the quality bonus program? Are they somehow bidding less because, oh, we've got this source of money that, as I understand it, is outside this table?

DR. HARRISON: No, it's inside the table.

MR. HACKBARTH: Oh, it is inside.

DR. HARRISON: Right, so the --

MR. HACKBARTH: Okay. I misunderstood --

DR. HARRISON: The benchmarks have been puffed up for the quality bonus.

MR. HACKBARTH: Okay. I misunderstood that point.

DR. HARRISON: Yes.

MR. HACKBARTH: Okay. Scott, why don't you lead this.

DR. MARK MILLER: Can I say one other thing about that? So that also means, because the bonuses are in there, that the 107 on payment is probably closer to fee-for-service than 107.

DR. HARRISON: Yes, I would bet maybe like 104 or 105, probably.

DR. MARK MILLER: So that's the other thing. Just to your point, because it is, in fact, ground into this table, it also means the payments over fee-for-service are closer if you had those bonus payments out.

DR. HARRISON: Mm-hmm.

DR. MARK MILLER: If you see what I'm saying. So -- everybody with me? Okay. I got one nod, so I'm done.

MR. HACKBARTH: Why don't we still just plan on doing one round with clarifying questions and comments in one round. Scott?

MR. ARMSTRONG: First, I probably should know this, but the discretionary bonuses that take the three stars, is there a time limit on that? I mean, how will that

play out over the next couple of years?

MR. ZARABOZO: [Off microphone.] Twenty-fourteen is the demonstration.

MR. ARMSTRONG: And at that point, the payments are limited --

MR. ZARABOZO: And it goes back to the statutory four-star and above.

MR. ARMSTRONG: You said 2014?

MR. ZARABOZO: Yes -- 2015.

MR. ARMSTRONG: Twenty-fifteen?

MR. ZARABOZO: [Off microphone.] The demonstration is 2012, 2013, and 2014.

MR. ARMSTRONG: Thank you. Thanks. No, I don't think I have any comments. Glenn, I just was -- I had reacted to this information in a way that's similar to yours, and that is that it seems that there is good news in some of this data in that I don't know what MedPAC's role is in drawing conclusions like that, but the relative cost to the Medicare program of MA plans compared with fee-for-service is getting closer to where we want it to be.

Second, you see a real distinction in the progress, and I suppose this has been historical between the

different plan types, and I know we describe the differences, but I don't know that we've ever weighed in on those things that we may do through our role in encouraging faster growth of those plan types that are giving us the better results and the better return on our investments, and it just might be something to think about.

And then, finally, given that we are going to be teeing up a conversation on down the road around premium support, it really does seem to me that the closer these MA plans get to fee-for-service 100 percent benchmarks, the -- I mean, that starts becoming really an interesting part of the conversation that we would have there.

But in terms of the chapter itself, I don't really have anything more to say about it.

DR. BAICKER: I think it's a really useful point to make. Even though on some level we're all aware of it, I feel like it hasn't quite percolated through into the public discussion that a big reason we pay MA plans more is not because of their bids, but because of the benchmark. So I thought this laid that out really clearly. And what I wasn't as clear on in thinking about the star system is our goal is to pay plans -- reward plans for providing high-

quality care in an efficient way, and I wonder how the star system does or is intended to evolve over time in two ways.

One, if fee-for-service gets higher quality, should the stars get ratcheted up? Should we expect MA to be meeting or exceeding fee-for-service performance or an absolute performance metric is one dimension.

And the second dimension I wondered about is it seemed from the chapter that people, if I'm remembering correctly, disproportionately enroll in higher star programs, plans, which you would hope. People should be moving towards higher quality if we're giving them enough information about it. Eventually, do the stars track actual enrollment patterns in the sense that will every plan that a person is actually enrolled in be a five-star plan eventually, or will that move up as people move into higher-performing plans? And then I know all of it is up in the air in a pilot, but how is it supposed to function?

MR. ZARABOZO: Well, one thing about the five-star plans is that they can enroll year-round, so that's an advantage to being a five-star plan, in addition to the higher bonus payments, especially in the absence of the demo, you are going to get those bonus payments. Part of

the -- you know, there was a table that showed distribution by type of plan. There are no five-star plans -- for example, regional PPOs are all three-star, pretty much. So that distribution happens to be the current situation, but it does reflect that HMOs tend to have better quality than the other plans, at least in the current measure.

Now, in terms of the benchmarks and where the standard would be, CMS is working on how to incorporate improvement into the star system. Right now, it's relative within MAs to a certain extent. They do have threshold levels for, like, the four-star performance is at a certain threshold level and that is typically unchanged from one year to another. But otherwise, it is in relation within MA. So the point about we have always said you need to be compared to fee-for-service, and hopefully at some point there will be a comparison to fee-for-service.

MR. HACKBARTH: Kate, we did a report, was it two years ago now, Carlos?

MR. ZARABOZO: March 2010, it was released.

MR. HACKBARTH: Yes. It was a report that Congress specifically requested on how to go about making comparisons of MA plans to fee-for-service. There are some

challenges there, suffice it to say.

Cori.

MS. UCCELLO: Okay. I have some comments and suggestions on the quality part. There's a lot of information there, a lot of good and important information, but my eyes did start glazing over at all of the detail. So I tried to think about, well, what are the questions I want this information to answer, and I think, actually, in your presentation, you kind of laid things out this way. But one thing is are the metrics themselves meaningful and do they produce meaningful differences between the plans? And what are the overall trends in quality? Is it improving? And are there specific areas that need more attention? And then how does the quality vary by plan type and between MA and fee-for-service, and then also with the dual eligibles and SNPs plans and those things. And then in areas where there are big differences between these plan types, are there lessons that can be learned from MA and transferred to fee-for-service or vice-versa? I mean, those are just kind of the big issues that I'd hope that this kind of quality information can answer.

MR. HACKBARTH: Peter.

MR. BUTLER: So, Scott, as you were referencing our incrementalism, the flip side of this is that these are a little bit so five years ago, too. These numbers have moved, but not much. And as the enrollment has grown in Medicare -- another way to look at this is as the enrollment has grown in Medicare Advantage, it has been more expensive. So everybody that's enrolled in there is more than the fee-for-service, as much as we as a Commission have valued the incentives associated with them.

Now, what I wanted to ask you to clarify in my own mind, we annually report on the status. Is that part of our legislative activity, or is that -- did we just decide to do an annual status report?

DR. MARK MILLER: I'm pretty sure -- I would really like to just put my eyes back on the legislative language again. I think it says if we're making payment statements to the Congress on fee-for-service and MA that goes into the March report.

MR. BUTLER: But we're not --

DR. MARK MILLER: Well, but we have --

MR. BUTLER: Right.

DR. MARK MILLER: -- so it turns out this time, we

haven't, but some of this movement that you see in these numbers that are so five years ago, in your words -- or Scott's -- came from recommendations that we did make. So it turns out this time in the chapter, no, we don't necessarily have recommendations, but we have in the past.

MR. HACKBARTH: Peter, was your question specifically about payment recommendations, whether we're required to make payment recommendations, or whether we're required to --

MR. BUTLER: I know we don't make payment recommendations unless we have a change in the system. There are no updates to provide.

DR. MARK MILLER: Correct. Exactly.

MR. BUTLER: I understand that.

DR. MARK MILLER: Yes.

MR. BUTLER: I understand that, and we choose nevertheless to report in the March chapter how the program is doing --

MR. HACKBARTH: Yes, and my recollection --

MR. BUTLER: -- and we have had selected studies that we are required to do by Congress, and so I'm just trying to clarify. But beyond that, we don't in our

legislative -- I mean, as we were constituted, we do not have to report beyond that level, right?

MR. HACKBARTH: Beyond that level. So my recollection, Mark, and help me out, is that there was a period when we didn't have Medicare Advantage in the March report and one of the Congressional committees said, you know, the way we read MedPAC's statutory requirements for the March report, we think you need to report each year on Medicare Advantage, not make payment recommendations since that's the way the MA payment system works, but at least report on the status. And we said, of course, we will do that. The language was ambiguous to us, but we said, if that's what you want, we will do it, and we've done it each of the last, I don't know, three or four years.

MR. BUTLER: Yes. So, I mean, I don't need to tell you, Glenn, you repeat it fairly often, the original 95 percent of AAPCC is still a long way away from what we are seeing from the plans. So we have 35 pages here. It's just kind of interesting that we have 35 pages out of probably hundreds that we report, and I just kind of wonder as we move more to likely, whether it's ACOs or more Medicare Advantage, whether we should be a little more proactive in

thinking about how to shine a little brighter light and a little bit more of our attention on the issue, because this is complicated. And I'm sure the new Commissioners who haven't been involved with Medicare Advantage, this thing takes a long time to go through and understand if you haven't been a part of it and I think it's really important.

MR. HACKBARTH: For the benefit of the new Commissioners, when I first joined the Commission, Medicare Advantage payment rates were a very hot issue and we made a number of recommendations on those that went basically unheeded for a number of years. And then in PPACA, Congress moved in the general direction that we have been recommending. The PPACA approach isn't precisely what we had recommended and it has some bells and whistles, like the quality bonuses that we didn't necessarily contemplate, or at least not in the magnitude. But directionally, it moved in a way we have been describing as far back as 2001, 2002, 2003. PPACA passed a couple of years ago. Now, I think the next policy debate around the role of private plans in Medicare, as Scott indicated, is in the premium support context, and so we as a group will need to decide how we wish to engage in that debate.

Mike.

DR. CHERNEW: So I always like these reports, so thank you, and I just have one comment. There's a slide you have about the number of plans, I think, going from 21 on average to 12, or -- on one of the slides. But -- this one. Between 2010 and 2011, the average number of choices -- I assume that means the average number of plans -- dropped from 21 to 12, and I assume a lot of that was consolidation of private fee-for-service plans that needed to have a network and dropped out?

DR. HARRISON: That's correct.

DR. CHERNEW: Right. And then there were also some efforts to encourage plans to consolidate in general, and you don't see that generally picked up in the enrollment. In fact, the enrollment was rising.

So my comment is that the last time we had really big MA payment changes -- well, actually not -- the last time we had really big MA payment reductions, we saw a ton of plans existing, and although you see plans consolidating here, it's not clear you see a lot of exiting, all of which I think is a good thing, although I just want to say, we've been doing some work looking at this in more detail and you

do see different patterns, and I can show you the results across the quartile. So now they've set up a system where the generosity, if you will, varies by quartiles, and there's a lot of noise going on for all the reasons you said -- privacy, plans leaving, and plans being asked to consolidate within the same insurer and stuff like that. But there does seem to be some effect within quartiles.

The other thing that's going on which I think is really important to understand and why I think you see growth in MA amongst other reasons is there's a bunch of reasons why I think the non-MA system, the traditional system, is going to become less appealing to individuals. Employers are cutting back. A bunch of things are going on. MA remains a place where you can get access to some of the benefits that you might want in a way that, you know, still might be cost effective for individuals. So I think you're seeing the demand for individuals for MA plans really rising and so you see a lot of enrollment, despite the fact that the payment rates are becoming -- are scheduled to become less generous. And we saw our results when they just froze it. Before they even implemented them, we saw some level of consolidation, although we didn't see it in enrollment. So

the enrollees are finding ways to go somewhere else.

So again, I think that this is really good. It will provide a great baseline. You are going to see a lot, even more as we go forward, as these cuts come in, because there's a big change across certain counties when you move from the benchmark system the way it had been set up to the benchmark system the way it's going to be set up. There's some places that actually -- we had great presentations before about how overly generous some places were because of some of the craziness of the payment system and some of that's getting unraveled by the Affordable Care Act and we can trace what happens, and this is the start.

My only point is, as you go forward, thinking about that in the sort of quartile world is important. And I'll share with you the work that we've done.

DR. DEAN: These are encouraging numbers. I had some of the same questions that Cori did about the measurement of the quality and also the impact that it has, and it sounds like those things, too, are moving in a way where the measurements are more sophisticated and hopefully more accurate.

How much difference is there for the plans to move

from, say, three to four stars, or four to five stars? I assume that there's still incentives to keep pushing on those measures, is that correct?

MR. ZARABOZO: Right. There are different levels of bonus payments, depending on the star level. And again, after the demonstration, you have to be at four, four-and-a-half or five stars to get a bonus, so --

DR. DEAN: For each step up --

MR. ZARABOZO: You have --

DR. DEAN: -- there will be an additional bonus --

MR. ZARABOZO: -- different levels --

DR. DEAN: It's enough of a step to really provide an incentive, as far as you know?

MR. ZARABOZO: Well, it is more money, so --

DR. DEAN: But is it enough to make up for the difference of the investment that they'd likely make to --

MR. ZARABOZO: Well, the other thing is, again, the five-stars get to enroll year-round, so that's sort of a little boost there, also.

DR. DEAN: Are there any other non-monetary rewards besides the year-round enrollment?

MR. ZARABOZO: The marketing. At the Medicare.gov

website, the five-stars plans are indicated as being exceptional plans, and the plans that are at the other end, the 2.5-star plans, are labeled as this plan has not been good for a couple of years or something, so --

DR. DEAN: And the five-star plans are the only ones that are labeled that way?

MR. ZARABOZO: Right. Right.

DR. DEAN: Okay.

MR. HACKBARTH: So how many five-star plans are there?

MR. ZARABOZO: I think we have -- well, this -- nine. Thank you. My consultant here says nine.

[Laughter.]

DR. HALL: Just a couple of comments. One is, this was really a good chapter. This was -- I've seen lots of MA descriptions in a variety of different places and this was really very, very informative and I really thank you for that.

In terms of the star system, certainly, that's been a good idea, but it's a little bit like what do we do when everybody's five-star? Do we then stop worrying about things, or is it sort of like Lake Wobegon, that when all

the children become above average, you don't really know what to do with them anymore? So one of the things, and I guess I'm -- so I think there's a -- we have to keep a close eye on whether we really have reached nirvana or perfection when we use these star systems.

The other thing that I think is correct, and there's sort of some other data that I've looked at recently, is that for any of the major national providers, underwriters for MA services, the rubric or the metric they often use is that in 80 percent of our localities, we are four-star, something like that. But then when you dissect out the regional data, there will be pockets of the country where they're not really very good, even though on a national basis they're really quite good. So the regional variation still exists and this is very, very difficult for consumers to understand. They can go to Medicare.gov and look this stuff up, and I'll tell you, it is a real challenge when you go do that.

So not that I have any really good ideas on this, but as we follow this, I think at some point, when everybody gets to be five-star, we have to push the industry to do what it really should be doing and that is to become even

more innovative than five stars, and I don't know what that means.

MR. ZARABOZO: Well, I'm not sure that's necessarily the case, that everybody will become five-star, again, because of the relatives, that is, within -- I mean, it will be the best plans that are the five-star plans. Other plans will be below that.

DR. HALL: But they're trending that way.

MR. ZARABOZO: They're --

DR. HALL: Yes, I know, that was an overstatement.

MR. HACKBARTH: The measures in the system are not fixed, either --

DR. HALL: Right.

MR. HACKBARTH: -- and so the measures presumably will evolve -- hopefully, they'll evolve to be more effective measures of quality, and so this isn't a static system where people are moving at a fixed target.

Bob.

DR. BERENSON: Yes. I have two data issues and then one comment. Scott and I talked earlier about two data things which I think it's useful to bring up publicly as a question. One is that Marsha Gold's analysis of Medicare

Advantage that she produces at Mathematica for Medicare -- I'm sorry, for Kaiser Family Foundation has a different number of Medicare Advantage enrollees and it's -- Scott and I, I think, have figured out that it's because she includes the costs of HMO enrollees. And so, just quickly, could you explain who they are and whether it makes more sense to include them in Medicare Advantage? The difference is two percent. In her data, we're now up to 27 percent of Medicare Advantage, and I just want to understand that.

DR. HARRISON: Yes. I think one percent is probably due to the numerator and one percent is due to the denominator. CMS puts out all kinds of different total numbers of beneficiaries, so you could end up picking ones that are slightly different from one another. So I'm thinking that's where part of it is.

But the part that I do know for sure is that so there are these HMOs called cost HMOs and what they are is you can sign up for a closed panel -- you as a beneficiary could sign up to get your care from this closed panel, but you don't have to get all of it from the closed panel. You're allowed to go outside of that network and whenever you do, you pay normal Medicare cost sharing. When you're

in the network, you're going to pay nothing or something lower. So there are some big pockets of the country -- Colorado is covered by a cost plan completely, I believe. Scott and White has lots of parts of rural Texas. And actually even Kaiser in a couple locations is considered a cost plan. And those plans do not submit bids, so they're not really paid the same way. But they may be something worth looking at in the next year or two.

MR. HACKBARTH: Scott, is it possible for a plan to get a new cost contract --

DR. HARRISON: No.

MR. HACKBARTH: -- or these are people grandfathered in under old contracts?

DR. HARRISON: Right.

DR. BERENSON: So these are clearly not risk -- I mean, they're not Medicare Advantage per se, but they're also not pure fee-for-service, so they're in some middle ground, but okay.

DR. HARRISON: Right.

DR. BERENSON: The more important issue, if you could go to Slide 7, Peter said that the new Commissioners may have some difficulties. I've written a half-a-dozen

articles in Health Affairs and don't think I understood this, because Scott and I were talking. I have long assumed that because MA plans get to decide where they want to go and that they would typically disproportionately settle in places with high benchmarks, high fee-for-service spending, that the fact that the ratio wasn't adjusted for equal distribution -- I mean, I basically assume that if they were equally distributed across the country, that the number might be somewhat different rather than what you're showing here, which I assume showed a bias towards going to high-cost fee-for-service areas. You suggested earlier that you're making an adjustment. Could you explain that, what you're doing?

DR. HARRISON: Right. So let's just say we have one plan. So I would take the plan, and I know where their enrollees are and I know the risk scores of their enrollees, and so I assume that those are -- and so I, in a sense, create a different plan with the same enrollment patterns and the same risk patterns and see what those people would cost under fee-for-service, okay. And so we're comparing to a demographically and geographically similar population.

DR. MARK MILLER: [Off microphone.] It's MA to

fee-for-service --

DR. BERENSON: Right. Right.

DR. MARK MILLER: -- not across the country, and your comment almost sounded like it was an across the country kind of --

DR. BERENSON: Well, now I'm not sure what -- I mean, basically, if my hypothesis is that there's a lot of MA plans in Miami and New York, which you've told me there are, and those are very high fee-for-service spending areas, that if I -- and those are all the plans we had, we would show a pretty low ratio of bid to fee-for-service which might give a misleading picture of how efficient MA plans were if they were actually equally spread across the country. And so I guess the question is, have you made that kind of an adjustment so that your -- do you see what I'm asking?

DR. HARRISON: Yes. These numbers are all based on where the plans draw their enrollment.

DR. BERENSON: All right. So that adjustment hasn't been made. The one that I'm suggesting needs to be made to be able to say anything about our MA plan is lower cost than fee-for-service, which is a question that policy

makers like to ask.

DR. HARRISON: Now --

DR. BERENSON: We don't really know that answer.

DR. HARRISON: Now, the problem is that you may not trust or like the fee-for-service numbers in Miami, but that's what they are, and so --

DR. BERENSON: No, I understand that --

DR. HARRISON: Yes --

DR. BERENSON: -- but if one were wanting to project what a policy might be, one would want to know what the limitations are of the data and one of them might be, well, these plans have gone disproportionately to high cost fee-for-service areas. If they were actually --

DR. HARRISON: No --

DR. BERENSON: -- if we did away with traditional Medicare and all we had were plans, what might we expect? We don't really know that without doing that kind of geographic adjustment --

DR. HARRISON: No --

DR. BAICKER: Doesn't Scott's number give us a better sense of what that number would be than what you're proposing in that the counterfactual is what fee-for-service

is spending, you know. And so if we're observing beneficiaries in MA disproportionately in areas where fee-for-service spends a lot and they're spending less than fee-for-service there, we want to know that they're located in areas where fee-for-service is spending a lot and not say, oh, wow, the enrollees in Medicare Advantage in Miami are spending a lot more than the fee-for-service enrollees in Minneapolis, that that's not the informative comparison. The more informative comparison is what the MA enrollees in Miami are spending relative to the fee-for-service enrollees in Miami and what the MA enrollees in Minneapolis are spending relative to the fee-for-service enrollees in Minneapolis.

DR. BERENSON: That would be better than -- comparing Miami to Minnesota wouldn't be helpful, but also I think it would be helpful to do a geographic adjustment to estimate what the spend would be if the plans were sort of naturally distributed or equitably distributed. I don't --

DR. BAICKER: But then you'd have to do the same thing to fee-for-service, right, because that looks different in different parts of the country, too.

DR. MARK MILLER: [Off microphone.] And the other

thing that occurs to me -- the other thing that occurs to me in this, that one of the issues that would get raised in this is you can't necessarily assume that a managed care plan would go to every part of the country, and I get worried that if you make an assumption that says, okay, let's take this and assume it all the way across the country, if you really paid in such a way relative to fee-for-service, there are certain areas of the country where managed care plans wouldn't go.

MR. ZARABOZO: We can't do what Bob would like us to do, I don't think, because you would have to say, when this company goes to Iowa, let's say, that had never been there before, we think their bid will be such, and that's X percent of fee-for-service. We can't do -- we don't know what that bid would be of an HMO going to Iowa. All we know is what is out there.

MR. HACKBARTH: I think it is reasonable to believe that private plans will be more successful in some parts of the country than others relative to fee-for-service because -- not just because the level of fee-for-service cost varies across the country, but also because the care delivery systems vary.

So in a market where you have few providers, a sparsely populated rural area, and those providers have few competitors and therefore substantial market power when dealing with a private insurer, that's a tough market to make a private health plan work and beat Medicare's administered price system, especially if you're talking about the swaths of the country where the utilization rates are also low. So the unit prices are low and the utilization is low.

In other parts of the country, you have the reverse situation, where you've got many providers, opportunities for plans to negotiate, steer their beneficiaries towards particular providers, and play one provider off against the other in the negotiating process. And in addition to that, they have high utilization rates.

So Bob's observation is exactly the right one. Plans historically have tended to cluster in the areas that have high fee-for-service costs and many providers. That's the rich environment for them and they've avoided the low utilization sparse provider areas of the country until Congress said, well, we want private plans everywhere and adopted the policy of paying way above fee-for-service rates

in those sparsely populated areas with few providers in order to attract private plans in.

And that's how we got into this situation that somebody alluded to earlier that we had payments way above fee-for-service rates in many parts of the country, ratios like 140 percent, as I recall, Scott, in some parts of the country. MA rates are 140 percent of fee-for-service cost. And what's happening now with PPACA is we're moving away from that and moving closer to having MA payments broadly linked to underlying fee-for-service costs with very important exceptions to that. But I do think it's true that plans cluster in the high-cost areas for understandable reasons.

And as I understand these numbers, Scott -- now, to get back to Bob's specific question -- these numbers in this table -- whoops, that table -- the fact that HMOs are 95 percent of fee-for-service, that reflects the markets that they choose to be in, the markets that HMOs are actually in.

DR. HARRISON: Right. Now, I would like to point out, though, that they are going into more and more markets.

MR. HACKBARTH: Yes.

DR. HARRISON: The HMOs cover, and I was looking for the number and I don't see it, but I think something like 83, 84 percent of beneficiaries now have access to an HMO, whereas that's way higher than it was before.

DR. BERENSON: But the penetration is obviously very different, with some counties being 60, 70 percent and others being -- in any case, I don't think we can continue this now. I would just point to the fact that policy makers and editorial writers like the New York Times a few weeks ago are going to want to argue as to, in a context of premium support discussions, which is more efficient, traditional Medicare or Medicare Advantage, and to the extent that we're able to help ground that debate in facts --

MR. HACKBARTH: Yes --

DR. BERENSON: -- I mean, that editorial writer had it wrong --

MR. HACKBARTH: Right.

DR. BERENSON: -- it would be helpful. And so I actually did, then, understand what you had done and hadn't been wrong for all those Health Affairs articles, so --

MR. HACKBARTH: That's good.

DR. BERENSON: -- so it's helpful. Let me finish my comments and then I'll move it along.

The comment I wanted to make was on the quality side, which I found quite disturbing, the SNP findings. In fact, for regular MA, we do have a choice construct and people can look at the data and deal with their own preferences and decide whether to join an MA plan or not.

There's an increasing discussion now about for the dual population about mandatory enrollment in managed care, and so I find the one area that at least some people are contemplating that seems to be the area which was supposed to be sort of the sweet spot of what private plans could do is working on patients with chronic conditions and multiple comorbidities, et cetera, and in that area, at least, for the quality measures we've got, they're actually doing worse than sort of unmanaged fee-for-service. So I'm not sure if there's anything more you can amplify on that, but I find that one is not everybody is getting to five-plus in that area and that's the area that may, in fact, be the most immediate one of policy relevance for us.

MR. ZARABOZO: Well, I think the SNP plans would say that some of these measures are not appropriate for

them, and the famous one is the colorectal cancer screening measure, which they say -- which is percent up to age 85 that have the screening, and they say for many of their people, it is inappropriate to get that screening even though they will suffer in the HEDIS measures by not doing it.

DR. BERENSON: No, that -- I mean, clearly, that's a problem across the whole program, where you should stop that at 75, I believe, seems to -- no. Okay. So I'd like to know a little more about what we think about those measures. I mean, the ones -- the flu vaccination --

MR. ZARABOZO: Right. That's where -- I mean, it's clear there it's lower and I don't see an explanation why it should be lower --

DR. BERENSON: Yes. Okay. I think that one deserves some -- if we're sort of setting out priorities for future work, I think understanding what the SNPs are doing in quality, to me, would be a high priority.

MR. ZARABOZO: Yes. And again, it's difficult to identify them because they're often under a larger contract, which is the reporting entity. So we sometimes can't figure out what exactly is happening in the Special Needs Plans.

MR. KUHN: A couple quick questions. One, Scott, take me out to, if we could, the 2015, when this current demo ends on the quality that's going on, or maybe Carlos, whoever is working on that one. So we go out to the end of this demo and see the numbers here where the bids are starting to come down. Is there a likely scenario that when the demo's done that we'll see bids start to creep up, maybe be above the benchmark, the extra benefits that people get as coming below the benchmark start to disappear, and we start to see a migration back to fee-for-service and out of MA? Is that a plausible scenario that we could see when this demo ends?

DR. HARRISON: It's kind of hard to know what would happen there. I mean, there's going to be a continuing quality program, and as time goes on, that will get a little bit stronger because it's being phased in. It won't be fully phased in until 2017. So there is still going to be quality money. It's just that it's not going to be sort of for the average plans. It's going to be for the four- and five-star plans.

MR. KUHN: And those four- and five-star plans -- or, I'm sorry, the three-star plans are the ones that are

getting this money as the result of a demo. You know, kind of where Bob was talking about, where plans are kind of clustered, are they clustered in parts of the country that are at risk of losing access in the future, or do we know where they are?

MR. ZARABOZO: The -- I did look at the geographic distribution to the extent possible because of the way the contracts are set up and the lower-star plans tend to be -- well, Puerto Rico is one situation, but in the South. The five-star plans are spread across the country, so you have Massachusetts, Maine, Washington, California.

MR. KUHN: Okay.

MR. ZARABOZO: I do have a correction. In the four-and-a-half and five-star plans, the increase in the benchmark is the same percentage, so that in 2014, it will be a five percent increase in the benchmark for all those four-and-a-half and five-star plans.

MR. KUHN: I guess the reason I'm just curious is that it appears to me that we may be looking at a cliff in 2015 and I'm just curious, order of magnitude, what that cliff may or may not be and could it hit certain geographic areas of the country as we go forward.

My second quick question has to do with coding intensity. You know, this morning we made recommendations on payment updates for hospitals because of coding and others out there. PPACA had some coding intensity adjustments that are part of the MA plan experience now, started, I think, in 2010 and continues to go forward. Do we -- based on the analysis that you're all doing, do you think the coding intensity that's in place now and moving forward is sufficient to capture the coding that's going on in the MA plan world or do we think there's opportunity for further recommendations or review in the future in this area?

DR. HARRISON: There's a variety of opinions about how well the risk system is doing. I think that some actuary types think that there's even more coding that's being corrected for. The coding adjustment factor will go up starting next year. It goes up through, I think, 2017 or maybe even 2019. It keeps going up for a while.

But we don't have a really good way to figure out what we think the coding adjustment should be. You know, first of all, CMS changes the model every couple of years and there's also coding changes going on in fee-for-service.

So we're really not comfortable saying what we think the true adjustment should be at this point.

DR. MARK MILLER: But we do have on our agenda to look at some of the risk adjustment issues here as they relate, how well HCC does, thinking about how it would apply in a dual eligible type of world. And at least on this topic, while what you've said is correct, we don't have an, okay, we know the answer to it type of posture, we are kind of poking around a little bit and looking at this. So it's not just completely stagnant. I think Scott is correct to be cautious as to whether we're going to have something to bring to you, but we are kind of messing around a little bit here.

DR. NAYLOR: Just let me echo Bill's comment. I think this was an excellent report. I have no further questions.

MS. BEHROOZI: Yes, it's really thorough, and after six years, I'm starting to understand it. And I would just echo the concern that you raise with respect to the star measures applying to broad contracts rather than to units. It kind of goes to Cori's point about, like, we should know what we're measuring, and when somebody sees a

star rating, they should know what it's measuring as opposed to some disparate geography, like is McDonald's better than Burger King? What about your local McDonald's on the corner, that kind of thing.

MR. GEORGE MILLER: I generally support the recommendation. I guess I would have a question on the total cost as compared to fee-for-service if the MA plans weren't there, if we had the total impact of the entire system for the MA plans and then compared that if there was no MA plans and fee-for-service just to show the magnitude of impact to the system.

DR. HARRISON: You mean in billions of dollars or --

MR. GEORGE MILLER: In billions of dollars, yes. Soon, we're talking about real money.

DR. HARRISON: We have put that number in the report in the past.

MR. GEORGE MILLER: Yes.

DR. HARRISON: I guess we could do that.

MR. GEORGE MILLER: Just curious. It's billions, right?

MR. HACKBARTH: -- all part of magnitude in the

past.

MR. GEORGE MILLER: Twenty billion?

DR. HARRISON: Yes. I bet it's lower now, though. I'll bet it's maybe ten.

MR. HACKBARTH: Yes. I was thinking ten, 11, something in that neighborhood.

MR. GEORGE MILLER: And then the follow-up question, do we get value for that. Certainly, measured by patient satisfaction, it seems that we do, but I'm just --

DR. HARRISON: There are extra benefits that the beneficiaries get and now you could argue that there's also you're getting quality.

MR. GEORGE MILLER: Okay. Thank you.

DR. STUART: I agree with Bill. I think this is a fascinating chapter. I've enjoyed reading it every year. It's a dynamic area and so seeing what's happening within MA is really interesting. And having said that, it strikes me that it would be useful to think about whether we could do this with the Part D MA-PD plans. In other words, in the chapter, the prior chapter, there are some very useful comparisons between MA-PD and PDP. But the question I would raise is are there differences in such things as average

premium, premium-free plans, proportion of plans that offer gap coverage among the different MA-PD types.

DR. CASTELLANOS: I really appreciate the effort that you put into this. I thought it was great and I look forward to it each year.

George, I'm a little concerned that you're supporting a recommendation and Glenn may ask for a vote, so maybe I've been asleep and I don't know.

[Laughter.]

MR. HACKBARTH: I'm one vote behind, Ron, so --

[Laughter.]

MR. GRADISON: Thank you for your work. The jury is still out on these programs, but this is very helpful to have an annual review at this level of depth. Thank you.

DR. BORMAN: Good job. No questions.

MR. HACKBARTH: So, let me just go back to Herb's question about what happens at the end of the demonstration, the quality demonstration, and there's a significant reduction in the total payments going out to plans. This is a critical and interesting policy question.

My belief has been that while we could, as a result of that, have somewhat fewer plans and somewhat lower

levels of enrollment, on the other hand, there may be some benefits in terms of the type of plan that we get. In order to continue to offer attractive benefits at lower levels of Medicare payments, we may -- my hypothesis would be that we would see plans start to become more organized and more effective and doing what we want private plans to do, which is effectively manage care for Medicare beneficiaries.

To put it another way, when we had very high levels of payment relative to fee-for-service Medicare, there was little reason for plans to aggressively manage or try to identify efficient providers and steer beneficiaries towards them. They could, with the excess payments, offer generous benefits to attract new enrollees while not doing much to actually manage the care, and that's sort of the worst case scenario for the program. You get a high enrollment at a high cost and private plans are not engaged in doing the things that we need private plans to do. We have them in the program because they have the potential to do things that traditional Medicare finds difficult.

And so I am hopeful that as PPACA unfolds and there's more pressure on the plans, that we will see the private sector innovate and restructure itself, redesign how

they work so that they can compete effectively at lower rates. I believe in private plans in the market. I think there's lots of room for them to do very well in Medicare even at lower rates.

Scott.

MR. ARMSTRONG: Just one more point to build on what you just said. First, just to disclose, so I do work for an organization that has a Medicare Advantage plan that is one of the nine five-star plans in our country. But I will tell you that it's very difficult, and I would just tell you, we do not presume we will be able to maintain our five-star status, even with all the advantages that our organization has. And so in today's bonus payment structure, as we've been talking about it, there are very strong incentives for our organization to figure out how we maintain that. And I think to the degree that -- so, first, I would just say I think it's hard to imagine that the whole industry clustering around five-star, I just don't think that that's going to happen.

To the degree there continues to be strong incentives through this bonus structure for advancing exactly the kind of results that we're trying to advance in

so many other ways, we ought to be paying very close attention to how this informs us. And I was just thinking, you know, we're about to talk tomorrow morning about benefit design. There are a lot of features of this five-star quality program, but the Medicare Advantage plans themselves, I think, very naturally flow into some of the goals that we'll have in that chapter, too.

MR. HACKBARTH: Thank you, Scott and Carlos.

We will now have our public comment period. Before you begin, let me just quickly review the rules. No more than two minutes. When the light comes on, that signifies the end of the two minutes, and please begin by identifying yourself and your organization.

MR. SPERLING: Thank you. My name is Andrew Sperling. I'm with the National Alliance on Mental Illness. NAMI is the largest organization representing Medicare beneficiaries living with severe and persistent mental illness in this country.

This certainly probably goes in the category of futility, but I will make the comment nonetheless. NAMI would again like to express extreme disappointment in the decision made by this Commission relative to cost sharing

for low-income subsidy and dual eligible beneficiaries in the Medicare program. This is a profound mistake and could lead to severe disruptions in adherence and treatment for dual eligible beneficiaries, particularly vulnerable beneficiaries, not just with a single condition but with multiple chronic conditions who take many, many medications.

We're disappointed that this proposal, quite frankly, appears to be divorced from the real prescribing patterns that go on for these low-income beneficiaries that have multiple chronic conditions, and the idea that, somehow, their brand prescribing is driven by them insisting on brand medications, in fact, they have very little control over the prescribing decisions that are made for them on behalf of their physicians. Many of them have mental impairments and other disabilities that, quite frankly, make adherence difficult, and we're extremely concerned that this proposal is going to disrupt their ongoing treatment and, in fact, cost the Medicare program more in the long run.

We recognize this Commission tried to make some concessions by deferring to the Secretary to make the decision about which therapeutic classes will be subject to higher cost sharing. That gives us little confidence, quite

frankly, and a decision over time where the Secretary is making more and more decisions that are driven by cost control rather than ensuring strong, good clinical outcomes for vulnerable beneficiaries that, in fact, cost will overcome these decisions. We'll see more and more therapeutic classes subject to higher cost sharing.

We're disappointed that in terms of the lowering of the cost sharing to zero, that appears to be only for generics in classes that are designated by the Secretary. So, in fact, many beneficiaries would only get that if their class were designated for the higher cost sharing.

I want to be clear. For someone to stay adherent to a brand name medication that's prescribed by their doctor, specifically by their physician, they could be subject under this proposal to cost sharing increases as high as 200 and 300 percent. That would be the cost to that beneficiary to stay adherent to a particular compound prescribed by their prescription, regardless of specialized circumstances in terms of polypharmacy, other drugs, contraindications, the fact that other compounds from that class may have been tried and failed for that individual.

So, again, we understand the decision has been

made. It will now be transmitted to Congress. We will have to engage our grassroots advocates and all 1,100 affiliates that are in all 50 States and all 435 Congressional districts to educate their members about what the potential of this proposal is for ongoing strong clinical care for dual eligibles and LIS beneficiaries in the program. Thank you.

MR. HACKBARTH: Okay. Thank you.

We will reconvene at 8:00 a.m. tomorrow morning.

[Whereupon, at 4:32 p.m., the proceedings were adjourned, to reconvene at 8:00 a.m. on Friday, January 13, 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, January 13, 2012
8:05 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 [8:03 a.m.]

MR. HACKBARTH: Okay. Good morning. We have two sessions today, one on reforming the Medicare benefit package and the other on our mandated report on rural payment adequacy. So who is leading off on the benefit design? Julie? Okay.

DR. LEE: Good morning. In today's presentation, we continue our discussion of potential changes in Medicare's benefit design. Recall that we began this discussion last October and November.

We have the following goals for today's presentation: We are working toward draft recommendations in spring. To make that happen, we need to define the key characteristics of the new benefit design you wish to include and address policy questions relative to implementing new benefits, such as an excise tax on supplemental insurance.

The Commission has been considering ways to reform the traditional benefit package for several years to give beneficiaries better protection against high out-of-pocket spending and to create the 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.

So let's begin with a brief recap of the two previous meetings on the topic. In October's presentation, we discussed the current fee-for-service benefit design and presented three alternative benefit packages for you to consider. All three shared a common benefit structure in that they had an out-of-pocket maximum and a combined deductible for Part A and Part B services.

In addition, the first package, presented as a reference point, had 20 percent coinsurance on all services between the deductible and the out-of-pocket maximum. The second and third packages had a set of co-payments instead of co-insurance. The Commission has expressed a preference for co-payments because they are more predictable for beneficiaries.

In November's presentation, we focused on the role of supplemental coverage. Specifically, we used one of the co-payment packages from October and combined it with the three alternative policies related to supplemental coverage. They varied in the degree to which Medicare's cost sharing

can be filled in by supplemental insurance.

The Commission at that time expressed a strong preference for imposing an excise tax on supplemental insurance rather than regulating supplemental benefits.

Today's presentation has two main parts.

First, we'll go over two benefit packages with a revised set of co-payments. The first package would keep beneficiary cost-sharing liability roughly the same as current law (but program spending would be higher), whereas the second package would keep the Medicare program spending about the same (but beneficiary cost sharing would increase).

In the second part of the presentation, we'll overlay an excise tax on supplemental insurance on these two benefit packages. This was the guidance you gave us in November as your preferred policy option toward supplemental coverage.

There are a couple of issues discussed in November that are not on this outline. We want to note here that the analysis related to income and the value of insurance are not forgotten and will be presented in the future.

If you recall, the fee-for-service benefit package

from November had a co-payment structure of the type more common under Medicare Advantage. It was labeled "MA-neutral" because it had approximately the same average cost-sharing liability as the current fee-for-service.

Today, we present two illustrative packages that show key tradeoffs between some design elements. We'll first go over what these packages look like. Both have a $5000 out-of-pocket maximum and a combined deductible for Part A and Part B services. Remember that under the current benefit package, there's no out-of-pocket cap, and beneficiaries face a high deductible of over $1000 for Part A and a low deductible for Part B. As typical in most private plans, we differentiated co-payments for primary care and specialist visits. In contrast, under current law, all physician services have a 20 percent coinsurance.

MA plans also told us that they have a co-payment for advanced imaging services. The $100 co-payment we included here is similar to what MA plans charge and almost equal to the average cost sharing for those services under current law.

Co-payments for skilled nursing facility services are higher compared to current law, which currently has no

cost sharing for the first 20 days.

Finally, our cost sharing on home health is consistent with the $150 co-payment per episode the Commission has included in the March report from last year.

These two packages are quite similar in their structure, but the levels of co-payments do differ because they were set to meet two quite different budget constraints.

Under the first package, average beneficiary cost-sharing liability would be about the same as the current law, but Medicare program spending would be higher. This package is referred to as the "beneficiary-neutral" package on the slide.

Under the second package, average beneficiary liability would be higher compared to current law, but Medicare spending would be roughly equal to current law. This package is referred to as the "program-neutral" package on the slide.

Comparing the two columns, the second has a higher deductible -- $750 versus $500 -- and a higher co-payment on skilled nursing facility days -- at $100 versus $80. These differences are highlighted in yellow.

Generally, compared to current law, the distribution of cost-sharing liability across type of service is quite different under the two alternative packages. Because of the combined deductible, beneficiaries with very low Medicare spending would pay higher cost sharing overall compared to current law. Those with a hospital admission, on the other hand, would pay lower cost sharing. Those with very high Medicare spending would also see their cost sharing go down substantially because of the out-of-pocket maximum.

This is the chart that you've seen before. It shows the results of simulating changes in out-of-pocket spending and premiums for 2009 if the alternative benefit package had been in place. The second and third bars correspond to the two benefit packages we just described. The first one reproduces the distribution from November.

So let's start with the one in the middle that is the beneficiary-neutral package. The bottom part of the bar -- that's the blue and green -- shows that 9 percent of beneficiaries would see their out-of-pocket spending go down by $250 or more under the new benefits. Generally, these are the beneficiaries who reach the out-of-pocket maximum.

On the other hand, at the top of the bar -- that's the orange and red -- about a little over 20 percent of beneficiaries would see their out-of-pocket spending go up by $250 or more. Mainly, these are the beneficiaries who are spending more out-of-pocket due to the deductible.

The distribution under the program-neutral package is shown in the third bar. Recall that this package has a higher deductible and overall cost sharing is higher compared to the beneficiary-neutral package. And this difference you can see in the top part of the bar: about 30 percent of beneficiaries compared to about 20 in the beneficiary-neutral package would see their out-of-pocket spending increase by $250 or more.

We want to point out here how the picture might look different over a longer period of time. These charts show the distribution in a given year. But as Karen has pointed out in November, people's needs and preferences for insurance change over time as they age.

For example, even though a little over 20 percent of fee-for-service beneficiaries have at least one hospital admission in any given year, that number goes up to more than half if we look over five years. That means that many

more beneficiaries would see some years in which their out-of-pocket spending would be lower under the new benefit over a longer period.

If you recall, in November's presentation, we looked at three policy options that restricted what supplemental insurance can and cannot do. At that time, the Commission expressed a strong preference for the excise tax approach over the regulatory approach. Its main argument was that under the tax approach, risk-averse beneficiaries who wish to buy first-dollar coverage or reduce the uncertainty in their out-of-pocket spending through supplemental insurance should be allowed to do so. Instead of restricting how supplemental coverage can fill in Medicare's cost sharing, the tax would charge the insurer for at least some of the added costs imposed on Medicare of having such comprehensive coverage.

As a result, in today's presentation, we show an illustrative example of a simple 20 percent tax on Medigap and employer-sponsored retiree plans. Assuming the average annual premiums, this 20 percent tax translates into $420 per year on Medigap plans and $200 per year on retiree plans.

There are two main effects of a tax on supplemental policies:

First, the tax would provide revenues to help recoup some of the additional Medicare spending associated with supplemental coverage.

Second, as the insurers pass the tax along by raising premiums, the tax may provide incentives for beneficiaries to switch or drop supplemental insurance.

For modeling changes in the take-up of supplemental insurance in response to higher premiums, we consulted the Actuarial Research Corporation. Unfortunately, there is very little data on this question. The conventional assumption seems to be that the response to a premium increase among those who have purchased Medigap policies would be minimal, at least in the short term.

The Commission may wish to consider several policy design questions with respect to the tax:

What should be the appropriate tax rate?

Should the tax be imposed only on plans above a certain threshold of generosity?

Should the tax apply only to newly purchased plans rather than all supplemental plans?

As mentioned in the previous slide, we made a very simplistic assumption that a 20 percent tax would mean that beneficiaries' expenses would be $420 higher for those with Medigap and $200 higher per year for those with retiree benefits, even before we consider the changes in their cost-sharing liability. You can see the effect of this reflected in this chart, where we see a noticeably bigger change compared to the previous slide, which was Slide 8).

Focusing on the top part of each bar, we see that the majority of beneficiaries would see their total out-of-pocket spending go up by $250 or more -- 70 percent under the beneficiary-neutral package and 75 percent under the program-neutral package. For this chart, we assumed that beneficiaries keep their supplemental coverage and pay the tax on their supplemental insurance.

This slide summarizes the relative change in annual Medicare program spending under the four policy combinations we presented today -- the two benefit packages with and without a 20 percent tax.

For example, if we hold beneficiary cost-sharing liability roughly equal to current law, program spending would increase by about 1 percent. That's because of the

catastrophic protection for high-cost beneficiaries. But tax revenues would offset the increase by 1.5 percent -- that's the second row -- leaving a net budgetary effect at a half percent in savings.

In contrast, under the program-neutral package, Medicare spending would be about the same, but beneficiaries' cost sharing would be higher. With the 1.5 percent in revenue offsets, the net budgetary effect under this option would be about 1.5 percent in savings.

We want to reiterate several caveats and limitations of our modeling because it represents an imperfect approximation of the policies outlined.

First, our results provide a one-year snapshot of relative changes. We want to emphasize that these are not budget scores, which will have to take into account additional factors. But the results do show the relative budgetary effect of alternative policy options, which are useful to keep in mind as you consider and weigh different aspects of the benefit design.

Also, the scope of our modeling excludes dually eligible beneficiaries because we assumed that Medicaid would fill in any changes under the alternative benefit

package and would keep the cost sharing the same for those beneficiaries.

As we discussed in November, our results are sensitive to the behavioral assumptions underlying the model. In addition, our model contains some important simplifying assumptions on supplemental coverage.

Finally, we want to point out that throughout our analysis, our numbers do not capture the value of insurance that risk-averse people get when they insure against undesirable outcomes. This value of insurance is real and important for many beneficiaries.

To ensure that a new benefit design is flexible enough to respond to changes in medical evidence or delivery system reform, you may want to identify elements of the benefit design that are fixed and those that can vary.

For instance, you may want to create incentives to encourage the use of high-value services and discourage the use of low-value services. One way to do this would be to give the Secretary the authority to reduce cost-sharing for services that medical evidence has identified as high value.

For your discussion, we present an illustrative example of possible recommendations. IN this example we

tried to capture the main threads of the discussions to date.

First, direct the Secretary to develop a new fee-for-service benefit design with: out-of-pocket maximum, combined deductible for Part A and Part B services, co-payments that may differentiate by type of service and provider, such as primary care versus specialist visits.

Second, authorize the Secretary to reduce cost sharing on high-value services where there's evidence.

The next bullet point is more of a direction for implementing the first two. In today's presentation, we combined two constraints in putting the benefit package together, keeping the beneficiary liability neutral versus keeping the program cost neutral. What's the ultimate number you wish to work toward in designing the new benefit?

Third, establish an excise tax on supplemental coverage.

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

MR. HACKBARTH: Okay. Thank you, Julie.

So today let's do our customary two rounds, round one being clarifying questions. Karen, do you want to lead

round one?

DR. BORMAN: Julie, if you could go to Slide 6, I just want to make sure I'm correct. The outpatient per visit we're talking about here would be like emergency department or hospital outpatient department? Is that what we're capturing there?

DR. LEE: That's correct.

DR. BORMAN: I just want to be sure I'm interpreting that correctly. Great. Thank you.

MR. GRADISON: Under the current circumstances without a cap, a catastrophic benefit, do we have any idea what actually happens with regard to those rather large sums, that is, whether they're written off or whether they're paid or who they affect in terms of socioeconomic factors?

DR. LEE: So with respect to socioeconomic factors, people who have a higher income tend to have supplemental coverage, so they would get catastrophic protection in that way. In terms of who is reaching that very high level of liability, we know that it is pretty stable in that it's about 5 percent of the beneficiaries, but as to exactly who they are, that kind of detail we do

not -- or the kind of detail that one would wish, we do not have that. It's very general.

There would be some part of that beneficiary responsibility that would not be paid, but actually I do not know at this point to what extent that would be.

MR. GRADISON: Thank you.

DR. MARK MILLER: Let me just draw a distinction. We have a model built specifically for the purposes of doing some of this estimation. I think your question could be approached differently using a different data set, and we've done some work a few years back where we were looking at distributions of beneficiaries and who was in the extreme tail of the distribution. Again, that's something that we could revisit and bring back to you, but I think Julie is sort of speaking more to, I think, what's in this model where it is not highly detailed to answer the question that you're asking.

DR. LEE: Certainly on the socioeconomic variables, we really do not have that much information.

DR. MARK MILLER: Right. But we could approach that question through a different data set. So, Bill, we'll try and dig that -- and we've actually done it a few years

back, and we can dig some of that back up and bring it back to you.

MR. GRADISON: I'd appreciate that. I still have wounds that haven't healed since the Medicare catastrophic dispute of a few days ago.

DR. CASTELLANOS: Just on Slide 13, you mentioned creating appropriate incentives. I totally agree. We need to discourage low-value services and encourage high-value services. I see the problem being to be able to at this point in our discussions to clearly identify high- and low-value services. I don't know how you plan to do that. Maybe Mike will help us. Okay. Thank you.

MR. HACKBARTH: Ron, why don't we get to that when we get to the round two discussion. Bruce, clarifying questions?

DR. STUART: Yeah, I don't have the slides, but it was one of the earlier ones showing the characteristics of the new benefits -- not the effect but the -- yeah, right.

I'm curious about outpatient visits at $100 a pop because that seems to be directly contrary to what we talked about yesterday in terms of equalizing payments across site of service. So I think we open ourselves up to criticism by

having such a recommendation. Even if it's only illustrative, it doesn't strike me as being a particularly good illustration here.

MR. HACKBARTH: That's a good thing for us to keep our eye on. I would note, though, that our recommendation yesterday was about equalizing payment for E&M services, and outpatient departments are providing a wide range of other services. But good thought.

MR. GEORGE MILLER: Yes, thank you. On Slide 11, as I understand the presentation, if we chose to make this effective only on new purchase plans, would that change the budgetary implications of this slide going forward?

DR. LEE: Can you repeat the question

MR. GEORGE MILLER: Yeah. I believe you said in the presentation we could choose the option of only making this applicable to new purchase plans going forward. So if we chose that option, if I understood that correctly, then would that change the value of the slide?

DR. LEE: Yes, that will change the revenue offsets from the tax. That will decrease significantly.

MR. GEORGE MILLER: Thank you.

MR. HACKBARTH: Mitra, any clarifying questions?

MS. BEHROOZI: Yeah, I think a couple related to what Bill was asking, and I think we've asked them before, and I forget.

Of those 5 percent of beneficiaries who reach the catastrophic level, is it the same approximately 10 percent who don't have supplemental coverage? Or is it the 5 percent of all beneficiaries who are exposed, who are, in fact, exposed to the high out-of-pocket?

DR. LEE: So in very broad terms, people who just have Medicare only, they tend to be younger and healthier. So in terms of the probability of getting really sick, it tends to be a little lower. So that's kind of what's reflected.

Now, I actually do not remember -- we did look at this cut of the data before, but I actually cannot remember what that was. But it was not actually noticeable in that direction.

MS. BEHROOZI: So of the 10 percent who don't have supplemental coverage of some kind, it's probably around the same 10 percent of that group who reaches the -- who has no -- I'm sorry, 5 percent of that group who reaches the out-of-pocket level? I'm trying -- you know what I'm trying to

get at? The percentage total of the overall Medicare population who, in fact, is exposed to the catastrophic cost. Not to minimize it. I just want to get an idea.

DR. LEE: So I think you are referring to the actually cost-sharing liability, not necessarily their out-of-pocket spending, right? The people with supplemental coverage would have -- they could have a very high liability, but, in fact, be paid very small.

MS. BEHROOZI: That's not who I'm talking about.

DR. LEE: Okay. So you said the liability --

MS. BEHROOZI: I'm talking about the actual expose -- the actual liabilities --

DR. LEE: So the liability, that reflects the overall spending. So if you are younger and healthier, it's a relatively smaller portion of that group that will be reaching that liability.

MS. BEHROOZI: So it's less than 10 percent of the 10 percent?

DR. LEE: Yeah.

MS. BEHROOZI: Okay. Thank you. Now just leaving that alone then, the 10 percent of people who don't have supplemental coverage, how has that changed over time?

That's what I understand to be sort of the present snapshot, but like ten years ago, what was the ratio of people who didn't have supplemental coverage to those who did?

DR. LEE: So this is one of the things that -- it's from year to year in the chart book. I don't know where -- Dan? Dan would know.

DR. ZABINSKI: [off microphone] What's that?

MR. HACKBARTH: The question is whether the share of Medicare beneficiaries with some form of supplemental coverage has been relatively constant over time.

DR. ZABINSKI: [off microphone] Yes, it has. Around 10.

MR. HACKBARTH: Yeah.

MS. BEHROOZI: Thank you. And one more question. Sorry. On Slide 10, the changes in out-of-pocket spending in premiums, so this assumes that the premiums will go up because the plans will be covering the excise tax? That's how you get to --

DR. LEE: Yes, and we assume that the entire tax will be passed on to the beneficiary.

MS. BEHROOZI: Right, and it didn't assume any change in pricing behavior or whatever by the insurance

company?

DR. LEE: So we did look at it -- so under beneficiary-neutral package, we did not assume any changes in the premiums because the overall cost-sharing liability under the new package was roughly equal to current law.

Under program-neutral package where cost-sharing liability is higher compared to current law, we do believe that both the Medigap and retiree plans, there will be change in the premium. For Medigap we did look at how much of -- you know, where the premium increased, that that will shift the distribution of this chart a little bit higher. What is presented here, we did not assume premium changes for this particular chart, but we did look at for Medigap.

DR. NAYLOR: Just to make sure I understand, when you define the characteristics of the program on Slide 3, you talk about reducing exposure to unexpected out-of-pocket spending. I don't want you flipping through slides. My understanding is one way in which this has been modeled on Slide 11 is expected increases in Medicare spending for catastrophic under the beneficiary. But the one that I don't understand is how these models are mindful of effects on people in poor health.

DR. LEE: To the extent that they are the ones who will incur the higher cost-sharing liability, they would be more likely to benefit from the catastrophic cap.

Now, to the extent any special provisions addressing that third point, our current -- what we presented today did not make that distinction.

DR. NAYLOR: I guess one way to do it is thinking about if cost sharing gets to lower-value services, and value means higher quality at reduced cost, that might be. But I wasn't clear in how --

DR. LEE: So all the discussions today with specific benefit packages, we are mindful of the effects on low-income beneficiaries, but what we have modeled has not distinguished those characteristics.

DR. BERENSON: I'm following up on Mitra's questions about the interaction between the benefit changes and then what happens with supplemental insurance, so go to Slide 10. Just looking at this, with 75 percent of people having higher cost-sharing obligations and maybe 6 percent being significantly benefitted, it doesn't look like a good tradeoff from that point of view. But what happens -- I want to understand a little more what the response of the

Medigap plans would be. They no longer have to pay for the catastrophic expenses. They don't have to reserve for catastrophic expenses. I assume they reallocate that into covering most cost sharing.

So isn't it close to a wash? In fact, if people still were buying Medigap insurance, they wouldn't actually be paying this $310 on average. They would be paying roughly the same premiums and having the third party picking up their cost sharing. Is that not right?

DR. LEE: So that was the rationale we used for beneficiary-neutral package because under that package we rejiggered the cost sharing so that by putting on extra benefit with the out-of-pocket maximum, there were other, you know, increases in cost sharing. So the kind of average value of that package was -- in terms of cost sharing, that was roughly equal to current law.

Now, if we look at program-neutral package where overall cost sharing has increased, so even though Medigap supplemental plans might not have to now pay the catastrophic level, there have been enough increases in cost sharing at the lower end of it to increase the overall cost sharing. So we would think then Medigap premium will -- the

cost of that will increase.

DR. BERENSON: What order of magnitude of an increase?

DR. LEE: So the average cost-sharing liability for program-neutral package was about $130 higher a year compared to current law, using 2009 data, and that was -- so if we assume the average admin load of 25 percent, that translates into about $160 per year in Medicare -- Medigap premiums. So that was kind of a very simplistic back-of-the-envelope calculation we did.

DR. BERENSON: That helps. Thank you.

DR. HALL: Julie, that was a very clear presentation you gave. I appreciated it. I have a little bit more to say in round two, but you just mentioned very briefly one sentence, that it's very difficult to predict what sort of behavioral changes would occur in one model versus another, particularly in terms of out-of-pocket expenses. Difficult, but is it impossible? Or is it beyond the scope of this Commission? If the answer is we don't know, I'll wait until round two to come back to that.

DR. LEE: We have been asking experts for their opinion. It's a lack of data that I think has been the

challenge. So they are happy to express what they think, but they always qualify it with, "Well, this is just my personal opinion."

MR. HACKBARTH: So, Bill, are you focused on patient response to cost sharing at the point of service or how beneficiaries might respond to an excise tax?

DR. HALL: Yeah, how beneficiaries would respond to what they see as various incentives and disincentives to be insured or not be insured; and, conversely, how willing would recipients be to accept lower costs of one sort or another based on behavioral changes -- the sort of thing that's being done in industry.

MR. HACKBARTH: But is it their decision to purchase insurance or their decision to get medical care?

DR. HALL: No, no, I think it's to buy insurance like Medigap.

MR. HACKBARTH: Okay. I'm just trying to understand what part you're focused on.

DR. HALL: Medigap would be a good example.

DR. MARK MILLER: And I want you to know that there have been -- I think the sense that one way to put your question is I have now this clearer schedule of co-

payment, and as a patient I might then say, "Well, look at the value of the insurance and this increase and the premium, and do I want to continue to purchase it?"

And so we've had a number of focused on conversations with people out in the field, and they really -- we have really had a hard time getting a good estimate or sense of when you hit this price point, people will start to change their behavior. And that's what I think Julie is saying, that it's going to be very hard for us to say this is it, now the behavior will change. And I wouldn't anticipate a lot more precision there, although you seem to...

DR. LEE: So where people seem to be more comfortable is if you already have Medigap insurance and whether the incremental increase in premium is, you know, $20 a month or $40 a month, it's much more difficult for them to drop that Medigap insurance.

Now, people did point out that if you are actually coming to that decision whether to buy Medigap or not as you age into Medicare, so you currently do not have it but it's that initial decision, then the higher price might have a bigger effect. So there are various factors that can change

that decision, but for the current holder of Medigap policies, there is that inertia.

DR. HALL: Thank you.

DR. CHERNEW: What I was going to say is most of the time people assume that there's loosely going to be some continuous response, so it's not like no one responds for a nickel and no one responds for a time, and then all of a sudden it's 15 cents and everybody responds. Getting the magnitudes are hard, although it could be investigated in a whole number of ways. One of the challenges regarding this, of course, is you have to decide what employers are doing. So a lot of people are also getting their supplemental stuff subsidized by employers, and there's a bunch of other reasons why there's changes going on in the employer market.

My general sense is over time you would also see people shifting to less generous -- they're still buying supplemental coverage, but, remember, in the individual market there's the letters -- you know, C and F are the biggest ones of the supplemental, and so they'll switch to lower premiums in that regard. But I guess what I would say is although people wouldn't want to give you a number, I would be astounded if in the absence of evidence the right

assumption is no behavioral change to a price change. And then the question is what level, you know, a conservative or a less conservative assumption or some version of that. But so far there has been incredibly stable participation in supplemental insurance coverage, and I would be surprised if that stayed. In fact, I think a lot of the reason why people have moved to Medicare Advantage is because this gets more -- the other place people run when the premiums go up is they run to Medicare Advantage, which has a whole separate set of benefit design issues.

MR. HACKBARTH: It seems to me that this is a really important question because if you were to assume that the excise tax had no effect on purchasing behavior and people just continued to fill in all of the cost sharing, then basically what we've done through the restructuring of the benefit package is nullified largely because people aren't seeing those incentives, and it's just a question of how good is the excise tax as a new revenue source for the Medicare program. And, you know, you compare it to, say, the Part B premium. The Part B premium is a national constant amount, whereas an excise tax would vary according to health care costs in different markets. And some people

might think that's a good thing or a bad thing. The Part B premium has some income-related elements. Excise tax, just a straight excise tax would not. And so you'd evaluate the different ways of raising revenue for the Medicare program.

If, on the other hand, you think that the excise tax will affect purchasing behavior of supplemental coverage and, therefore, the reformed benefit package has a different effect, then you've got a whole different set of questions.

So this is really a central issue in this whole effort, and, unfortunately, there's not a lot of evidence, the experts are telling us, to make an assessment.

DR. MARK MILLER: I agree with all of that, and the other way to think about what's happening here, I think, if you guys could track this carefully, is we're sort of assuming at this level of taxation you don't get a lot of movement, which is also a conservative assumption about the effect. I mean, you're basically counting the revenue, but not counting a lot of additional effect beyond that. And I think -- this is correct, right? One nod, that's all I'm looking for. And I think what we feel a little strapped on is, you know, we didn't hear a lot of information from the environment to be more bold in saying, okay, I'm going to

assume this utilization effect because, you know, both on a hired basis and just making a phone call basis, we didn't get a lot of people saying you're going to get a big effect here.

DR. CHERNEW: There are estimates of the elasticity of demand for insurance from the literature. The question then becomes this is a different population and it's subsidized insurance and you could sort it out. But the assumption of zero as a default assumption for lack of any information strikes me as not -- "we don't really know so we're going to assume no response" doesn't strike me as the right assumption.

I would start with an assumption of the literature says in this other population you get this, and now we're going to try and figure out, we're going to shade that a little bit one way or another for this population.

DR. MARK MILLER: And I don't think it's no response. I think we have like very small --

DR. LEE: That's correct. There was about 3 percent dropping at 20 percent tax.

MR. ARMSTRONG: Just a question on this point. So the analysis isn't just about the sensitivity to different

pricing structure for a Medigap policy. It's also about the relative value of the basic benefit, too, and we're changing both. And so if we're changing the value of the basic benefit to make it more valuable, that too will have an influence over people's choices.

So, I mean, I think even more strongly to Mike's point, people are going to move. The question is really, you know, how do you predict how much.

MR. HACKBARTH: Let me play back what I thought I heard, Scott. The underlying structure of the Medicare benefit package will logically affect the propensity to buy supplemental coverage, but it is, again, difficult to know exactly how much. But to the extent that the benefit package is simpler and more readily understood by beneficiaries and maybe reduces some reservations they have about co-insurance when they -- you know, it's going to be 20 percent of some bill that they have no idea what it might be, and that creates uncertainty. Fixed co-payments may provide some greater confidence and simplicity and understandability in the benefit. The catastrophic may provide reassurance. And so the effect of a tax on the purchasing decision on supplemental coverage is going to be

also influenced by what the underlying benefit package is. You've got multiple variables at play here that really complicate the analysis, I think.

So let's get back to our round one clarifying questions.

DR. DEAN: How much has the premium on supplemental policies varied over, say, the last few years? Has it followed what private insurance does, or has it been more stable?

DR. HARRISON: Generally it follows the cost of the Medicare benefit because it's a wrap-around and that's what the insurance companies would be liable for, is the cost sharing on Medicare. So it tends to track Medicare spending.

DR. DEAN: So has that gone up in the same way that individual insurance has gone up?

DR. HARRISON: It has certainly gone up as Medicare has gone up. Now, the last couple years -- this data is from 2009. I don't think there have been big changes since 2009 because Medicare spending has been growing pretty closely. But it has gone up some.

DR. DEAN: And I take it that the rises have not

affected the take-up of the insurance; in other words, the proportion of people that are buying the policies has stayed pretty steady.

DR. HARRISON: No, I think Medigap has fallen off.

DR. DEAN: It has fallen off?

DR. CHERNEW: And they moved to MA.

DR. HARRISON: That's right.

DR. DEAN: Oh, okay.

DR. HARRISON: Right.

DR. CHERNEW: To some extent, Medicare Advantage payments haven't necessarily risen. For example, the actuaries at CMS have predicted a drop in Medicare Advantage enrollment because the generosity of payment for Medicare Advantage plans has been less, to my understanding. But you see Medicare Advantage plans are rising, and part of the reason is the Medicare Advantage market is connected to this market. So when you're trying to make choices between what you want to do -- the other thing that's going on is the employers are changing what they're doing in ways that we don't know a lot about. But if you don't have employer coverage, you're deciding between getting your gaps filled through a Medicare Advantage plan or through this plan --

and people shift between the markets. And I agree, we don't know a lot about those shifting, and so the overall amount with total supplemental coverage has changed. But the mix has definitely changed over the past few years as Medicare Advantage enrollment has changed.

DR. DEAN: I see. Thank you.

MR. HACKBARTH: Mike, did you have any further clarifying questions?

DR. CHERNEW: No. I think I'm halfway through my clarifying and a quarter of the way through [off microphone].

MR. BUTLER: My questions were around price sensitivity, too. Another way to look at it is to say, Do we know anything about the profile, the socioeconomic profile of the people in each of the categories now, the 10 percent that have no supplemental insurance, those that are employer sponsored, those that are picking the typical supplemental and those that are picking Medicare Advantage? I'm wondering if we knew their profiles that would help us understand their behaviors today. Can we match that?

DR. HARRISON: We don't have the data in this data set to do that. We hear things, but Medicare Advantage

enrollees tend to be sort of in the middle-income brackets. They're heavier there. The employer-sponsored people tend to be -- the most well-off people tend to have employer-sponsored coverage, and the Medicare-only are probably lower income but not Medicaid.

DR. MARK MILLER: And this goes back to some of the exchange there again. This data set has certain characteristics that allow us to do some of these things, most notably bringing together the supplemental coverage for the beneficiary in a place where we can do this kind of modeling. These kinds of questions probably require going out looking at different data and going -- I'm thinking these are the same people, but not precisely within this data set. We don't have the demographics.

MR. BUTLER: So I suspect that the healthy 25-year-old that says, "I'm going to just take a catastrophic and pay a low premium" is one thing. There probably aren't a lot of those that are 65 and healthy and saying, "You know what? I've run my numbers, and even though I've got the money to pay for the supplemental, I'm not going to pay for it." I don't know that, but there probably aren't many, is what you're saying, in that category.

MS. UCCELLO: Okay. I'm going to ask for a clarification of your clarification to Bob, who clarified Mitra. On Slides 8 and 10, the assumption is that for the program-neutral case, the Medigap premiums are going to go up somewhat. But I'm not sure I heard exactly -- are those premium increases included in these slides?

DR. LEE: [off microphone] The premium --

MS. UCCELLO: Or do they only reflect the excise tax part?

DR. LEE: What's here reflects only the excise part. We did run --

MS. UCCELLO: But you're including --

DR. LEE: Yeah.

MS. UCCELLO: Okay. I just wanted to make sure I knew what I was looking at. Okay. And now I'm going to open up a can of worms. You know, when we think about where to set this excise tax, we're kind of thinking of -- we could think about it in a couple of ways. We could think about it as we're trying to, you know, set it high so that people drop this coverage and in combination with the incentives in the other parts. Or we could set it to more kind of accurately reflect the extra cost that these

beneficiaries are incurring. And those extra costs not from selection but given that -- meaning that, you know, people who think they're going to use more get Medigap, but the increase in cost due to the cost sharing -- due to filling in the cost-sharing rates.

DR. CHERNEW: Increase in Medicare costs.

MS. UCCELLO: Increase in Medicare costs, yes. So I'm trying to get a sense of how does that 20 percent compare to what we think those extra costs are, and then that relates back to what we think the revenue offsets are going to be. And do those revenue offsets depend on people maintaining that coverage? And how does that change if then people drop it? Is that going to come up with the same savings to Medicare?

DR. LEE: So even using very conservative estimates of what the induced demand from having that first-dollar coverage from supplemental insurance, that if you translate that difference in spending and then to base that to the Medigap premiums, then it becomes a very high number. So it's definitely over 20 percent.

So if you kind of think of it as what's the revenue source versus if somebody drops it and then loses

that induced demand from having the first-dollar coverage, so if 20 percent is lower, then the behavior, in fact, will be higher than the revenues.

MS. UCCELLO: Okay. So -- all right. That's helpful. Thank you.

MR. HACKBARTH: Julie, what I heard you say was that, in fact, if you set the excise tax at the level to try to cover the cost of the induced demand, it would have to be a much higher percentage than 20 percent. How much higher, roughly?

DR. LEE: Roughly it was over 50 percent.

MR. HACKBARTH: Okay.

DR. MARK MILLER: Yeah, I thought even in some of our conversations it was 60 percent.

DR. LEE: [off microphone] -- 50.

[Laughter.]

DR. MARK MILLER: Actually, just to spell this out a little bit more -- I'm sorry, Mike -- what you're doing is you're saying there's this utilization effect, and now I'm going to build it into a premium that is designed to wrap around. And that's why the percentages get eye-popping really quickly.

And just to follow up on the second half of your question, but what if they didn't have that, and then what would be the effect on utilization of facing this new cost-sharing structure, now obviously that we could model, but, you know, that's the tradeoff you're trying to set up in this conversation. And the punch line is at this level of an excise tax you are not recovering, you know, the full effect of the utilization -- the utilization effect of the first-dollar coverage. I'm sorry.

DR. CHERNEW: The reason why the percentages seem high is because Medicare is such a large share and the Medigap portion is such a small share. And so --

MR. HACKBARTH: A lot of leverage

DR. CHERNEW: Right, exactly. And the leveraging is what makes it high. But the only other thing I would say in response to that that I think is really important, I don't view this excise tax as a tax because you're really just charging people for something they're getting from the -- you're sort of pricing it correctly. You're not taxing it in some way. I don't know if that makes --

DR. BAICKER: You're offsetting a subsidy.

DR. CHERNEW: You're right. There's this big

subsidy that's going on that these plans are getting that you're kind of making them just pay their full price, which is slightly different than the way you would think of a tax. And the tax language has some -- might have some burden with that word.

[Laughter.]

DR. CHERNEW: But if anyone cared about the language, I think recognizing that what we're really doing is pricing the plans correctly for the full cost they're impose is a different activity than taxing.

DR. MARK MILLER: More correctly.

MR. HACKBARTH: Yes, and that's an important point.

DR. BAICKER: So I'll want to focus a little more, shockingly, on the insurance value in round two, but in thinking about that, we've talked before about different ways of parameterizing the gain that people are getting, even talking about sort of beneficiary-neutral, it looks like -- it looks like they're paying more and getting nothing if you just look at the numbers, whereas we know they're getting this nebulous insurance value.

It sounded like you didn't have enough

longitudinal data to be able to say how much is your individual variance reduced under this plan. But is there a way to capture how much the variance is reduced either for a cohort or, you know, for synthetic cohorts to say imagine that the 66-year-old we observe today is actually one year from of the 65-year-old we observe today, which is obviously not quite true, but can you use a model like that to try to capture how much variance is reduced over a span of time for someone and put a number on it to balance against what looks like, well, wait, beneficiaries are just paying more and not getting anything else? What other mechanisms are available to parameterize reduction in variance?

DR. LEE: So in terms of just looking at Medicare utilization and spending, we can create a fairly large panel for that. The limiting factor is we do not have the information on their supplemental status, so that's -- and the effect of a new benefit does depend on your out-of-pocket spending, which is a function of the supplemental coverage. So that is kind of the limiting factor for simulating what the effect would be, how much variance is reduced under a new package.

In just terms of how your overall spending varies

over time, that we can get, but I don't think that is what you are getting at. It's how much of the variance -- reduction in variance under an alternative package, right?

DR. BAICKER: So you don't have individual level -- for the individuals you observe, you don't observe their supplemental coverage. You have a sense of the supplemental coverage of the cohort so you could make some assumptions about let's just tag people with coverage based on the distribution of coverage for the whole group.

DR. LEE: For one year we have individual information, so that's why we've been just looking at a one-year analysis.

DR. BAICKER: That also seems like it might be an important input to these other conversations about how Medigap coverage might change under different models because, you know, Glenn was saying, oh, the certainty of a co-pay versus a co-insurance, but I would think that the bigger effect would be you now have an insurance product that's more valuable. If you were paying for Medicare and you had a reduced variance Medicare package, that should come with a different premium, which should then affect the value of the Medigap plans. You're getting a different

item, a less valuable item in Medigap because some of the variance has been taken care of by Medicare. So being able to parameterize how much the variance is reduced seems like an input into lots of different calculations to be able to say we've just given you a more valuable Medicare package, you're going to pay less for Medigap because -- you're going to be willing only to pay less for Medigap because it's now worth less because it's not picking up that variance.

MR. HACKBARTH: I didn't understand all that, Kate. We need to translate that into lawyer language.

DR. BAICKER: But it was so lucid.

[Laughter.]

MR. HACKBARTH: But one thing that I thought I heard you allude to was looking at this over time and not just a year at a time in terms of evaluating the benefit of the coverage that people get. And so if you look at it over time, especially in a population of seniors, the likelihood that people are going to incur high costs and benefit from the catastrophic presumably grows as you look at the analysis -- not one year at a time but five years at a time. Is that --

DR. BAICKER: Actually, having multiple years of

data would let you do some additional analysis, but what I was actually hoping to capture doesn't necessarily hinge on having multi-years of data. What I want to know is how much risk are you exposed to this year.

MR. HACKBARTH: But only one year.

DR. BAICKER: And one good way to figure that out is to look at paths over time and see what might happen to you over a wider window. But another way would be to look across people and say, "I could be the lucky person who stays healthy or I could be the unlucky person who's diagnosed with an expensive disease," and look at a cohort of people who are representative of the many different things that might happen to you. So you don't necessarily have to look over time, although that's a very helpful way to capture that. I was being cognizant of data constraints, trying to think of other ways to say the package is more valuable even if your individual spending goes up by $10, if your risk of exposure to $1,000 has gone down, even if that isn't realized today, you still got some insurance value. And I'd love to be able to put some numbers on that to balance against the, well, wait, average spending went up, why isn't that just a bad deal for everyone? We don't have

the number that helps put weight on that.

DR. MARK MILLER: I guess the last thing I -- can we go to 8, I think? So if we were able to do that -- and notice the real careful choice of words, because I'm also just trying to visualize -- I also now understand how you're saying -- you know, I know it's an over-time phenomenon, but perhaps cross-sectionally you could -- okay, I see that. Not necessarily how to do it, but I see the concept. Then you would actually have -- you think you could derive a dollar value that you would then say put in -- because, I mean, in the end, people on the Hill are going to be saying, "So how does this happen?" Would I really overlay that into a chart like this?

DR. BAICKER: That's risky because to put a dollar value on the insurance value, you have to put in a bunch of assumptions about how people feel about risk and how -- you know, it doesn't come out of just summary statistics of the data. But you could create some parallel exhibits that weren't layered on and, you know, looking like apples and apples when they're not. It would say something like, you know, the share of people whose risk was increased versus decreased or -- I mean, everybody's risk should be going

down with this, but something to help visually capture and quantitatively capture, even if it's not directly overlaid with this, the fact that people are gaining some protection.

MR. HACKBARTH: You can't do this slide just for multiple years of data? So this isn't trying -- actually, I want the one where you're not including the effect of the premiums, sort of the first one where you showed the different benefit packages and how they --

DR. MARK MILLER: That's the [off microphone].

MR. HACKBARTH: That is this one? Okay. So you can't just do this over time and say that if you look at a five-year span this is how many beneficiaries would experience higher out-of-pocket costs and lower out-of-pocket costs?

DR. LEE: We can do that for their cost-sharing liability, but we do not have individual supplemental coverage information.

MR. HACKBARTH: That's what I'm saying, just for the liability.

DR. LEE: Liability we can.

MR. HACKBARTH: Yeah, and how -- I would think that over time, if you look at it over, that it would show

that the catastrophic coverage is more valuable. Wouldn't that be an interesting exhibit to have?

DR. LEE: So the kind of simple proxy we tried to do was to look at we know that your overall cost sharing is lower compared to current law under the alternative packages if you have at least one hospitalization. And so we looked at, you know, the number of years that you had at least one hospitalization over a five-year period. So the probability in any given year of a hospitalization is about 20 percent, and that goes up to about 50 percent if you look at 50 years. So that was kind of a way to see, you know, how over time this one-year snapshot might look different.

DR. BAICKER: I think that that would be very helpful for two reasons. One, it would capture that, in fact, this one year may not be a good proxy for how you benefit over time, and just looking at Medicare, not with Medigap, is then capturing the value of this program. It doesn't tell you how individual exposure is changing, but it's telling you how the value of the benefit package is changing. If anything, that's understating the improvement in risk protection that you see because there are some things that are idiosyncratic year to year and there are

some things that are persistent. And so the persistent -- you also don't know if you're going to be diagnosed with an expensive chronic disease that's going to show up year after year or if you're going to have an idiosyncratic hospitalization that's not going to show up year after year. That will smooth away one kind but not the other, but it's at least getting you partway there.

MR. ARMSTRONG: So, Julie, I'm not sure if this is for you or for Kate, but is "parameterize" really a verb?

[Laughter.]

DR. BAICKER: Oh, yes.

MR. ARMSTRONG: I mean, Julie, you just didn't flinch.

DR. BAICKER: And then "parameterization" is a noun, and keep going.

MR. ARMSTRONG: The Harvard talk.

[Laughter.]

MR. ARMSTRONG: My question is much simpler. Actually, it goes back to some questions raised earlier. The outpatient per visit out-of-pocket $100 deductible, I'm familiar with this really being targeted at emergency room visits, and that often it's much higher than that. This

seems to be kind of generic hospital outpatient. I'm wondering if you looked at, modeled higher costs for emergency room visits and discarded that, or if that's something still worth considering.

DR. LEE: So for physician services, we went back and actually got much more granular data. Now, for outpatient services, we have not done that, so we just have, you know, all different kinds of outpatient visits, including surgeries to emergency room visits, that are just in that number of outpatient visits. We do plan to get more granular information so that we can make such distinctions, but we have not done it yet.

DR. BERENSON: I'm going to jump in, Scott, because we were talking a couple of days ago on this very issue, and maybe you can help us, or anybody else. The concern that I have is that we're modeling a traditional Medicare benefit package on a good HMO-type benefit package, and we're going to basically go from 20 percent cost sharing for physicians to a co-payment for a visit. And I'm just wondering if there are models, benefit designs that actually do have more -- that move away from just 20 percent of something you don't understand, but recognize that there are

physician services that cost thousands of dollars in many cases.

So my question to you is: Is there a way to do this without forgoing 20 percent of revenue and at the same time not creating huge barriers to that care?

MR. HACKBARTH: And let me just piggyback on that, Scott, and others who are familiar with current approaches to structuring packages.

One particular question that we were asking one another about is what happens today in HMOs when a patient is hospitalized and using physician services, perhaps a surgeon, a radiologist, anesthesiologist, various other consultants. Under this benefit package, as we understand it, there's no cost sharing for the patient for all of those physician services. You're just paying the $750 co-pay for the hospital visit. Is that the approach currently used by Group Health and other plans or something --

MR. ARMSTRONG: Yes, that's correct. When you are hospitalized, it's an all-inclusive bill, if you will. We have a lot of examples where we are really differentiating the out-of-pocket costs for some of these outpatient services that are not associated with an actual admission to

the hospital, and we would be happy to describe those. But I think most notable, the advanced imaging and the emergency room services are those that tend to be low value, discretionary, and we place a high out-of-pocket cost on those in particular. But there could be more to that.

I think -- and this would be a point I'll make in round two -- part of the issue we're dealing with here is that the HMO plans don't just use out-of-pocket financial incentives. I mean, they have these whole care management infrastructure and all sorts of other things that are really complementary to this, and that is, I think, part of the issue we're dealing with.

MR. HACKBARTH: I think that's part of the issue here. We're talking about adopting an HMO-type benefit structure for an open-ended fee-for-service plan that doesn't have those care management factors, and so it's mirroring two different types of ideas.

Okay, round two comments, questions?

MR. GRADISON: This is going to be a little stream of consciousness but it won't take long. I lived through this, through Medicare catastrophic, and there are a few things I'm proud of from serving in public office. One is I

went down with the ship. I never voted to repeal it because I was convinced that, on balance, it would be beneficial to the participants in the program.

They didn't see it that way, and I've been trying to understand why it is so hard to bring about change in the Medicare program, and that's a pretty good example of what was happening in that time -- resistance to change.

I would summarize my experience that the losers know they're losers, but the winners don't know they're winners. And the winners do have a value. There is a value in insurance. I know that. But you really don't know that you're going to have catastrophic expenses until it's too late to do anything about it and go out and buy the insurance. But our own numbers show that most people -- I'm not talking about dollars, but most beneficiaries are losers. We show that. They actually are going to end up paying more than they pay today under the present system.

And so I asked myself, well, why is this? And this is a pretty broad generalization, but I've been trying to figure out why are we basically stuck with a 1965 design. That's the screen at which I look at it. And you say, well, it was a prevailing design at that time; it was based

largely on the Federal Employees Health Benefit Plan as it existed at that time. And the world has changed. I mean, today this kind of overall structure doesn't exist in nature, so to speak. I don't mean it doesn't exist at all, but the world has passed it by -- not only with HMO plans but with changes through POS and so forth.

So I think that as far as bringing about these changes is concerned, I still am trying to grapple -- I was trying this in my first round -- with learning a little bit more about the potential winners and losers.

My hunch is that newer beneficiaries would be much more comfortable with this than existing beneficiaries, and you could say, well, of course, because the older ones are used to this pattern and they would just resist change. But I think it's deeper than that. I think newer beneficiaries have been covered under plans which don't look anything like this. And so we're moving closer, in a small sense at least, towards the experience that they've had.

You can justify and say, "What are you driving at?" And I'd have to say it's sort of a stream of consciousness, but I'm really concerned whether we can -- I like what we're doing here, but I'm not sure we can pull it

off.

MR. HACKBARTH: Bill, let me just pick up on your point about newer beneficiaries might be more comfortable with this than older beneficiaries. Does that imply that a possible approach would be to do this on an age-in basis, that -- and obviously I haven't thought through administrative implications of this, but say that, you know, for people joining the program after some date certain, there's a new benefit package and one that will look familiar to them based on recent experience with private insurance?

MR. GRADISON: I think that's well worth thinking about, because up until now we've talked about for everybody -- which I still think makes sense. I hope that's clear.

MR. HACKBARTH: Again, the politics of this are difficult. These ideas have been around, you know, for decades, and they don't gain political traction. In one instance they did. There was a strong backlash and it was repealed. And, you know, it's folly just to pretend that that history doesn't exist.

DR. STUART: I had the same reaction that Bill did in the sense that in a way we have gone through this before

with the Medicare Catastrophic Coverage Act, and there are obviously differences between what you're proposing or -- I'm not saying proposing -- what you're examining and what was actually enacted in 1988. But I think that it would be very wise to go back and look at that experience and not just the numbers part of the experience but the reaction by those who knew that they were losing.

If you go to Slide 10, the main concern I have with this is a Medicare catastrophic concern. You tell me -- you guys are coming up with a proposal that is going to make 85 percent of Medicare beneficiaries worse off? The face validity of this thing I think is going to be really problematic.

Having said that, I agree with Michael that this outcome is highly unlikely, and I say that for a reason. I'm looking at it from the standpoint not so much of those with employer coverage but those who are currently buying one of the Medigap plans, and I add up the extra prices on this, and using a Laffer curve approach by saying, you know, if the price gets to a certain point, then, you know, you get no revenue and the market just completely collapses, and here are the four parts.

The first part is Kate's part. If you change the benefit so that you provide catastrophic coverage, you improve the insurance value of the Medicare program, which means that you reduce the insurance value of the Medicare catastrophic coverage. We may not know how much, but we know the direction.

Secondly, if you have a 20 percent excise whatever you call it, it's still something that people have to pay, and so the price jumps immeasurably.

Third, the Medigap policies already have extremely high loading, and if you look at the demand for Medigap policies, people have said, well, why do people buy this insurance anyway because it's such a lousy value.

And then, fourth -- and this is a point that Michael also raised -- is that when you raise the price of this alternative, this 20 percent premium on a good that has less value than it did before, then the alternatives look better and the MA plans look much, much better.

And so if I put all four of those things together, my best bet is that the Medigap market would just disappear. You know, I don't know whether that's true, but I'd be willing to put bucks on -- not $10,000 but a few bucks on a

bet --

[Laughter.]

DR. STUART: -- that said if we were able to try this, my guess is that people just wouldn't buy Medigap policies anymore. They'd just go right to the MA plans, and the MA plan -- and this is the other thing. There's going to be a supply response to this thing. I would really expect that the PPO part of the MA plans would really expand. In fact, the insurers are the same people. They're the ones that are offering the current Medigap plans, that are offering the PPOs, you know, and it's not that difficult to move from one product line to another.

So there are two parts to this: the perceptual part, which I think is really problematic, and I would strongly urge you to have something in the language of this that recognizes that we've been through something like this before, and so we don't want to make that mistake; and then you have to pay attention to behavioral responses somehow.

And the last point I'll make is that we've concentrated here on kind of the price response to value in the insurance product, but I think we're on much firmer ground in terms of making behavioral assumptions about what

will happen when we change the nature of the product. In other words, we have much better research about the elasticity of demand for Medicare services than we do for the responsiveness to the insurance price.

MR. HACKBARTH: Bruce, you've made a number of good points. I want to go back and just be the devil's advocate on the very first thing you said. You look at this, and a significant, large majority of Medicare beneficiaries end up paying more, and, you know, isn't that -- I can't remember your exact words, but isn't that sort of a non-starter as an idea, and it may well be.

But if you step back and look at this in a bigger policy context, one of the fundamental issues facing the program is if, in fact, we need to lower Medicare costs or slow the rate of growth so they aren't consuming as much of the national resources as they have been, how do we distribute that across the different participants in the system? Increasingly, you know, providers are saying, "You can't take it all out of us because you're going to adversely affect access to care, quality care, and we need to figure out ways to share the responsibility of lowering Medicare costs." So the question is: To what extent, if

any, should Medicare beneficiaries share in lowering the costs of the program? And what are the different policy alternatives for increasing the beneficiaries' share?

And this whole conversation introduces some potential elements in terms of how you structure the benefit package or whether you right-size the premiums for supplemental coverage by having beneficiaries pay more for supplemental coverage, and then in turn each of those possibilities has pros and cons in terms of the incidence of the burden and which beneficiaries bear a higher cost.

I don't think we should, in other words, just stop at your initial observation and say, "Oh, beneficiaries on average are paying more; therefore, it's a political non-starter." If we do that, I'm not sure we're doing a service to the Congress.

DR. STUART: Actually, that wasn't my point. My concern here is that if you show that slide, the conversation stops and that whatever else we are trying to do here just doesn't go further because people are not going to -- that was my point.

MR. HACKBARTH: I understand your subsequent --

DR. STUART: I'm certainly not against analysis.

I think the whole point of this is that we think that there are significant problems with the supplementary insurance that Medicare beneficiaries currently have, and what we'd like to do is to move them into something else. We're not trying to get them so that they don't have anything. We'd like to move them into some other kinds of products. I mean, that's in part why I think it's important that we take on the issue of value-based insurance design here. We've got to say something. I mean, that's where the returns are, is getting rid of things that have low value.

If we get rid of everything, then, you know, again, I think we're at a point where we're going to hit this wall, and then the policymakers are just not going to listen to us. That's my fear.

MR. GEORGE MILLER: First of all, this has been a very helpful discussion in hearing everybody's point of view. This is not one of my strong suits, so this is very educational and beneficial as we try to provide additional service to the Medicare beneficiaries.

I'm struck by a couple of things. On Slide 10, it seems to me that it would be very helpful -- I'm sorry, on Slide 7. It seems to me it would be very helpful as we have

had the discussion maybe to identify an ED visit separate from an outpatient visit, to push that as a point of trying to move folks from abusing the ED versus just the outpatient line, which I think would be embedded in there, and then try to move folks away from using the ED as a place, especially probably low-income beneficiaries using that as a point of entry to get health care benefits.

The other thing that I think as we listened to this, if we think about just applying this to newly purchased plans, that may have some traction, but I certainly would like to see the analysis of what impact that would have on the numbers. I think that had the question answered earlier. I'm not sure who said it, but I'm not too crazy about the term "tax" -- "tax benefit" -- I forgot the name of it.

MR. HACKBARTH: "Excise tax."

MR. GEORGE MILLER: "Excise tax." If we could come up with a better name for that, a correct -- I think Michael said it, correctly pricing that benefit, it would just eliminate the political negativity about the word "tax" in that design.

MS. BEHROOZI: So I think I have two pages here.

I'll try not to take two pages' worth of time. I'm trying to distill it into, you know, conceptually how to organize these thoughts.

I'm trying to go back to the beginning, which is that I feel like we're doing two different things here. One is providing the catastrophic protection, and the other quite separate thing is trying to build a better benefit design to help control excessive spending in the program. And they're really quite separate things.

I think thinking about the 10 percent who don't have supplemental coverage I feel like puts into sort of sharp relief how mushing these two things together might produce some not so great results, because as you said, among that 10 percent probably a smaller share of them will actually get to that true out-of-pocket catastrophic level than among the general population. So you said among the general Medicare population it's 5 percent in a year, so it's less than 5 percent of that 10 percent will actually be protected strictly by the Medicare program being redesigned. And where will the burden fall? On those others who don't have catastrophic coverage who are lower income, as you said, and with a combined deductible in particular, they're

not going to be able to access their Medicare benefits. They're not going to be able to afford to get to the point where their Medicare benefits will kick in. I think a combined deductible -- and I said this, you know, when we were talking about this in prior years or last year, or whatever -- I don't think it's a good idea. I think we want people to go to the doctor when they're sick, and the lower Part B deductible is designed, I think, somebody thought, it's better that people get to the doctor sooner rather than waiting until they can somehow come up with, you know, $500 over the course of a year, or thinking that they can't and so they never go.

So, you know, there's a reason that different types of services have different thresholds, cost thresholds, before you access them, right?

MR. HACKBARTH: Could you tell us a little bit about how your plan is structured in that regard?

MS. BEHROOZI: I can't talk about our main plan because we have no point-of-service costs because we use all those other management tools that Scott talked about and we have a very low cost, but it's the all-in cost.

We do have a couple of plans that have some point-

of-service cost sharing, but we don't have deductibles. It's just co-payments, because I still don't get the point of deductibles. That's just an insurance pricing feature as far as I can tell, and, you know, from conversations with Mike, it's just a way of keeping the premium down or keeping other costs down that you otherwise might shift. But I think it's kind of the worst -- it's the least thoughtful, shall we say, the least targeted way of shifting costs. So if we're worried about the 10 percent who don't have insurance coverage -- or supplemental coverage, I think we're hurting them the most by covering that smaller share of them with Medicare dollars.

For everybody else who does have some kind of supplemental coverage, it's just a question of which pocket it comes out of or how it comes out of their pocket. And, clearly, the people who have chosen Medigap plans because they value the insurance protection, the risk aversion, they've chosen to pay a premium not at the point of service -- they don't like, you know, showing up and either not knowing how much they're going to pay or having to shell out dollars at that time. They like being able to write a check once a month or, you know, an automatic deduction from their

checking account. And, yeah, those who get it through employers, they may be also contributing toward that during the course of their working time by forgoing raises or whatever.

It does seem like more people have a preference, to the extent that they can afford it, to kind of spreading their costs via premiums, via forgone wages, and that instinct I don't think is necessarily reflective of a conscious choice, but it tends to align with what I think we see coming out in the evidence that, you know, the whole issue of whether point-of-service costs deter unneeded or needed care. You know, we keep talking about induced demand as though the demand wouldn't be there but for the coverage. Well, maybe the utilization wouldn't be there but for the coverage and people would forgo needed care and then there would be -- they would suffer consequences. They would suffer poorer health status. Or there would be higher costs later on, and I've cited the research before, but, you know, there's slowly more research coming out demonstrating a cost offset in terms of acute costs later because of forgone care, drug coverage and physician coverage costing more at the front end ends up in some cases -- well, it was the

Medicare population, Medicare Advantage population in California I think that was studied that showed a hospital offset, you know, longitudinally, three years later or something like that, the hospital costs presented a higher cost to the plan overall.

So whether people know that when they're purchasing that coverage or they just have an aversion to risk or whatever, I think we should pay attention to that signal; and if we are, like I said, worried about that 10 percent who don't have coverage -- and I am -- I really don't think this is the right thing to do to them. I think that putting so much cost up front in the deductible is the wrong thing to do.

As far as taxing plans, frankly, when we were talking about initially, I didn't think of it only as applying to the new benefit design. I thought of it applying it to the current benefit design. But I would just suggest there because people do have the choice to go to MA, they should also be able to make a choice about their Medigap plans, and they can choose to pay more for more coverage or choose to pay less for lower coverage. That's the way it is now. I think, you know, as Mike says, it's

right, load more of the actual cost into those plans. But I think we've got the example in PPACA of the so-called Cadillac plan tax going into effect in 2018. It has to apply to all plans; otherwise, it kind of doesn't make sense because you're trying to, you know, recover the revenue, give people time to choose whether they'll stay with their current plan that's going to be, whatever, 30 percent more or 40 percent more, or go to another plan that might be 10 percent more because it offers less generous coverage -- I think it should track the generosity of the plan -- or move to MA. And maybe you'll see insurance behavior changing. Maybe they'll squeeze some more out of their load, as Bruce says, to be able to compete to keep the business and not pass along all of that additional cost, whatever you want to call it -- the excise thingy -- to their beneficiaries.

I think that's it. Those are my two pages.

MR. HACKBARTH: Let me just nail down one thing, Mitra. What I hear you saying is you're not sold on the combined deductible, even, you know, if we stipulate --

MS. BEHROOZI: [off microphone] Not sold.

MR. HACKBARTH: If we stipulate that, you know, there's going to be significant cost sharing because there

is an existing Medicare benefit package, you are particularly worried about the effect of a combined deductible on access to physician services and would rather see separate deductibles or no deductibles at all, although I suspect that that would imply very, very high co-pays, huge co-pays. And so --

DR. MARK MILLER: You would be pushing the catastrophic cap way out, the co-payments up.

MS. BEHROOZI: Exactly, and it's not that I want anybody to suffer the higher catastrophic spending, but it is a very small number of people, and, you know, I think the question -- I'm sorry. Somebody on this side asked what happens -- I think Bill asked what happens to those people. I doubt that it's like in the general population where more than 50 percent of personal bankruptcies are driven by medical costs. I don't think that's what happens when you have that high catastrophic costs among that share of people who are lower income or whatever. I bet that ends up in the unreimbursable and gets reimbursed by DHS probably. I mean, you know.

MR. ARMSTRONG: Glenn, just one brief comment on this. So we have plans now that have deductibles, but we

exclude from the deductible preventative visits or a whole series of visits around 12 chronic illnesses where we want those patients to have no cost out-of-pocket in order to get in to see those providers. And so there is a way, actually, to have both a deductible but to not create the disincentives, Mitra, that you're talking about. So that just may be something for us to look into.

MS. BEHROOZI: Yeah, I think that's kind of the problem with a fee-for-service, you know, unmanaged package where -- and then to load more into the deductible without being able to do those things, I mean, you know, unless Medicare wants to administer that. That would be cool. That would be really good.

DR. NAYLOR: Nothing new to add to this rich conversation.

DR. BERENSON: I don't have much to add. This has been very interesting. I'm still formulating my own views on a lot of this, but I'm encouraged that we're doing the right thing here and that we actually can make a case for the kind of package that we're putting together. I do think in a couple of areas we need more work, like trying to figure out what this sort of hybrid is between a tightly

managed HMO and just sort of a traditional indemnity-based 20 percent across-the-board, whether we can do something more creative on the physician side. Wherever we can build in some notions of value-based benefits like with identifying services that are excluded from the deductible, I think we should take advantage of.

I guess what I want to talk about a little bit is are we going to just get into trouble by proposing something that's smart but is -- I guess you said had no face validity, I think, Bruce, was your -- or was sort of dead on arrival, or whatever. And I don't certainly have a good answer on that. My sense is that -- well, not my sense. I don't think we would be proposing this as a stand-alone, let's redo catastrophic from '88 and just say let's adopt this plan. I'm assuming that Medicare over the next few years is going to be subject to intense review and scrutiny and that there will be proposals and at some point some agreement on some restructuring. Whether that goes all the way towards a premium support model or puts expenditure targets in the program or whatever it might be, in the midst of that kind of a restructuring, this isn't the only -- this could be sort of presented also as part of it. In other

words, this is not the stand-alone, we're going to redistribute towards people who have catastrophic illnesses from low-income people who now may have difficulty finding -- I mean, that's not what we want to do.

I think what we want to do is have a series of options available, having analyzed them, that it just makes sense if there's a program restructuring that we do take on the benefit structure, which is not a very good one right now. So I'm really thinking aloud here.

On a number of these issues, I don't think there's a correct answer. I can argue on the deductible. There's pros and cons of going to the combined deductible and not going to the combined deductible. We've identified beneficiary-neutral versus program-neutral as a policy decision. We've talked about what I guess I'll call a surcharge, not an excise tax -- maybe that's a more neutral term -- versus regulating first-dollar coverage as a design issue.

I'd just throw out the possibility that rather than sort of having a defined package that we vote up or down on, that we actually do a very good job of laying out design options, the advantages and disadvantages, and I

think present a pretty clear picture of where policy would come out, but don't presume to judge the politics of it.

So I just throw that out as a possibility that we might want to talk through, but I guess the major thing I want to say is I don't think we want to be positioning ourselves to endorse a specific package and say we think the Congress should legislate this tomorrow.

DR. MARK MILLER: I agree and I want to build on that. So if I could get you just to flip to the last slide, there's a couple of points that you could imagine.

I think Bob is absolutely correct that we wouldn't be coming along in a report with a recommendation that says here's the benefit package. We're not doing that. Okay? We're cranking through this for a lot of analytical reasons: to make sure people understand impacts, how levers work, all the rest of that.

Notice this slide where you could imagine a set of statements that the Commission says -- and, Mitra, obviously there's at least one in here that you don't agree with, but, you know, we think there should be an out-of-pocket maximum, we think there should be designs and benefit that work like this, co-payments instead of co-insurance. I'm deftly

moving past the flashpoint with Mitra.

You know, the notion of trying to focus on high-value services and at least giving the flexibility to deal with those as evidence arises, you could imagine statements like that. And then you have illustrations through the chapter, but you're not saying it is $101 for this service.

Bob has even, I think, a point off of that, which says say here are the issues, design issues, pros and cons, and the way you could think about them. And so I want to just take this opportunity to focus you on a final product and make sure that you understand. We wouldn't say, "This is it," you know, because there's detail underneath this that just really needs to be thought out past that.

I'm hoping that was building on your point.

DR. BERENSON: Absolutely building. Absolutely.

DR. HALL: So what I've taken away from the discussion so far is that life is hard, and I already knew that, but that the implications of a lot of these decisions about price point and where you actually interject the price point, we don't know that much about it, and particularly we don't know much about how it influences human behavior, maybe a little bit more about the impact on health.

But it seems to me it's so important because this business of price points isn't the same thing as to whether I buy a Kindle or an iPad 2. It has implications in terms of future Medicare expenses if people make wrong choices, and it also has implications in terms of quality of life if we want to throw that into it.

So the reason I ask the question of is there anything known about the psychology of choice that we can even interject into this that makes any sense, or at least any proposals we've put forward, say that at least somebody ought to take a look at this, so I have a little challenge here for Mike and for Kate. I'm way out of my league here, but I've been sort of dabbling in some of this business of "Slow and Fast Thinking" by Daniel Kahneman and a few of his experiments in how people view various medical procedures.

Isn't there still -- let me give it one more try on this. Isn't there still some way we could interject this kind of thinking into how we judge the relative value of the different options we put forward?

MR. GRADISON: Bill, one possible way would be to look at the choices actually made in the Medigap market among the defined plans. The statute has defined what can

be offered, and I'm not sure where this would lead us, but there's real information there somewhere about how people deal with the choices that are available.

DR. CHERNEW: Two quick things about that. One of them is prior to, of course, standardization, the view was the market was pretty dysfunctional, and you had to standardize it to support the choices. And I would say -- and maybe Kate can -- where the more cutting-edge research of people I know would be going would be to try and quantify the mistakes that people made for a whole bunch of reasons. So I think you used to have a paradigm that if you let the market work, people make a bunch of choices. They're telling you something about their preferences, which is really great if you're getting through econ grad school.

It turns out that, I think, increasingly people are thinking, looking at a set of choices, realizing how sensitive those choices might be to seemingly minor choice setting modifications and asking, boy, we need to think more strongly about how we set this up, and simple things that would have been the standard answer, we'll just give them information, aren't nearly sufficient to try and modify those, although what I would say in response to Bill's

comment is that's exactly right. I don't think -- and, again, Kate can comment. I don't think the science is anywhere near close enough to figuring out exactly how you would do that, because one thing that is true is you have to have a good set of values for what you think other people should do before you start fiddling around with some of these things. And that's a harder lift than one otherwise might have, but it is a challenge, particularly in this population, as challenging as any population, to see that they're making the right choices. And I'm not even sure I know what "right" means, but choices you think are reasonable in the Medigap market. There's a lot of inertia. There's a lot of misinformation. There's a lot of other problems. Kate can...

DR. BAICKER: Just super briefly, I don't want to get us off track, but my reading of the evidence on this is that the strongest empirical evidence comes from prescription drug use in part because the setting is amenable to people playing with the choice architecture and the nudges that we think might influence behavior day in and day out as opposed to major procedures where there isn't that same opportunity, and that there are a set of findings

that help us understand when people are likely to underutilize or underadhere and when they're likely to overutilitize and that price is one factor, but all these other choices -- all these other choice architecture, nudge, contextual factors are really important in those and that there's less information on how those factors affect insurance choice, but where we see the most evidence is from take-up of public programs like Medicaid where it's hard to write down a rational model that explains people not taking up very low cost benefits that are available to them through public insurance programs, and that we can learn some things from there about how people make choices, but it's a different population and we don't have that same kind of data for a Medicare population, in part because in a good outcome most people who are eligible for Medicare are taking it up, and then you're left with these choices that are very constrained in the Medigap market or in the employer wrap-around coverage market that don't give us as strong evidence as we have from some of those other contexts.

DR. DEAN: What do we know about the group of people that do not buy supplemental coverage? Do we know -- I mean, I assume we know -- is it because -- is it a group

that's basically healthy and doesn't think they need it? Or is it a group that feels they can't afford it? Or is it, as I assume, some of both? I wonder how much that helps with some of these questions.

DR. LEE: So both of those factors are relevant. If you are young and healthier so you perceive less need for supplemental insurance, then you would not get it. But then even for those who feel they need it, but then affordability can play. So exactly, you know, the relevance of those two factors we don't know.

DR. DEAN: I would certainly think that we should do everything we can to move toward these value-based structures, because one of the things that I found frustrating over the years is people -- to oversimplify, "If Medicare pays for it, I'll do it; if Medicare doesn't pay for it, I'm not going to do it." Even for services that I've recommended that I really thought were valuable to an individual and for individuals that I knew full well had the resources to cover it, even so I've had a number of situations, like I said, which I found very frustrating, where people decided they weren't going to do it just because there's this sort of mind-set, like I said, "If

Medicare pays for it, I'll do it; if Medicare doesn't pay for it, don't bother."

And so the more that we can move to the kind of structures that Scott just mentioned, I think it helps to get past, you know, what I consider to be pretty irrational decisions. But it benefits, I think, both the program and the beneficiary.

DR. CHERNEW: I think part of the challenge here is that there are two main goals and they don't always fit well together. The first one I take as our goal is to essentially save money or reduce revenue -- increasing revenue or save money by reducing the distortion associated with supplemental coverage in the supplemental coverage market, sort of this idea of right-pricing, and inherently that's going to shift the burden to consumers one way or another. And I am 100 percent on board with the comment you made, Glenn, that, of course, the alternative is some of the other stuff that we really dislike, and so at least in situations where you think there's a distortion, ignoring the politics, I think we certainly have to think about how to do that. And you could do that without -- so that I think is the first thing, and then the tension in that

general array seemed to have been do we prohibit or do we tax. I tend to find taxing more appealing, and I don't like the word "taxing," so I didn't -- by "taxing," I meant something else. But I tend to find "charging" more appealing than "prohibiting" because there are people that might want something. It strikes me as the extreme case scenario is what you said, Bruce, all right, no one is going to buy. So that just gets us to where we would have prohibited it one way or another.

DR. STUART: No, actually, I think the point that I wanted to make is that there would be a market response to that and that this would drive the market into MA, and it would be the least managed of the MA because those are the easiest for the insurers to develop. So we might agree that that's a place that we want to go.

DR. CHERNEW: But, I mean, there's odd things that one has to think through because, of course, the MAs get paid based on the fee-for-service cost or the extent that people are left in the fee-for-service cost but now they're not covered as much in the fee-for-service -- so there's some complicated dynamics as to how that works, but all of that plays through some notion of we want to get the pricing

right to avoid this distortion that I think we all agree exists in the supplemental coverage market, and we want to do that basically for financial reasons because we have pain that has to be shared, we have to fix the SGR, there's a lot of payment that's going on to physicians, for providers that potentially could be problematic over time under current law, and we need to think about that. And so I agree with what you said, Glenn, about that.

The second thing that we're trying to do which I view as a reasonably separate thing is improve the value of the package the way it's designed in one way or another to get more value, and that includes a range of goals. One of them, of course, is we want to improve the insurance component of it with the cap. The second part is we want to simplify it in various ways, which I think also matters. And the most important part, I believe, is essentially we want to encourage good behavior change, and by "good," I mean drive people to use the services we want them to get and get them not to use the services we don't want them to get.

Ron pointed out that that's a lot easier to say than do, although I think there are a lot of areas where at

least at a minimum we could identify what those things are, and I think there will be more if we get half of what we hope to get out of some ongoing research areas. And I do think a little more emphasis on those -- we've had more emphasis in other versions of this type of chapter. Oftentimes these ideas go under the rubric of value-based insurance design, but they're kind of different. One of them of course, is what Scott said, which is the -- or different versions of the same basic philosophy: the carveout within the deductible. So I actually am where Mitra is. I think deductibles aren't useful. For sick people they're just a tax on being sick, and for healthy people they often discourage them from getting the services that you want. But they could be useful if you think there's a lot of waste going on in certain types of services. But if you were going to impose them there, you would want to think about carveouts the way that I think Scott would.

We've had, I think, very useful discussions of least costly alternative type programs or other more nuanced benefit designs, and I think there is the potential for doing that.

The one thing that I don't understand -- so this is a round one question. I don't know exactly the restrictions that managed care plans are under if they wanted to charge you for a low-value service one way or another. Is the rule that if Medicare has a certain -- there's a certain amount that the fee-for-service system would pay for a given service, are you allowed to charge patients more for that, Scott?

So say there was one of these proton -- and Ron would probably say this is high value, but at least in my circles, everyone uses this proton beam, whatever these things are. They're big machines.

DR. STUART: Expensive machines.

DR. CHERNEW: Big, expensive machines, and what I understand from the evidence, they're considered not that great value. Are you allowed to charge people a lot for that even if Medicare covers the cost?

MR. ARMSTRONG: So you're asking me as a provider or as a health plan?

DR. CHERNEW: As a health plan.

MR. ARMSTRONG: So I can just not cover it.

DR. CHERNEW: Even if Medicare covers it?

DR. BAICKER: Don't you get flowback then?

DR. CHERNEW: And are you allowed to cover it but just at a higher copay, or do you actually have to not cover it at all? So if you wanted to --

MR. ARMSTRONG: Well --

DR. CHERNEW: -- do a least costly alternative version, for example, could you do that?

MR. ARMSTRONG: I think so --

DR. CHERNEW: Anyway, without going through the --

MR. ARMSTRONG: I don't know --

DR. CHERNEW: -- the clarifying questions to the non-presenter --

[Laughter.]

DR. CHERNEW: -- knowing what their limits are, knowing what flexibility the MA plans have to do these better designs and making sure there aren't barriers to them doing them, I think, is important.

DR. HARRISON: Yes. Plans cannot do -- cannot make coverage rules that are discriminatory against sick people or things like that. So when they bid, they can propose different fee schedules. They can, for instance, put some copays on home health that are not currently in

Medicare, but they have to be careful that, like their total SNF copays are no more than the total SNF copays under fee-for-service. So they could change the structure of them, but the total has to be the same. And then there's some actuarial equivalents rules, but --

MR. HACKBARTH: [Off microphone.] So the rules issued within the last several years about the structure of cost sharing on, for example, very expensive oncology drugs, and my recollection is that at a point in time, plans were really charging very high -- some plans were charging very high copays on oncology drugs and Congress moved to restrict that, or maybe it was CMS by rural moved to restrict that.

DR. HARRISON: Yes, so Part B drugs, 20 percent in fee-for-service. There were plans that were charging more than 20 percent and that -- I believe CMS said they couldn't do that anymore, but there was also some general legislation that talked about nondiscriminatory --

MR. HACKBARTH: So there is flexibility, but it is also constrained --

DR. CHERNEW: Flexibility, subject to review.

MR. HACKBARTH: Yes.

DR. BAICKER: But I do think that's a different

question than what Mike asked. I mean, you know, if you impose a copayment on all oncology treatments, you're discriminating against people with cancer. You're discriminating against sick people. Mike asks about least costly alternative. It's not that you won't cover prostate cancer treatment, but you'll pay for it only at the rate of regular old radiation therapy and not proton beam therapy. That, I believe the Medicare Advantage plans can do.

DR. CHERNEW: And so my broader comment is think -

DR. MARK MILLER: This is what's kind of been bothering me about this conversation, too. So in that example, the managed care plan could have a higher copayment on the proton beam whatever we're talking about here.

DR. HARRISON: They would have had to have written it into their original bids, but --

DR. MARK MILLER: [Inaudible.]

DR. HARRISON: -- service, I'm not quite sure how CMS would have reacted to that --

DR. MARK MILLER: Because it's a matter of actuarial equivalency, and then how far out of line it appears in review that you might be discriminating against some set of patients.

DR. HARRISON: My guess is that they would handle it through coverage rather than through copay differences.

MR. HACKBARTH: Actually, it may even be neither. It may just be handled through clinical decision making.

DR. CHERNEW: Right.

MR. HACKBARTH: That would be, to me, the most likely outcome. They're not changing copays for different things. They're just saying, our clinicians don't recommend it.

DR. CHERNEW: So I think the broader point I would make is separating out the first goal of this supplemental coverage distortion from the second goal of figuring out how to design the benefit package in order to encourage beneficiaries to use those things we want them to use and not use the things that we don't want them to use, I think, is a worthwhile discussion and one that we have done in other chapters. There was the whole -- Joan ran the whole VBID workshop stuff and there was the least costly alternative. There was a whole set of options. And I think in much the spirit of what Bob said, thinking through those and how they might work in the Medicare traditional type program and how they could work outside of that in terms of

flexibility, I think, is an important exercise for the chapter to get into.

The last thing I would say is all of this, the behavioral assumptions are going to be crucial, so it depends a lot on how much help you could get from various people would depend a lot on what your time line is for doing some of this. But I think you could get reasonable advice on assumptions that at least -- you're still going to get the same -- Julie's same comment of, well, this is our opinion, but I think there can be opinions guided in at least where the literature is, you know, and we can help with that.

DR. CASTELLANOS: Can I comment just for a second, because we're all looking at 30,000 feet down to the ground and where Karen is, where I am, and where Tom is and where Bill is, we're on the ground. We're where the tire hits the road. And we all have to work together. If you give the practitioner some ability to have appropriate guidelines and you can protect that person from liability if he or she decides based on good medical evidence, a lot of these issues can be dealt with on the ground level. Now, we're looking at the 30,000-feet level, but I think we need to --

in our discussions, as we've done over the last four or five or six years, we really need to kind of put this all together in that respect, too.

MR. BUTLER: So I struggle still a little bit with what problem are we trying to solve, and I think in the end it's engaging the beneficiary in part of the reform of the program in a way that we haven't. Glenn made some of the comments I would make, but it does get discouraging when we kind of spend 90 percent of our effort in this Commission on the provider side and often not just looking at ways to influence their behavior and often accusing them of being mischievous or illegal or evil, you know, we almost end up there in some aspects of this when we're trying to kind of do the right thing for an awful lot of committed people that are delivering care.

So when I step back and look at this issue, we're also trying to dive right into some of the -- as a Commission, we also like to be as specific as we can in recommendations because just floating concepts doesn't do a lot of good. So I'm struggling here, because we dive right into the copays and the deductibles like, okay, that's our comfort zone. We like to talk about all those things, yet

we can't really model them. And so what's the sweet spot in terms of what we pass along here is I think we need to think about.

And I wouldn't underestimate the importance of just educating at the front end and kind of resetting the dial and really saying this is about engaging a player in this, the beneficiary in a very positive way. And we need to say we understand that the traditional Medicare has been wildly popular as a government program and that supplemental insurance has provided incredible security for so many people. And we understand that.

But we also do need to say very explicitly, there's a price to that, and as Glenn said, one option is just to charge everybody the true costs of that. If you do that, you can keep the same system you have now, the unfettered kind of access and so forth, but there is a price to that and we really need to be clear about that as we introduce the chapter because there's no free lunch in that.

And I don't think that even the legislators really understand that very basic, you know, this front end, front dollar coverage, because we wouldn't end up with a health reform package that covers the uninsured now with, guess

what, the same first dollar coverage in many of these newly insured under Medicare. And so we're kind of going to repeat some of the same ways of not engaging the consumer.

Similarly, it's been two years, I think, since we've looked at shared decision making, for example, in our Commission, and yet it's, you know, it's such an important concept in the way we're going to help reform the package.

So I caution us from getting too -- the right balance is tricky. I like Bob's idea of give them some options and some samples, but make sure that we're not so rigid and use this formula, because they'll lift that formula as opposed to missing this opportunity to kind of, hopefully kind of provide education at a little bit higher level, because there should be more pages in our work on this kind of issue than we have taken on in the past.

MR. HACKBARTH: So, Peter, I hear some similarity between your comments and Bob's comments. So the track that we were on was framing this issue as a benefit redesign issue and working towards broad principles, not a specific benefit package, as a recommendation. But what I think I hear both Bob and Peter saying is even that may be too tight a focus and the framing maybe should be more engaging of

beneficiaries in making the system more efficient and effective and what are the policy options, try to frame some of the policy options for doing that. You know, Bob went so far as to link it even to the discussion about premium support as another type of mechanism for trying to engage beneficiaries. So it's sort of a brad frame as opposed to tight knit on just benefit design. Am I hearing the two of you correctly?

DR. BERENSON: I mean, I think Peter's notion needs to be included. I don't know whether I would have that be the frame, which is that this is about consumer or patient engagement, because there are benefit design issues here which -- so, I mean, I think we could figure out how to do both.

But in terms of stepping back a little bit and laying out a context for all of this, I think that -- exactly what those words would be, I'm not sure, but I think we wouldn't want to lose the context by jumping right into here's the principles. We want to spend some time on what is it that we're trying to achieve here, and I think --

MR. BUTLER: I think that's my main point --

DR. BERENSON: Yes.

MR. BUTLER: -- the context in a way that, whether it's the beneficiary, the legislator, or whatever, it kind of sets a bigger context. We can get into the specific design. Otherwise, we won't be given them much other than concepts. So --

DR. DEAN: Just yesterday in the Times there was a story about -- which really relates to what Peter just said -- about the Fairview system in Minneapolis was using an instrument to measure what I think they called patient activation, and they had surveyed something like 25,000 of their patients and then categorized them into those folks that really understood and were involved in decision making and those that weren't, and then were using that to focus some of their advice and counseling and -- I don't know. I didn't get into all of the details. But at least they had invested a substantial amount of money in trying to figure out which of their patients really were using the system properly and had -- they didn't have all the -- they weren't clear through the assessment of this, but their sense was that those that were, quote, "activated," were -- they could sort of make the decisions on their own. And then there was also a fairly large group that didn't meet those criteria

that really probably would benefit from some assistance and some help in making the decisions. At least in their view, that was a good investment, so --

MS. UCCELLO: I think we've had a lot of really great comments so far, and I really like the way that Bob talked about making sure that we're fairly comprehensive in the chapter on discussing various approaches, even if we come to a consensus of something else. And so to that end, I want to suggest making sure we include a couple of things.

In terms of coordinating changes in the fee-for-service design with supplemental coverage, we are strongly supporting this surcharge or whatever we want to call it. But I think we just want to make sure that we discuss in the chapter the regulatory approach and its potential implications. And as part of that section, I think it would be useful to include looking at adding the out-of-pocket cap on a true out-of-pocket approach, that being one of the options that's discussed.

Also, with respect to adding the out-of-pocket cap, the way we're looking at this is looking at the neutrality in terms of the beneficiary or the program. But what we're really trying to do, we're adding this out-of-

pocket cap and figuring out how to pay for it and we're paying for it really just through the other cost sharing provisions. And there are actually other ways to pay for that out-of-pocket cap, including adding a premium, an extra premium.

That may not be something we want to pursue, but I think it's something worth talking about, and it somewhat gets at what Mitra was talking about a little bit. It's kind of somewhat philosophical of do we want to be spreading costs over everyone or do we want to be spreading costs more on those who are actually spenders, the ones who are getting the care, because you're going to get kind of different effects and different people are going to be targeted depending on which approach is chosen.

A couple other things that are a little more in the weeds but I think we need to think about, and I'm comfortable with using a combined deductible, but what would that mean for those who are only in Part A? Would they continue under the current cost sharing rules? What kinds of things would happen there?

Also, I think we need to think about whether there are any impacts on the trust funds. Are we actually

shifting costs from Part B to Part A, or -- is that the way? Yes. Yes, between them. I think we need to kind of think about what -- because that has implications for the funding of the program generally.

In terms of when we're looking at levying a surcharge on these supplemental plans, the issue of whether we levy it on only the new people coming in or everyone, it's a slightly different case than the Cadillac tax under ACA, I think. With the Cadillac tax, it's on employer plans that are really looking at -- they're doing their pricing on a year-by-year basis. The Medigap plans have -- they can have a little bit more prefunding. So their premiums could be a little higher in the early years and their premium increases somewhat lower than they would be normally just to reflect the increases in cost over age. So that prefunding -- if we were thinking about doing something on a regulatory approach, I think it would be more difficult, I think, to implement changes on everybody because of that. And it would be more appropriate to make changes just on the new folks.

In the surcharge case, it may be less of an issue, but I think we still need to think through whether or not

there are implications for some of that prefunding and whether people who then drop out, maybe already paid for something they're not continuing on -- I'm not sure it's as big of a deal, like I said, but I think it's something we need to think about.

And I don't know if this is helpful, but I was thinking of, when Bruce was speaking, we're looking at these tables on 8 and 10, looking at what the effects on beneficiaries are going to be given our assumptions of their switching behavior. But the issue is, well, this is what's going to happen to them given most of them are just going to stay, it sounds like. But if they actually have other choices that would save them money -- if they dropped their plan and save more money, then I'm less worried about an increase that they would incur if they're staying with what they have. So I'm wondering if looking at things on a prototypical person basis and laying out their choices and looking at, well, if they stay with what they have or what their other choices are and if we see what their potential gains and losses are as opposed to just looking at their gains and losses assuming they stay or change. Does that -- Yes. So I think that's my list.

Oh, one more thing. One more.

[Laughter.]

MS. UCCELLO: Bob mentioned this a little, and I think I may have brought it up before, but maybe one of these -- if we're thinking very comprehensively, we also need to include whether or not there should be a public Medigap type of plan, and that, again, feeds into -- that's on that premium support continuum.

DR. BAICKER: So I think there are two separate issues conceptually that interact with each other, so I understand why we may want to bring them together in a chapter like this, but I'd at least like to lay out very separately the issue of good insurance value and value-based insurance design, even though they have a couple of words in common.

And by the first, I mean we're inherently offering an inferior insurance product. It doesn't have an out-of-pocket stop loss. The reason people buy Medigap policies in large part is to get the protection that you would think a good insurance policy would provide against catastrophic expenses. And so a consequence of that is that people buy these policies that have these spillover effects back to the

main Medicare program that aren't right priced in the Medigap premium and we could fix all of that or improve it by offering a better insurance product with better back-end protection that would then make these alterative policies less attractive, and if they were right priced, that would also make them less attractive, but they would be less important because people would have better protection through the main product.

And that seems like just an improvement to the program that could be done in their revenue-neutral kind of way or not, but that would improve the insurance value and, in essence, shift something that's being provided through this inefficient Medigap market into being provided through the main benefit and payments could shift accordingly. So that could be done in a revenue-neutral way.

I'd love to make that point more strongly, that the basic benefit is not providing as much insurance value as it could, and we talked in round one in the past about ways to capture that in a more vivid way to juxtapose against what looks like a figure where 80 percent of people are losing out in the transaction, and I would argue strongly that they're not. Even if some of their costs are

going up this year, they're still gaining valuable protection. And the fact that they were buying Medigap policies shows that they value that protection.

So if there's a way to make that point more strongly, even in the language throughout, that I don't want to call it neutral. I don't want to call it beneficiary-neutral when they have better risk protection. Even though I know what you mean by that, I think that kind of language minimizes the insurance protection that we think that people should be getting from the basic benefit. So that point, I'd really like to make more strongly.

And then there's the second point of value-based insurance design where we know that a more innovative insurance product would charge less for services that were really of high value, would encourage high-value use, discourage low-value use, and all of that could be modernized in a way that we're seeing some private insurers experimenting more with and that we have some evidence. That's a bit of a separate issue in that that's not about insurance protection. That's about driving high-value use within a given risk profile, or within a given insurance package.

Now, I see that they kind of go together in that if you're going to provide this catastrophic coverage protection and you want to make it revenue neutral, then you're going to increase payments in some ways, and if you're going to start messing with copays, you might as well do it in a value promoting kind of way. So I can see how the end product might be a blend of the two, but I'd almost like to start with the concepts being more separate and then think about what the program's goals are in terms of the insurance product that we're delivering and then how to put those resources to the best possible use.

MR. HACKBARTH: So, Kate, just to pick up on that, so the first part about what constitutes a good insurance product, that's a more static idea, whereas the people, to use your point, said it ought to cover catastrophic costs and protect people against that. That's an element of good basic insurance design.

The value-based piece of it is a more dynamic process that is changing based on available evidence about different things. So I always think of these things in terms of who the decision maker is in the policy world. You can imagine Congress writing a piece of legislation that

redesigns the basic structure of the benefit package. I find it difficult to imagine Congress repeatedly changing that to incorporate value-based principles, and that's something that it seems to me would be more appropriately delegated to the Secretary within boundaries established by the Congress.

DR. BAICKER: Yes. At first when you said "dynamic," I thought you were going more towards the effect on future costs and all of that --

MR. HACKBARTH: Yes. No. No.

DR. BAICKER: -- and abstracting from all of that. Yes. In some ways, the way this recommendation example --

MR. HACKBARTH: Right.

DR. BAICKER: -- is laid out is consistent with that in that we're sure that insurance protects you against potentially very high expenses. This isn't something we need more evidence on.

MR. HACKBARTH: That's right.

DR. BAICKER: This isn't something -- we can all agree that better protection against very high expenses is higher insurance value and that we could design a package that improves that.

DR. CHERNEW: [Off microphone.] -- expenses --

DR. BAICKER: Oh, you.

[Laughter.]

DR. BAICKER: But the challenge, then, is in something where we're getting all -- improves evidence over time or changing sands and you don't want to try to write down, these services should have this copay, these services should have that copay. And there, you could say we want to promote this through more innovative structures or more flexibility in beneficiary copays over those services and that could be a separate piece of flexibility, not a prescription.

MR. HACKBARTH: Yes. Scott.

MR. ARMSTRONG: Yes. At this point in this conversation, which I think has been really terrific, most of the points I would want to make have been made. I just would, I think, reiterate a couple of things.

First, despite the fact that Bill's wounds are still healing, I'm really glad that we're pushing this and I think it's an important agenda for us. This whole idea that's been articulated, I thought, very well, of balancing our ability to influence the design of payments to providers

with the incentives that are in the benefits structure for the beneficiaries themselves, I think, is just an expanse -- an area of work for MedPAC that I really look forward to us spending some real time in.

I also -- I thought Kate did a great job of articulating a point I would have made a little more simply and with simpler verbs --

[Laughter.]

MR. ARMSTRONG: I think the Medigap industry is a symptom of a deficient benefit and that I'm really glad that we're diving into some of those issues.

One other point I would make is that I do think what we're talking about, in fact, is consistent with and potentially has more alignment with many of the other principles behind other policy proposals that we've been putting forward, you know, the whole idea of bundled payments for post-acute services or ACOs and other things. I look forward to an opportunity for us to think about, well, how could you actually begin to marry benefit structure with provider payment structure and really create even more influence over behaviors by doing some of those kinds of things. I think until we get into this, we just

won't even be able to start asking, let alone answering, some of those questions.

And I think that's all I'll say.

MR. HACKBARTH: Anything that you want to ask about, Mark, to get clarification for next steps?

DR. MARK MILLER: No. I think what we're going to have to do is huddle and sort of outline how we would walk across the range of issues that were put on the table here. And then once we have -- and there are some additional analyses that we have got to bring.

And then I think I've got to talk to you and Bob about this, you know, how principles versus -- and then how to come back to the Commission on that continuum is sort of that. And I'm not being articulate, obviously.

One thing that Cori said on that front in following up is whether the Commission just ends up saying there are six major design principles and here's the pros and cons and here's how you could go, or whether the Commission sort of says, and on this one, we lean this way, or we more than lean, we stand. That might be a way to bring together both your thought and are we going to lean -- so that's kind of what I was thinking, even though I can't

say it.

MR. HACKBARTH: Yes. And I'll be equally inarticulate about it, but that was sort of my sense, as well. This has been a very helpful conversation for me and I have a different sense of this than I did when it started, and part of it is that we need to broaden the frame a little bit and have a run-up that frames the issues. I hope we can also conclude with some statements, directional statements about here's how we might be inclined to resolve some of those issues. But I think the broader framing is important. And highlighting just, you know, there are, as Bob said, pros and cons on many of these different things and trying to educate before we get to, oh, there ought to be a redesigned benefit package that looks like this, I think is important.

DR. BORMAN: Just briefly, Glenn, and a piece of this issue that I think maybe we're not -- we haven't talked about yet or I haven't heard yet and that ultimately needs to be brought in. The market as we have it now not only reflects sort of the bad benefit -- or the limitations of the benefit that we provide, but it also is a measure of our inability to communicate to people at a time when they're

better able to make rational decisions about their choices and how to think about them.

So whatever package or options or whatever we recommend going forward, we may need to give some thought about do we need a more structured educational program, if you will, because right now, as you watch the ads, for example, on TV, you can see how very quickly people get sucked into sort of the fear factor or other ways that they use to make a decision about something that would -- the kind of education about this, for example, needs to start way before you've picked up your Medicare card, and we need to think about how do we better share choosing options. I realize that comes very close to a perilous boundary between what's public and what's private obligation here, but I think that whole education part and communication to help the beneficiary make smart choices is something that we should carry forward wherever we go in terms of the specifics of the issue.

MR. HACKBARTH: [Off microphone.] Okay. Thank you, Julie and Scott.

So our next session is on the mandated report on rural issues.

[Pause.]

DR. AKAMIGBO: Good morning. Our aim today is to provide a recap of our findings on the four areas MedPAC was mandated to study, and clarify our guiding principles for each area.

Today, Jeff and I will summarize those findings, discuss payment adequacy as it pertains to rural providers, and we look forward to your guidance on the plan as we complete the rural report this spring.

So for a quick overview, this report was managed by the Patient Protection and Affordable Care Act and requires us to examine four specific issues. The first is access to health care services, which we discussed last February. Second is quality of care, which we presented in October of 2011. The third is adequacy of rural payments, which was separately discussed in detail in each sector back in December but we'll summarize again today to incorporate access and quality when Jeff talks about the adequacy of Medicare payments later in the presentation. The last issue was payment adjustments to rural payment rates, which we discussed last September.

The rural report is due June 2012.

We have found, as others have, that there are fewer physicians per capita in rural areas. The difference is in specialists. Non-primary care specialists are even more acute. And recruitment of physicians continues to be a serious challenge for many rural communities.

However, despite the differences in the number of physicians, we showed back in February that access to care is relatively equal in both rural and urban areas as measured by volume of hospital services, outpatient visits, and utilization of skilled nursing, home health, dialysis and pharmacy services.

Now in some cases, rural beneficiaries may have to drive further distances to access care, but travel times were relatively similar for urban and rural beneficiaries. In addition, our analyses of different surveys confirm that Medicare beneficiary satisfaction with their access in rural and urban areas were relatively equal.

With Commissioners' guidance over the past year, we have developed guiding principles to examine rural health care for Medicare beneficiaries. The principle for access to care posits that rural beneficiaries should have equitable access to health care services. Equity and access

can be measured by volume of services, number of visits, prescriptions, as well as beneficiaries' reports of their experience once they interact with the health care system.

And when we discuss equity and access, we recognize that some rural beneficiaries may drive longer distances, although not necessary travel for longer periods of time, than their urban counterparts.

The quality findings we presented in October, which inform these principles, are summarized on the slide. Overall, we found that quality of care in rural and urban areas is similar as measured in each setting, namely skilled nursing facilities, home health agencies, and dialysis facilities.

On the other hand, hospital quality across rural and urban areas is mixed. Readmission rates are roughly equal but mortality rates are worse in rural areas and were only partially explained by volume. Clinical quality measures, as reported on Hospital Compare, were also generally worse for rural providers and tended to worsen as providers became more rural.

Now on to guiding principles for rural quality of care. First, the quality of non-emergency care delivered in

rural areas should be equal to that of urban areas. This reflects the reality that non-emergency care, where there is a choice of whether to treat the patients locally or transport them to a larger urban facility, should be held to the same standards as the urban facility. The small rural facility should be as good as the alternative site of care.

However, emergency are is different. There may be no alternative and small rural hospitals are obligated to treat those patients. In these emergency situations, our expectation for outcomes in small rural hospitals may not be as high as they are for larger facilities. Our expectations, therefore, should reflect the inherent limitations that may exist in small rural hospitals compared to large urban hospitals.

Finally, most hospitals are currently evaluated on the care they provide to Medicare beneficiaries and their performance is public reported on Hospital Compare. However, some critical access hospitals have been exempted from some quality reporting requirements.

As the Commission has stated, providers should be evaluated on all the services they provide. This includes measures common among rural and urban providers, as well as

measures that are specific to rural providers, such as timely communication of patient information after a transfer.

To allow equal access to information for rural and urban patients, all hospitals should be subject to public disclosure of their performance scores. This may improve accountability and hopefully improve the quality of care delivered in small facilities.

Jeff will now pick up with our discussion of payment adequacy and special rural payments.

DR. STENSLAND: In your mailing materials, and during our December meeting, the analysts for each sector discussed the adequacy of rural Medicare payments. So in this session, I'm going to try to bring together the different findings on rural payment adequacy from the different chapters and the different presentations you heard in December. We will use the same criteria for rural adequacy as we do for overall payment adequacy, examining variables such as volume of services, payments, and costs. However, we will also examine whether rural payments are adequate relative to urban payments, given our mandate. As we have discussed throughout the process, we will compare

different types of rural areas, including the more sparsely populated rural counties.

When we discuss rural physician payment adequacy, we have limited financial data so we tend to focus on access to care indicators. In general, those access indicators of payment show that adequacy is good and similar to urban. Our survey indicates that rural and urban beneficiaries report that they have similar ability to obtain physician appointments when they want those appointments, and to obtain new physicians when they're looking for a new physician to accept them into their panel.

Consistent with that, when we look at claims, we see that rural beneficiaries have roughly equal volumes of visits as urban beneficiaries.

Similarly, rural home health agencies appear to have adequate payments. The number of home health services per capital is similar in rural and urban areas. In addition to that, we tend to see much more regional variation in home health use than we do rural/urban variation. Quality scores are also similar, as are profit margins. Given the rural/urban similarities, we do not see any systematic differences that would require additional

assistance to all rural home health agencies.

The SNF story is similar to the home health story. There is a similar number of SNF services received by rural and urban beneficiaries per capita. Quality scores are also similar and margins tend to be high in all types of rural areas. Hence, we do not see any rural payment adequacy concerns for the different types of rural counties.

For hospice we do see some rural/urban differences. Hospice use is a little bit lower in rural areas but the rate of hospice use is growing. In addition, rural providers tend to have smaller hospices and have slightly lower margins, as Kim discussed last December. However, given the Commission's discussion that there is a need to broadly refine the hospice payment system, the small rural/urban differences we see should be seen as a secondary concern to the larger effort of refining the hospice payment system.

In addition, we had a recommendation to adjust hospice payments to pay more for the first days of the stay and more for the last days of the episode. And that would tend to benefit rural hospices. So given the potential changes to the hospital payment system that would benefit

rural providers, and given that most rural counties still have healthy profit margins under the current system, there does not appear to be a pressing need for additional payment changes that would target solely rural providers.

Now when we turn to IRFs, it's a little bit different because all areas do not have IRFs, and in some of those markets patients will receive care in other settings such as SNFs. So patient volumes in IRFs for different geographic areas is a less useful measure.

When we look at profit margins, we have a more complicated story than we've seen in the last few slides. In general, IRFs with more discharges per year tend to have higher profit margins, as you heard yesterday. In the margins for urban IRFs, who see an average of 942 patients per year across all payers was 9 percent while the margin for the handful of IRFs in the rural areas next to urban areas, who saw an average of 104 patients per year was negative 5.6 percent. Certainly, part of that is the economies of scale issue.

However, the story is mixed in the most rural IRFs, the ones that are located in counties not adjacent to urban areas and that don't have a city of 10,000 people had

a margin of 16.1 percent. This was despite still having relatively few patients per IRF.

There's a few things I would like to mention about this. First, notice on the first row, you'll see the numbers we are talking about here are very small. In the adjacent to urban areas, that's only 13 IRFs we are looking at in our sample. In the non-adjacent to urban, it's only 17. There's a lot of variation in IRF margins. A negative 20 margin is not uncommon, a positive 20 margin is not uncommon. So take it with a grain of salt because there are so few.

The second, if you look at the ones that are adjacent to urban areas, they have 104 patients per year. But their census is only about three. So if you're trying to run a business with only three patients in there, you can see where you'd have some real economies of scale problems.

The next one, the average census is four. And so maybe from three to four that still sounds small but from a percentage basis it's a pretty big difference and it might explain part of the differential.

Finally, probably due to pure chance, there's more free-standing IRFs in the last column than there is in the

third column and that can also affect the numbers. So I'm trying to give you some flavor on why you see the difference between those two different categories of urban areas. A lot of it might be the small numbers, some of it economies of sale, and some of whether you're free-standing or non-free-standing.

The current policy for IRFs is that they all receive an 18.4 percent add-on if they're in a rural area. There is some concern that this policy is provided to all IRFs and not targeted just to low volume IRFs that are necessary for access.

The payment for dialysis appears adequate as capacity has grown by 4 to 5 percent per year in rural areas. While rural Medicare margins have historically been lower than urban margins, a negative 3.7 percent compared to 3.4 percent due to lack of economies of scale, starting in 2011 small dialysis facilities with fewer than 4,000 services per year will receive an 18.9 percent increase to their payments. And it goes to all low volume facilities, no matter what your distance is from another facility.

So first of all, this raises some concerns about it not being targeted, if we're giving this addition to two

dialysis facilities that are both one mile apart from each other, that might not be an efficient use of Medicare dollars.

Also, because the low volume adjustment will have a significant affect on rural profit margins, we have a plan to really look at this again next year and once again look at rural profit margins once they start receiving this low volume adjustment.

The other factor we looked at is quality, and for dialysis patients, the process and outcomes measures do appear to be similar in urban and rural locations, and the rates of hospitalization are slightly lower in rural areas but the differences are very small and not statistically significant.

The share of hemodialysis patients who receive adequate dialysis virtually the same across rural and urban areas. And for new to dialysis beneficiaries in 2009, those who have a catheter, where we generally think rates are better -- though not always, as Karen has said -- also show that the rates are similar across urban and rural areas.

With micropolitan areas, those micropolitans being the rural areas with a city between 10,000 and 50,000

people, show the best rates of all the groups.

So I would say, in summary, the rural story is kind of lets wait and see until we have this extra rural add-on in the mix.

Rural and urban patients also receive similar numbers of hospital services during the year, as we've discussed in our February meeting. We also found that quality of care is mixed when we look at hospitals, with readmissions being equal for rural facilities. But the smallest facilities tend to have higher mortality rates, as Adaeze just mentioned.

When we examine profitability, the most rural facilities tend to have the highest margins. This reflects the special payments provided to rural facilities, which we'll discuss later. As we can see on the next slide, this is a relatively new phenomenon, where rural hospitals have higher Medicare margins than urban hospitals.

I think the purpose of this slide is to explain why the story might change in our 2012 report compared to what we said in 2001. Somebody might read our 2001 report and then listen to this discussion and say why has MedPAC changed their story? I think the reason is that the

underlying story has changed, and that's reflected in how the data has changed.

If you look at the slide, you can see back in 2000 rural margins were much lower than urban margins. We mentioned that in our report. We made a couple of recommendations to change payments to make them more equitable in rural and urban areas. Those recommendations were largely adopted. Rural margins improved relative to urban margins. And then there was some additional payment adjustments that came into play that further helped rural. And that's how we ended up with the rural margins now better than the urban margins.

Now we can examine some of those special payments that we talked about and also discuss the issue of special payments, which is part of our mandate. This slide lists some of the special adjustments that were made to increase rural hospital payments. There's really just two points to this slide. We won't go through each one of these adjustments.

First, I want to note that there's many adjustments, and this explains part of the graphic that you just saw on the prior slide. Second, we want to reiterate

that some of these adjustments were, in fact, MedPAC recommendations and they did fit some of the principles we've discussed in terms of targeting low volume hospitals that need special assistance. However, some of the other adjustments that were added have not fit our principles that we discussed in our prior meetings.

This slide looks at some of the special payments for the other sectors. First, we could say that many of these adjusters are not targeted. They're either going to all the providers in a frontier state, in some cases to all rural providers, or in other cases to all low volume providers. And they generally aren't targeted to low volume isolated providers.

Just to go through an example that we can use to show how one of these adjusters might not fit the principles that you discussed in some of our prior meetings on special adjusters this past fall, we look at the hospital low volume adjustment. Starting in 2011, this year, small hospitals will be entitled to an additional low volume adjustment and that will stay in place through 2012. What this will do is it will widen the difference between the rural and urban margins.

As I've said before, I think there's generally three problems with this low volume adjustment. First, it's not targeted to isolated hospitals. Second, the adjustment is not empirically based and it uses just Medicare discharges to determine whether you're low volume rather than total discharges across all payers. Third, the sole community hospital and Medicare dependent hospital programs cause some duplication of payments with the low volume adjustment program.

If we added the new low volume adjustment to our 2010 margins, we would see those simulated margins would rise to a projected 14 percent, which would be far above the margins of other hospitals.

So in summary, while a low volume adjuster may be needed for some providers, in this case the adjuster isn't targeted and it isn't empirically justified.

So now I'll discuss some of the guiding principles for the special payment adjusters. And we're trying to summarize what we heard from you during the last time that we talked about special payment adjusters in the fall.

The first principle is that low volume adjustments should be targeted to isolated providers. The general idea

here is it doesn't make sense to provide a low volume adjustment to two competing providers when they're both one mile apart or five miles apart and both suffering from low volume.

Second, after we identify who is eligible for additional payments, the question is how much should they get? We want the amount of adjustments to be empirically justified.

Third, with respect to low volume adjustments, the adjustment should be tied to the total volume of patients, not just Medicare volume.

Fourth, the low volume adjustments should not duplicate other adjustments, as they did in the case of the current hospital low volume adjustment.

Finally, it's important to think about the financial incentives associated with the adjustment. Different ways of payment can carry different incentives and, all else equal, prospective payment adjustments tend to have stronger incentives for cost control than cost-based payments.

So that's a summary of the four topics that are mandated under our required report. For each of those,

we've tried to summarize first, what we found; and second, the principles which were tried to be a summary of what you have discussed at the prior meetings on payment adequacy, quality, access, and special payments.

Now we'd like to hear from you any comments or questions you have on the report, any suggestions you have for changes to the principles, or any other guidance you have as we start to draft the report this spring.

MR. HACKBARTH: Okay, thank you. Herb, why don't we start with you.

MR. KUHN: Are we going to do two rounds or just one? How do you want to do that?

MR. HACKBARTH: Let's do two.

MR. KUHN: Two quick questions, just on clarification. I think I've asked this in meetings before, and if I have, excuse me for this, I forget the answer. But when we look at the documentation and coding adjustment that's out there, there has been some conversation that it is not as powerful an adjustment in the rural areas because of the types of cases where there's the opportunity to code more accurately is -- they don't see a lot of those cases, perhaps, in some rural hospitals.

Is there evidence that there is a differential here, as a result of DCI, that would -- as we make the adjustment, that we might be disadvantaging rural hospitals because we're suppressing their payments further.

DR. STENSLAND: There isn't evidence of that, and there's two ways to look at it. At the really granular level, you can look at the different MS-DRGs. And basically what we saw is we saw a movement in all the MS-DRGs, up from where more of them are showing higher rates of complications and major complications. So what we're saying is it's going across the board, your pneumonia admissions, your heart failure admissions, as well as your more complex type things that go to tertiary care hospitals.

So because it happens at all the different DRGs, those ones that are treated at small hospitals and those at large hospitals, it's not surprising that when we see the change in case-mix, we see roughly the same change in the small hospitals as we do in the large hospitals.

MR. KUHN: Thank you.

The second question, when you were talking about quality, the observation from the data that you shared is that it's pretty much the same, for post-acute care

hospitals it's a bit mixed. If you were a Medicare patient seeking care in a rural area and you went to one of the compare websites, would you be able to differentiate that from the Compare websites? Or is this a different analysis that goes beyond what's available on Compare?

DR. STENSLAND: It's a different analysis, and this was one of the things we talked about. The way the Hospital Compare does its analysis is it uses what it would call a random effects model. The important thing to remember about the model, the key thing that's driving it, is it has this kind of prior assumption that everybody's at the mean. And if you have a really low volume of cases, it's going to assume basically that you're at the mean and it's going to create a weighted value for you on the CMS Compare website that's basically almost completely weighted at the mean and very little weighted on your own data.

So if you look at the Hospital Compare website, all the really small hospitals, they're going to look like they're really close to the mean no matter what their actual performance was because what essentially CMS is saying is if it's different from the mean, because the number is so small, we're really not confident on whether that's random

luck or really differences in quality. So we're just going to say they're average.

Now what we did is we didn't look at the individual observations. So we didn't say oh, this hospital has 15 discharges in CHF. Let's exactly know what that hospital's mortality rate is. That would cause a lot of low volume problems.

What we did is we said let's combine the data from a whole bunch of these small hospitals. Like we combined the data from all 1,300 CAHs. So once you combine it from, 1,300, you have a much bigger n and you have much more confidence in the n, and you don't have to move to these kind of random effects models like CMS did.

So then we can now, looking at this big group, how does the big group compare to this other big group. And then we see that the smaller hospitals tend to have higher mortality than the bigger hospitals, and we also see that rurals tend to have a little worse mortality than urban. And those findings aren't like some news flash. Those are also the same things you will see in the literature for the past 10 years.

DR. NAYLOR: Great report.

On Time Table 15 can you -- and I know you put the time of each of these MedPAC recommendations and so on -- but can you help to clarify the relative impact of say the three MedPAC recommendations on what we seen in terms of changes? I don't know that that's important or not, but to give it a sense of this was instituted and this was the impact? I don't know if that's possible.

DR. STENSLAND: Off the top of my head, so this is really rough, first increasing the rural base rate up to the urban base rate was a pretty big move. I'm thinking on the order of a percent difference in your margins. The way it used to be structured is when they originally set up the system, it looked like rural providers had lower costs, for some unknown reason, than urban providers. But over time, we kind of got better at measuring case-mix and other things. And when MedPAC looked at this in 2001, they said there's really no justification for having a lower base rate for a rural provider than an urban provider. Meaning, if their wages are the same and the case-mix is the same, they should get the same.

So MedPAC recommended that. And that was a material bump up in the rural profitability when Congress

adopted that.

The DSH payments was also a material bump up. That was pretty significant. The rural folks used to get a much lower DSH payment even though they had the same share of low income people than urban folks. In 2001, we basically said that wasn't equitable. We made that adjustment. It made a significant change in rural payments.

The third was the low volume adjustment. What happened here is when we estimated this, I think we saw a low volume effect closer up to 500 discharges or so. The way it was enacted was CMS, the Secretary, was given discretion on how to enact it. And they looked at it and they said they were only going to give a low volume adjustment to folks with 200 or fewer discharges.

And what happened over time was a lot of these really small ones just became CAHs. So this low volume adjustment, as it stood, had almost no effect. Because there just isn't very many with 200 discharges that aren't CAHs.

Those are our three policies and how much they affected the margin.

DR. NAYLOR: Thank you very much.

[Pause.]

MR. GEORGE MILLER: Yes, on Slide 5, first of all, I want to state I think that no matter what the quality parameters should be, they should be of high standards and really no difference than any other provider. I'm just curious on the mortality rate. Do you know if that's a function of maybe travel time and distance, why the mortality rate is lower? Do we know the reasons why they would not be at a higher level? I think you said they're mixed, and mortality is one of the reasons they're mixed. Do we know the reason why?

DR. STENSLAND: Well, when we looked at this, the two things that we highlighted were pneumonia discharges and CHF discharges. And if you do look at the travel times, there's probably an extra 10 minutes, on average, travel to the hospital. But for a CHF admission or a pneumonia admission, we don't think that's really going to do it. We didn't focus on the AMI admissions in our analysis.

MR. GEORGE MILLER: Folks that are AMI, but you're telling me this includes both CHF and pneumonia?

DR. STENSLAND: Yes.

MR. GEORGE MILLER: All right. Ten minutes

wouldn't make the difference on those. I'm just wondering about the AMI. All right. Thank you.

DR. STUART: I think you've done a great job. Thank you.

DR. CASTELLANOS: Yes, on Slide 17, you describe a 15 percent add-on to physician payments billed by the critical access hospital. How about the physician in the community that's seeing the same patient, doing the same service, but not being billed by critical access? Does he or she get the 15 percent?

DR. STENSLAND: No. They have to assign their billing to the hospital.

DR. CASTELLANOS: Why?

DR. STENSLAND: I'm not sure what the rationale there is. I don't know if they were trying to promote integration or what they were doing, but that's the policy.

DR. CASTELLANOS: Well, that's similar to a discussion we had yesterday. I don't think it's -- I guess that's an equity issue.

MR. HACKBARTH: Is that statutory?

MR. GEORGE MILLER: [off microphone] Yeah.

MR. HACKBARTH: It's written that way in the

statute. This isn't by regulation.

MR. GEORGE MILLER: It is statutory, and I think the reason is it was a recruitment issue to areas. It was just a recruitment issue, how to get more physicians in the rural areas, if I remember correctly the rationale for that being --

MR. HACKBARTH: I think Ron's point is --

MR. GEORGE MILLER: I understand his point.

MR. HACKBARTH: Okay.

DR. CASTELLANOS: Slide 8, the limited financial data, now that, you know, physicians are employed by hospitals greater than 40 percent, is that data available through the hospital side? Limited financial data on physicians' practices, you know, now that physicians are employed and it's greater than 40 percent, I would think some of that data may be available on the hospital side.

DR. STENSLAND: I would have to think about that. I don't think the cost reports are really designed to pick up all of that. We have the clinic part of the cost reports, so we can look at the clinic. And I'm not sure if we wanted to only look at the clinic either when we started to look at what the physicians' expenses are, if we thought

there was some difference in relative efficiency between the hospital-based clinics, which are a small share, and the free-standing, which are a big share. I'll have to think about that more to get you a better answer.

DR. CASTELLANOS: Okay. Then on Slide 6, just the first one, services provided by the rural hospitals that they choose to deliver. You know, there's some of us -- I go to a rural hospital one day a month. Now, obviously that hospital doesn't have that quality the other 29 days. Maybe I'm making a mountain out of a molehill.

DR. AKAMIGBO: I'm not sure I understand the question.

DR. CASTELLANOS: Well, you're talking about quality of care should be equal for non-emergency services. In the areas where the provider chooses to deliver that service.

DR. MARK MILLER: Ron, where this came from in the discussions -- and this is something that some of the Commissioners were saying -- if a rural hospital decides it's going to do hip replacement or some procedure like that, the thought process is that's a choice and that we should expect quality outcomes to be the same. If somebody

arrives at your doorstep after a car accident and it takes 30 minutes to get people into the hospital and take care of that patient, you might reasonably anticipate that there's some difference in quality in that circumstance.

That's what this is trying to say. It may not be getting at --

DR. CASTELLANOS: I guess I'm trying to ask whether it -- I think we best just leave it like it is.

MR. GEORGE MILLER: I think, Ron, for the days you provide care at that rural hospital, the standard of care should be the same as any other place while you're there. The days that you don't provide it, then that service is not available and there's no prerequisite for the standard of care when you're not there.

DR. CASTELLANOS: Thank you for clarifying that.

MR. ARMSTRONG: Do we know, when we look at the overall Medicare program, how much we spend on what we would define as rural care versus everything else? Just order of magnitude?

DR. STENSLAND: So the rural people are probably about 20 percent and maybe the rural providers are going to be a little bit less than 20 percent.

MR. ARMSTRONG: So we would generally think this chapter is covering something less than 20 percent of the overall spend for the Medicare program?

DR. STENSLAND: Correct.

MR. ARMSTRONG: Okay, great. I just wanted to get...

MR. BUTLER: So this is an older than average population, if my memory serves me right, and I'm still trying to get the profile of the post-acute care services in the average rural community. Go to Slide 11.

You've done a nice job kind of slide by slide walking through the post-acute sectors, but just as an example, you know, it looks like about 40 percent of the hospices in the country are in rural areas, yet you say the use is lower. So, obviously, there are a lot of, a disproportionate number of hospices but they're not being used. They could be dinky hospices.

So my own visual sense of this is that there's probably more dependency on SNFs than in urban populations, less dependency certainly on IRFs, a little bit of underutilization of hospice, and sporadic availability of home care. But I'm trying to get the -- it might be as you

roll this up, you almost look at per capita spending by each of these segments and compare it to the urban areas, and just to get a sense of the dependency on the various post-acute sectors in a rural area versus an urban area, because I think it tells a little bit bigger story than just showing the number of facilities and then one at a time the utilization. It doesn't paint the bigger picture of what the web of services are or are not available in the community.

DR. STENSLAND: And I think we can -- that's a good idea, to paint that bigger picture, and the picture here we're painting is the provider picture, so you do see a lot of home health, a lot of SNF use. There's kind of a side picture we can present, which is the patient's picture, and I think the patient's picture is a little different. For some things, like you don't see LTCHs in the rural areas, but rural people in Louisiana use LTCHs because they get transferred out to the LTCH in the urban area. So there's kind of two pictures there that we have to paint: the picture of the rural providers and then the picture of the providers that rural patients get their services from, which are a little bit different.

MR. BUTLER: Well, as Tom would remind us, if you've seen a rural area, you've only seen one rural area. They're all a little bit different. But I'd ask him, is that general, am I right that SNF is a bigger participant in general in post-acute care?

DR. DEAN: I think that's a fair -- I mean, of course, you know, I'm looking at it from a very sparsely populated area, and it isn't necessarily typical. I'm in an area that probably presents some special problems, but much of what is in this category defined as rural is very, very different from where I live. But where I live, yes, the answer to your question is yes.

MR. HACKBARTH: Along, I think, the same lines as Peter's comment about painting a picture, in terms of use of physician services -- and Peter focused on the post-acute care, but can we say something about where rural beneficiaries go for physician services? But my impression has been that they probably get more services from hospital outpatient departments than people in urban areas. My recollection from 2001 is that when you look at the ambulatory visits, the rates are similar between rural and urban, but the mix is somewhat different. Rural

beneficiaries are somewhat more likely to see advanced practice nurses as opposed to MDs. So if we can sort of add some more texture to the description, I think that would be helpful.

MR. GEORGE MILLER: I, Glenn, to your point, I think if I remember correctly, also the rural population is older, they're sicker, they're poorer, and have other attributes that probably their urban counterparts would not have as well, and to add that context to the chapter might be helpful as well.

DR. STENSLAND: We should clarify. You know, we did talk about the demographics, I think in February, of the population, so there are some differences in what we have so far in that mailing that we think will end up in the final report that we should discuss if people have issues with that. First, whether they're sicker is we really found a mixed bag depending on which measure you used. They look healthier on HCC scores. They have more of some co-morbidities, less of some co-morbidities, and we didn't see a big rural/urban difference on the sickness. We saw a big regional difference, like if you look in the south-central states -- Kentucky, Alabama, Mississippi -- there you see

people poorer and sicker. And then on the income side, there was some work by the USDA on that where they said if you look at raw income, it's a little bit lower; but if you adjust for the cost of living, it's actually higher. And then if you look at wealth, especially farmers are way wealthier. So it's more complicated than some of the simpler story that we always hear.

We will have all that in detail in the report, and you'll have a chance to comment on it, but I just wanted to be clear that it might differ from the standard story.

DR. DEAN: Just on that point, after the report, I went back and looked at some of that stuff, and it did appear that there is a difference between the general rural population and the rural Medicare population, and the statistics that I saw at least were actually better for the Medicare population. The thing that George just stated held true for what I looked at if you looked at the rural population in general. But when you looked at just the Medicare population, what Jeff says, it wasn't as dramatic.

DR. MARK MILLER: [off microphone] And that's one of the points we've been trying to make, is that sometimes there's that basic description of the rural people that then

just kind of carries over into the policy conversation, and there is this distinction -- in part there is this distinction because that's what Medicare set out to do.

DR. DEAN: In some ways it's reassuring. I mean, it testifies probably to the value of Medicare.

DR. CHERNEW: First of all, I want to support what Peter said, even though he's running away, about the population focus to some extent. But the question I had is: You've structured this where you've gone through our normal payment thing that we just went through on our long march yesterday, but you didn't have anything about managed care payment. Is that outside of the scope of how you think about payment adequacy?

DR. STENSLAND: It has been so far. For this report we haven't --

DR. MARK MILLER: There's a little more advanced answer to that.

[Laughter.]

DR. CHERNEW: It was not a normative question. It was a clarifying questions.

DR. MARK MILLER: Yeah. The Commission certainly considers managed care. If you read the mandate, we've read

this to be asking us to pretty much focus on fee-for-service. It's providers of services -- Jeff and Adaeze, I'm blanking a little bit on the language. But your first plain reading is tell us about fee-for-service, is sort of the way we saw it.

MR. HACKBARTH: And I think that is a sensible focus for this. Tom, do you have any further clarifying questions?

DR. DEAN: I just wanted to follow up a little more on the mortality rates. Are those risk-adjusted? I mean, I guess the thing that comes to mind is that we see a fair number of people with complicated illness who have received a majority of their treatment in major centers, and when the implication -- or when the effect of that treatment has sort of run its course, they come back and we take care of them. And if it's a terminal illness, they tend to die in our facility. And so they, you know, come home to die. It isn't huge numbers. Of course, we don't have huge numbers. It's a very small facility. But it is a phenomenon that we see, and I wonder if that is reflected in these numbers.

DR. STENSLAND: We're using the AHRQ risk

adjustment method, which is based on the 3M method, so it is risk-adjusted. But I guess you're asking is there some sort of omitted variable where there's some sort of severity of illness which isn't picked up in that risk adjuster which also sorts people that rural folks are more likely to go to the hospital to die than urban folks? It is possible.

MR. GEORGE MILLER: I think what Tom is asking is: Is there a way to track where that person got care? If they got the majority of their care in an urban area and then chose to come back and die -- they didn't choose to, but they came back to the rural facility and died there, the majority of the care was given in an urban area. Is there a mechanism or a way to track the census track or another way to track where they got the majority of their care? I think that's the genesis of Tom's question.

DR. DEAN: I think if I -- and, I mean, you can tell me if the statistical logic is right, but I think that would tend to -- as a proportion of our total activity, the total care we give, I think that would make our mortality rates look higher.

MR. GEORGE MILLER: Correct. Isn't that the genesis why the MS-DRGs were changed so that the severity of

the care -- yeah.

MR. HACKBARTH: [off microphone] -- would this be beyond what you would capture through that sort of severity adjustment.

DR. BORMAN: I certainly don't know any data source for that, but having been on the receiving end at the intake to come for the big care, I guess I would say back to you that it's oftentimes extraordinarily hard to get those people back to their originating care area. So that while I absolutely accept that in your practice and experiences you've seen the traffic in that direction, I assure you that it also stays -- there's a fair amount of them that stay.

So I would hope that, by and large, it's a wash because I think this would be incredibly hard to tease out the motivation for a transfer. It's kind of like trying to figure out people that made -- a family or a patient made a decision to withhold or withdraw care we can't really tease out very well from the mortality. I think this would be incredibly hard to ascertain, and I think it goes both ways.

MR. HACKBARTH: Well, that's what I was just going to say. There's also potentially some sorting not detected by severity adjustments going the other direction. There

are patients that are especially difficult and challenging that, you know, on paper it looks like the same MS-DRG, but the clinicians are saying, "Boy, they really need to go to the urban hospital."

DR. DEAN: I'm saying it's those patients who have had their care in the urban center and have reached a point where the decision has been made --

MR. HACKBARTH: I understand that. You're saying that the rural mortality may look artificially high because of that sorting --

DR. DEAN: Because they're coming back after --

MR. HACKBARTH: But it also could be true that there are patients in a rural hospital that are sent to urban centers because of the difficulty and they die there. That makes the rural mortality look lower.

DR. DEAN: As Peter said, you know, I'm sure it works both ways, but at least in my experience we certainly see the former.

DR. HALL: No comments.

MR. KUHN: I want to thank both of you for a good year of work, and this is a wonderful summation of kind of where we are. And I think picking up on something that Jeff

said at the end of his presentation that the underlying story has changed from the report that was produced in 2001 to the one we're going to produce in 2012. And I think as we sit through and listen to the recitation of all the reports and a summary of the data that we've seen in the past, I think there's a good story to be told here that Medicare has brought a lot of stability and a lot of predictability to the rural areas and rural care that's out there.

And I can see a report that could be constructed where we could catalogue the changes that have occurred over the last decade and perhaps not a lot of recommendations. We might have some. We see the information here on dialysis. There might be some others. But rather than folks that thought this might be a report that's real robust with a whole new set of recommendations that will be the road map for the next decade of all these changes in rural health care, that might not necessarily be the case given some of the data that we've looked at and some of the areas that were there.

But having said that, you know, one area that might be helpful for us to look at in this report as we

continue to go forward is as a little bit of predictive of what we might see in rural care over the next decade and, in particular, access, picking up a little bit of something that Glenn had made an observation to one person's question or comment, is that, you know, we look at the data in terms of on access, and we know we have a deficit of providers, particularly physicians in rural areas, but care is basically equal because people are willing to travel to get care that's out there.

One of the things I know I raised when you presented that data the first time is was there a way we could stratify that data by physician age, the notion being that perhaps a lot of these physicians that are practicing in rural areas are a lot older than in urban areas. We've done some of that work in Missouri, and it is indeed the case. And so we will probably start to see some retirements over the next decade, and could that lead us to a position where we might have even greater access issues that are out there?

Picking up a little bit on what Glenn said in terms of primary care access with APNs and PAs, you know, I go back to some of the data we looked at in the December

meeting when we were looking at access, when we were looking at physician payment, and the survey we did of the Medicare beneficiaries and those that were below Medicare, but fully a third were now getting primary care from an APN or a PA.

So as we go through this report, if it's not going to be a real major robust report with a whole lot of policy recommendations because that may be directionally where we don't need to go, one of the things that might be helpful, I think, for the rural community overall but for the Medicare program is if there is any kind of predictive modeling we can do in some of these areas, particularly in access, and look at what might be out there, at least give some policymakers some things to begin thinking about. Are there different ways that we might want to think about medical education or different aspects to make sure that we deal with that inevitability that's going to occur in that space.

MR. HACKBARTH: So as we go around in the second round, one thing that would be helpful to get people to react to is the plan for this report, and our sense right now is that we will report data responding to the specific questions asked in the mandate. We will outline principles but not have bold-faced recommendations on which we vote.

So that's our plan to this point, and I'd invite people to react to that.

Then just a question about the physician age issue. Are there reliable national sources of information on physician age that could be used to look at that?

DR. BORMAN: A huge number of the specialty organizations are already reporting that for various purposes, and I suspect the AMA Master File also would be places. But there's aging of physicians and a whole bunch of things both in terms of location and in terms of specialty. So I think those data are pretty accessible.

MR. HACKBARTH: Well, I have often heard the point made that Herb just made, that this is a particular issue in rural areas. It sounds like you've done it in Missouri. If we can shed some light on that on a national basis, that might be an important contribution.

DR. NAYLOR: Let me just echo much of what Herb has just said. I think that this is a good story for Medicare, and I would highlight where you can, it's a good story for MedPAC, and maybe thinking about superimposing when recommendations went into play right on top of where we began to see these migrations in margins I think would be

terrific.

I think Peter's point about this being a story about post-acute care and where there are lessons learned here about the capacity to substitute other services, so not having IRFs doesn't mean that people can't get access, because your big story is about quality. And I think that the quality measures and satisfaction measures look good. So does that mean that there are opportunities here for a continuum of post-acute services, et cetera?

I do think, picking up on the hospice, both access on one hand and little utilization on the other is an area for further exploration.

And the recommendations about, you know, predictions of the future and future directions I think is really important because in your proposed efforts around targeting payment where we're continuing to see maybe great opportunities that are on the one hand unmet and opportunities for savings where we have duplication of payment, you know, options or two hospitals right next to each other I think are very, very important.

I would also say this is a good-news story for Medicare and HRSA because HRSA has placed a tremendous

amount of its attention on building the primary care workforce, and one of the reasons we have 33 percent APNs and PAs but many more proportionally in rural areas is because of the kind of combination of efforts on the payment and workforce delivery effort. So I think it would be great to highlight that as well.

MS. BEHROOZI: I think you've done a great job of organizing the discussion and stating the principles in ways that I think we can all support. And I know that this is not something that you can change -- you know, the horse is already out of the barn on this one, but, you know, kind of consistent with Scott's question, it's not really a comparison between rural versus urban. It's rural versus everybody else. And in that 80 percent there is a huge amount of variation both in terms of where people live and what their access to services is. And I fully recognize that, you know, this was a congressional mandate and there were important reasons that MedPAC made the recommendations that it did, lots of which had to do with access and quality for beneficiaries living in areas where they didn't have sufficient levels of access and quality. But as we, you, all move forward, I wonder if there will be an opportunity

to consider truly urban areas where there are problems of access and quality, there are problems of low health status because of socioeconomic status, because of conditions that people live in, and really separate out the high-density, low-socioeconomic status areas from, you know, greater metropolitan statistical areas and suburban areas and places like that that I think probably bring that overall so-called urban, the everybody else level up, and it's great to bring urban -- I'm sorry. It's great to bring rural to that level, but it would also be really good to bring true urban up to that level.

Thank you.

MR. GEORGE MILLER: Yes, I concur with everything that has been said. I think this is, although it's mandated, it's still a very good report and I think it is fair and balanced and it certainly deals with what Mitra just illuminated, dealing with the issues of access and quality for rural areas, and I certainly want to thank the staff for the efforts that have been done to date.

I would agree with Herb in that I'm not sure there necessarily needs to be recommendations, but certainly fine tune around the edges. And I also agree that this is a

success story not only for the Medicare program but for MedPAC recommendations. If you look back to 2000 and where we are today, and again, except for tweaking around the edges, I think there are successes, and particularly to the point about mid-level practitioners. In most rural areas, we live and die with mid-level practitioners to certainly help augment and support the physicians who provide care in the area. That also is a success story in many ways. Where we can't recruit physicians, mid-levels have stepped into that gap, still supervised and overseen by the physicians, but still provide a valuable service.

I think the other thing as we move down this path, what Mitra said, is that -- and I agree with her, because she hit right in my sweet spot, dealing with disparities and inequities and pockets, whether they be in urban areas, rural areas, or wherever they be. We certainly should pay attention to those beneficiaries that may fall through the cracks or are not meeting that same standard of access and quality no matter where that beneficiary is, and certainly at some point we'll focus on that, as well. So thank you.

DR. CASTELLANOS: I just want to comment that I totally agree with what's said. I just go back to

yesterday's discussion. I think maybe this is a good example of a targeted approach to solving some problems in the Medicare system and we may want to consider that in the safety net hospitals, et cetera. I know that was a real concern yesterday concerning care, as George said and as Mary said, as Mitra said.

MR. GRADISON: I think it's wise to stick with the principles rather than recommend specific changes in the programs. However, having said that, I think this information will not only be responsive to the Congressional request, but also extremely helpful to us as we have to deal each year with decisions by the silos, because it gives us a little more color, a little more flavor and detail about the rural, frontier, and the other categories of non-urban institutions or non-urban settings than we might otherwise have. So I think we're going to get a lot of value out of it here, but it may not be so much from just looking at rural as it is looking at SNFs or looking at hospice or other categories.

DR. BORMAN: After almost six years, I'm sort of out of adjectives and adverbs to say what really fine staff work this represents, and it is just another example of

that. We should celebrate that ongoing work.

I think we also celebrate this as a success story of identifying a problem that interventions -- that we recommended things. Interventions were undertaken, albeit perhaps in a patchwork quilt way, as so often health care policy is, and yet we have a good outcome, and we should celebrate that in this instance, the process will work well.

I think that maybe the view to take of where we go next is really more a phase of refinement and to think of it in that way, and that because of the success, we can now focus on refinement. So refinement is things like Herb mentioned. What are the things that are high points to monitor for the future? Where do we think the flash points may be, so that we don't end up so far behind the eight-ball that we did that led us into this era, this phase of activity that we've had. So that would be one.

Secondly, I think the targeting the dollars to the best effect is something that we've tried to look at pervasively in all the areas of the program, and I think to the extent that we can comment on that in this particular report in a very positive way -- we've done the experiment here where we've done a number of kinds of programs. Where

have been the best results and how best do we target to ensure that?

And then, finally, I think that as we're in this refinement phase that we've shown, somewhat surprisingly in some areas, perhaps, that, by and large, we are providing equivalence as a result of these good interventions. So now the driving metric, it seems to me, is quality. And as we've defined, what are the appropriate -- or how do we appropriately say what applies in these different population efforts, and I think I continue to support the urgent versus non-urgent services as good a break as we can come up with -- there will be no perfect one -- that now we -- as long as we monitor that access is still out there, then I think the important thing that we follow is being more rich or more deep about quality, making sure we've got that part right, making sure that we're incentivizing as we look to targeted payments and all the other things that we do, make sure that those now incentivize quality appropriately in these areas. That would be the driver, I think, that we would want to conclude, also, for going forward. But this is really great work.

MR. ARMSTRONG: So I, too, I don't have the six

cycles that Karen has of going through this, but would affirm that the report that you've pulled together is really outstanding.

I also would echo that it seems that we had an issue. We targeted solutions through payment policy and we've had a real impact, and I think we have a lot to learn from that.

I would, however, just acknowledge that the payment structures we have for rural markets are really complicated and kind of confusing and that I have to believe that there's inefficiencies in it and that the principle that you have with respect to avoid duplicating payments, I think, is a little light. I think that while we've gotten to where we are right now, in the years ahead, I think we should aspire to rationalizing and simplifying without screwing up what we've done. So I just would want to add that point.

And then, second, our point of view around rural services seems to be how can we through our payment policy keep it from being -- keep our beneficiaries from being, like, harmed by the special concerns that care delivery providers have in rural communities. And at some point, I

would hope we could flip that a little bit and recognize that care delivery systems in rural communities actually achieve spectacular results given limited resources and that there's probably a lot to be learned from that.

I mean, Tom and others have talked about the creative use of mid-level providers, you know, kind of actually replacing post-acute services, one for the other, depending upon what's available and what really works. I mean, some of those kinds of things, I think in the years ahead, could actually offer insight into the ways in which we evolve our payment policy in urban areas, and so just a thought on that.

DR. BAICKER: I agree with Scott that the principles make a lot of sense and could even be dialed up, that we want to, even better than paramaterize, rationalize, as you said, the payment structure. These overlapping payments can't be efficient and aren't particularly good at targeting. As you pointed out, the goal is to target sole providers, and I might add in, with the explicit goal of guaranteeing access or promoting access, that it's not just because you're one, it's because you're what stands between the beneficiary and not getting access to care of acceptable

quality and that that acceptable quality may vary across circumstances, emergency versus non-emergency. But to harmonize those payments so that we are effectively targeting that particular goal would make the policy much more effective.

MS. UCCELLO: Yes. Agreeing with Scott and Kate, although there's a lot of good news in here, we have shown that we're not -- we could target better. We could refine things so they are more empirically justified, you know, base things better. So it's not like there's nothing to worry about here. There's still some room for improvement, and so we need to keep that in mind.

But I agree in general with just sticking to these principles and laying those out and I think the ones that you've listed here are really excellent.

And just adding to the chorus of everyone here, thank you so much for the tremendous work you've done over the past year-and-a-half or longer working on this stuff. It really shows.

MR. BUTLER: Okay. Enough of this congratulations. I want to set the bar even higher for the final draft --

[Laughter.]

DR. MARK MILLER: [Off microphone.] It looks like we're out of time.

[Laughter.]

MR. BUTLER: But let me tell you why. I'm reminded frequently that we're working for Congress, and in an area like this, this was not just the normal business. This was a specific request by a lot of important members of Congress, Senators that represent primarily rural States, Representatives that sit in primarily rural areas. I think, so more than ever, think about the final draft as something that is not only addressing the points, but something they can use for a communication vehicle for their Representatives, or if they were to come out and sit with a SNF administrator or a hospital administrator or a community group, it would kind of make sense to them.

And that's kind of one of the reasons I mentioned the post-acute profile. Make it -- this is a great opportunity to cast just a little different light on it and make sure it can be used effectively in many forums, because these are a lot of important people in Congress and the more you can kind of -- I won't say "dumb it down," even though I

just did, because I don't really mean that because it's complicated and it does need to include the kinds of points Scott made, as well, if you want to dive deep around there. But I think it is a great opportunity to make the best of a chapter and go beyond addressing a technical policy issue and communicating a message.

DR. DEAN: I certainly agree with the principles that were laid out. I think that they really direct appropriately the direction that our inquiry should go.

I appreciate, obviously, what Scott just said, but I'd make the point that -- and one of the things that I have found appealing about rural practice is there are things you can do in small systems that are very much more difficult in larger systems, and the net effect of that is that they are tremendously dependent on whatever capabilities or leadership or whatever is there in that particular setting. And if you have those capabilities, you can do great things relatively easily. If you don't have it, things can get real bad in a hurry.

For instance, in our own setting, every morning, we meet with all the physicians, the nursing staff, physical therapy, and social service. We all get together and we go

over every patient in the hospital. And our readmission rate is somewhere around four or five percent and I think it's due to that issue. We all know what's going on. If there's a problem, we'll -- you can't do that in most facilities. I mean, it's just out of the question.

So I think that we have some opportunities that have nothing to do with the particular capabilities but just it's possible to do things in that kind of a setting that you can't do in bigger facilities.

I guess having said that, I do have some concerns about some of the statements. I'm not sure that just measuring number of services is really the answer in terms of defining access. I think it certainly is an important measure, but it doesn't say anything about the timeliness of those services and how quickly people reach. I mean, for instance, I would say that, basically, everybody in most rural areas that has an MI eventually gets the care. The question is, do they get there in ten or 15 minutes or do they get there two or three hours later? There's all kinds of ways you can do it. But I think to really determine access, I think we need to tie it to some kind of outcome measures, as well, to validate that and to see if it's

important.

Also, as Peter said, there really is tremendous variation and I think we probably need to get to look at the range of variation across the country, because there are a lot of geographical differences and we've tended to look at averages, which I've mentioned before, which frustrate me, but which are sometimes useful, but I think also can hide variation. We need to look at how much variation there is in each one of those measures, from the best to the worst, and determine if that's a narrow span, then the generalization is clearly justifiable. If there's a wide span, then I have a little more concern about it.

I think we looked at some of the cost issues related to Critical Access Hospitals, and as I've said before, the CAH program has been a tremendous boon and I think has really stabilized care in many rural areas. At the same time, it has been criticized, legitimately, because there probably are a number of facilities that qualified where you could really question whether they met the basic intent.

Also, I think sometimes we jump to the conclusion that, well, if they have cost-based reimbursement, they're

automatically financially stable. The numbers are that a substantial portion of CAHs also have negative margins, something like 40 percent of them was the number I saw. That's not immediately an issue, but I think we just can't assume that they are automatically living easily, or that it's an automatic sort of gravy train, because there are still stresses out there. And I think the concern has been raised that that takes away any pressure for cost control. I don't think it's that simple. Certainly, I know in our setting, our administration does worry about cost considerably because they do have negative margins about half the time.

Finally, I guess the other thing which I have raised before, in some of these, especially the home health area, which I'm sure you're tired of hearing me talk about, we really need to look at the total spectrum of home health agencies and not just freestanding ones. In South Dakota, and you've heard me say this before, there's two-thirds, at least, of our home health facilities are associated with Critical Access Hospitals and aren't even included in the analysis that we do in terms of margin. Now, I understand there are problems with measurement, but to make the

generalization that rural home health agencies have the same margin is, I don't think, accurate. At least, it's not accurate in the areas that I'm most familiar with. So I'm not exactly sure how you do that, but in South Dakota, freestanding facilities only exist in about ten percent of the counties and the rest of the State is all dependent on provider-based facilities. So I just think there is a deficiency. I'm not sure just how to solve it, but it is a concern.

Overall, I agree. There's a lot of very useful, and I think there's been a lot of progress. And clearly, the recommendations that have been made have moved the whole state of rural health care forward considerably and it's, in general, much more solid than it was when I started practice quite a few years ago.

The recruitment issue is a real worry, but it's a worry across the country. That's not a real -- isn't uniquely rural, although it is a particular concern because we are so dependent on primary care physicians and they are, obviously, as everybody knows, the group that's in most demand and in smallest supply.

So, anyway, I'll stop there.

MR. HACKBARTH: Tom, the point about variation, which I don't disagree with, for me, the challenge is figuring out how to deal with it. So one approach to not just talking about rural averages is to subdivide rural into subcategories -- micropolitan, adjacent to urban, not adjacent to urban. We sometimes use the frontier classification to try to give a flavor for the varieties of ruralness that exist.

Another more sort of statistically-minded approach to variation is to, with everything, report not just the median or the mean, but the standard deviation and all that stuff. I'm not sure that that really helps a whole lot of readers. There are certain readers that look at that and it's very meaningful to them. It isn't particularly meaningful to me. And if you have to do that for every statistic reported, you've got this incredibly challenging to present and read document.

So I agree with your basic point. I don't know how to solve it.

DR. DEAN: I guess I would respond that we have done this in some just reporting 25th and 75th percentiles or something along those lines, in terms of whether it's

utilization or whatever. I think that's sort of the first cut and that may or may not qualify with these other categories, you know. We sort of assume that the more sparsely populated, the worse it would be. In some cases, that's clearly true, but obviously, in other cases, it's not true, and --

MR. HACKBARTH: [Off microphone.] Jeff, can you put up Slide 11? Oh, I'm sorry. So it could be any one of these tables.

DR. DEAN: Yes.

MR. HACKBARTH: So if we now subdivide, in this case, the rural into three categories and show -- are these means or medians here? Are these medians, Jeff, the Medicare margin numbers?

DR. STENSLAND: Aggregates, because we're adding together all the payments -

MR. HACKBARTH: Oh, that's right, because we're just combining them all together. Yes. So with that approach -- I'm statistically challenged here. So you can't even report the 75th and the 25th percentile here. This is the aggregate of the whole pool.

DR. STENSLAND: Yes. We could also present the

75th and 25th as a separate way of doing it. It would just triple all the numbers in here.

MR. HACKBARTH: And that's the point that I'm headed to. If you imagine for every table that we're doing that, do we have a document that is readable? Mike, can you help me out?

DR. CHERNEW: Well, it might be useful, and maybe not for all of these, to have a sort of scatterplot or some other type of graph that just shows the range, because what you really want to know -- I think what the comment is, is if there's big outliers one way or another that's pulling these averages down. So if you saw they're basically the same but there's a few in some weird place, you could actually look at them.

I don't think that's useful for the report, but what it might be useful to do is to look at so then when someone asks a question, you can say, this looks like distributions that are just shifted, which is sort of what you get when you think about it, or they're pretty much on top of each other with a few outliers, particularly the one that has the 17 and the 13 observations and you can't tell. If you looked at where they were distributed, you would get

some sense of whether they're really just systematically different distributions or there's just something going on with the sampling. But once you know what the answer is substantively, I would then simplify it for the presentation.

DR. DEAN: Yes, I would agree with that. I think as a test to see, for instance, these three criteria, micropolitan, adjacent, and non-adjacent, is that really telling us what we need to know? I think as an example, in the chapter we looked at, I guess it was last time, about home health, there was that table that listed 23 of 25, or whatever it was, most expensive areas were all rural. Well, that was -- they were also all located in a very close geographic area, and I think the problem was not that they were rural, it was that they were in a particular geographic area because -- so I think we -- it's just as a measure, because I think if you looked at those same data, there was a wide spread in terms of cost.

MR. HACKBARTH: The point about the home health margins, I very much agree with you. To me, that seems like a little different issue --

DR. DEAN: Yes --

MR. HACKBARTH: -- and to me, that's one --

DR. DEAN: [Off microphone.]

MR. HACKBARTH: Yes. Well, actually, I think it is a major issue, and my comment when it got around to me was going to be that I think one of the things that should be really highlighted here is the artificiality of this urban-rural distinction, and there is a huge amount of variation. For example, this home health statistic, the regional variation swamps the urban-rural variation.

DR. DEAN: [Off microphone.] That's right.

MR. HACKBARTH: And we have these policy categories that are driving lots of dollars that in some ways are artificial.

MS. BEHROOZI: Well, and then isn't it the same thing on the rural side --

MR. HACKBARTH: On the urban side.

MS. BEHROOZI: I'm sorry, on the urban side.

MR. HACKBARTH: Yes.

MS. BEHROOZI: So if you're going to compare apples to apples, I mean, you're still going to get the washout of urban being a bigger group, but then you should also do 25th to 75th on the urban side. You can't just do

25th to 75th on the rural side and compare it to the average on the urban side.

MR. HACKBARTH: Right. Right. Right. Yes.

[Off microphone discussion.]

MR. HACKBARTH: Okay. Were you finished, Tom? Any other points, Bill?

DR. HALL: Pass.

MR. HACKBARTH: Bob?

DR. BERENSON: I was going to make the same point about the regional variations being very striking and not to minimize that. I guess what I'd say is where a sub-analysis looking at the variation is very revealing of something, then it goes in, but not routinely. In other words, where I have -- based on everything I've heard, I have great confidence that you guys have control over this paper and would be able to identify those instances where that kind of an analysis would actually add something versus -- and just not doing it routinely, just as a matter of statistics. But I think this is in very good shape.

MR. HACKBARTH: Okay. Thank you very much. Very good work.

And we'll now have our public comment period.

[No response.]

MR. HACKBARTH: Okay. I think we are done. Thank you all. See you in March.

[Whereupon, at 11:52 a.m., the meeting was adjourned.]