MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 4, 2012
9:45 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:45 a.m.]

MR. HACKBARTH: Okay. Good morning. Before we begin our first session, let me just make some general comments. Actually, let me first acknowledge the change in the schedule that was initially published. We moved the physician geographic practice adjustment issue to first on the agenda. For any of you who have been inconvenienced by that, send your e-mails to me, not to Mark. I am totally responsible, and so I apologize for any inconvenience.

DR. MARK MILLER: See me for the e-mail. I'll give [off microphone].

[Laughter.]

MR. HACKBARTH: Actually, he told me that he has a slide prepared with my e-mail address on it.

Now, to the substance of the meeting, an important part of the meeting is to continue our work on three reports that the Congress has asked for: one on physician geographic adjustment, the work portion of the rate; second, on Medicare payment for ambulance services; and the third is on the outpatient therapy benefit.

Congress has asked us to provide recommendations on those issues before year end. In order to do that, we

will be reviewing today draft recommendations that I have prepared and am offering to the Commission for discussion. We will discuss those draft recommendations, and based on the discussion at today's meeting, I will make whatever changes are necessary, and we will have votes on those issues at the November meeting.

Now, the actual detailed report on those issues, you know, with all of the text that usually accompanies MedPAC recommendations, will be published in the June MedPAC report. So we'll have a disconnect in time between when our formal recommendations are made in November and the actual publication of the material.

Another issue that is on our agenda for this meeting that also has time connected to it is the SNP issue under Medicare Advantage where that reauthorization -- that authorization expires at year end, and so Congress has asked for whatever thoughts we have on that issue as well.

Then, finally, we'll be returning to some other issues, including an important issue about addressing differences in Medicare payment levels for the same service based on the location of that service. That is an issue that we have taken up before and we will be revisiting. So

we have lots of important work ahead of us the next couple days.

The first issue that we're going to address is the geographic adjustment in the work portion of the physician payment, physician and other health professionals payment rate. Before we get into the presentation on that, let me just say a word about our approach to these three mandated reports in general -- the physician GPCI, the ambulance, and outpatient therapy.

In formulating draft recommendations, what I've tried to do is apply a consistent framework for approaching those issues, and that framework is that if the Commission is going to recommend an increase in Medicare expenditures above the current law baseline, I think we ought to do that based on evidence that we think that that expenditure would improve access for Medicare beneficiaries or improve the quality of care for Medicare beneficiaries or facilitate movement towards new payment systems that we think are important for the Medicare program.

I proposed that framework actually drawing on comments that Peter Butler and Scott Armstrong made at the September meeting, and I think the approach that they

suggested made a lot of sense. And so that way of framing these issues informs all of my draft recommendations on the three mandated reports.

So, with that preface, let's turn to the issue of the physician fee schedule and the work portion of the rate. Kevin?

DR. HAYES: Thank you.

The mandate that Glenn spoke of was in the Middle Class Tax Relief and Job Creation Act of 2012. It directs the Commission to consider whether certain payments under the physician fee schedule, payments for the work effort of physicians and other health professionals, whether those payments should be adjusted geographically.

In fulfilling the mandate, the Commission is to assess whether any adjustment is appropriate to distinguish the difference in work effort by geographic area, and if so, what the level of the adjustment should be and where it should be applied.

The Commission must also assess the impact of the current adjustment, including its impacts on access to care.

The Commission's report on these matters is due June 15, 2013. However, a temporary floor on the current

adjustment expires on December 31st of this year, and so with that date in mind, we will have the draft recommendation that Glenn mentioned.

To fulfill the mandate, we are assessing policy options by considering issues of cost, access, quality, and payment reform. Glenn went through and listed the different items, specific questions that we're trying to address in this area, so I won't repeat them, but they are listed here on this slide for your information.

For today's presentation, we will first briefly recap points made at the September meeting about the fee schedule's geographic payment adjustment for work effort. That is known as the geographic practice cost index for work.

We will review the GPCI's purpose conceptually and, from a more practical standpoint, how it has been implemented.

Then, new for this meeting, we will present an empirical analysis of the GPCI conducted by our contractor, RTI International.

The second topic we will be addressing is the GPCI's impact on access to care.

Third, to follow up on questions at the September meeting, we will provide specifics on the GPCI's impact on spending.

And, fourth, we have a Chairman's draft recommendation for your consideration.

The theory relevant to the GPCI says that the wages paid to workers for a unit of work should be equivalent in terms of the goods and services they can purchase with those wages regardless of the geographic area where they work.

Factors that vary geographically and believed to influence wage differentials include cost of living and amenities. Data on wages paid, therefore, would include the effects of both factors.

Data specific to the earnings of physicians and other health professionals can be influenced by three additional factors: market factors, volume of services, and the return on investment received by practice owners.

When thinking about a payment adjustment such as the work GPCI, there's also the issue of circularity. If the data on the earnings of physicians and other health professionals were used to construct the work GPCI, there

would be a circular relationship between the work GPCI and the data used to construct it.

The work GPCI is constructed with data on the earnings of professionals in selected occupations. Specifically, CMS develops the GPCI with Bureau of Labor Statistics data on the earnings of professionals in seven reference occupational categories, such as architecture and engineering; computer, mathematical, life, and physical science.

As you discussed at the September meeting, this method of implementing the GPCI raises two issues.

One, the data available on geographic variation in physician earnings are quite limited. As a result, it is difficult to assess the validity of the GPCI.

Two, some say that the labor market for physicians and other health professionals is different from the labor market for professionals in the reference occupations. Health professionals may value amenities differently compared to other professionals.

As an example of the limitations of data available on the earnings of physicians and other health professionals, consider data from the Bureau of Labor

Statistics.

BLS collects data on the earnings of workers in most, if not all, occupations. However, in work for this report, we found that the data on physician earnings are: first, sparse at the level of individual specialties in smaller urban areas; second, limited by having censored responses at upper-income levels -- those greater than $187,200 per year; third, the data include wages only and omit benefits; and, fourth, they include earnings of residents and fellows.

Nonetheless, we did conduct an analysis of the BLS data. Such an analysis was proposed by the Institute of Medicine's committee on geographic adjustment of Medicare payments.

The proposal was that, if cost of living and amenities are as important to physicians and other health professionals as they are to those in the work GPCI's reference occupations, geographic data should in theory show that the earnings of health professionals are highly correlated with the earnings of workers in the reference occupations.

The first analysis compared physician earnings in

one type of low-cost area -- rural areas -- and metropolitan areas.

Previous research shows that the earnings of physicians in rural areas, when adjusted for cost of living, exceeded the earnings of physicians in urban areas by a statistically significant 13 percent.

BLS data were analyzed for two physician specialties -- family medicine and internal medicine -- judged to have sufficient data to permit reliable estimates for metropolitan and rural areas. For each specialty, an index was computed as an area's average wage divided by the national average wage.

The findings were consistent with the previous research. The average wage index for family medicine physicians was 1.03 in rural areas but 0.99 in metropolitan areas.

For internal medicine physicians, we see a similar result: an average wage index of 1.06 in rural areas but 0.99 in metropolitan areas.

By contrast, a wage index constructed with data on the wages of professionals in the work GPCI's reference occupations shows lower wages in rural areas, with an

average index value for rural areas of 0.75 compared to 1.03 for metropolitan areas.

A conclusion that can be drawn from these results is that earnings differentials for the reference occupations are consistent with economic theory, but the differentials for physicians are not.

Here again, however, the data on physician earnings as currently collected can be influenced by the factors discussed earlier: return on investment, service volume, and market power. Clearly, better data on physician earnings are needed.

The second analysis with BLS data was an analysis of the correlation of the work GPCI with physician earnings. The results were not surprising given what I just said about differentials in physician earnings, rural areas compared to metropolitan areas.

The wages of professionals in the work GPCI's reference occupations are correlated with the wages of physicians in internal medicine, but the correlation is negative. The correlation coefficient for this relationship is minus 0.202, and it is statistically significant.

The data have limitations: censoring, earnings of

residents are included, and so on, as I mentioned earlier. But to the extent we can measure physician earnings with these data, the earnings of professionals in the work GPCI's reference occupations do not track the earnings of internal medicine physicians.

Given the concerns about the work GPCI, we thought you might wish to consider alternatives. At the September meeting, you asked about a measure of the cost of living. To compare the work GPCI to the cost of living, we used a cost-of-living index named after the American Chamber of Commerce Research Association.

With this index as a measure of the cost of living, we analyzed the correlation between that index and a second index constructed with the BLS data used for the work GPCI. The analysis shows that the correlation between the two indexes depends on the level of earnings.

In areas where professional earnings are below average, there is very little correlation between those earnings and the cost-of-living index. The correlation coefficient for that relationship is 0.09.

By contrast, the correlation of professional earnings with the cost-of-living index is much higher in

areas with above-average professional earnings. For those areas, the correlation coefficient is 0.65.

A conclusion we can draw from this analysis is that professional earnings behave somewhat differently from the cost-of-living index. We are not sure how to interpret this result, but did want to conduct such an analysis given the discussion at the September meeting.

Kate will now discuss another alternative to the work GPCI.

MS. BLONIARZ: So one question you asked at the September meeting was how the GPCI stacks up to the hospital wage index, and to do this analysis, we used MedPAC's construction of the hospital wage index because, unlike the CMS version, the MedPAC index does not have any exceptions, special rules, or reclassifications. The MedPAC index also smoothes the values across counties so there are not sharp differences in regions abutting each other, and uses a broader basket of wages across hospital and nonhospital employers.

The correlation between the work GPCI and MedPAC's hospital wage index is quite strong -- nearly 0.8. So the work GPCI is highly correlated with another measure of

geographic variation used to adjust payments to hospitals and other sectors in Medicare.

On Slide 8, Kevin showed you mean physician earnings, showing that, on average, rural was higher than urban. But that's not the whole story.

In general, earnings vary geographically across all types of sectors. And as you saw on the previous slide, the hospital wage index, which measures the earnings of the types of employees hired by hospitals, shows significant variation. Similarly, we do see geographic variation in physician earnings across the country.

This table shows the means and interquartile ranges of physician earnings for two specialties. For example, the interquartile range for family and general practice in metropolitan areas is from 0.9 -- or 10 percent below the median -- to 1.11 -- or 11 percent above the median. This is the first line on the slide.

The second line shows the corresponding ranges for rural areas, and you can see that the variation is slightly less -- from 0.94 to 1.10. These data, limited as they are by the methodological concerns affecting all physician data, do show geographic variation. And so this provides one

rationale for adjusting wages geographically.

I'm now going to change topics and talk about the GPCI's impact on access to care.

As discussed in the Commission's June 2012 report on serving rural Medicare beneficiaries, the Commission's principle for access to care is that beneficiaries living in different geographic areas should have equitable access to services. And we've applied a similar framework here. The bottom line is that while we see differences in the supply of physicians and other health professionals across low- and high-GPCI areas, we don't see differences in service use.

There are differences in the number of professionals per beneficiary. It is lower in low-GPCI areas and higher in high-GPCI areas. The one-year growth rate in the number of professionals billing Medicare was generally the same.

But, despite these differences in supply, there is no difference in service use or volume of care in areas where the work GPCI is less than 1 and areas where the work GPCI is above 1.

So this slide shows the service use figures. Both the ranges and the means for the number of office or

outpatient visits are similar across areas with work GPCIs below and above 1.

The mean is 10.2 visits per beneficiary in areas with GPCIs below 1 and 10.0 visits per beneficiary in areas with GPCIs above 1.

The distribution of service use was also similar, with similar minimum and maximum values for the rate of office or outpatient visits per beneficiary. So, despite the differences in supply, beneficiaries are receiving similar levels of care.

This matches our finding in the rural report, where, across different types of rural areas and urban areas, we found no overall difference in service use.

We have also not seen differences in service use across rural and urban areas over time. In the rural report that the Commission produced in 2001 using data from 1999, the Commission did not find a difference in overall service use across rural and urban areas. And this was prior to the enactment of the floor on the work GPCI. So because we see similar findings in rural and urban areas with respect to resource use, both before and after the floor, it does not seem that the work GPCI floor has had an impact on access to

care.

Finally, even if there are observed differences in access across regions, the Medicare program has other ways to improve access that may be more targeted. For example, Medicare pays a bonus for primary care services as well as a bonus for services provided in the Health Professionals Shortage Area, or HPSA, and there are other programs, such as those run by HRSA, to support health professionals in underserved areas. It may be that those options are a more effective way of improving access to services provided by physicians and other health professionals.

So you might be surprised that we do not see an effect of the work GPCI on access to care. To help explain that finding, this is the chart that Kevin showed you last month that shows the impact on spending of the work GPCI with its upwards and downwards adjustments. Overall, the average change in payments due to the GPCI is around 1.2 to 1.4 percent. The maximum change is plus four and the minimum change is around minus three percent. That is excluding Puerto Rico. So the relatively small size of the adjustment may be the reason that we don't see any real differences in access across low and high GPCI areas.

Another way to present the spending impacts is to show how it affects spending for different types of services. We picked three different fee schedule services, a Level 3 E&M visit, transthoracic echocardiography, a type of imaging, and knee arthroplasty, a knee replacement surgery.

The top line on the slide shows how much the work component contributes to the payment amounts. This will determine how much the work GPCI affects the overall payment for the service. And you can see that imaging is relatively lower and surgery is relatively higher.

Then the bottom line on the slide shows how much the spending varies between the 90th and the tenth percentile of localities. The service with the highest share of the payment attributable to work, knee replacement, has 51 percent of its payment attributable to work. You can see that on the top right. And for that service, the work GPCI has the highest impact on payments, a 4.4 percentage point difference between the 90th and the tenth percentile. That is the bottom right cell.

So after going through that, I will turn it back to Kevin.

DR. HAYES: So to summarize our presentation to this point, there is evidence of the need for geographic adjustment of fee schedule payments for professional work. Cost of living varies. Earnings vary for the professionals in the work GPCI's reference occupations. And to the extent we can measure them, physician earnings vary.

However, the current adjustment, the work GPCI, is flawed in concept and implementation. Conceptually, the GPCI is based on the earnings of professionals in the reference occupations, but it is unclear whether those professionals value amenities in the same manner as physicians and other health professionals. And implementation of the work GPCI is flawed because there appear to be no sources of data on the earnings of physicians and other health professionals of sufficient quality to validate the GPCI.

Another summary point: There is no evidence that the GPCI affects access. Access may be better addressed through other targeted policies, such as the HPSA bonus and the primary care bonus.

But there is no evidence to support a change in current law. Current law is the one-quarter GPCI applied to

all localities. Departures from current law would increase Medicare spending.

Looking ahead, to geographically adjust payments for the work of physicians and other health professionals, it is necessary to collect data. If the decision is to continue with the current approach, it would take a large-scale survey of professional earnings. The survey would need to meet minimum requirements for sample size and representation of professionals as they practice by specialty and geography. As we have seen in our work with the limited earnings data that are available now, the data to be collected should be data on the earnings of employed professionals, should exclude residence, should permit an adjustment for market power, and should account for the volume of services furnished. Clearly, CMS would need resources to do this.

In addition to these data issues, the Congress may wish to explore alternatives to the work GPCI. Alternatives you have discussed include a cost-of-living index and the hospital wage index. A third alternative might be a new reference occupation index, but one that can be validated with the data that would be collected on health professional

earnings.

This brings us to a Chairman's draft recommendation, which reads as follows. Medicare payments for work under the fee schedule for physicians and other health professionals should be geographically adjusted. The adjustment should reflect geographic differences in the market fees paid to physicians and other health professionals. Because of uncertainty in the data, the Congress should adjust payments for the work of physicians and other health professionals by the current one-quarter GPCI while the Secretary develops an adjustor to replace it.

Impacts of the Chairman's draft recommendation are as follows. First, there would be no impact on spending.

Second, there would be no impact on access to care, with the understanding that the access is better addressed through other policies, such as the HPSA bonus and the primary care bonus.

Third, we are unable to determine whether the work GPCI has an effect on the quality of care.

And fourth, changing the work GPCI does not advance payment reform or move the Medicare program away from fee-for-service and toward a more integrated delivery

system.

That concludes our presentation. We look forward to your questions.

MR. HACKBARTH: Okay. Thank you, Kevin and Kate. Really well done.

If I may, I'm going to kick off the clarifying round, and I think I may.

[Laughter.]

MR. HACKBARTH: So ordered by the Chair.

[Laughter.]

MR. HACKBARTH: So, Kevin, in your presentation, you made a brief reference to the IOM report on geographic adjustment. I went back and I looked at that and I am going to try to briefly summarize what I read. Please feel free to correct me if I don't have it right.

My take on what they said was that, first, they addressed the conceptual issue of whether the work portion of the rate should be geographically adjusted. The report I read said that there was actually a range of opinion on the committee on that conceptual issue. Some thought yes. Some thought no. Some, I guess, were in the middle on that. The nature of this report was that there was not a vote and

people said, you know, "I am in favor of geographic adjustment of work," or were not. So they just characterized the discussion.

Then, in addition to that, they went into considerable detail about the challenges of trying to measure what the geographic adjustment should be, assuming that there is a geographic adjustment. The inference that I drew from the presentation was that, on balance, despite the diversity of opinion, the IOM is saying there should be geographic adjustment conceptually. We need to do more work to improve the accuracy of the adjustment.

So that was my summary. Is that accurate?

DR. HAYES: That is a fair summary. It sure is.

MR. HACKBARTH: Okay. And in case people are wondering about where the IOM landed on this, that is what they have said to this point.

Then the second clarifying point that I want to make actually pertains to the draft recommendation. And you'll see here in the second sentence, they say the adjustment should reflect geographic differences in market fees, and I just wanted to elaborate a bit on my thinking on that.

At the September meeting, we talked about physician compensation as being sort of a benchmark on how well we were adjusting, and as we talked, Mark, Mike, and I talked more about this, it occurred to me that, actually, that might not be the proper reference point in that what we're talking about is adjusting fees per unit of service, whereas compensation is a function both of fees per unit of service and the volume of service. And so if our goal is a per unit of service adjustment, then what we would want to use as a reference point is a variation in fees per unit of service.

My thinking is that that also has a nice side benefit. For reasons that we've discussed, measuring differences in compensation, the data for that are challenging, problematic. There are holes in the data. It may be that, in fact, information, reliable information about variation in fees paid by other payers outside of Medicare is much more readily available information from private payers. And so making the necessary calculations may be facilitated by using fees as opposed to compensation as the variable.

Of course, implicit in this approach is that we're

talking about abandoning the reference profession approach that is in the current work GPCI, and based on our conversation at the last meeting, it seemed like there was widespread discomfort among Commissioners with the reference profession approach because of differences in the dynamics of different service markets, physicians versus architects, for example.

So my approach, my proposal is that we say -- get away from reference professions. We need an index that more directly is relevant to physicians, and the best measure is fees, variation in fees, as opposed to compensation, which is a price times quantity calculation.

So those are my clarifying comments, and with that, Craig, do you want to go next on round one clarifying questions.

DR. SAMITT: Sure, just one, and it actually pertains to the information about access to services. There was detail in the briefing about comparing access to services prior to the floor and with the floor, with the recognition that there wasn't change of access in some of the more rural areas or those below one.

I guess my question that I didn't see is, is there

any information about what the impact on access would be if those above one came down to one? So is there any history there to suggest that, historically, prior to a GPCI or what have you, there were access-related concerns in those markets above one, because I think we need to look at it from an access perspective from both directions.

DR. HAYES: The short answer is that you'd have to go back a ways to try to identify any effect of that nature. When we think about the history of the GPCI, it's been in effect since the inception of the fee schedule in 1992, and so about the only thing I can think of that would come anywhere near to try to address your question would be if we think back on the assessments of access to care that were done, you know, before and after -- to compare access before and after the fee schedule itself was implemented, and that's -- and I can talk about that because I did a fair amount of that work years ago, if that would help. But is that -- do you think -- was that relevant at all to this, or does that go too far back?

MR. HACKBARTH: So we're talking about 20 years, basically --

DR. HAYES: Yes. Yes.

DR. SAMITT: No, I don't think 20 years would be very helpful. It's just it's hard to get my head around how we're assessing the impact on access either way. We talked about the notion even of discontinuing the GPCI, and it's hard to interpret what that would mean below the line and above the line. I'm trying to get more information on that.

MR. HACKBARTH: And conceptually, I think your point is a valid one. It's just by happenstance that we have sort of this natural experiment with before and after the floor. We have some data, relatively recent data, on access before the floor and after the floor, but we have no comparable information on the high and the greater than one areas.

The other thing I would say on access is that, setting aside the work GPCI for a second, when we've looked at the broader issue of access to physicians for Medicare beneficiaries, work that we've done and work that others have done suggests that there's not a very tight link between reported access by Medicare beneficiaries and differences in Medicare fee levels, or differences in Medicare payments relative to private fees in the same market.

I remember, for example, the Center for Health Systems Change, maybe four or five years ago now, looked at that latter issue, where Medicare fees are low relative to private fees. You might think, oh, those are areas where we would have worse reported access for Medicare beneficiaries than areas where the gap between Medicare fees and private fees are lower. In their analysis, the Center for Health Systems Change found no relationship between the gap and reported access.

Some other work that we've done on the access issue suggests to us that where there are access problems, often, the issue has little to do with Medicare payment levels. In particular, in fact, the access issues, where they exist, are more related to more fundamental imbalances in supply and demand for services that go beyond the Medicare population.

So in areas where, for example, you've had rapid population growth, in particular, an influx of retirees that are heavy users of service, sometimes the physician supply doesn't keep up and so there are access problems, not just for Medicare beneficiaries, but for everybody in that market because there's a fundamental imbalance between supply and

demand. It's not a function of Medicare fees per se but just the need for services and the supply of services.

And so Medicare fees in and of themselves, we've not seen, in looking at them various ways, have a real strong relationship with the presence or absence of supply, or of access problems.

MS. BLONIARZ: I know this isn't quite a round one question, but just following up on what you were saying, I think the evidence on the imposition of the floor is pretty good for looking at the effect on access and I have no reason ex ante to think there would be an asymmetry, although there always could be. The fact that we have an estimate of the first order effect that's minimal suggests to me that then the second order effect of the asymmetry within that has got to be minimal on minimal differences. But that's just a follow-up comment.

I really liked all the new data that you brought to bear on this, coming at this intractable problem from lots of different angles, given the paucity of data, which I thought was really helpful.

And I had a follow-up question on Slide 8's data. I thought it was great to have the distinction between fees

and wages and between wages and earnings, and I wanted to be sure that I understood this because I thought it was a very telling graph. What's captured by wages? Is this per unit of work, or is this a per hour, or is this an earnings --

DR. HAYES: It's an annual earnings number.

DR. BAICKER: So this is really -- I would call this more earnings than wages, then, in some sense, because that is then conflating price and volume together --

DR. HAYES: That's --

DR. BAICKER: -- as opposed to the price that we're trying to get in on.

Then a follow-up question to that is to what extent is the GPCI already baked into the differences that we're seeing between rural and urban here, in the sense that the pattern is a little reversed from what we would expect to have seen and what we do see in the reference professions --

DR. HAYES: Mm-hmm.

DR. BAICKER: -- but then we're compensating people with this GPCI with the floor already built in.

DR. HAYES: Right.

DR. BAICKER: Now, the later data showed that it

was a small percentage difference, but do you think that that's actually showing up here --

DR. HAYES: Yeah --

DR. BAICKER: -- or is that too small for us to worry about?

DR. HAYES: Yeah. I would say that it's too small, in general, to worry about in the sense that -- and the data here, once again, are not as current as we'd like for them to be, but physicians vary in the extent to which their revenue stream is dependent on Medicare, and it varies, say, by specialty. So the data we have now on this go back ten years anyway, but specialties such as family medicine, internal medicine, are more in the area of 20 to 25 percent of their revenue is coming from Medicare, whereas, as you would expect, other specialties, such as orthopedic surgery, ophthalmology and cataracts, are more in the area of 50 percent.

So the answer is a little bit kind of fuzzy here, but on average, we have to think that we're somewhere -- given that family medicine and internal medicine account for a big share of Medicare spending, we would -- and given that those happen to be specialties where we do have some kind of

data to work with -- we had to figure that that's not such a big factor on this slide. Not to say that it's so unimportant that you would want to just say, oh, well, let's have a GPCI based on earnings and not worry about the circularity problem, because we do believe that, particularly for some specialties, and if you were to do this on a kind of ongoing basis, that you might get into a situation where the GPCI is starting to drive earnings and you wouldn't want to do that, necessarily.

MS. UCCELLO: Yes, I agree with Kate. Thank you for that additional analysis. It's really helpful.

I was someone who was not as uncomfortable with the reference occupation way of doing things, but I think that one thing that could make me more uncomfortable is if those occupations are not correlated with each other, which adds credence to the idea of the way different professions value the amenities or the amenities across areas aren't consistent, which then makes it not as good to then apply those to physicians. So was any analysis done on the intra kind of reference profession correlation?

DR. HAYES: Not exactly. It was more an issue of looking at how the reference occupations compared to other

occupations, right. So there was some analysis of earnings of the reference occupation professionals with all occupations, or with just managerial occupations, that kind of thing, and the correlations were pretty high, you know, in the 0.65 or above kind of area. But I just -- I'm sorry. I don't have anything on the components of these reference and how well they hang.

MR. HACKBARTH: So on this issue of amenities, this is an elusive concept for me, a non-economist, non-actuary, and I just want to make sure that I've got it right. So take physicians as the example. When we talk about amenities, we're not just talking about is it a beautiful place to live, are there good schools, are there cultural opportunities. We're also talking about profession-specific amenities, for example, access to other colleagues. Am I correct in that?

DR. HAYES: Yes, and I can run down the list. It's access to colleagues. It's --

MR. HACKBARTH: Facilities --

DR. HAYES: Pardon me?

MR. HACKBARTH: Facilities --

DR. HAYES: Facilities, resources and facilities,

call, that kind of thing.

MR. HACKBARTH: So in that sense, inherently, there are going to be differences in the amenities that are meaningful to physicians versus architects, and so an area that could be reasonable attractive to architects on their amenities might be unattractive to physicians because they're interested in different amenities.

DR. BAICKER: In some ways, I wish we'd get away from calling it amenities and call it --

MR. HACKBARTH: Yes.

DR. BAICKER: -- because I think that sounds trivial, like --

MR. HACKBARTH: It does.

DR. BAICKER: -- oh, you know, the lighting is better in this room.

MR. HACKBARTH: Right.

DR. BAICKER: I think of it more as the totality of local area characteristics, and the local area characteristics may be differently valuable for different professions and that's why we're struggling with what the right reference group is. But the idea is to sort of equilibrate across areas. There are these big differences

in this bundle of characteristics that are associated with working in a particular locality versus another.

DR. HOADLEY: Yes. I really appreciate the access analysis and the before and after look, and I was wondering -- I actually couldn't remember. When did the floor go into effect, and how much before and after are your data points that you're looking at?

DR. HAYES: The floor was in the Medicare Modernization Act of 2003 and actually implemented in 2004. The before and after look was -- the before look was our access report, our rural report in 2001, I believe, with 1999 data -- correct me if I'm -- okay. And then the more recent analysis was in our July 2012 report, and that was based on data in 2008, I believe.

DR. HOADLEY: So the data were well before and after --

DR. HAYES: Yes.

DR. HOADLEY: -- the change. Is there any other sort of less quantitative evidence on impact of the floor that has sort of come up in discussions? In terms of access issues.

DR. HAYES: Yeah. No. I mean, the only other

thing to point out is just to reiterate kind of a point that Glenn was making, is that all along here, we do our assessments of access to care every year with the assessment of payment adequacy in conjunction with the update, and there, we've pretty much seen consistent, you know, reached consistent conclusions about access to care being what it is.

DR. REDBERG: It's sort of a -- if I understood the data, there isn't really any good data then GPCI is affecting in a positive way access or quality of care, because -- is that correct?

MS. BLONIARZ: I think we saw no -- we were not able to say that it was affecting access, and on quality, we didn't have any data to do that analysis.

DR. REDBERG: Because it would just seem to me, as our goals are to, you know, optimize access and quality of Medicare resources, there seems to be absolutely no data, and, you know, as a physician, as a cardiologist, actually, in a specialty where we see a lot of Medicare patients, I don't think that GPCI really influences distribution.

It's such a one tiny part of so many moving pieces, and so what concerns me is just this idea of

spending more CMS resources in trying to get this tiny little part that really isn't making a difference. I'm okay with the recommendation as it is, but I think in the big picture and the long term, this is not a good use of CMS resources or our resources because we're not achieving our goals of improving access and quality with all this playing around with this tiny little GPCI.

DR. HALL: I'm also a little bit confused and disturbed by the use of amenities, but my real question is, when we work these data, how static or dynamic are they? Are we looking at this data that was, say, first established in 2007? Is this annualized every year? Because it's a very mobile U.S. population. There are changes in, I guess you would call the amenities. Charlotte, North Carolina is not the same place it was five years ago, et cetera, et cetera. Are we looking at real-time data, in other words?

DR. HAYES: When it comes to the GPCI, we're looking at data. I don't know whether I would say that they're real-time or not, but they are updated on a regular basis. The statute says that the GPCI will be updated at least every three years, and that's been the cycle that CMS has been on since the beginning of the fee schedule.

So the current GPCI, for example, is based on the sixth update of the GPCI. I'm sorry, I just don't remember the vintage of the data themselves for it, but I can say that the next -- the next update is due within the next year or two and it will be based on the most currently available, most recent BLS data.

MR. GEORGE MILLER: Yes. Back on Slide 8, please, and I'm just trying to understand the definition of, again, of wages. Was that an annual wage?

DR. HAYES: Yes.

MR. GEORGE MILLER: So how would you account if someone working particularly in a rural area part-time? Do you take their hourly wage and then annualize it?

DR. HAYES: Yes.

MR. GEORGE MILLER: But they only work part-time so you'd only take half of that?

DR. HAYES: No. They would just, you know, make an adjustment to the number and say, Well, if this person had worked a full year, 2,080, 2050, whatever it is, hours per year, what would the wage have been. So they make an adjustment to account for the fact that the person was part-time.

MR. GEORGE MILLER: So if I employ five part-time people, you will make the leap, the annualized amount, and what does that have -- I'm trying to understand the correlation if I have a lot of part-time people. But you annualize it and how it affects or does it affect the rate? I guess I'm asking the question. I'm a little confused by the hourly versus the -- the hourly rate versus the annual wages.

DR. HAYES: Right. So for those five workers, my understanding is that the BLS would adjust upward all the wages for all five workers and say, Okay, well, if they had -- depending on the actual hours that they worked, if we inflated them up to a full annual rate of hours worked at 2,080, what would they have been paid? What would their annual earnings have been?

MR. HACKBARTH: So the goal is to assure that an area that has a lot of part-time physicians isn't penalized and recorded as having a low wage.

MR. GEORGE MILLER: Right, okay.

MR. HACKBARTH: Say do it on a full-time equivalent basis.

MR. GEORGE MILLER: Okay. So they're comparing

everything equally?

MR. HACKBARTH: Apples to apples.

MR. GEORGE MILLER: Thank you.

DR. CHERNEW: I have a question about Slide 17, two questions. When you talk about the work GPCI, these numbers here, that's not one quarter of the work GPCI. So the actual --

MS. BLONIARZ: It is.

DR. CHERNEW: Oh, this is one quarter of the --

MS. BLONIARZ: Yes. The definition of GPCI is one quarter of the variation in the reference occupations.

DR. CHERNEW: Okay. So just to be clear, the GPCI says there should be a certain amount of variation. We're using one quarter. We're dampening that to one quarter of it, so getting rid of 75 percent of that variation. And this is that impact.

MS. BLONIARZ: That's right.

DR. CHERNEW: And then this is the 9th to the 10th, but this is done, if I understand correctly -- that's my question -- without the floor?

MS. BLONIARZ: That's right.

DR. CHERNEW: So if I wanted to compare the real

impact of where this is, this is what it would be if I got rid of the floor between the 90th and the 10th?

MS. BLONIARZ: That's right, that's right.

DR. CHERNEW: I need to apologize. I will be leaving early. It's not because I'm mad. Your answers were wonderful. For those that are interested, and I can't imagine you aren't, my daughter is getting bar mitzvah'd. I have some family things to do, so I'll be leaving, but I really am happy with you all.

MR. GRADISON: It wasn't clear to me, with regard to your recommendation, whether it would continue to protect those in situations in which the GPCI is less than one.

MR. HACKBARTH: No. My recommendation is that, as it says in the last sentence, that we stick to current law and the current law is that the floor expires December 31st and we revert to a one quarter GPCI adjustment.

MR. GRADISON: Thank you.

DR. MARK MILLER: And, I mean, it is, just to be -- so it's not the full effect. It's just --

MR. HACKBARTH: The one quarter.

DR. MARK MILLER: -- the one quarter. So in that sense, the variation is bounded on both sides of it.

MR. GRADISON: Thank you.

DR. COOMBS: In your evaluation of access, did you do anything other than looking at the beneficiary rate? Was there any other markers such as the time to see a provider or any of those?

MS. BLONIARZ: We looked at service use and also looked at the number of health professionals per beneficiary or per capita. I don't think we've looked at other measures of access like wait times. I think we would -- it would be hard to get it at the right -- like down to the level of the geography. We would need to have, you know, an analysis by GPCI. So that was one constraint we faced.

DR. COOMBS: And another question, I think George kind of alluded to it and some people were talking about the whole notion of how you extrapolate this notion of the beneficiary per provider. That's not always an adequate reflection of -- the provider productivity in the rural areas may be very different than the productivity of an urban doc and I don't know what the two might vary.

But the assumption is, is there is, you know, fewer providers in a given area. They may have a greater productivity and have a different yield in terms of what

they can deliver to accommodate the increased requirement for the patient demands within a given area.

DR. HAYES: And so, what we have with the BLS data are just, you know, an annual earnings number, which you're spot-on, that that is a function of just the number of hours and productivity that each practitioner would work and could be influenced, therefore, by any productivity differentials across areas.

The only thing then that I could say in response to that would be that we did try to work with an alternative data source. This is the annual survey data from the Medical Group Management Association, where they, as part of their survey, they not only collect data on annual earnings, but also on relative value units for the services that were billed for each practitioner.

And so, the MGMA survey is very useful for constructing compensation plans and so forth and you can see why they would collect RVUs. They were very helpful in accommodating our request for data and so forth, but the reality is that there are limits on how much data they have.

Nonetheless, we did end up with consistent results, you know, comparing MGMA and the BLS data in the

sense that with the end adjustment for productivity with the adjustment for RVUs, rural physicians still ended up with somewhat higher earnings than their urban counterparts.

DR. COOMBS: Thank you.

MR. HACKBARTH: Okay. Let me just think if there's anything else. The cost of extending the floor, what would that cost? So the current law baseline assumes the floor expires and we go back to the GPCI, one quarter of the GPCI calculation. What does it cost to maintain the floor, Kate?

MS. BLONIARZ: It's in the range of a half-a-billion dollars a year.

MR. HACKBARTH: Okay. Round 2 comments. And since we have a draft recommendation, in particular, I'd ask people to address that. This is our opportunity to collect the intelligence that we need to formulate a final recommendation for our next meeting when we'll vote. So, Craig, Round 2 comments.

DR. SAMITT: So what I like about the recommendation is --

MR. HACKBARTH: Very good, Craig.

[Laughter.]

DR. SAMITT: I remember, I remember. Follow instructions well. What I like about the recommendation is the recognition that the GPCI is flawed. I think that I sense consensus around that issue, that absolutely it's a methodology that needs to change should we want to preserve the methodology.

What I'd change about the recommendation, my bias would be somewhat similar to where Rita was going, which is, is this really our time well-spent? My bias would still be, since the GPCI is so flawed, to eliminate the GPCI because there isn't a correlation with access and quality and it doesn't further the Commission's agenda. However, if that's not possible for whatever reason I would underscore the imperative to find a better match for reference occupations that would mirror what we are trying to accomplish here.

I think I'd need to think a little bit more about the market fees. I was trying to process it as you were describing it, and I'm worried that that, too, has dynamics that have unintended consequences, that if we look at market fees comparing to commercial payers or what have you, there are market forces, whether they're payer forces or provider forces, that I would imagine creates skew there as well. So

I'd be nervous even about market fees.

But if we are going to preserve the GPCI, I think it's imperative that we find an appropriate match methodology. I also have to believe that there are ways to adjust for the concerning market dynamics, whether it's circularity or return on investment. I think we alluded to some of them in the September meeting.

We look at employed physicians. We look at physicians who don't own the practices. We adjust for volume differences as we look at earnings to really assess earnings per unit as opposed to just earnings in total, and so on and so forth. So I'd advocate for changing the methodology should we decide to preserve the GPCI.

And then finally, I'm wondering if the default, while we're finding an alternative, really shouldn't be elimination of the GPCI while we're waiting for a better GPCI. Perhaps it would be a learning laboratory for us. And again, I understand the complexities of that, but maybe instead of just letting the skew occur, even at a quarter, we say the GPCI is on hold until we re-evaluate and determine a better methodology for GPCI. That is the final recommendation to the final change in the recommendation

that I would advocate for.

DR. BAICKER: I think the recommendation seems quite reasonable. I'm persuaded by the imperfect evidence that some adjuster is necessary, that the GPCI is not a perfect adjuster, but that we don't have a good alternative to propose right now. So I don't see any evidence to suggest that an alternative would improve things. The fact that it doesn't seem to affect access, to me, doesn't argue therefore we should eliminate it. It says therefore, this imperfect adjuster is not doing harm in that dimension that we would really care about.

But I would echo Rita's point that while I think an improvement in the methodology in the longer run is absolutely in order, I would think you wouldn't want anyone to devote a lot of resources to a giant new survey that would surely be expensive to field and still imperfect; rather, find a way to use existing data sources more -- in a more targeted way to get a better measure, but not devote a lot of new resources to getting data that would not necessarily leave us in a better place.

MR. HACKBARTH: And that was what I think is one of the advantages of a fee-based approach as opposed to a

compensation survey approach. Cori?

MS. UCCELO: I agree with Kate that this is reasonable. Like I said, I'm less uncomfortable with the current method, but I can see that it is not perfect, although I don't think perfection is what we can reasonably strive for. I still am, like Craig, maybe a little uncomfortable with specifying here the market fees given some of these potential circularity issues and other issues. I just wonder if there's a way we can make this point without specifying fees.

Can it go back to -- maybe not -- Mike before, last month, had talked about the purchasing power kind of thing. I mean, that's not a faction item, it's a goal, but so I don't know if this should be more kind of goal written up as opposed to specifics.

DR. HOADLEY: I guess like Craig, I agree that we need to do something a little bit differently. I'm unconvinced that keeping the current GPCI as opposed to no GPCI is necessarily the right way to go. I'm still open to thinking that part through.

I guess I wanted to comment on the market fee issue. I'm thinking a little bit about -- I mean, we're all

struggling with that and I think there's a sense that something like market fees or something else would be better than these reference occupations that just doesn't seem to cut it. How much the market fees are, at this point in time, already pretty dependent on Medicare fees? Certainly in structure they are in a lot of markets. Levels do vary and maybe that's something that can be captured.

But also, the degree to which market fees are also driven by local insurance market situations and is that the right thing to be capturing or is that associated with as many other problems as some of the things we just talked about?

MR. HACKBARTH: Just to respond to that point, I think that the fee calculation or the fee-based index is imperfect. It is contaminated, if you will, by local market dynamics, both on the purchaser side and on the provider side. In that sense, it is not a pure competitive market fee level you might ideally want as a reference point.

And so, the question for me is not is it perfect, is it better than the basic conceptual alternative of the reference occupations? I think it is. Personally, I have a lot of issues with the reference occupation approach.

And then the second question for me is, is it doable without an enormous expenditure of scarce resources at CMS? And I think the fee approach is likely to be more readily achievable than starting with a new compensation survey of physicians. Medicare has a long and difficult history with Medicare surveys of physicians, requiring a lot of effort and getting low response rates and data that people have a lot of reservations about. So that's a history that I have in mind.

On the issue of, is there evidence that no GPCI is better than the one quarter GPCI, I wouldn't disagree with what you said. Yeah, there is no evidence to tell you one is better than the other. What I would say is one is current law and the other is not. And so, going to no GPCI requires us going to Congress, making an affirmative case that, Oh, you ought to take this away, and then they will say to us, Based on what evidence? And I will be at a loss for how to answer that question.

Whereas, reverting to the one quarter is current law and requires no legislative change. So that's just how I'm thinking. Your issues are all legitimate, but we're dealing in a constrained set of circumstances with imperfect

options.

DR. HOADLEY: And just a quick follow-up, and that may be compelling on that last point. On the market fee, maybe like Cori was trying to think, you know, the sentence where we say, Should reflect geographic differences in the market fees, maybe we just soften that somewhat, Should reflect a different approach such as, or some kind of wording like that, that puts a little bit of -- unless we convince ourselves that -- [off microphone].

DR. DEAN: Yeah, I would share all of those concerns. I guess I was bothered right from the start, and probably it's more semantics than anything else, that in my mind, work is work and a certain service, whether it's done in Florida or South Dakota, the item of service probably doesn't change very much. The cost of doing it, I suppose, does change somewhat, but I'm concerned about the circularity part of it and the fact we're sort of reinforcing the status quo when we know by implementing these kind of corrections, even though they're obviously fairly minimal in their impact. So that's one problem.

And I noticed that, you know, the Slide 8 that shows the differences between income in rural areas, that

fits with my experience and I think it demonstrates that this phenomenon simply doesn't work, and it would probably be even a greater difference if the GPCI was taken away, although I suspect a relatively minor change.

And it just seems that that shows us that we may well need -- if it shows us that there are other things that work that allow those differences to develop, then I think what we're seeing here is overall market forces that, in fact, it is more difficult to get folks into some of these, especially physicians, into some of these areas and there are factors that are simply not being measured in this parameter.

So I guess my preference would be to do away with the whole thing, but I understand the political realities and I can't argue with those. And I also acknowledge that it's a small issue and we shouldn't expend a lot of time or effort. I guess I would -- in the second sentence of the recommendation, I'm a little bothered by focusing just on fees, and maybe we need something, that an adjustment that would reflect geographic differences in, you know, overall market forces, or something, although that may not be quantifiable. I understand that.

But I think that's what we need to get to, that there are a lot of other factors that play, that are important factors, that simply aren't captured in this measure. So I'm comfortable with the whole thing, but maybe, for all the reasons people have brought up, it's not worth investing a huge amount of effort in.

MR. HACKBARTH: All of these reservations that people have stated about the use of fees are all legitimate. I wouldn't try to talk you out of them for one second. But my thinking about this is very much influenced by what is achievable. And if we were to take out fees and just say there should be some adjustment and we are silent on it, we're not providing much help to either the Congress or the Secretary.

In fact, I think the likelihood is that means that we just are stuck in the status quo with the reference occupations. I have reservations about the reference occupations approach, and so I'm trying to come up with a practical alternative that I think actually might be doable without a huge expenditure of resources that would be better than reference occupations. However imperfect, better than reference occupations. So that's just how I'm thinking

about it. Rita?

DR. REDBERG: I like the recommendation as written, and I share the reservations about reference occupations, and I would just suggest, if the Secretary is developing an adjustment to replace GPCI, and I would, of course, be okay with abandoning GPCI if it was possible, that the adjuster should be tied to access and quality. Because right now, there's just across the board GPCI rewards inappropriate procedures, procedures, and things that, you know, we know there's already incredible geographic variation and that a lot of those procedures don't seem to be improving beneficiaries' health.

And so that any kind of GPCI would be tied to actual outcomes data so that it was actually affecting access and quality of care and not just kind of an across the board thing.

DR. HALL: Just some semantic concerns on 20 here. As a stand-alone document, I'm wondering if this is understandable to all the people who will read it, or is this in the context of a larger recommendation?

MR. HACKBARTH: It's in the context of a recommendation with text explaining and amplifying. So it

won't be, strictly speaking, a free-standing document.

DR. HALL: For example, in mid-sentence, the adjustment should reflect geographic differences, et cetera, because of the uncertainty in the data. Well, what data? I know the data, but, I mean --

MR. HACKBARTH: Yeah, and specific suggestions for improving the language are always welcome. And so if you could just suggest some language.

DR. HALL: Okay. Thank you

MR. GEORGE MILLER: Yes, it was very helpful for you to paint the framework and the reality, so that may temper some of my comments, understanding the reality of what we're dealing with. But a couple points first, and then I'll get to -- I understand the recommendation in terms of the way you framed it. Like Rita mentioned, I'm concerned that we have a document that's not tied to access and quality, and I'm a little bit concerned about how we define access as well in the document. We somewhat use the number of visits as a proxy for access. Were there other factors to deal with access? I think Alice said it earlier in the first round about the time it takes to get to an appointment, how long you have to wait for that appointment,

and then wait at the appointment. You know, if I'm in a rural area and a physician is there and I can get access tomorrow versus then if I have to drive two hours to get an appointment, you're counting that same visit as if there's no difference in distance and time and transportation. So I would like us to address that at some point, and I understand we can't do it in the framework of the current recommendation.

The other point that I want to raise is that eliminating the floor, which is understand the context, but that's still a half million dollars -- a half billion dollars, if I remember the number correctly, a half billion dollars. And for those of us who use those dollars to recruit physicians, with that going away, the graph on page 8 shows that there seems to be equity in payment, or maybe even rural physicians may get even a little more money than those that you listed. With this going away, what would be that impact? Because that's a half billion dollars we will not have with the floor going away.

Again, I understand the context in which you have to make the recommendations in theory, but talk about unintended consequences, that half billion dollars will not

be available particularly in rural areas so that gap may be different. I don't know if we analyzed that.

The final thing I want to make is your explanation in the beginning about maybe we should be measuring the unit of service versus the salary, I'm wondering if your thinking was that we then may be able to drive appropriate use by changing -- by rewarding, for example, primary care as the unit of service higher than a procedure for plastic surgery, which really would not add value. And if that's the case, I would love to see some language in your recommendation to deal with that issue as well.

MR. HACKBARTH: Well, on the general issue of differences in patterns of utilization, I believe -- and I think collectively we've said this many times -- the best way to influence those is by changing the payment system.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: Not try to manipulate price per unit of service as a mechanism for changing utilization patterns, but leaving fee-for-service altogether and going to episode payment or ACOs global payment.

MR. GEORGE MILLER: Yeah, but that's not before us today in this recommendation.

MR. HACKBARTH: Right, and so this recommendation is a recommendation about the Medicare fee-for-service payment system, which is the question we were asked, and how do we make it a more accurate payment system. It accepts the limitations of fee-for-service payment as they are. This is a recommendation about that payment system.

I would be happy to add to the text to say, you know, there are big issues about utilization of services, and we can tinker with the GPCI until the cows come home, and it's not going to help us one way or the other on those. We've got to move towards new payment systems for that.

On your first question, George, about visits not being the only way to measure access, we do measure access as part of our update analysis using different tools, importantly a beneficiary survey. So each year we survey 4,000 Medicare beneficiaries about their access to services and 4,000 people who are in the age group just before Medicare eligibility, and then we do some breakdowns of that.

Unfortunately, even with -- it's a pretty big survey -- 8,000 people, you know, we can't report reliably results for all of the physician payment areas. There are

real limitations on how far you can break down the numbers without losing any statistical reliability.

We do do urban-rural breakdowns, and my recollection -- and correct me if I'm wrong on this -- is that we find that rural beneficiaries' satisfaction with access to care -- and it includes dimensions -- they're asked specifically about time, how long does it take to get a routine appointment, how long does it take for you to get an appointment for urgent services. My recollection -- and please correct me if I'm wrong -- is that the rural beneficiaries report quite comparable satisfaction on those dimensions with urban beneficiaries. Is that correct?

DR. MARK MILLER: Yes, that's correct.

MR. GEORGE MILLER: Under the current scenario [off microphone].

MR. HACKBARTH: Right, but that has actually been true as long as we've been doing surveys. Now, I'm not going to be able to remember off the top of my head whether our surveys pre-date the floor or not. I think they do, but I'm not 100 percent certain of that.

DR. HAYES: Which surveys are you referring to?

DR. MARK MILLER: Telephone.

MR. HACKBARTH: The telephone surveys of Medicare beneficiaries.

DR. HAYES: No, they don't pre-date the --

DR. MARK MILLER: About coincidental -- [off microphone].

MR. HACKBARTH: About coincidental with the imposition of the floor.

DR. MARK MILLER: But the other thing -- and I'll dig this up because I don't have this fact really tightly in my mind. But the same analysis that Glenn was talking about earlier that HSC did on utilization, given the Medicare rates relative to the private rates, also, if I remember correctly, had some discussion of kind of wait times and getting appointments. And my recollection is that it also didn't seem to have much relationship, but we'll dig that out and make sure that we have that in what comes to you next month.

DR. CHERNEW: I have a few specific comments, but first let me say the overall theme of my comments are going to be that there's an old saying that in the Land of the Blind, the one-eyed man is king, and here I think the modification would be in the Land of the Blind, current law

is king, because there's a lot we don't know. And so what I'm worried about, to get to sort of my specific comments, is how what we say in this debate influences other things that we're going to say later in other places. And what I mean specifically is, for example, I'm wary of moving to sort of a reasoning that says the amount we pay for -- the GPCI doesn't matter, if you're above or below, because it leads you to think that, well, the amount we pay physicians doesn't matter. And so it leads some to say, well, if it doesn't matter if you pay high or low, why don't we just move everyone to the lowest possible one because we can't figure out where it matters at all. And I'm worried about going there. And I'm worried about going to a place where we say work is work, because as soon as we say work is work, how do I justify increasing the pay each year in the update? They're working two hours this year, they're working two hours next year. Work is work. What's it matter that it's now 2015 as opposed to 1990?

There's an amount of goods and services that we're transferring to physicians that they should get transferred to them one way or another, and as inflation goes up, I believe physicians should be paid more so we have some

rationale for how we set fees, and as soon as we move away from that to other types of paradigms, I'm afraid that while we think it might work well in this context, there will be other situations where we want to think about fees where it won't work quite as well. And keeping that logical paradigm at least on the table I think is important.

So my general view is we adjust geographically for a whole bunch of other things. The general view is we adjust for all kinds of other differences in costs geographically and wages for nonphysicians and stuff, and it's very hard to say that somehow physicians are magically special in a world where we're trying to think about workforce of different types and say, well, you know, nurses, we'll geographically adjust nurses from various things, but we won't physicians for certain various ways.

So I'm worried about how it all fits in, and I will be the first to admit that, per my theme, we are empirically pretty blind as to how we should do that adjustment in a number of ways. And I agree a lot with what Craig said about that. But I do think that fees are conceptually better than earnings, which I think is a better word for what we're looking at than wages, actually, but in

any case, I think fees are a conceptually better measure because we're trying to adjust prices, and at least to some extent, we can get volume out of the mix and a few other things. The fees suffer from all the problems that have been mentioned as do all the other observable metrics we have. I think fees just have two advantages. They suffer a little bit less from some of those things -- a little bit less -- and they're a lot more observable in a bunch of ways.

So I wouldn't say that the right thing for the Secretary to do would be to just look at the fees and set the rates at exactly that. There's a bunch of adjustments. We're worried about the market dynamics. We're worried about how we deal with practice expense things.

So there's some -- you know, I wouldn't interpret this as saying get a database on fees and set it equal to that database. There's some other work that needs to be done. But I think it's conceptually better, it's less resources to do, and it maintains the recognition that we in all of our fee schedules are trying to adjust in some ways for purchasing power and input costs. And I'm very worried about moving away from that basic paradigm for physicians

because I think that will come back to bite us and a bunch of other things where we begin to talk about physician compensation, if we tried to argue why should we -- if we got rid of the GPCI, for example, then the question is, well, why is the level where it is? Why don't we just move it down if we say there's no impact on access from what we pay? And I'm worried about that one way or another.

So I don't know exactly what the right thing to do is. So I'll revert back to my introductory thing that current law in my mind seems to be key. It's partly the path of least resistance, but more than that, I think it's a -- there are situations where I think current law would be bad. We can't show that reverting to current law would be particularly bad in our best pre-, post analysis. We can't justify spending more than current law, as near as I can tell, based on sort of the pre-, post, and other analysis. We have other tools if those problems arose. And we're already dampening, what a reasonable person could say, the GPCI -- we're already dampening it by 75 percent by paying only by one quarter. So, you know, if you thought we should go to one-tenth, you know, who knows? But we have a particular system, and I think I'm where Rita is. I don't

think it's worth a ton of effort to change the entire paradigm with the way we think of physician labor versus nurse labor versus other types of inputs, the way we think of fees. And so I am comfortable with the recommendation just to move us forward.

MR. ARMSTRONG: Glenn, I too support the recommendation and basically would have made the same points Mike did but with half as many words.

DR. CHERNEW: Thank you.

[Laughter.]

MR. GRADISON: I guess I better be careful here.

First of all, I want to compliment the staff for an outstanding analytical job. With regard to the substance of the language, I really do like the idea of saying "such as market fees," or something like that.

I'm not as optimistic as some of you about the ability to gather than data. It's often extremely -- these are often extremely well-kept secrets, particularly where health plans are involved. But it's worth a try.

I do have one particular substantive suggestion, and that is that we recommend that this be extended with a sunset period, say two years or three years. There are

several reasons for this.

First, if we do put in what seems like a reasonable period of time for the analysis that we recommend to take place, it becomes an action-forcing event to try to get the work done by that date. Also, from a scoring point of view, it cuts the scoring way down because the scoring is done on a ten-year basis. And if it sunsets, if this sunsets in two to three years, at least I think -- you can check it out if I'm wrong, but I think we might come up with a more attractive number.

MR. HACKBARTH: So what would be [off microphone]?

MR. GRADISON: It would go away.

MR. HACKBARTH: But this has zero cost. This has zero score.

DR. MARK MILLER: What goes away.

MR. HACKBARTH: Yeah, so --

MR. GRADISON: Oh, okay. I misunderstood you. Fine. Then scratch that idea.

MR. HACKBARTH: Okay.

MR. GRADISON: When Rita was talking, I was -- this is a very small diversion from the substance of our discussion. When Rita was talking, the name Professor

Parkinson came to my mind. You may remember Parkinson's law, which is work expands to fill the time available. Then Cori really triggered my recollection of Professor Parkinson's writing when she used the word "perfection," because I think this is actually, not to make light of it, but an example of one of his other laws, which is perfection of planning is a symptom of decay. I mean, we're dealing with a really minor thing, and it is extremely hard for me to say that it makes a hell of a lot of difference at the end of the day what we do with this one in terms of the ability to serve the clients, which is not to say the work hasn't been done well or that we shouldn't make the recommendation which you put in front of us.

MR. KUHN: Glenn, I think when you laid out, this recommendation, I think one of your comments you made was that, you know, what's doable? And I think in that context that really struck me as part of this.

As I mentioned at the last meeting, I'm kind of where Tom is, and I know Mike and I had a bit of an exchange at that meeting. I'm still one of those in the camp where equal pay for equal work and work is work, but I understand the countervailing arguments on that.

But having said that, I come back to, again, the notion that you laid out there of what's doable, so in that regard, you know, this is doable. It results in a zero score. And so I'm generally -- and because it continues to perpetuate or continues to include the compromise that was struck back in the 1980s when Pope and others kind of advanced this issue of the quarter adjustment, it's probably a reasonable way to go.

The one thing I do worry about is that particularly on Slide 16 when that came up and it shows the stratification of those that are above and below zero on the index, those on the left-hand side will see some dropoff as a result of that. And so if I remember right from the last meeting, the order of magnitude here wasn't great, but I can't remember exactly what it was. So one thing that we do know in the Medicare program is that it's rife with transitions and blends and phase-ins, et cetera.

One thing we might want to think about in this recommendation, do we create a softer landing for those that are on the far left end of that tail as part of a transition would be? The only thing I would think of a modification here is a possibility.

MR. HACKBARTH: So let me just make sure I am interpreting this graph correctly. So the way I read it is that the vast majority of the localities have an adjustment of less than 2 percent in their payment rates. We've got a few outliers. The big outlier is Puerto Rico, as I recall. And so we're talking about in most cases, you know, small adjustments, 2 percent or less.

MR. KUHN: Yeah, and it just would be interesting to go back just to kind of look at those numbers just to get the order of magnitude. So 2 percent on an E&M office visit is pretty small compared to 2 percent on a major procedure. So, again, would that create some issues? It would just be interesting to look at it that way.

MR. HACKBARTH: And we do have the example that Kate put up with some more expensive procedures and how much the effect is. Kate, do you want to just explain that, maybe using the knee replacement example?

MS. BLONIARZ: Sure. So starting from the second line on the top right, that's the national payment amount, about $1,500 for a knee replacement. For the locality that's at the tenth percentile -- and that's probably in the range of about 2.5 percent or 2 percent reduction -- it

would take about $30 off that payment amount.

MR. HACKBARTH: Okay.

MR. KUHN: That's helpful. That gives me some context on that, so thank you.

DR. NAYLOR: I, first of all, support the recommendation. This was really an excellent update by the staff. Overall analysis was terrific. I really love that we have a framework guiding us. I agree we should get away from reference group focus on the market with all of the limitations, especially because it is observable.

I really like the attention that you're paying to physicians and other health professionals, so I want to make sure that I acknowledge real deliberate efforts on the part of everyone to make that explicit, and so thank you.

DR. COOMBS: So I support the first sentence of the recommendation, and I think I'm in agreement with everyone around the table.

My concerns, as mentioned before, have to do with other parameters for access, and working in a very richly endowed physician area such as Massachusetts, I have experienced docs closing practices and opening practices depending on their economic status, in terms of whether or

not the cost of doing business in the area was conducive for their overall overhead and to be successful. I am just concerned just about other areas because Massachusetts is really rich with doctors and how any small tweaking of the system might influence access.

So one of the charges that, Glenn, you so well outlined is. Will it improve beneficiary access to care? That question. It's a great question. And then the second one is, Will it improve the quality of care beneficiaries receive? And the piece of it that is hard to get your arms around -- and I don't know if this is ever -- but this should be a part of our wish list, and this should be MedPAC's wish list, and that is, to understand that getting to the doctor is not the only piece of access. It really is when you get to the doctor, because if the onset of the illness and the progression of chronic disease gets to a point that it changes the trajectory for that patient, it makes a big difference.

So I think it's really imperative for us in all of our decisions to consider not just access as when I touch the providers. If I'm getting to that provider late because the panel's filled, the appointment book is filled, I think

it's really an important issue going forward. And I really do appreciate the data that has been put forth, but I think this whole notion of -- and, secondly, I think this whole notion of stratified information, it is interesting that the standard deviation of those two groups was, I would consider, quite wide so that within that group there might be subsets, and when you stratify, you find that there's some really interesting information that is yielded from that. Did you say that this cohort or this population within the group is suffering an untoward event going forward?

And so, Mark, you've actually said very well that so far we don't see any problems with access, but I think it's something that we need to keep our pulse on -- our finger on the pulse. Thanks.

MR. HACKBARTH: Yeah, for sure. And I think we're all in agreement on that. The only thing I would add -- and it's in addition to instead of your point of view -- is that when we identify access problems, the best way to deal with them may not be across-the-board increases in payment, including areas that don't have access problems, but, rather, more targeted interventions that direct resources to

areas that have demonstrable problems.

So as Kate said, this particular keeping the floor would cost $500 million a year, over ten years $5 billion. If we're worried about access for Medicare beneficiaries, are there better ways to spend $5 billion over ten years? I can think of some, like targeted investment in health profession shortage areas, which is an existing program, but, you know, funded at relatively low levels.

So access is critically important, but reconciling that with appropriate use of taxpayer resources suggests targeting, targeting, targeting when we have concerns.

MR. BUTLER: So I fear the lack of enthusiasm from some of us about this topic has permitted the vacuum to be filled by the statisticians and economists who make me feel like I'm definitely not the sharpest tool in the shed. But there's a little bit of a -- but I'm fully on board with, Glenn, the practical side, which I do kind of look at this from, and what I would -- and so I am in favor of where you're headed on this.

But I wouldn't underestimate Bill's point about the clarity of the recommendation, and it's hard to write it by committee or even us to individually provide comments. I

would say exactly what this is compared to what currently or currently is not in place, so I would say -- I would mention the floor right in the recommendation, and I would mention, you know, the GPCI now and before and after and kind of limit the recommendation more to exactly what is changing, not, Oh, and by the way, there's lousy data and there are other things that, you know, you need to take into consideration.

So I'd just be a little crisper in the stand-alone recommendation, exactly what it is so that you understand, you know, what it is now and what it's going to be, and then the rest can be kind of explained in the document itself.

I do think, though, that -- I kind of made fun of the statistician and the economist, but it is confusing to me still, the earnings, the wages, the input prices, the cost of living, and now market fees, which we really don't kind of reference in the chapter itself. So I keep saying, What are we talking about? Is that what insurance companies pay to doctors? I was, you know, just not exactly clear, and so it gets muddled in the recommendation where it probably doesn't belong. It belongs in the chapter, I think. I hope that helps.

MR. HACKBARTH: Fair enough. Again, let me reiterate, suggestions for changes in wording are more than welcome. And I agree with Peter. You know, it's really not effective for us as a group to try to rewrite things, but if you individually can send either to me or to Mark suggestions on wording changes, they are appreciated.

Okay. So I think we're done. Good work, Kevin and Kate. We really appreciate the analysis, which I think addressed a number of the questions that came up at the last meeting and was in helpful in advancing the discussion.

Okay. So our next topic is a return visit to the issue of trying to reduce, synchronize, if you will, Medicare payment rates for the same service provided in different settings. And this is an issue on which we made a recommendation in, was it last June's report or last March's report?

DR. MARK MILLER: I've forgotten. I think it's --

MR. WINTER: March.

DR. MARK MILLER: March.

MR. HACKBARTH: March report. I haven't looked at the presentation yet. Are you going to briefly recount the March recommendation in your presentation?

MR. WINTER: Just briefly, and we can discuss in more --

MR. HACKBARTH: Okay --

MR. WINTER: -- during the discussion --

MR. HACKBARTH: -- because I think for the new Commissioners to have a little background on our journey to this point would be good.

DR. MARK MILLER: Yeah, and I'll take responsibility for that. We were worried about time, and so that's one of the places where we cut back. So I think it's pretty thin in this, but --

MR. HACKBARTH: Well, let me just do a short version and then you guys can decide whether to skip over what you've got.

So we've looked at this issue before. We made a recommendation to pay the same rate for evaluation and management services regardless of whether they're provided in the physician office or a hospital outpatient department. We recommended that that change be phased in over a period of three years, and we recommended also that there be a stop loss provision so that any given hospital would lose no more than two percent of their Medicare revenue, as I recall. Is

that correct?

And then, finally, we also recommended that the Secretary monitor the impact of this with a particular eye on whether this change and other things that are going on in the market impede access to needed services for low-income beneficiaries, and the reason for concern about that being that there are some hospital outpatient departments that are very, very important providers of service to some communities, and in those communities, there may not be a lot of physician office alternatives and so we need to take care to make sure that needed access is not lost.

So that's a quick summary. Yes.

DR. MARK MILLER: And the only thing I would add to that is some of the spark for this came much further back than that when Commissioners were saying, I'm seeing lots of motion out in the environment where practices are being purchased and I suspect some of it is being driven by revenue concerns, some by perhaps trying to integrate. And that's what set us off to begin with, starting well over a year ago, I think.

MR. HACKBARTH: Thanks for that, Mark. To put that same point in a little different way is if, in fact,

there is a significant move towards hospitals signing up physicians in salaried practice, bringing them to a hospital, or buying the practices and keeping the physicians located there but as hospital employees, what that means under the current rules is an increase in Medicare expenditures, even for the same service provided in the same location, and an increase in beneficiary out-of-pocket costs at the same time. And so this is one of those cases where doing nothing has consequences if, in fact, the world is changing around us.

So, with that background for the new Commissioners, Ariel.

MR. WINTER: Okay, great. Good morning. As we've been talking about, we'll be exploring in this session payment differences across settings for ambulatory services. I want to begin by thanking Jeff Stensland and Lauren Metayer for their help with this work.

So Medicare has different payment systems for ambulatory services based on where the care is provided. However, similar patients often receive similar services in each of these settings. And the payment systems for each setting have often developed independently of each other,

which has frequently resulted in different payment rates for essentially the same service. As one example, the payment rate for laser eye procedures is 90 percent higher in an outpatient department than in a physician's office. And these payment variations may lead to higher program spending, beneficiary cost sharing, and Part B premiums.

So this slide outlines some key principles that should guide Medicare in paying for similar services in multiple settings. First, patients should have access to settings that provide the appropriate level of care. But if the same service can be safely provided in different sectors, it may be undesirable for a prudent purchaser to pay more for that service in one setting than another. Therefore, Medicare should base its payment rates on the resources needed to treat patients in the lowest-cost clinically appropriate setting.

However, there are reasons why payment rates should be allowed to vary across ambulatory sectors. First, hospitals incur costs to maintain stand-by capacity and to provide emergency care, and these costs are not incurred in physicians' offices.

Second, patient severity may differ between

settings and it might be more costly to provide the same service to a sicker patient.

And third, there may be differences in the unit of payment across settings. For example, the hospital outpatient department outpatient payment system typically includes more ancillary items and services in the payment rate for a test or a procedure than the Physician Fee Schedule.

So, as I noted earlier, payment rates are often higher when the service is provided in an outpatient department than in a physician's office. But there are some services that are paid the same across these settings, namely MRI studies, outpatient therapy, mammography, and clinical lab tests.

Now, along with higher outpatient department rates for many services, we have been seeing a migration of many services from physicians' offices to outpatient departments. For example, the share of echocardiograms provided in OPDs grew from 22 percent in 2008 to about 25 percent in 2010, while the share provided in physician's offices declined. In addition, we've seen the share of E&M visits provided in OPDs rapidly increase. And this migration leads to higher

program spending as well as beneficiary cost sharing.

As Glenn mentioned up front, in our March report, the Commission made a recommendation to equalize payment rates for non-emergency E&M services across settings, and we can talk about this more during our question and answer section. We do have a slide that provides more detail about the recommendation.

So now I'm going to pause and we're going to move on to Dan, who's going to talk about options to address payment variations for other types of ambulatory services besides E&M visits.

DR. ZABINSKI: All right. Our next step is to evaluate ambulatory services other than E&M visits that have payment disparities between the physician and outpatient systems. For some services, it may be reasonable to have equal rates whether they are provided in OPDs or free-standing offices, as we recommended for E&M rates. But for other services, payment rates could actually be higher in OPDs than in free-standing offices, but the extent of the current differences could be narrowed.

We have identified four attributes for services that could have equal rates in OPDs and free-standing

offices. The first is that a service should be frequently performed in physician offices. We define this as services where at least 50 percent of the ambulatory volume occurs in free-standing offices. This makes it clear that the payment rate in the Physician Fee Schedule is adequate to assure beneficiaries access and that the service can be safely provided in physician offices.

The second attribute is that the service should have a similar unit of payment across both settings. This is a concern because the Outpatient Prospective Payment System often includes much more ancillary services in the unit of payment than does the Physician Fee Schedule, making services appear more costly in OPDs. Therefore, to be considered for equal payment across settings, a service should have less than five percent of its total cost from ancillaries under the Outpatient PPS.

The third attribute is that the service should be infrequently provided with an ED visit when provided in an OPD, which we define as less than ten percent of the time. We include this attribute because services rarely provided with an ED visit are likely to have minimal ED costs reflected in it.

The final attribute is that there should be minimal differences in patient severity between OPDs and free-standing offices for the service. We include this attribute because greater patient severity may result in higher costs of care.

The Outpatient PPS grouped services that are similar in terms of cost and clinical characteristics into Ambulatory Payment Classifications, or APCs. All services that are in the same APC have the same payment rate, and we sought to identify APCs that meet the four criteria from the previous slide, and we have identified 25 such APCs. Most are diagnostic tests, such as a Level 2 echocardiogram without contrast. But some are procedures, such as laser eye procedures. And we refer to these 25 APCs as Group 1.

In contrast to Group 1, for other services, it is reasonable to have payment differences between OPDs and free-standing offices, but the payment differences could be narrowed from current levels. For example, we have identified 61 APCs that meet three of the four criteria for equal payment across settings, but they miss on the criterion of a similar payment unit across settings because the Outpatient PPS packages the costs of ancillary items

more so than does the Physician Fee Schedule.

This group covers a broad spectrum of services, including minor procedures, more advanced procedures, cardiac imaging, lab tests, and other tests. For these services, Outpatient PPS payments could be set equal to the amount needed for equal payments in OPDs and free-standing offices plus the cost to OPDs for additional packaged ancillaries, and we refer to these APCs as Group 2.

On this slide, we provide a summary of the characteristics of Group 1 and Group 2 APCs. The two groups have three similar characteristics. They are predominately provided in free-standing offices. They are infrequently provided with ED visits. And they have similar patient severity across settings. The point of departure is that the level of packaging is the level of packaging in the Outpatient PPS for the two groups. The APCs in Group 1 have less than five percent of their total costs attributed to packaged ancillaries, while the APCs in Group 2 have at least five percent of their total costs attributed to packaged ancillaries.

On this diagram, we show a policy for setting equal payment rates across settings for Group 1. We used

the APC for laser eye procedures as an example, and Table 2 in your meeting paper provides more detail.

The first column of numbers shows the payment of this service as provided in a free-standing physician's office. The entire payment comes from the Physician Fee Schedule and goes to the physician and totals $389.

The second column shows payments under the current rules if this service is provided in an OPD. The physician receives a payment under the Physician Fee Schedule. The hospital receives a payment under the Outpatient PPS. And the total of those two payments is $738, which is 90 percent higher than the payment in a free-standing office.

The third column shows payment in an OPD if payment from the Outpatient PPS is adjusted so that total payment is equal across settings. The payment to the physician from the Physician Fee Schedule stays the same, but the payment from the Outpatient PPS drops substantially, to $30. So total payment in an OPD would decrease to $389, which is the same as the total payment in a free-standing office.

For Group 2, it is reasonable to allow for higher payments in OPDs because of the greater packaging of

ancillaries under the Outpatient PPS, but the payments should otherwise be equal across settings. This diagram illustrates how this could work for the APC for Level 1 echocardiograms without contrast. There is more detail about this in your meeting paper.

The first column shows that total payment under the Physician Fee Schedule if this service is provided in a free-standing office is $143.

The second column shows that if this service is provided in an OPD, total combined payments from the Physician Fee Schedule and Outpatient PPS is $319, which is 123 percent higher than the total payment in a free-standing office.

Looking to the last column, if we wanted to make total payments equal across settings, the payment to the OPD would have to be dropped to $99, but this APC has an average of $41 of ancillaries packaged with it in the Outpatient PPS. So we should add that to the $99 payment. That would produce equal payments across settings, which would produce a payment to the OPD of $140. Total payment if this service is provided in an OPD would be $184, which is only 29 percent higher than the rate paid in a free-standing office,

and the entire difference is due to the cost of the additional packaging in the Outpatient PPS.

And we have performed simulations of the effects of the payment policies illustrated on the previous two slides. Aggregate effects of these policies include that program spending would decline by about $900 million per year and beneficiary cost sharing would decline by about $250 million per year.

We also examined the effects at the hospital level. The last line of this slide indicates that, on average, hospitals' overall Medicare revenue would decline by 0.7 percent and Medicare OPD revenue would decline by 3.4 percent.

The top two lines indicate that the effect on overall Medicare revenue varies widely among hospitals, as ten percent of hospitals would lose 0.2 percent of Medicare revenue or less and ten percent would lose two percent or more.

We also examined impacts by hospital groups and found that major teaching, other teaching, and non-teaching hospitals would all be affected by about the same percentage. Also, Medicare revenue of voluntary proprietary

and government-owned hospitals would be affected by about the same rate. But the loss experienced by urban hospitals would be near the overall average while rural hospitals would lose more than the average, 1.2 percent.

It appears that the relatively large effect on rural hospitals is a combination of two factors. First, OPD revenue as a percentage of overall revenue is higher among rural hospitals than urban hospitals. And second, rural hospitals get a larger share of their OPD Medicare revenue from advanced imaging and minor procedures than do urban hospitals, and these types of services are heavily represented in our analysis.

Peter, when we did our analysis of the effects of equal E&M rates across settings, you were concerned about the hospitals that would be most affected and asked us to look at the 100 hospitals at the end of the distribution. For this analysis, we again examined the 100 hospitals that would face the largest reductions in revenue from these policies we discussed today. We find substantial differences between these 100 hospitals and hospitals overall.

Obviously, these 100 hospitals would lose more

than the average hospital, 4.8 percent versus 0.7 percent. Also, these 100 hospitals tend to have lower DSH percentages than other hospitals, suggesting that they serve vulnerable populations to a lesser extent than does the average hospital. Other differences include that these 100 hospitals are less likely to have a major teaching hospital and have a rural location. These 100 hospitals also are much more likely to be proprietary hospitals than the average hospital.

The 100 hospitals that would have the largest reductions have three characteristics that largely distinguish them from the overall hospital population. First, these 100 hospitals are much smaller than average. They have 41 beds, on average, whereas the average hospital has 193 beds.

Second, 60 of these 100 hospitals are specialty hospitals, and 47 of those 60 specialty hospitals are orthopedic or surgical hospitals, which we have found to focus on outpatient services.

In addition, we have found that specialty hospitals are less likely than other hospitals to have emergency departments, and this is reflected in the third

difference between the 100 that would be most affected and all other hospitals in that ED visits are a much smaller share of overall Medicare revenue for these 100 hospitals compared with other hospitals, 3.7 percent versus 8.1 percent.

And we have identified two issues of concern that we think we should discuss. First, payment rates in the Physician Fee Schedule serve as the benchmarks for the policy we discussed today. But MedPAC and others have raised concerns about the accuracy of some Physician Fee Schedule rates. Some services, such as primary care, have become under-valued while others have become over-valued. However, the Commission has found that overall access to services covered by the Physician Fee Schedule has not been a problem. Also, the Commission has made recommendations to improve the process for identifying and correcting mis-valued payments. Because of our recommendations and other changes, the payment rates for primary care services have increased in recent years, but the Commission still has concerns about the accuracy of the data that are used as the basis for Physician Fee Schedule rates.

A second issue is that some have argued that the

relatively high payment rates in OPDs can be beneficial because they can lead to lower costs downstream, resulting in lower episode costs. But we have found a very weak correlation between hospitals that benefit the most from higher OPD payments for services included in today's analysis and hospitals' costs per episode.

On this diagram, along the X-axis, we display hospitals' 30-day episode costs, which have been risk adjusted. Along the Y-axis, we display the percent of hospitals' overall Medicare revenue that comes from the higher OPD rates for the services we analyzed today. Each hospital is represented as a data point on this diagram.

Now, if the higher OPD payments do lead to lower episode costs, we would see the data points clustering around a downward-sloping line like this. But the data points don't cluster around any line. They appear largely random. And the R-squared from a regression is 0.04, meaning that the percentage gain from higher OPD rates explains just four percent of the variation in 30-day episode costs. This suggests a weak relationship between hospitals' benefit from higher OPD payments and their costs per episode.

Finally, possible topics for the Commissioners to discuss today include providing feedback on the policy options we discussed today to eliminate or reduce payment differentials; addressing payment differences across settings for services that are frequently provided with an ED visit in OPDs or that have costs that are significantly affected by differences in patient severity across settings. We are continuing our work on differences in patient severity across settings, but an obstacle we face is that adequate cost data aren't available to effectively determine what cost differences should be for patient severity.

And now we're ready for your discussion and questions.

MR. HACKBARTH: Okay. Ariel and Dan, thank you. Two clarifying questions. The first has to do with rural hospitals. You showed that there would be a higher than average impact on rural hospitals. I just want to make sure I understand. So this does not include critical access hospitals because they are paid on a cost basis for the outpatient services?

DR. ZABINSKI: That's correct, yes.

MR. HACKBARTH: And then hospitals with fewer than

a hundred beds on the outpatient side, I think, still have a hold-harmless, do they not?

DR. ZABINSKI: Correct, yeah.

MR. HACKBARTH: How would this intersect with the hold-harmless?

DR. ZABINSKI: Essentially, let's see. Well, obviously it reduces their payments to -- basically their hold-harmless would go up under this policy. So to the extent that they would be impacted by this would be softened by the hold-harmless.

MR. HACKBARTH: And your impact analysis did not factor in the hold-harmless?

DR. ZABINSKI: It did not.

MR. HACKBARTH: Okay. So for the new Commissioners who haven't been through this issue, on the outpatient prospective payment system, Congress has established and renewed, a least a couple times, several times, a hold-harmless that says that your payments will not fall -- in fact, I should let you guys explain because I'll screw it up -- the hold-harmless, just say how that works.

DR. ZABINSKI: Okay. To get paid their standard outpatient PPS rates throughout the year, and at the end of

the year, CMS makes a comparison between what they received under the outpatient PPS versus an estimate of what they would have received under the previous cost-based system that preceded the outpatient PPS. And under current rules, they get 85 percent of that difference added on at the end of the year.

MR. HACKBARTH: Yeah. And just to reiterate, the impact analysis here does not factor in the effect of a hold-harmless.

DR. ZABINSKI: That's right.

MR. HACKBARTH: Okay. Well, last clarifying question. You said an impact of $900 million a year. What does that assume about growth rate in things moving from physician offices to outpatient settings? Do you assume that's constant or do you assume a growth rate there?

DR. ZABINSKI: That's a good question. It was static in that sense. You know, we just took -- just looked at one year of data. Okay, the revenue goes down by X dollars.

MR. HACKBARTH: So to the extent that there is movement away from physician office, the physician fee schedule payment into the outpatient payment system, that

would be a lower bound of the estimate, the budgetary impact?

DR. ZABINSKI: Yes.

MR. HACKBARTH: Okay, thanks. Peter, clarifying questions.

MR. BUTLER: Okay. So you've done a lot of great work on this, including being responsive to some of my questions last year. I felt we wanted to get ahead of the curve on impact and I think you've done that here. So I do have four questions on four slides. I start with 14. And just to make sure then I understand.

So when you take this in combination with the E&M recommendation, you say they're about 2.1 billion between the two, so roughly this is equal in size to the impact of the E&M reduction that we made last year. So you could roughly double these impacts if they were to both be implemented, right?

DR. ZABINSKI: Yes. This one is slightly bigger, but, yeah, roughly equivalent.

MR. BUTLER: Right. Well, you had 1.1 billion on this and then 2.1 billion overall?

DR. ZABINSKI: Yeah.

MR. BUTLER: Okay. That's an easy one. Page 11, this is a little more difficult and I'll try to be clear. So obviously I'm fully supportive, as I was last year, if you're sitting out in an office and you're suddenly employed and you get a big increase in rate just because you're employed, that's not a good thing and we want to definitely not encourage that and it's not needed to integrate and all the rest of the reasons that it's advocated.

But the methodology, if a physician is employed under this example and you're saying, Let's give the facility fee for 30 bucks and the physician fee for 360 for the same total 389, who cares what pocket it comes in? It may impact internal physician comp, those things that you have, but who really cares if the physician is employed?

But also, people will tell me there are a fair number of physicians that aren't employed that would be doing this sort of thing. And I don't know if that's true or not, but if it were, certainly a facility is not going to give them the shop for 30 bucks for one of these and let the doctor, you know, say, Oh, you can take your 360, because they'd say, Hmm. Now, suddenly, the physicians would have a huge incentive to go to the institution.

Of course then, the facility would say, Not so fast because I'm not going to do this on your behalf for 30 bucks. But my question relates to, do we have any understanding of the extent that this occurs with non-employed physicians? It could be through contract or whatever, but in effect, where the physicians themselves are getting the money directly as opposed to being in an employment arrangement? It might impact how you do this significantly.

MR. HACKBARTH: Peter, let me just make sure I understand this scenario. So the service is provided in a location that is part of the hospital outpatient department system. The dollars are flowing through the Medicare OPPS payment system. But under your scenario, the physician is not an employee, so that the money is going to the hospital and then the issue is how the hospital divides it with the physician?

MR. BUTLER: When they're not employed.

MR. HACKBARTH: Yeah.

MR. BUTLER: Personally, almost all the situations I know of, the physician is employed and this wouldn't be an issue. So I'm not saying that there are a lot of examples

where this would occur, where the physician would not be employed. But if they are not and they still are qualified to be, you know, a provider-based clinic, then this kind of split would be kind of strange.

MR. HACKBARTH: Yeah.

MR. BUTLER: I'm not arguing with the total.

MR. HACKBARTH: Would the dollars in Peter's scenario actually be split by Medicare and separate checks sent, or is all the money going to the hospital for the hospital to divide with the physician according to their rules?

MR. BUTLER: No, it is split, the payment, because you get a facility fee plus a physician fee.

MR. HACKBARTH: So you're saying if it's a salaried physician, it's all billed through the physician practice foundation or whatever, but if it's a non-employed physician, they may be submitting a separate bill?

MR. BUTLER: Right. And to the extent -- you know, there are rules to qualify as one of these clinics.

MR. HACKBARTH: I'm just trying to understand this.

MR. BUTLER: But if there's much of that going on,

then this would be one of those maybe unintended consequences or maybe not. Maybe this would quickly shut these things down and you'd say -- but that's just a -- so I just don't know. I don't know of many arrangements where you do have non-employed or contract physicians coming in and doing this. But it's a question worth knowing the answer to.

MR. WINTER: I don't think we have data on that, but we'll go back and check some more and look at it.

MR. BUTLER: So at a minimum, it would suggest that you'd think a little bit more about what the split would be between the facility and the doctor side if you were going in that direction. Okay.

On Page 15, this is where you specifically reference me, and I don't know that I said the top hundred.

DR. ZABINSKI: I think you said about 3 percent.

MR. BUTLER: You probably looked at the transcript and then you said, Okay, top hundred. So okay, I appreciate the responsiveness. This really kind of surprised me, because it looked like it was a totally different list from the E&M code impact, which was heavily major teaching hospitals, safety net hospitals.

And it looks like almost the utilization issues might be more of a concern in this sphere, in the second round of this, than maybe they were on the E&M code side. So then I would ask, on Page 18 -- so that's a comment. I guess that's a Round 2, but that's -- then on Page 18, you looked at the correlation between the -- for these tests and procedures to downstream revenue.

What would be really interesting would be to look at -- go back on the E&M exercise and do the same thing. Or maybe you have.

MR. WINTER: We might have done that. I'm looking to Jeff and he's nodding his head. Do you want to address that, Jeff?

DR. STENSLAND: Basically the same story.

MR. BUTLER: So there's no --

DR. STENSLAND: There's really a weak correlation. It doesn't tell you much about whether they're a low-cost hospital or a high-cost hospital and like whether they do [off microphone].

MR. BUTLER: Okay. So a lot of interesting data, at the very least here, and especially on whose impacted on these 25 APCs, and I don't quite understand the specialty

hospital proprietary, because I didn't think that they actually were necessarily employing a lot in those kinds of institutions. They have plenty of shared ownership, but maybe those are qualifying for some of these clinics even though the physicians aren't employed. I don't know.

MR. WINTER: Especially a hospital as an investor, they are likely going to be, you know, maybe doing the service in the OPD and then billing it through the OPD, rather than -- they're more likely to be doing it in the OPD if they're investing in the entity than doing it in their office. It's one of the motivations for it, too.

MR. BUTLER: I understand. My question is, are they doing it as private physicians? They're owners of the facility, but they are private physicians that get -- you know. It says a little. I just didn't know that that was going on, if that's what is occurring, and that's a problem.

MR. WINTER: Investors in the hospital, they are going to ultimately share in some of the OPD revenue.

MR. BUTLER: Right. But this would provide them yet more of an incentive to set these things up, and if you're permitted to be able to do this as a private physician, you know, that's one more -- I just thought this

was all about employed physicians and this is potentially another can of worms I was not aware of.

DR. COOMBS: Thank you. Thank you for an excellent presentation. The for-profit hospitals on the graph on Page 18, Slide 18, are they clustered in here in a region? Were you able to kind of find a trend?

DR. ZABINSKI: I think we could identify -- we haven't thought about identifying them, where they lie here, but I think we could.

DR. COOMBS: Okay, thank you.

DR. NAYLOR: So may I say that I got to the last page of your report. This is a comment. It said something about something being a bit complicated and I burst out laughing. This was an extraordinary analysis, so congratulations.

Slide 13. One of the most really important pieces of data that you presented related to the E&M was the difference between free-standing and hospital outpatient cost beneficiary cost sharing. And so, your Slide 13 is the first that I'm beginning to put an appreciation on what that might mean. I'm wondering, is this Group 1, Group 2, the 250 million estimate, and can we begin to also understand it

in terms of the top codes in Group 1 or Group 2 so that we have these examples of what this could mean?

DR. ZABINSKI: It's both together. They're both in there. As far as -- we can figure out where the -- thank you. That's the table I made and I forgot about it. You know, the items that, you know, where spending goes down the most, we have listed here in Table 3 in your paper, echocardiogram without contrast, cardiac imaging, nerve injections.

DR. NAYLOR: I'm looking at it from the cost beneficiary. It's in there, too?

DR. ZABINSKI: Yes.

MR. WINTER: It's broken down between the program spending and the beneficiary cost sharing.

DR. NAYLOR: I missed it. All right. And one last question, on understanding ancillary packaging and whether that should be in -- how we should interpret including whether or not we focus on 25 or 61 CPTs. Am I -- usually the ancillary packaging -- I mean, as you're looking at those 61, they also don't meet any of the other three criteria. So I'm trying to make sure that we're not talking about risky procedures.

And so the way in which you look at mitigating risk is that these were not people with high severity -- I'm reframing this in a way to understand that -- with not high severity did not have associated emergency department visits? In other words, all of that was put together to say, now, whether or not we should also look at this group beyond 5 percent ancillary. Is that right?

DR. ZABINSKI: I think the most important thing in that direction is that these services are all predominantly provided in physician offices, and so that the risk to the patient, forgetting furnished in an office, is not great.

DR. MARK MILLER: And just to point out 10 for just a second, because I want to just make this really clear just in case there's an uncertainty on it. Both groups meet all three of the criteria, and then the only split between the groups is whether there's a lot of packaging or no packaging or, you know, very little packaging.

DR. NAYLOR: And I just wanted to clarify that because honestly --

DR. MARK MILLER: I felt like that's what you were trying to clarify and we worked on this slide a little bit, because after we went through it we were thinking, Now, is

this clear enough, and what I want everybody, including the public, and you may all have -- all the Commissioners may have it -- they all meet all of the criteria. They only differentiate on the packaging and that's what this was.

MR. KUHN: Three quick ones. On Pages 11 and 12, you put some nice examples of what a Group 1, what a Group 2 would look like and the big differentiation was the packaging that was just referenced by Mark in the previous slide. But earlier you had mentioned that one of the things that we have to look at in this area is the cost of stand-by capacity. So how would we value that in future modeling?

MR. WINTER: Given that we selected, if a procedure or an imaging study was commonly done with an ED visit, then we would expect there to be some of the ED costs or stand-by capacity would be reflected in the cost of that service. An example could be fracture or it could be fracture repair, which is commonly done with an ED visit.

So we eliminated those from our analysis and we were just looking at ones that are infrequently done on the same day as an ED visit. So we would expect that a small share of their costs would be related -- a minimal share of their costs would be related to the hospital needing to

maintain stand-by capacity and to operate an emergency department.

MR. KUHN: Okay. I think I'm following you, but I want to think about that one some more.

DR. MARK MILLER: I want to say -- I'm sorry to interject. I've been quiet for a long time. This conversation has come up a lot in discussing this. Implicitly, the way I see this -- and you guys need to correct this if this isn't right -- we're accepting the hospitals' argument that there are places in the hospital where you have stand-by capacity and it's correct to pay more there because I have people standing around waiting for an ambulance to show up.

The criteria is designed to exclude those kinds of services and that's what the low ED criteria is about.

MR. KUHN: Got it.

DR. MARK MILLER: Is that okay?

MR. KUHN: That's helpful. Thanks. The second question I had is that as you looked at the various services that were identified through this screen, many of them, as you indicated, were diagnostic services and many of them tend to look like they deploy imaging, whether it's DXA,

echocardiogram, et cetera. I think as we know, a couple of years ago, there was a change in terms of payment for imaging services where the productivity adjustment went from 50 percent to 70 percent, or something like that.

How does that factor in terms of this spread, or is it neutral as part of the process? Does it narrow it? Does it expand it? Would that change? I'm just trying to get a sense of how that might impact the differences between the services between physician office and outpatient.

MR. WINTER: Okay. This is quite complicated because what you're referring to is the assumption on how frequently the equipment is used and that went up and that thereby reduced payment rates --

MR. KUHN: Right.

MR. WINTER: -- for services on the physician fee schedule side, for the technical component. The complication is that many affected advanced imaging services, MRI and CT primarily, which were already -- those rates were already -- on the physician fee schedule side, were already capped at the outpatient department level.

So until the DRA came into effect in 2006 or so and this policy was implemented in 2007, the fee schedule

rates for many advanced imaging services were actually higher than the OPD rate, and then you had the new policy of utilization, the equipment utilization assumption, which reduced those rates and sort of, you know, narrowed the gap, and in some cases will start lowering them below, you know, the OPD level.

And under our policy, we're going to say, Okay, the OPD can't be higher than the fee schedule rate for some of these services, so it could have the effect of, you know, bringing the OPD rates down. So to make a long story short, we'd have to go back and look at specific codes and how those payment rates have changed over time to really -- to be able to give you a good answer to your question.

But the point I'm trying to make is that many of these rates, the fee schedule side, were above the OPD level and therefore would not have been affected by this policy we're talking about here. Now, given these changes, over time, they're starting -- some of them are starting to come below the OPD level, particularly some CT services. It's really not an issue yet for MRI, but for some CT services, yeah, the fee schedule rate might be below the OPD and those could be falling in these, you know, the group of APCs that

we've identified.

I'm looking at the list quickly. I don't see any CT codes on the top 20. There are no CT codes in the top 20, but it might affect some that are lower down. So we'll have to get back to you on that.

MR. KUHN: No, that's helpful because I was curious about whether that would move that down and it sounds like collectively it probably will over time if it hasn't already. Okay, that's helpful.

And the third quick question, going back to something that Peter raised, which I was really interested when I saw this data as well on this Page 15 chart, and that was these top 100. And if you go back, as Glenn laid out at the outset, when we did the E&M code activity, one of the big concerns that was raised was access, particularly for safety net providers, because there was a large number of those that fell into that category. And so the Commission put forward recommendations of a phase-in as well as the hold-harmless that was out there to manage that.

What I'm wondering here is that obviously if you have a cohort of safety net hospitals that are doing a lot -- basically, the provider in that community providing those

services, obviously you're going to need imaging or you're going to need diagnostic services probably to go along with that.

I was interested because if you look at the chart based on the top 100, they don't look like they're the same institutions. But if there was a way we could crosswalk the ones with E&M with this other set just to see kind of who all is in there as part of that process, because this might then raise a conversation we need to have down the road of again phase-in, hold-harmless, things like that.

DR. ZABINSKI: We can definitely do that. That's not a big deal.

MR. KUHN: Okay.

MR. HACKBARTH: Bill, can I jump the queue? Mike needs to leave early.

DR. CHERNEW: [Off microphone] -- and it happens that it both follows from Herb's comments as well and I'm going to say it in twice as many words as Scott would have.

[Laughter.]

DR. CHERNEW: The issue of stand-by capacity is one which I understand, based on Herb's question, which is you've basically taken out services from this analysis where

you thought there might have been a lot of stand-by capacity need. But there's a lot of cross-subsidies going on which makes a lot of this analysis complicated.

So my question is, loosely, do we think that those services for which there is a need for stand-by capacity have that need for stand-by capacity in the price for them? If that makes sense. In other words, there are a bunch of services that aren't in this analysis because they don't meet the criteria because of the stand-by capacity need.

If I understand some of the arguments and some of the things that I've seen is, well, you need to pay us for these other services because we're using up the cross-subsidized stand-by capacity for things you're not looking at, and if you take away our money for this, even though we weren't using it for that, we're going to have a problem down the road.

So my first point is, it's really important to get the prices right because if you get the prices wrong, people go to the wrong institutions, people get -- all kinds of stuff happens that don't help the patients. They just are sort of arbitrage things. So getting the price right I think matters. But getting this price right and leaving

price wrong is also a concern. So I'm interested in how those other prices are. Three times as many words.

MR. WINTER: So what we tried to do is be very conservative in terms of drawing a line about APCs where we're comfortable in either setting the same, equalizing the payment rate across settings or minimizing the differences, allowing some differences for packaging. And so, we were probably overly conservative in terms of assuming -- in terms of excluding services that may have some stand-by capacity. We don't know.

We don't have the data to really estimate what percent of the cost of fracture repair, for example, is related to the fact that it's often provided with an emergency visit. We don't have those data.

One thing we could look at in the future is, rather than bench marking -- we could think about trying to minimize the payment differences by looking at a set of efficient outpatient departments, those that are both low-cost and high-quality, and see how much does it cost them to provide the set of services that we've excluded from our analysis today, because there are other patients that are sicker or there's more stand-by capacity, and could that be

a benchmark, a way to, you know, reduce the payment gap between the settings. But that analysis is very complicated. We could talk about that more, you know, if you want later. But I hope that helps with the question.

DR. CHERNEW: That's useful, and I think the bottom line is the other services. It's just very hard to separate out what the stand-by capacity portion is.

MR. WINTER: Yes.

MR. GRADISON: I want to call attention to Page 13 and comment briefly upon the second point here, beneficiary cost-sharing would be declined by $250 million. I accept that's correct. I think, however, it's useful whenever this comes up to point out, as the background document does, that about 90 percent of this is actually covered by MediGap. Therefore, the out-of-pocket costs -- out-of-pocket savings on these assumptions is $25 million to the beneficiary and $225 million, at the outset initially, to the insurer, and then if that gets folded back into lower rates, that's spread across all of the policies, not just the people who were involved in this particular type of care.

That may sound nit-picky, but I'm really -- I think when you say, By golly, this is a great campaign,

we're going to save $250 million for the beneficiaries, yes, but. Okay.

MR. ARMSTRONG: Ariel, you, in responding to Mike, made a point or expressed a point of view that I share, and that is that this analysis is conservative in a lot of ways. So two questions I have. First would be, if we were less conservative -- I mean, we've estimated that the impact of this particular change is about a billion dollars to the program, if I remember correctly.

If we made a change like move from 50 to 75 percent, the percentage of these that were done, or down to -- or whatever the less conservative direction was -- how much more is that worth? And I don't know if you've done that kind of an analysis, but it would be interesting to me to see how sensitive some of the adjustments in those assumptions were to the financial impact.

DR. ZABINSKI: Moving it down could have a potentially large effect. One thing I found, there's not a lot of services that are close to 50 percent. It's like you're either predominantly OPD or predominantly physician office, and I don't have a recollection of what the cutoff was for, you know, around 75 percent, but it could

potentially be pretty large.

MR. ARMSTRONG: It might be interesting to see that.

The other question I had is -- Glenn actually asked this earlier, but a different version, and that is, there's been, you know, a huge volume moving from the physician offices to the hospital outpatient departments in the last several years, and I just wonder if our analysis is, you know, already kind of behind that or how that kind of movement, again, would add a degree of conservatism to this. Would that 50-percent cutoff still be relevant? Or would you get a different conclusion if you were, like, three years earlier because of all the movement that's been taking place?

DR. ZABINSKI: In that sense, no, I mean, we looked back -- perhaps this wasn't long enough, but we went back to 2008. The base of the analysis is 2010, but we did go back to 2008, and we didn't really pick up much. But, again, I think that's primarily because, as I said earlier, most of these things -- by "things," I mean services -- are predominantly either OPD or physician office. So a shift from OPDs to physician offices might not move things -- or,

sorry, the other way around, offices to OPDs might not move things over the 50-percent threshold very much. But for another threshold, it might make a big difference.

MR. ARMSTRONG: Thank you. That answered my question.

MR. GEORGE MILLER: Yes, I liked Peter when he said -- and I agree -- if a physician practice was purchased by a hospital and that same work was done in the hospital, no-brainer, it shouldn't be any difference. But on Slide 11 -- and I think there may be all the numbers in the package -- I'll speak for one rural hospital -- I am able to bring physicians from out of the community to provide services in my community to my patients. So if I understand the analysis, $389, if it's done in a physician office, of that $389, $217 of that is for practice expense, correct? Am I correct?

DR. ZABINSKI: Is that something in the paper?

MR. GEORGE MILLER: It was in your --

DR. ZABINSKI: Okay. Then that's what it is.

MR. GEORGE MILLER: Yes, thank you. Okay.

[Laughter.]

MR. GEORGE MILLER: But now, if it's done in the

hospital, that same procedure is done in the outpatient department of the hospital, that payment -- that physician still gets his $389, and $187 of that is for his practice expense, although he or she is doing it in the hospital, and you would pay the hospital $30 for that overhead expense.

DR. ZABINSKI: Correct.

MR. GEORGE MILLER: Okay. So let me understand this. You're going to give the physician, while doing the service in the hospital, $187 for his or her practice expense. But for the hospital's overhead, you're going to pay them $30.

DR. ZABINSKI: In this case, yes.

MR. GEORGE MILLER: That's nuts. That's just absolutely nuts. And for my rural hospital, that's what you're telling me, that we get $30 to cover all our expenses for overhead, and while he or she is doing the procedure in our hospital using our services, our lights, our physicians -- excuse me, our nurses, and all the things it takes to provide that service, you pay us $30, but he or she still gets $187.

DR. ZABINSKI: This varies from service to service. There's other ones where the hospital -- the

relative amount for the hospital versus the physician practice expense is, you know, much more even or even higher for the hospital relative to the physician.

MR. GEORGE MILLER: Tell me how this makes sense.

DR. MARK MILLER: Well, but I think the other way to look at it is when it happens in the hospital, the taxpayer pays $379.

MR. GEORGE MILLER: Okay, I'm not arguing that that payment may be too high, and that's part of the argument. You said we should right-size the payment. I'm not arguing that it should be too high. But your philosophy ought to be consistent that if you're paying for a practice expense for someone who is not using those resources in someone else's facility and paying $30 versus $187 of the $359, you're saying the payment shouldn't change for the physician.

DR. MARK MILLER: But even in the $30 example, you're still getting the practice expense component of the physician, which now comes to the hospital.

MR. GEORGE MILLER: No, it doesn't. That goes to that physician. There's separate billing.

DR. MARK MILLER: If it's employed by --

MR. GEORGE MILLER: No, we didn't say -- I didn't say employed. I agree with you --

DR. MARK MILLER: Oh, I see --

MR. HACKBARTH: George is focused on Peter's --

MR. GEORGE MILLER: That's exactly right. I agree with you, if it's -- because it doesn't make any difference. If it's employed and still done in their office. I'm saying, like me, I bring in a cardiologist to do a procedure, or I bring laser surgery in my facility, you're going to pay me $30 for that facility fee, but you're still going to pay him as part of that $389, or her, $187 of the $389 for their practice expense.

MR. HACKBARTH: So -- yeah?

MR. GEORGE MILLER: Which is on page 16 in your paper. That's where I'm getting those numbers from.

MR. HACKBARTH: And so there is this case that we need to think more about where the service is provided in a hospital facility but the physician is not employed --

MR. GEORGE MILLER: Employed, right.

MR. HACKBARTH: Being a lawyer, you know, when I hear sort of the anomaly that you're describing, I'd say, well, I've got to negotiate a different agreement with the

physician as part of this contractual relationship which he or she comes in to use my facilities and we're going to split the money differently.

MR. GEORGE MILLER: But the risk -- the way --

MR. HACKBARTH: You have a contract with this individual, so you negotiate terms.

DR. MARK MILLER: You take some of his money.

MR. GEORGE MILLER: Right, yeah, okay. Or he can say, "Well, I'll go somewhere else and not bring the service to your community."

DR. MARK MILLER: That's possible, too.

MR. GEORGE MILLER: Yeah, well, then we're talking about access and quality of care. So now that patient in that community has got to drive 100 miles to get the service because we can't provide it because you're giving me $30.

MR. HACKBARTH: Well, I'm not sure that I follow that. Again, you --

MR. GEORGE MILLER: Well, the facility --

MR. HACKBARTH: You have --

MR. GEORGE MILLER: -- reimbursement is 30 bucks.

MR. HACKBARTH: No, you have an opportunity to negotiate. There's a total revenue stream coming in from

Medicare to cover the facility expense and the physician, but you're entering --

MR. GEORGE MILLER: It's now 30 bucks.

MR. HACKBARTH: You're entering into a contract with the physician about the terms on which this service will be provided in your facilities. All I'm saying is there is a negotiating opportunity there on how the revenue is split.

MR. GEORGE MILLER: No, I disagree. He is going to bill for the services, so I'm going to tell the physician, "Yes, Medicare used to pay you $389 but now I need to get some of your money, some of your $389"?

MR. HACKBARTH: Yeah.

MR. GEORGE MILLER: Yeah?

[Laughter.]

MR. HACKBARTH: As part of the deal by which you use --

MR. GEORGE MILLER: Good luck with that.

MR. HACKBARTH: As part of the deal by which you use my facilities, we're going to negotiate on how we split the total Medicare revenue from this --

MR. GEORGE MILLER: Where does this happen now

currently?

MR. HACKBARTH: Well, I used to run a physician group, George, and I negotiated those sorts of agreements all the time.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: You need a new lawyer, George.

[Laughter.]

MR. GEORGE MILLER: No. I think the methodology is flawed, not the lawyer, and that may be the problem -- the lawyer.

[Laughter.]

DR. HALL: Well, George, I want to know how you really feel about this.

[Laughter.]

DR. HALL: Let me make sure I got this right. I think I'm asking the same question I asked two months ago on this. So the hospital-owned practices can be within a 35-mile radius of the epicenter of the activity, correct?

MR. WINTER: Yes.

DR. HALL: It's on page 9 of the material we read at home. I thought that that 70 miles only included ambulatory practices that were totally acquired by the

hospital and were not an independent fee-for-service system. When Peter was talking, I guess my whole worldview has suddenly changed. Can you help me understand that?

MR. WINTER: Okay. So if they're off campus --

DR. HALL: Within the --

MR. WINTER: -- and they want to do provide-based billing, they have to do it within 35 miles of the main campus. The entity -- let's call it a physician practice here -- has to be totally owned and operated by the parent hospital. It can't be a joint venture, okay? Which is not the case for an on-campus entity. You mentioned something about fee-for-service billing. They can still bill on a fee-for-service basis, this off-campus entity.

DR. HALL: That works through the hospital?

MR. WINTER: Yeah, the billing has to be done through the hospital, right. There has to be sort of the same financial integration --

DR. HALL: All right. So I wasn't as confused as I usually am.

MR. WINTER: I'm sorry. There are some exceptions to the 35-mile rule, which I can go into more next time in greater detail.

DR. HALL: No, that's not important. So here, let me just ask you -- I think this is the question I asked before. We've all been alluding to the fact that it's outrageous to pay for the same service a different fee if there's nothing different other than ownership. But, roughly speaking, what percentage of these acquired practices -- in a way, I guess I'm trying to think of -- they're all basically being paid the same way within this 35-mile radius. Is that right?

MR. WINTER: If they choose to do provider-based billing.

DR. HALL: All right. So then a question is: Are the majority of these acquired practices out in the community, or are most of them still in traditional outpatient facilities that are connected by a walkway or a tunnel or are actually part of the hospital campus? Because without knowing that, I think we're -- I'm not sure that the metrics are the same for the two.

MR. WINTER: Unfortunately, CMS does not collect data on that at a national level. There may be some data at the contractor level, the MAC level, but, you know, we investigated this about a year or two ago.

DR. HALL: Okay.

MR. WINTER: We weren't able to get any kind of data that we could use to address this, because it's a very important question and it was asked last time around when we dealt with it.

DR. HALL: I think I was the one who asked --

MR. WINTER: Probably were.

DR. HALL: I forget the answer, but now thank you again.

DR. MARK MILLER: But isn't the inference that as the proportion of these services that are being paid in OPD is increasing, that somehow whatever the proportion is, which we can't tell you, it's moving more out from the hospital proper unless the hospital is building things on its actual campus.

DR. HALL: Right. So the argument that I get when I talk to some hospitals is, well -- I say, well, you're doing this just because you get more money by nominally ownership of these practices. You could acquire those practices without this extra fee if you really wanted to. And that may or may not be true. But others would say, no, this is the way you develop an accountable care

organization. This is the way you're able to deal with bundled payments.

MR. HACKBARTH: That's a really important point, Bill, and I think we talked about this some last time, that I think it would be a mistake to say, well, what we're trying to accomplish here is to discourage hospitals from acquiring practices, developing relationships. In fact, a lot of things that we recommend -- we want that to happen, or at least we're neutral on that issue, if not leaning in favor of it.

The goal here is not to discourage that. The goal here is to make sure that that development does not have the consequence of a dramatic increase in Medicare costs and beneficiary costs. We're not for or against development of integrated delivery systems. We are for making sure that it doesn't have an adverse impact on the Medicare program.

DR. MARK MILLER: And let me just put -- we're way behind but let me quick flag go down for round two, because I think this discussion should occur, because there are other doors people can walk through. You can become an ACO and start to share in the savings, and if this proposition is true, this will create efficiency, although we've raised

some real questions, at least so far, whether that's true. Then there's a door somebody could walk through in which they could reap the benefit of those savings.

And, you know, what I think is a hard argument to hold is, well, I don't want to walk through that door, but I do want you to keep paying these higher rates, and trust me, it'll all come out in the wash. And at least the wash so far, it's not coming out.

DR. REDBERG: So for these facilities -- that was an excellent presentation. But for these facilities that are more than up to 35 miles away, they're paid at the OPD rate on the assumption that they have all the other -- because they don't have the emergency room and everything else.

MR. WINTER: Right, they don't have to have an emergency room. So when CMS created the rules that allow hospitals to bill for other entities as if they were part of the hospital, you know, they had two kinds of categories: one category would be entities that are on the main campus of the hospital; another category are entities that are off the main campus of the hospital, but they have to be within 35 miles. And they did try to create some -- draw some

lines around this relationship to show that they were integrated, you know, at least financially integrated, share the same license, have some type of clinical integration, although, in my view, it's not very robust. And we could talk more about that if you want. So they did try to draw lines around it, but, you know, these rules were put into place about ten years ago, and the world has changed a lot since then. And there are also lots of questions about the extent to which these rules are being followed. There are questions about the extent to which they're being enforced. So lots of issues here that we could, you know, talk about more if you want.

DR. REDBERG: I also had a question. On Slide 13, when the assumption was program spending would decline by $900 million, is that assuming constant volume? Because isn't it true that often when payment rates drop, volume increases?

DR. ZABINSKI: Yeah, it does assume constant volume. Static in that sense.

DR. REDBERG: And then my last question. I just wanted to understand the hold harmless that you raise. So does that mean for the slide where you showed the -- Slide

16, the 100 hospitals that would see the largest payment reduction, most of them were smaller than 100 beds, I thought. So does that mean they would not actually see the payment reduction because of the hold harmless provision?

DR. ZABINSKI: No, because you have to be rural to get hold harmless.

DR. REDBERG: I see.

DR. ZABINSKI: And most of those 100 -- the rural representation in the 100 is a little bit below the overall average.

DR. REDBERG: And then just for the OPD part, does the hospital outpatient facility have to be associated with an emergency room?

MR. WINTER: In terms of provider-based status? No, it does not. It does not. If it does have -- if the outpatient department is on the main campus of the hospital, then it is subject to EMTALA. But an OPD that's off the main campus, A, it's not required to have an emergency -- offer emergency services. If it does, then it is subject to EMTALA. But it's not required to offer emergency services.

DR. REDBERG: But even on the main campus where a lot of specialty hospitals don't have EDs --

MR. WINTER: I'm sorry. That was the question. That's what we found in our specialty hospital work in 2004 and 2005, that many of them do not, particularly the orthopedic surgical hospitals do not. Cardio hospitals are much more likely to. And even when these surgical hospitals do have an ED, it's often not used, does not appear to be used very much. We visited a surgical hospital in Texas, and we asked to see their -- they did have an ED. I think they're required by the state to have one. And we asked to see it, and they opened up a door and turned the light on and showed it to us. So, you know, even where they do have an ED, it may not be used very frequently.

DR. REDBERG: But they still get paid at that higher rate for the incurred costs associated with an ED that was compliant with EMTALA?

MR. WINTER: So if that ED was providing emergency visits, they'd be paid the same rate as any other outpatient department. In terms of their other outpatient department services, yeah, they are paid the same rate whether they have an ED or not.

Danny, do you want to talk about this? There are two levels of emergency departments which do have different

rates for ED visits.

DR. ZABINSKI: Yeah, there's -- they call them Type A and Type B, not because one is hyper and the other is relaxed, but because the Type A basically has to be available 24 hours and the Type B has to be -- there's guidelines, but they're a little more relaxed than the Type A.

DR. REDBERG: Thank you.

DR. HOADLEY: Only one, and this really was a very good presentation on obviously a complicated subject. As you walked us through from the E&M services to this Group 1 and Group 2, can you give me a sense of magnitude of what amount of the pot is represented by either those three groups together or separately, or anything? Or if you don't have that now --

DR. ZABINSKI: What, you mean of the total outpatient --

DR. HOADLEY: Total outpatient/physician pot, say?

DR. ZABINSKI: Oh, outpatient/physician pot.

DR. HOADLEY: Whatever the appropriate denominated would be.

DR. ZABINSKI: I want to say the percent of the

outpatient pot is probably, ballpark -- oh, it's pretty big, actually. I want to say 15 percent, maybe? Something in that area.

DR. HOADLEY: Just a useful kind of context as we move through this, I think, to get a sense of what amount of the whole picture we're dealing with here. And if we eventually move to a Group 2 or 3 or 4, or whatever, continue to keep that sort of scorecard.

DR. BAICKER: Just a quick one. Can you give a few more examples of the types of things that are packaged that are making the difference between the Group 1 and Group 2 and whether we want them to be packaged. Is this an efficient bundling of things that should be encouraged? Or is this stuff that's just being added on? Or is this stuff that could just as easily be done independently?

DR. ZABINSKI: A lot of the packaging is drugs, then also, you know, kind of the more basic supplies. I think those are probably the two biggest components of it.

MR. WINTER: And for imaging procedures, a big one is radiopharmaceuticals are packaged in the OPPS, and that makes a big difference for nuclear medicine procedures and some other ones, and in the physician fee schedule, those

are paid completely separately. We've made a recommendation on the physician fee schedule side that there should be more packaging because we think it encourages greater efficiency.

DR. BAICKER: So these are things that, by and large, would have to be paid for anyway, it's just where they're getting paid for?

DR. ZABINSKI: Yes. Yes.

DR. SAMITT: Quickly, two things. Great job.

First of all, the 100 hospitals on this slide that's up here, the other 40 that are not the specialty hospitals, is there any rhyme or reason to them? Is it across the board? Are they critical access hospitals? These must be very small hospitals. Who are they and where are they if they're not specialty hospitals?

DR. ZABINSKI: That's a good question. Let's see. I think a good chunk of them are probably proprietary hospitals, likely -- even though in general the population is a little less rural than your average hospital, but for the remaining 40, I would think they would have to be more rural in nature. Beyond that -- just by, you know, being rural, they're probably small.

DR. SAMITT: It may be good to know that a little

bit. My second question --

MR. HACKBARTH: And, Craig, just on that point, we know they are not critical access hospitals because they're not subject to the outpatient payment system.

DR. SAMITT: Okay.

MR. HACKBARTH: And this analysis did not take into account the effect of the hold harmless. And so to the extent that they are rural hospitals with less than 100 beds, they could drop off the list once that's overlaid into the analysis.

DR. SAMITT: My second, I was going where Scott was, and when we talked about this last, I thought that a 50-percent threshold also seemed high. So my question -- I think I know the answer -- is: Do we have data to compare these percentages between OPD and physician from MA plans versus fee-for-service? Because I would imagine we would reveal some additional significant differences in a value environment than we would in a volume environment between what's done in the physician offices and what's done in the hospitals.

MR. WINTER: I'm not sure we have the Medicare Advantage data to be able to disentangle that, but I'm going

to look to see if any of my colleagues have anything to say about that.

MR. HACKBARTH: At this point we do not. Hopefully it's forthcoming at some point.

DR. SAMITT: Eventually, I'll learn to stop asking that question about MA data.

DR. MARK MILLER: Actually, we lost the Commissioner who asked it at every meeting, and so if you'd like to take that function over --

[Laughter.]

MR. HACKBARTH: Okay. So we are to round two. Just so you know where we are, we're roughly 20, 25 minutes over schedule. So as you formulate your round two comments, the number 25 should be flashing in your mind. Not that I'm trying to discourage really thoughtful comments.

MR. BUTLER: I'll be brief. Number one is I will take responsibility for scraping George off the ceiling. Don't worry.

[Laughter.]

MR. BUTLER: I think part of our problem is we probably used the wrong example, laser. I'm not sure that that is the heart of the issue.

If you look in the chapter that you drafted, almost half, 500 million of it or more, is tied up in the first two APCs, which is Level 2 echocardiogram without contrast and Level 2 cardiac imaging. So if we understand what is going on in cardiology by itself, we'll be in a better position to get this right. I think.

And having said that, and not fully understanding what's going on myself, I suspect you do have things like free-standing heart hospitals or something, the pressure on the fees for cardiology in general, and maybe you've got physicians setting up shop there that said, "I was doing these in my office. We've got a set-up now. I'll charge the fee, we'll get the fee through the facility side and the professional" -- something like that could be what is going on to some extent, which is, you know, something you don't want to have happen.

So understanding what's going on in those two in particular probably will give some guidance on how to make sure we get it right for the rest of us.

DR. COOMBS: With that thought, we had a similar thing in endoscopy where within some of the privates there were facility charges that were much higher versus a stand-

alone endoscopy unit. And I was looking through the list as well and looking at some of the things that can be done in the doctor's office very easily, and the rest of the list, when you get past the nerve injections, which we do a lot as an anesthesiologist, when you get past that, I mean, many of the things may be because the market forces -- and I'll use that word -- may change so that there probably will be some shifting of those procedures from hospital-based to more independent off-site basis. That in and of itself would probably be more of a cost savings in that it's a free stand-alone.

But I can understand George's point, which if you were the only place around where you can do an echo -- and many times when our guys do an echo, they ask the anesthesiologist to come in, I want you to give some propofol or something like that -- I didn't want to give you any today, George.

[Laughter.]

DR. COOMBS: But there may be reasons why people have advanced co-morbid conditions for which they need to be done in a facility, and I know there's probably some room to create that within some of the regulations. But that's more

rare than it is common. So the majority of the cases can be done in most of the stand-alone, in my own personal experience. But specifically the nerve injection ones are ones that people come in for an hour, they're out and about and could be easily handled within the confines of a pain unit.

DR. NAYLOR: So, again, a terrific report, principles. I really think that the analysis has really been guided by your overriding principles. I would be much more inclined to think about a broader definition that includes, given the information you provided, the ancillary. And while I know that most of the cost to Medicare and the beneficiaries are up in the top three, I think a broader list, as you've described, is worthy of consideration.

I do think it's important to take a look at, if you can, some communication of actual per beneficiary cost sharing. With all due respect, I think that these are dollars and how much people have to pay out of pocket or pay to others to get access to is really important. So a couple examples of what it would be like at a per beneficiary level would be very helpful. And I also think that all the issues around what's it take to maintain stand-

by capacity, and why are these specialty hospitals plus 40 looking different, and maybe there are these physicians that need to be able to access, so what proportion of those might be necessary, because that's the only space where they can do it.

But the principle of equal pay for equal services, I think, is a really important one, and I think taxpayers should know more about how much they're paying in one site versus another for the same access to the same high-value --

[Turned off microphone.]

MR. KUHN: Just one comment. I, too, think this was a very good discussion and some really terrific work of putting it together. But, basically, the conclusion this takes us to is basically further development of site-neutral payments as part of the process. But one alternative could be are we dealing really with a site-neutral payment set of issues or are we dealing with a set of overvalued APCs and is that another set of issues that we are -- or another way to look at this issue that we're dealing with.

So maybe in future conversations, if we could just either rule that out or at least have some more conversation if that's an option or something we ought to be considering

might be -- as we've looked at other over-priced procedures in the past, is that something we ought to be looking at.

MR. GRADISON: I'm supportive of the direction that this points us towards.

MR. ARMSTRONG: Yeah, I am, too. I think this work has been very impressive and I like the direction it's heading in. Just worth acknowledging that what's kind of interesting is that we've got this confluence of a couple of different principles that we're trying to advance, this site-neutral payment idea, but then also advancing payment reform that encourages system integration and so forth, and I think we're doing a nice job of trying to reconcile that.

I do think we are being conservative about this and that I think we could extend that site-neutral payment principle beyond what some of these assumptions tell us. But I think we ought to look at the numbers a little bit more before we know how far you'd have to go to, frankly, have any real impact on that.

The last point I would make is that let's not underestimate, too, the enormous implications, not just for the Medicare program but for commercial payments and the rest of the industry that is experiencing exactly the same

thing, because so many of those contracts are based on the Medicare payment structure, and that the sooner we can move on this, the sooner we'll have an impact, I think, even on cost trends, even beyond the Medicare program.

MR. GEORGE MILLER: If I can come down off the ceiling, as Peter described, again, let me be clear. I support the principles that have been articulated by everyone. And as Peter mentioned, in looking at the data that was provided, I saw what I thought was a flaw in that, and what I'm concerned about, if there's a trend of that going forth with all the other things we're looking at, particularly around the cardiology piece. And again, for rural hospitals, we invite cardiologists into our communities. We tell them to come, because you can bill for your part, we can bill for our part, and if that dynamic changes, then I want to make sure that we are appropriate. But I do support the basic principle.

But the cautions of not moving fast enough, is to making sure everything is correct and we get the appropriate payment. In my mind, the goal should be paying the appropriate value for the appropriate service, as Herb described, whether that be lower or higher, appropriately

for the value of the service, to keep quality of care in the communities we serve and access at the same level.

Change is inevitable. I don't have any problem with change, but it has to be done appropriately and correctly.

DR. HALL: I agree with everyone else that this is a really well done analysis, not only this time, but before, and I've certainly profited tremendously from it.

Just three points as we go further. One is I think we can all agree that if there's gaming of the system, that it should go away.

The second point that I think is made even more importantly is that it appears that a lot of the services that are migrating into this hospital sphere of influence are advanced technologies, technologies that have become easier to use, such as a number of cardiac diagnostic procedures is maybe the most prominent example. But there are others -- bone densities, mammograms, lots of things, although mammograms, I guess, have already been exempted.

One of the biggest cost drivers in Medicare is the rapid expansion of technology without clear-cut evidence of outcomes in every case. So I think an equally important

part of this is to be able to take and analyze whether some of this increase in technology is just because it's out there and if you're part of a system, it's more lucrative, so people are just going where the incentives are. And so I think we should take a look at that.

And then, finally, as a word of caution, the frailest elders, which are part of our mission here as MedPAC, are generally cared for by a different cadre of health care providers, both physicians and nurse practitioners and PAs and others. Virtually all physicians working in -- not all, but almost all working in nursing homes fall into that category. Many who deal with the very frailest in home care settings are in this sphere of sort of primary geriatric practices. I don't know a one of those in the country that could make a living if they weren't affiliated with an institution. They've grown up as part of institutions. So I think we need to be very careful in terms of unintended consequences that we don't further disincentivize this group of providers from caring for this small but extremely important and extremely expensive segment of the Medicare population.

DR. REDBERG: I'll be brief. Again, it was an

excellent report, and I certainly agree that we should be paying the same payment for the same services regardless of the location. But I think even more important is to look at the appropriateness of the services because we're still in this fee for service, which is really a fee for volume, and we're paying the same for services that actually help beneficiaries as the services that don't help them and may harm them and that we really have to be tying payment to quality and outcomes and not just keep paying and paying, and certainly that's true, as you pointed out, for technology. We know once you buy a very expensive piece of equipment, like a CT scanner or an MR, and a lot of these are advanced imaging, or even the echo machine, you do a lot more of them, and that doesn't mean that the patients need a lot more or are benefitting a lot more. So I think if we really want to improve care and get a hold of this, we have to start tying payment to quality and not to volume.

DR. DEAN: Yes. I would just echo some of a number of the comments that have been made. I mean, clearly, our goal should be to get the right payment for an individual service. But it's a very complicated issue, because, I think as Scott alluded to and some of the other

folks have, as well, we also want to move toward system integration and this may well work against that. And so it's not that it's the wrong thing to do, but I think we need to be cautious about it and move slowly.

I guess I think back to a few months ago. I had a conversation with Nick Wolter, who some of you folks will remember. And as you recall, Nick was pretty strongly opposed to the movement that we made on the E&M thing and his whole point was that if we do that, we impede system integration. I don't know that I accept that directly. On the other hand, we do need to move cautiously and understand that if we take away some of this flow of funds to hospitals, what is going to be de-funded because of that loss of resources? I mean, I realize it's a very difficult question to answer, but we just need to be sensitive to the risk, I think.

MR. HACKBARTH: Just for the record, Nick is as strongly opposed to this as he was to the --

DR. DEAN: I'm not surprised.

MR. HACKBARTH: Yes. Of course, and Mark touched on this earlier. Even if we shared Nick's goal -- and I, for one, do --

DR. DEAN: Right. Yes.

MR. HACKBARTH: -- the question is, is paying higher payments for all hospitals who are bringing these services in the best way to encourage the movement that Nick and I agree on, and I think there's reason to doubt --

DR. DEAN: It clearly is not the best way to pay for it. It's just that we've got to move cautiously and be sure we don't do damage in the process.

MR. HACKBARTH: Yes. Jack.

DR. HOADLEY: With some of these caveats, but mostly, I think this is really moving us in a good direction. Whether it's med, or like Scott was saying, whether we want to be thinking about some even looser use of some of these criteria or just think about a Group 3 and a Group 4 at some point in the future, you know, just -- and there'll be a point at which you can't go any further, clearly. But I think this is really moving us in a good direction.

MS. UCCELLO: Yes, I agree. This is great work and I'm supportive of us moving forward in this direction and trying to see if there are even further things we can do.

DR. BAICKER: Yes. This seems like a very measured step towards the reasonable goal of paying in a site neutral way, and these are pretty conservative criteria, so it seems like the right way to start.

DR. SAMITT: I also support the direction. I think this is the right way to go, with three additional comments. I believe there are other incentives and motivations to drive integration of the delivery system and I am not concerned that this would work counter to that.

I am a little concerned with Michael's comment, and I would echo some of his worries about the notion that in taking away some of these supplemental dollars for these services, it may expose other areas where some certain types of hospitals are underpaid and I think we need to watch out for that very carefully. It underscores the importance that if we need to make this change to get the payment right, we need to make sure there aren't other areas where the payment is not right.

And then, lastly, I look forward to taking on the MA Data Project --

[Laughter.]

DR. SAMITT: -- because I think there's probably a

lot more to learn there about where we can take this initiative even further.

DR. MARK MILLER: [Off microphone.] And I'll fill you in at lunch.

DR. SAMITT: Okay. Great.

MR. HACKBARTH: Thank you very much. Good work, Dan and Ariel.

We'll now have our public comment period, and let me see how many people we have. If you intend to make a comment, could you either go stand in line or at least let me see your hand so I can judge how many folks we've got.

You're all lined up so I can't see. Is it three? Three, okay. So just to repeat the ground rules, begin by identifying yourself and your organization, and please keep your comments to no more than two minutes. And when this red light comes back on, that signifies the end of your two minutes. And as always, I would remind people that this is not your only or anywhere near your best opportunity to provide input on the Commission's work. Your best opportunity is always to interact with the staff and, secondarily, communicate by letter to Commissioners. I think our record demonstrates that the Commissioners take

those letters seriously.

We also have on our website an opportunity for people to log comments specific to a given public meeting, so avail yourselves of all those other opportunities.

MS. ROWE: I'm Elizabeth Rowe, representing the Rowe Neurology Institute in Lenexa, Kansas. The massive shift of physicians into hospital employment and the high payments to hospitals for outpatient services are causing a marked rise in health care costs without any associated benefits. These additional costs are negatively impacting beneficiaries with the increased co-payments and insurance premiums, which you guys already referred to.

Hospitals hire physicians to capture downstream revenue from referrals. It's ironic that they are prohibited from buying dinner for a physician because of possible inducement for referrals, but they are not prohibited from buying a physician's entire practice.

In addition, hospitals are exempt from the self-referral regulations that apply to physicians, regulations that have effectively stemmed inappropriate self-referral.

Hospitals are able to purchase practices because of the inadequate reimbursement for these practices received

while free-standing. Even specialists in free-standing diagnostic centers are closing their doors because of hospital acquisition of their referral base. And you already know that as soon as physician becomes a hospital employee, the reimbursement rate increases by 80 percent.

The self-referral by hospital-employed physicians to hospital-owned facilities deprives patients of choice, limiting the quality of care, driving up costs for these services 200 to 300 percent of identical services provided by nonhospital-owned facilities. What can be done?

First, immediately notify all Medicare beneficiaries by mail about the vast cost differential between hospital-provided and nonhospital-provided outpatient care centers and encourage them to utilize the low-cost providers whenever possible.

And, second, require hospital-employed physicians to provide a list of alternative specialist and testing facilities whenever they refer a patient for testing or surgery.

And, third, as very well discussed today, payments for outpatient services between hospital- and nonhospital-owned facilities should be equal across the board, including

imaging and everything.

Thank you.

MS. MIHALICH-LEVIN: Good morning. My name is Lori Mihalich-Levin, and I'm with the Association of American Medical Colleges. The AAMC appreciates this opportunity to share our thoughts with the Commission this morning with respect to your second subject, the differences in Medicare payments across settings.

In your presentation today, you talked about the four criteria that you use to determine which APCs to focus on with the fourth criterion being that the differences in patient severity between settings are small. The AAMC is extremely concerned, both in the context of the E&M codes that you discussed last year and in the context of the new APCs that you're raising this year, about the severity of illness of the patients who are using these particular settings.

We know from our own analyses that teaching hospitals treat a disproportionate number of dual-eligible, disabled, and other vulnerable populations, and these are populations that rely heavily on the wrap-around services and on the integrated care that's provided in hospital

outpatient departments.

We believe that the Commission's analysis should be viewed from the perspective of these patients in addition to the perspective of the providers who provide the services. We encourage MedPAC to consider the impact on different cohorts of patients -- for example, dual eligibles, disabled patients, and complex patients -- to know better how they are using these HOPD services and to know how the effect of any cuts -- what the effect of any cuts would be on them.

On behalf of these patients, the AAMC strongly encourages the Commission to undertake a thorough analysis of both the E&M and the other proposed APCs to determine the effect any recommendations might have on the ability of these complex, high-risk patients to access integrated HOPD services.

Thank you.

MS. SCHULMAN: Hi, I'm Roslyne Schulman with the American Hospital Association. The AHA is extremely concerned that MedPAC is considering broadening the application of its site-neutral payment policy to other hospital outpatient services before we've even had a chance

to understand the impact of the Commission's previous recommendations to cut payments to the ten E&M services by $1 billion annually. This proposal could result in beneficiary access problems and a reduced level of services for the public overall. And now MedPAC is talking about recommending even more cuts. These are deep cuts to retain outpatient services that are integral to the service mission of hospitals.

In preparing for the AHA's We Care, We Vote Initiative, we reached out to the health care consumers, including Medicare beneficiaries, and they told us what they want are three things from the health care system: access to the latest and most advanced medical technologies and equipment, health care services that are available 24/7 in case of an accident or emergency, and no long waits to receive services or see their doctors.

The AHA is very troubled by the Commission's unwillingness to recognize that hospitals fulfill a unique role in the health care system in society. Not all services provided by hospitals, particularly those provided in EDs, are profitable, and this requires the cross-subsidization of costs across the hospital's entire book of business.

The impact of a $1.1 billion annual cut to other outpatient services added on top of the E&M cuts of $1 billion would be devastating to hospitals and will decimate patient access to care. MedPAC itself knows that Medicare outpatient margins for hospitals is already negative 9.6.

Cumulative annual cuts of $2.1 billion will mean that many hospitals will stop providing these services. It's simply not financially feasible to continue to provide services at a huge loss to the hospital. Remember, doctors currently refer their more complex, sicker patients to the hospital for these procedures, and that may no longer be a fallback option for community physicians.

Also at risk are the many types of wrap-around services offered by provider-based clinics and HOPDs to the most vulnerable patients, such as access to social workers, case managers, pediatric and women's care, and transportation assistance. Hospitals also will have a hard time financing teaching programs for interns and residents in outpatient settings with cuts of this magnitude.

In conclusion, we urge MedPAC to consider carefully the possible unintended consequences of expanding its proposed cuts to hospital outpatient payments. This

policy is short-sighted and could have significant long-term implications for the health care system as a whole.

MR. HACKBARTH: We're adjourned for lunch, and we will reconvene at 1:45.

[Whereupon, at 1:02 p.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day.]

AFTERNOON SESSION [1:57 p.m.]

MR. HACKBARTH: It's time to begin our afternoon session. First up is Medicare Advantage Special Needs Plans. Carlos?

MR. ZARABOZO: Good afternoon. Christine and I are here to talk about special needs plans, which is a Medicare Advantage plan that exclusively enrolls certain classes of beneficiaries such as beneficiaries entitled to both Medicare and Medicaid. We're examining SNPs, as they're called, at this time because the statutory authority that enables such plans to enroll only certain categories of beneficiaries expires at the end of 2013 unless Congress acts to extend the authority.

Under current law, if there is no change in the statute, SNPs must decide by the first half of 2013 whether they wish to continue in the Medicare Advantage program in 2014. If the authority allowing exclusive enrollment of special needs individuals does expire, these plans can continue in the Medicare Advantage program, but they will no longer be able to limit their enrollment to only special needs individuals.

To talk about policy options for the Commission to

consider, we'll begin by giving some background information on special needs plans and describing the current landscape. We'll review some of the issues relevant to special needs plans, including the extent to which such plans provide better quality care, improve access, and promote greater integration and coordination of care, as well as what the cost implications are, if there's legislative action to change the current SNP provisions. And we will present various policy options for the Commission to consider.

In order to evaluate the SNP program, we examined the current standards and requirements that apply to these plans, reviewed the literature there is about these plans, talked to SNP sponsors, and analyzed the most recently available data on enrollment patterns and data on the performance of SNPs, on the quality measures that are currently in use in the Medicare Advantage program.

At the outset, I should mention that all SNPs function as regular MA plans in the sense that they're responsible for the full range of Medicare Part A and Part B services for their members, and also for the Part D drug benefits.

There are three kinds of SNP plans. There are the

D-SNPs, which are the plans that exclusively enroll dually-eligible beneficiaries, that is those entitled to both Medicare and Medicaid, and that's the largest sector in the SNP environment. They have about one-and-a-quarter million enrollees, and as of next year, such plans will be available to about three-fourths of all Medicare beneficiaries.

Second are the C-SNPs which is for specified chronic or disabling conditions. There's a much smaller enrollment, under a quarter-million, and as of 2013, there will be a C-SNP of at least one disease type available to a little over half of all Medicare beneficiaries.

The smallest component is the I-SNPs, which is for beneficiaries and institutions, for example, nursing homes or living in the community at an institutional level of care. There are 48,000 enrollees currently, and as of 2013, they will be available to slightly less than half of all Medicare beneficiaries.

The composition of enrollment in the SNPs is different from general MA plans. For example, in the C-SNP, the case of C-SNPs, two-thirds of the enrollment is in four southern states, Florida, Georgia, South Carolina, and Texas. For the I-SNPs, half are in New York and California.

In the case of D-SNPs, Puerto Rico has 20 percent of all the D-SNP enrollees.

Also, the demographic make-up, as we pointed out in the mailing material, is different. There's a larger proportion of African-Americans in C-SNPs, for example, more duals in both C-SNPs and I-SNPs, but part of that reflects the geography of where the plans are being offered.

The SNP program was originally authorized in the Medicare Modernization Act of 2003 and the authority to limit enrollment to special needs individuals was going to end in 2008, as of the time that SNPs were introduced into the law. SNPs were then re-authorized several times and for the period 2008 and 2009, there was a moratorium so that no new SNPs could be started up.

New requirements were imposed as of 2010 and thereafter. The requirements included a requirement that D-SNPs have a contract with the state to arrange for the coverage of Medicaid benefits and to coordinate Medicaid benefits, and that's as of January 1st, 2013.

For C-SNPs, there was a tightening up of what conditions qualified for C-SNP status so that the plans that had specialized in the coverage of people with high

cholesterol or coverage of people with high blood pressure were no longer allowed in C-SNP plans. And for the I-SNPs, there was a change in the requirement of who could certify who was in the community living in an institutional level of care.

For all of the plans, as of January 1st, 2012, they had to be certified by the National Committee for Quality Assurance, and model of care and structure and process measures were imposed.

Before reviewing information on what we know about the quality of care in SNP plans, we should discuss why we are comparing SNPs to non-SNP plans in evaluating their quality. To reiterate what we said about current law, SNP plans will be allowed to continue in the MA program after 2013, but they can only operate as general MA plans. If a SNP continues as an MA plan, its enrollees will not be disenrolled from the plan, but will continue as members of the general MA plan.

So one issue to evaluate is whether there are differences in qualify between SNPs and general MA plans that would suggest that the target populations would be better off in SNPs rather than general MA plans. As we will

discuss in the next couple of slides, using current quality measures, there is not an entirely clear direct way of determining the extent of any differences in quality between general MA plans and SNPs or why there might be such differences.

As explained in your mailing material and as we've wrote about in past Commission reports, it is difficult to know how SNP populations are doing in their plans because many important quality indicators are only reported at an aggregate level; that is, quality indicators that are reported pertain to a combination of SNP and non-SNP enrollees within one organization.

Looking at the measures that SNPs do report at the SNP level and using a proxy method of comparing plans that are primarily or exclusively SNP plans to non-SNP plans, we find that for most of the currently collected process and intermediate outcomes SNPs on average do not perform as well as non-SNP plans.

But as is true of general MA plans, there is wide variation across plans and across geographic areas. For example, some C-SNPs do very well on the process in outcome measures. The I-SNPs do well on the new hospital

readmission measures, as do some D-SNPs.

Looking at a composite measure that includes process and outcome measures as well as access measures and administrative performance, which is a CMS star rating system, we see that SNPs generally do not perform as well as other plan types. However, there are exceptions. SNP plans in the four states listed on this slide do perform well under the star system.

One of the issues that the SNP industry has raised is that the quality rating system and the measures that currently exist are not appropriate for measuring special needs plans and the populations they serve. Other factors should be taken into account which affect the quality ratings, especially in the case of D-SNPs.

There are socioeconomic differences and issues such as health literacy and the lack of family and social supports that hamper the ability of plans to provide optimal care to these populations. However, how to go about taking such factors into account and to what extent is a difficult issue that the Commission has examined in other contexts.

The industry also suggests that there should be a different approach to evaluating these plans, that SNPs

should be compared to other SNPs for the purpose of determining quality bonuses and that like populations should be compared across sectors. On this last point, the Commission did attempt to do that, as we reported in the March 2012 report.

Using the results of survey data across MA and fee-for-service Medicare, we found that duals in SNPs have the same rates of influenza vaccination as duals in general MA plans and as duals in fee-for-service. Unfortunately, there are very few measures that can be looked at in this way.

Another point that the SNP industry has raised is that new measures should be developed that are more appropriate to the populations that SNPs serve. The Commission raised a similar concern in our 2010 report on quality measures in Medicare Advantage and fee-for-service, noting the need for more outcome measures and noting the lack of measures for older beneficiaries and for younger beneficiaries with disabilities, including mental health measures. Work is still underway to develop such measures which would be applicable to both SNPs and non-SNP Medicare Advantage plans.

Turning now to the policy options, with respect to I-SNPs there are several options. One is to re-authorize this category of SNPs. The argument for doing so is they serve a distinct population with clearly defined special needs. I-SNPs perform well on an important quality measure, namely readmission rates, and the model may not be easy to integrate into a general MA plan.

The second option is what will transpire under current law, which is that the ability to have a plan limited only to institutionalized individuals will expire. The consequence of this might be that although the current enrollees would be able to continue in MA if the sponsoring organization continues as an MA plan, the benefit package and range of services may be different from what they had been under the I-SNP.

A third option is to allow the authority to expire, but to provide greater flexibility in the MA program so that general MA plans can accommodate I-SNP-like benefit designs. Later, Christine will also discuss an approach that can be applicable to each of the three kinds of SNPs, which is to either temporarily extend the SNP authority or to have a moratorium on new SNPs pending further study of

the effectiveness of the SNP program.

For C-SNPs, some of the options and line of reasoning would be similar. C-SNPs can be re-authorized or the current law expiration of authority can remain in place. As we have noted, some of the quality indicators for C-SNPs show good performance for certain types of plans.

The second option is what will transpire under current law, which is that the ability to have a plan limited only to individuals with chronic or disabling conditions will expire. If this happens, current C-SNP enrollees could continue as members of plans that decide to continue operating as general MA plans.

We would note that of the 60 C-SNPs listed in 2013 data, all but five are part of a larger general MA contract, and of the five that are not, four are plan-serving individuals with end stage renal disease or HIV/AIDS. So a possible option, which we list here as Option 3, is to further narrow the categories of diseases eligible for C-SNP status.

The fourth option is to give general MA plans greater flexibility in designing benefit packages and provider networks to serve specific populations. This could

be a companion piece to either Option 2 or Option 3, which do not call for the full re-authorization of C-SNPs.

Christine will now discuss issues and policy options for SNPs serving Medicare and Medicaid dual eligibles and she will discuss the financial impact of possible options that affect all three types of SNPs.

MS. AGUIAR: We're focusing more on D-SNPs in this presentation because they are the current managed care-based vehicle in the Medicare program for the integration of dual eligibles, Medicare and Medicaid benefits. The Commission has been focusing on D-SNPs as part of our broader work on ways to improve integration of care for dual eligibles.

We first looked at whether D-SNPs improve beneficiaries' access to supplemental benefits. We examined this as a proxy for access to care because more robust supplemental benefits can increase dual eligibles' access to those services. A recent GAO evaluation found that D-SNPs tend to offer fewer supplemental benefits than general MA plans, but some of the supplemental benefits D-SNPs do offer are more comprehensive.

For example, compared to general MA plans more frequently offered oral surgery, extractions, and

restorative dental services. We also found that D-SNPs sometimes offer more comprehensive benefits than dual eligibles can receive from Medicaid. Common D-SNPs supplemental benefits such as vision, dental, and transportation, can also be Medicaid services.

For example, one D-SNP we spoke with offers comprehensive dental services, while less than half the states currently provide those services. The benefit to D-SNPs offering comprehensive supplemental benefits is that dual eligibles enrolled in these plans may have access to more comprehensive services than they could receive from general MA plans or from Medicaid.

The down side is that states can cost shift some of their services to Medicare. This occurs if the supplemental benefits that overlap with Medicaid services are being financed through the Medicare rebate dollars rather than by Medicaid. We also assessed whether D-SNPs integrate dual eligibles' Medicare and Medicaid benefits.

Stepping back a bit, I will first explain how D-SNPs can integrate Medicaid benefits. As Carlos mentioned, D-SNPs are required to have contracts with states. States can contract with D-SNPs to provide Medicaid benefits

through capitated payments or the contracts can cover coordination of Medicaid benefits, but not capitation for those services.

The Medicaid benefits that can be included in these contracts are listed on this slide. We refer to D-SNPs as financially integrated if they receive capitated payments to cover some or all long-term care services. We estimate that there are fewer than 25 financially integrated D-SNPs, and collectively, they enroll about 65,000 dual eligibles.

Moving on now to our findings, we found that integration with Medicaid benefits is likely to occur under two scenarios which are depicted on this slide. Under the first scenario depicted, the left side of the graph, one plan, the D-SNP, covers both Medicare and Medicaid services. These plans are the financially integrated D-SNPs that I described on the previous slide.

Under the second scenario, depicted on the right side of the graphic, one managed care organization has both a Medicaid plan and a Medicare plan, and the same dual eligibles are enrolled in both plans. In this scenario, the integration occurs across the two plans. It is not

necessary for the Medicare plan to be a D-SNP under this scenario. However, the benefit of a D-SNP here is that it can limit enrollment to dual eligibles and can tailor the benefit package and supplemental benefits to those beneficiaries. We are unable to quantify how many D-SNPs fall under this arrangement.

The remaining D-SNPs are neither financially integrated nor part of a managed care organization with a companion Medicaid plan. These D-SNPs do not integrate most Medicaid benefits, but they can coordinate them. Their ability to coordinate Medicaid benefits is limited and the extent of the coordination varies by plan.

We also found that there are administrative misalignments between Medicare and Medicaid that are barriers to integration. We wanted to highlight two of them. One of those is marketing requirements. D-SNPs cannot describe the Medicare and Medicaid benefits they cover in the same place on their marketing materials.

Another barrier is that Medicare and Medicaid have separate appeals and grievances processes. These barriers, both of these barriers can be confusing and burdensome for both beneficiaries and the plans.

This slide presents policy options on D-SNPs for your consideration. The first option is to re-authorize all D-SNPs. Under this option, the Medicare program would continue to have a vehicle for managed care-based integrated care programs for dual eligibles. The drawback, though, is that all D-SNPs would continue, including those that do not improve quality, access, or integration with Medicaid.

The second option is to re-authorize two types of D-SNPs, the financially integrated D-SNPs and D-SNPs that are part of a managed care organization with a companion Medicaid plan. These are the two types of D-SNPs that have the best environment for integration between Medicare and Medicaid.

This option is consistent with the Commission's interest in encouraging integration between Medicare and Medicaid for dual eligibles. Also under this option, D-SNPs that coordinate dual eligibles' Medicaid benefits but do not integrate them would lose their authority.

The third option is for D-SNPs not to be re-authorized past 2013. This option is already current law. D-SNPs could continue as MA plans once they lose their authority. However, the plans would no longer be able to

tailor their benefits to dual eligibles, and the Medicare program would no longer have a vehicle for managed care-based integrated care programs for dual eligibles.

The fourth option is relevant if all or integrated D-SNPs are re-authorized. If this occurs, some of the administrative misalignments between Medicare and Medicaid could be alleviated. For example, integrated D-SNPs could be permitted to market the Medicare and Medicaid services they cover as a unified product. The appeals and grievances processes for Medicare and Medicaid could also be aligned.

Carlos and I have discussed the policy options for each type of SNP individually. Now I will turn to the spending and beneficiary implications of a re-authorization of any type of SNP.

With respect to spending implications, SNP authority will expire under current law and the financial implications of this are already included in the baseline. A likely assumption is that a small number of beneficiaries currently enrolled in SNPs will return to fee-for-service once SNP authority expires.

If SNPs are re-authorized and those beneficiaries remain enrolled in SNPs, Medicare spending will increase

relative to baseline spending. This is because spending on beneficiaries enrolled in MA plans, including SNPs, is generally higher than fee-for-service spending. The beneficiary impacts will vary. Some beneficiaries will remain in MA plans if SNP authority expires, while others will enroll in fee-for-service.

This slide presents additional policy options that are relevant to all SNPs. First, if the Commission recommends that any type of SNP be re-authorized, the re-authorization could occur for a limited time period, such as for three to five years. At the end of this period, SNP authority would expire unless they are made permanent by Congress.

During the extension, CMS could conduct an evaluation that compares SNPs to MA plans and fee-for-service. The evaluation could also assess whether there are any design features of SNPs that are found to be effective and should become requirements for all SNPs if they are made permanent.

The time period of three to five years would enable CMS to use MA plans encounter data in the evaluation. In addition, SNP authority could be extended and a

moratorium on new SNPs could be in place. And as Carlos previously mentioned, there was a previous moratorium on SNPs.

This slide summarizes the policy options we discussed today. It is for your reference during your discussion. This concludes the presentation and we are happy to answer your questions.

MR. HACKBARTH: Okay. Thank you very much, Christine and Carlos. Let me ask a couple of clarifying questions. Could you put up Slide 17, Christine? So you said re-authorization will all result in a small increase in program spending. How small is small?

MS. AGUIAR: So we've estimated that in one year, it would be less than $220 million. I mean, it would be less than $220 million. I don't want to give just the exact number because it is somewhat of an estimate, but it would be about $220 million in year one.

MR. HACKBARTH: Okay.

MS. AGUIAR: If they were re-authorized. And this is based on the assumption that if they were to expire, that some of the beneficiaries enrolled in SNPs would return to fee-for-service.

MR. HACKBARTH: And so, it's very sensitive to that assumption.

MS. AGUIAR: Exactly.

MR. HACKBARTH: The ones that stay in MA, it would be a wash?

MS. AGUIAR: Exactly. And so, we made somewhat of a conservative assumption of about 10 percent of all SNP enrollees would return to fee-for-service. And so, under the scenario where SNPs were allowed to expire, and so therefore the cost of those 10 percent remaining in the MA program or remaining in SNPs was about $220 million in one year.

MR. HACKBARTH: Okay. Now, put up Slide 13, please. Here I'm going to focus in on the D-SNPs for a second. So a number of years ago, three or four, MedPAC recommended that to qualify as a D-SNP you needed to have a contract with the state or needed to be integrated otherwise. It seemed like it was hardly worthy of the title of integrating dually eligible beneficiaries.

That hasn't worked exactly as we hoped it would, and I gather that, at least in part, because of issues at the state level and their willingness to contract with plans

in different ways. That's not really important for this question.

So is it true that this slide describes the universe of possibilities so that existing D-SNPs are either the fully integrated or the two plan model, or are there D-SNPs that are neither of these types?

MS. AGUIAR: Exactly. There are D-SNPs that are neither type of these. These are the D-SNPs that we found from our research where the environment is right for integration between Medicare and Medicaid in a meaningful way. So there are other D-SNPs that are not on this graph that have what are called coordination contracts.

MR. HACKBARTH: And what are the proportions, roughly? How many? You said that there are a small number that are fully integrated. How many have a two-plan model versus how many are in the third category?

MS. AGUIAR: Exactly. So what we call the financially integrated D-SNPs, we estimate there are about 25 of those. We are unable to quantify how many fall into the bucket on the right side. It is my sense, though, that the majority of D-SNPs would fall under the other category where they're mainly coordinating benefits.

Now, there are some D-SNPs that may have contracts with states that cover capitation for, let's say, cost-sharing and wrap-around services such as vision, transportation, things like that. We're not considering that to be a real true integration between Medicare and Medicaid because that's not integrating really across both the acute and the long-term care side.

MR. HACKBARTH: Okay. And last question, and I apologize for having so many, we've spent a lot of time talking now about the planned demos for dually eligible beneficiaries. I'm trying to fit that development, which of course is demonstration work, it doesn't entail a change in the core statute governing SNPs, but I'm trying to fit -- understand how that development fits with the existing statutory structure for D-SNPs.

And so, there's a fair amount of interest among the states in doing this, and within this framework, I think they're talking about fully integrated SNPs, you know, bring the Medicare and Medicaid dollars together in a single organization, integrated accountability, et cetera. What happens to these D-SNPs in states that are moving aggressively to demonstration projects on dually eligible

beneficiaries?

MS. AGUIAR: So I think the answer to that will vary by state. I think in some states the financially integrated D-SNPs, for example, where you already have that one plan that has both the acute and the long-term care side, some of those may actually convert into demo plans. Again, that hasn't been completely set yet, but I think that is the road that some states are taking.

In Massachusetts, for example, that has come out with a memorandum of understanding with CMS, the way that that is working is that they already have the SCO Program which is a financially integrated D-SNP that's for beneficiaries age 65 and older, and their demonstration is for the dual eligibles that are under the age of 65. So in that scenario, you will still have those financially integrated D-SNPs operating alongside these demonstration plans. So it'll vary by state, but I think in some states, again, I do think some of these D-SNPs may be converted into demonstration plans, and others they may work alongside.

What we have heard from D-SNPs that are not one of these types, that have more of these coordination agreements, or they may, you know, have capitated

arrangements for some cost sharing and wrap-around services, is that there is interest in the state in having them continue because -- as an option for beneficiaries, were beneficiaries to opt out of the demonstration. So this way, the only option left that beneficiary is not either fee-for-service or a non-specialized MA plan.

MR. HACKBARTH: Okay. Thank you. Scott will lead off clarifying questions.

MR. ARMSTRONG: You may speak to this and I missed it, but I'm wondering about the stability of the plans, the SNP plans, and whether we're seeing much turnover. I see we've got an analysis of the number of enrollees in the different types of SNPs. Do you have a feel for that?

MS. AGUIAR: I'll speak to one instance where we do know that there was turnover, and there was a program in Minnesota, so Minnesota does have -- we classify some of those plans as financially integrated, and that is for their over-65 eligibility population. That program is still ongoing.

There was a program that Minnesota tried to -- you know, did implement that was for the under-65 duals, and there were SNPs that did pull out of that program. And we

have spoken with them to try to get a sense of sort of what happened, and my best understanding of that is that the under-65 duals, which in this case we're talking about beneficiaries with severe mental illnesses, with developmental disabilities, that they are very high need, they require very high care management costs. Sometimes there's an issue with compliance. And there was a question of whether or not they could financially be able to continue to serve that population under the SNP rates that they were getting. So some SNPs pulled out of that market. Carlos will be able to describe more broadly across SNPs.

MR. ZARABOZO: I'm just going to mention that in the case of the C-SNPs their regional plan, there has been a n increase in availability because -- it went from 44 percent to 56 percent because one organization is expanding to new states and adding another disease category, chronic lung disorders. So there's an expansion there.

MR. ARMSTRONG: I have very little experience, but I can imagine one issue would be that, particularly as we're thinking about a reauthorization of this, whether these SNP plans have been able to grow to a size that allows them to cover their risk and assure a kind of sustainability over

the course of time. Maybe the related question then would be: Do we have any information about the financial performance of the plans that are offering these SNPs?

MR. ZARABOZO: We're developing something [off microphone] --

[Laughter.]

MR. ARMSTRONG: Was that his calculator?

DR. MARK MILLER: We did go through some of the biddings, though. Right?

MR. ZARABOZO: The bidding, yes. But in terms of the financial stability and related to -- I mean, other than what we know about the bidding and where they are in relation to fee-for-service Medicare, we can look into that, but --

MR. ARMSTRONG: Okay. Thank you.

DR. MARK MILLER: Carlos, didn't we go through some of the information on how they bid relative to fee-for-service?

MR. ZARABOZO: Yes.

DR. MARK MILLER: And the answer to that is?

MR. ZARABOZO: The answer is they are at --

MS. AGUIAR: They bid higher. C-SNPs, I-SNPs, and

D-SNPs bid higher relative to fee-for-service.

MR. ZARABOZO: C-SNPs bid lower.

MS. AGUIAR: I'm sorry. C-SNPs bid lower. You're right, yes.

MR. KUHN: A couple questions here. One, on the quality bonus that's currently available for MA plans, is that also -- are SNPs also eligible for that quality bonus?

MS. AGUIAR: Yes, I do believe that SNPs are eligible for the quality bonus, but I believe you have to be three and a half stars or greater.

MR. ZARABOZO: Three or greater. The quality bonuses are done at the contract level. So the issue I mentioned that some SNPs are under a larger contract, all of the bonuses are determined at the quality level. And SNP factors are part of the basis for determining where the plans are in the star ratings.

MR. KUHN: Okay. So I guess maybe another way to think this through for me, are any SNPs receiving quality bonuses right now, or are those --

MR. ZARABOZO: Yes, those plans that I mentioned, for example, that are the four-star, four-and-a-half-star plans, are getting quality -- anybody with three and above

is getting a bonus, yes.

MR. KUHN: And second question is the barriers that you mentioned, Christine, in the presentation and also in the paper. Two of them in particular, one about the marketing and the other on the appeals process, are those statutory or are those regulatory barriers that currently exist?

MS. AGUIAR: I believe that those are regulatory barriers, and I say that because in the CMS demonstrations with the states, they are intending to try to address that, not having to do that through legislation. But let me get back to you about that just to confirm.

MR. KUHN: And then, finally, a little bit on the data on the measures and the overall performance of the SNP plans, and I guess the granularity of the measures. So if I've got this right, you know, it wasn't too long ago that percentage-wise the largest growing part of the Medicare population were those over age 85. Now it looks like it's the between age 65 and 70 because of the high influx of baby boomers aging into the program.

So on the various performance measures that are out there, whether it's for diabetes or all the things that

they're looking at, can we stratify whether the interventions are more effective for the younger Medicare population versus the older, or do we know that? And, I guess, how robust are the measures? Are we just going to need more measures in order to understand that better?

MR. ZARABOZO: Well, one thing about the measures is that many of them are for certain age categories. For example, the measures for diabetics are for diabetics between -- that are in the HEDIS measures, diabetics 18 to 75. So after age 75, because there's apparently no standard way of treating diabetics, there's not a measure that people can agree on for that group, there has been a push to get more measures for the older population, which many of the measures now, for example, the fall risk management, discussing fall risk, treatment of urinary incontinence, discussing physical activity in older adults, osteoporosis management, there are several, they are moving towards more measures towards the very old. For the very young, there still need to be more measures, particularly on mental health measures. But within the measures, it's a little bit difficult to do, to look at it and say that diabetics 18 to 75, if you want to look at the 20 to 25, that's a big

problematic because a lot of those measures are done based on a sample of medical records. So you're dealing with 411 people, and it's hard to then say below that level, within that what do you want to look at.

MR. KUHN: And how about for the disabled? How is the level of measures there? Are they sufficient or insufficient? Or is there additional --

MR. ZARABOZO: I think we think that more measures are needed for the disabled under 65.

MR. KUHN: Thank you.

DR. NAYLOR: So Slide 15, on option two and bullet one, so the idea that reauthorizing the integrated D-SNPs, it's 65,000 is in that first category. How many more in those with the companion Medicaid?

MS. AGUIAR: So that was the same group that Glenn has asked about, where unfortunately we are not able to quantify how many fall --

DR. NAYLOR: Great. Okay. [off microphone]. So I'm paying close attention.

[Laughter.]

DR. NAYLOR: On 18, I wanted to -- no, I'm sorry, maybe before, but I was wondering if -- I know that the

measures application partnership work group on dual eligibles is working on these quality measures, and I'm wondering how the timing of their efforts might align with your capacity --

MR. ZARABOZO: Yeah, we are trying to talk to CMS to see what their perception is of how long will this take, and we haven't yet talked to them about that, but we're looking to talk to them when we can expect the measures.

DR. NAYLOR: Let me ask one more, maybe, unless Glenn has already asked it. Twenty-five of 300-some plans, 22, are financially integrated. Your sense on -- thank you for an excellent report -- why so few.

MS. AGUIAR: Why so few? Well, I think it's a few reasons, and I think this was more fleshed out in the mailing materials than we could in the presentation, but when the D-SNPs first came about, you know, a lot of the rationale behind that was to take some of the existing Medicare-Medicaid demonstrations -- some people call them the "Medi-Medi demos" -- that existed in Wisconsin and Massachusetts and Minnesota, and to try to turn them into somewhat of a permanent status. And so there you have, you know, three programs with multiple plans. And then there

were some other ones, some other states that sort of saw this as an opportunity. There were some states that sort of wanted to both, you know, move towards moving their long-term care services, perhaps not all their behavioral health services, into Medicaid managed care plans, and then saw the opportunity to try to link that with Medicare through these programs. So that's why there are so few.

There are just many reasons why states are perhaps not able to or would rather just not coordinate with SNPs to capitate the long-term services. Maybe some of the behavioral health services that would get those plans to be the financially integrated, and I think that's why there are so few.

The question sort of now on the table is how will the states' interest in using the SNP as a vehicle for integrated care continue given that there are these demonstrations, because far more states have sort of become interested in that, at least about 25, 26, than have really become interested in using -- that were interested in using the SNPs as that vehicle for integrated care.

DR. COOMBS: Thank you very much. I'm glad you mentioned Massachusetts.

One of the things I noticed in the appendix on Table A5, there's this trend of, you know, the best -- say the poster child for performance, and I noticed that, you know, they're the same ones who actually applied for the part one of the demonstration project, and I've actually spoken with some of the people involved in the Massachusetts demonstration, and one of the things I was looking at and comparing is just the amount of resources that are available and what percentage of these states that are here actually have Medicaid waivers as well in terms of them being able to be innovative. I know that was really important because, you know, we have 98 percent coverage in Massachusetts in terms of insured or covered in some fashion and that they wanted to look to see how they could bring down costs, specifically with the dual eligibles, and do innovative things with both sides of, you know, the LTCHs and then being able to manage outpatient diseases as well.

So I was wondering specifically, have those states had the level of investment to look into Medicaid waivers? You know, I don't see Mississippi or any of the Southern crescent region where we talked about some of the poor performance.

MS. AGUIAR: I just want to make sure I understand. So is the question how many of these states are pursuing the demonstrations with CMS?

DR. COOMBS: No, just in terms of having simultaneous waivers to go along with their score. Did you see any trends with their score?

MS. AGUIAR: Oh, I see. With whether or not they have Medicaid waivers.

DR. COOMBS: Yes.

MS. AGUIAR: You know, I think we could work on pulling that. We don't have yet in-house whether or not they have the waivers, but I believe we should be able to find that fairly quickly.

DR. COOMBS: Thanks.

MR. ZARABOZO: The other point about these states -- and for the benefit of the audience, these are the states that were on the slide, which is Massachusetts, Minnesota, Wisconsin, and also California. Many of these plans are very longstanding plans that have been operating for a long, long time, specializing in duals.

MS. AGUIAR: And can I just ask Alice just to make sure, are you interested in any waivers, or waivers

specifically on like long-term care and home and community-based services or for the dual population in general?

DR. COOMBS: The dual population.

MS. AGUIAR: Got it.

MR. BUTLER: There are about 1.5 million members in these collective plans, and that number has changed which way over time?

MR. ZARABOZO: I think up over time.

MR. BUTLER: But a lot of growth or --

MR. ZARABOZO: I can't answer that off the top of my head. I think about the same rate, and maybe higher. I'm looking at Scott. Perhaps higher than the general trend.

MR. BUTLER: Okay. And the geography is a little strange, with Puerto Rico and then relatively few states, and then almost all of these are in the HMO style Medicare, MA plan. What about ownership of these? Are these in publicly traded for-profit health plans that we know about, or are some of them -- is there something different about the sponsorship in these that would be significantly different than the rest of the MA population?

MR. ZARABOZO: Well, you have two groups. You do

have publicly -- like UnitedHealth is involved in the I-SNPS. They are the people that was Excel Health, and that's the regional C-SNPs. AmeriGroup, Health Spring, which was purchased by --

STAFF: Cigna.

MR. ZARABOZO: Cigna, thank you. But at the same time, you have, for example, the Minnesota plans that are smaller plans. In California, you have the county-based plans that are SNP plans. So it's quite variable. You have both extremes in terms of what kind of plans we're talking about.

MR. BUTLER: But no systematic pattern that says something different about these enrollees and their sponsors than other MA plans?

MR. ZARABOZO: Well, I would say the ones that have been operating a long time, I mean the ones that were the demos, the Minnesota and Massachusetts were nonprofit plans, relatively small plans. But we can look into -- we can sort of do a distribution, if you'd like.

MR. BUTLER: I'm just trying to get at motives and likelihood of responses and a number of -- I'm just trying to understand the landscape of --

MS. AGUIAR: I would just add -- and I don't know if this is -- I don't believe we brought this up last April when we were discussing the demonstration programs with CMS between the states -- that there has been some more consolidation among both the -- in the insurance market for the plans that -- between the plans that focus more on MA and those that focus more on Medicaid managed care. And our understanding is that part of that was in response to these demonstrations and the response to a perception out there that the duals is really sort of the next great population that will be perhaps moved more heavily into managed care that is going to be continuing of the focus of it. So there has been quite a bit of both interest from plans in participating in these demonstrations, even though there has been concern about whether -- that the rates might be lower than they would get if they were just MA plans. And there also has been some consolidation about that, around that, too.

MR. ZARABOZO: And one point that we may have mentioned is the duals can enroll month to month. Every month they can go in and out of fee-for-service and MA plans. It was the D-SNP that was attractive for that reason

to a variety types of organizations so that outside of the October to December open enrollment you can be enrolling people in your plan.

DR. SAMITT: On Slide 9, I guess my question is less about the SNPs and more about the general MA plans. What is the sentiment by the general MA plans about whether they have an interest in facilitating offerings of I-SNP and C-SNP? Because that's certainly an option, is that -- is there desire there, or is there no comment or no interest?

MR. ZARABOZO: Well, many of the I-SNPs are United. The Evercare plans are United. Whether -- we have not talked to them about how would you integrate -- is it possible to integrate the I-SNP into a general MA plan? For the C-SNP situation, to do a benefit package that is, say, only for diabetics, it would require a different approach to bidding which says yes, for some people you can have a different benefit package than for other people. So that would be an issue to look at.

DR. BAICKER: Can you give me a better sense of what some of the barriers are to achieving the benefits that were hoped for from, say, improved coordination for these complicated patients or coordination across the duals in a

regular MA plan? I know that, you know, if one were to go the route of letting these expire but trying to free up some of those regulatory issues, what would they be? And is the selective enrollment of the targeted populations a necessary component of that strategy?

MS. AGUIAR: So we did -- again, as Carlos mentioned, we spoke with managed care plans that offered regular MA plans and D-SNPs, and most of that was really sort of to try to get at this. You know, do you need the D-SNP product in order for them to be able to do what they do? You know, what we found out is that the benefit is that the D-SNP benefit package can be tailored to their population, and a regular MA plan wouldn't be able to do that. We were given some examples of, you know, being able to offer assisted devices for plans that really focus heavily on maybe some of the more disabled beneficiaries that need those services. So a regular MA plan I think would be -- it's not that we think that they wouldn't be able to serve them. It's that they wouldn't have that benefit of being able to tailor their benefit package or of their supplemental benefits. And then I think that they would also have the same limitation that the D-SNPs that have

coordination agreements with the states have, which is they are able to sort of assess these beneficiaries for the Medicaid services and refer them to those services. But since they don't have responsibility for them, there's always going to be that limitation into how much they really can truly integrate those benefits. But as Carlos mentioned, there's quite a large number of duals in MA plans currently.

DR. BAICKER: Just to make sure I understand, suppose you have a particular set of benefits that's attractive to -- or that's intended to be targeted at somebody with a chronic condition, and you say if you have this condition, you get this benefit, you could still do that if you let all enrollees come, and people who don't have that condition wouldn't be participating in that aspect of the benefit. So what's the additional type of tailoring that's not possible under that kind of structure? Or am I missing some -- what am I missing?

MR. ZARABOZO: Well, you could not say, for example, cost sharing for diabetics is different from cost sharing for non -- you cannot say that currently. That would require a change in the approach.

MS. AGUIAR: And I would just refer to this -- we could expand upon this if you would like to. In the mailing materials what we referred to the GAO report that did look at the supplemental benefits, and they said -- you know, they did notice that while the D-SNPs tend to offer fewer supplemental benefits, they were more comprehensive. And, you know, sort of looking at that, you could really sort of see, you know, a general MA plan may find it valuable to the beneficiaries to offer like gym memberships and some things that are valuable to a non-dual eligible; whereas, the D-SNPs would tend to be focusing a little bit more on the specific population.

DR. BAICKER: And you can't say if you're diabetic, one of your benefits is a gym membership, but if you're not it's not. That's not possible.

MS. UCCELLO: So in a sense, this is getting at a VBID approach, but it's doing it by separating the populations and designing the benefit packages appropriately.

We're focusing a lot on D-SNPs, for good reason, but I was puzzled at why enrollment in the C-SNPs is so low considering the high number of people who must have chronic

conditions. And is it because, you know, plans aren't available, they're not aware of plans, they're not interested in those plans? You know, what's going on?

MR. ZARABOZO: Well, I think the issue is that you can also be in a general MA plan and get the same. I mean, it's not -- part of it also is the availability is not as great as general MA plans.

MS. UCCELLO: And if there are -- if they're going to an general, a regular MA plan, then are those kind of benefit design issues not really -- I don't know -- all that valuable?

MR. ZARABOZO: It probably depends on what the benefit package of a general MA plan looks like. For example, if they have very low cost sharing in general for everybody, then, you know, not too much of a difference between one and the other.

DR. HOADLEY: These are some really interesting questions, and it's a good paper with a lot of provocative information. A couple of my questions have already been dealt with, like the sponsorship question. I'm glad you could talk about that.

The one I'll raise came up in connection with your

issue of cross-subsidy between the state and Medicare. Is it true that all the supplemental benefits have to be paid through rebate dollars? Or can these SNPs also go into premium dollars? And if so, who's paying the premium?

MR. ZARABOZO: They can go into premium dollars, and the state can pay the premium if the state wants to pay the premium, yes.

DR. HOADLEY: But not automatically.

MR. ZARABOZO: Not automatically. You would have to -- yeah.

DR. HOADLEY: Do you know how much -- to what extent supplemental benefits are being paid by which route at this point?

MR. ZARABOZO: I don't think we know that. I do know that Alabama, for example, will pay the Medicare Advantage premium for duals to join a Medicare Advantage plan. I'm not sure what the -- but that was one of the states that -- because there is a specific provision that says you may do this, you may enroll these people and pay the premium on their behalf, if there is a premium.

DR. HOADLEY: And what about the question of how much of the supplemental benefits are being done on the

rebate side versus premium side? I know that's hard to calculate, at best.

MR. ZARABOZO: Yeah, I have a feeling that right now it's mostly the rebate side, much less of an arrangement with the state that says, yes, you pay us, we will provide these benefits.

DR. HOADLEY: Thank you.

DR. DEAN: What is the logic about the prohibition of marketing the combined benefits?

MS. AGUIAR: My understanding of it is I think it was more -- so, for example, we looked at the document that details how the marketing materials have to look like, and the way that they're set up is for any SNP. They describe their Medicare benefits in one section and then the Medicaid benefits that the beneficiary is entitled to in a separate section. So if you have a SNP that's not actually covering Medicaid benefits, that's fine. They see what they'll get from the SNP, and the Medicare benefits there are in a different section than the Medicaid. But when you have a SNP that's combining both, they are not allowed to in the same place say this is actually a package that you could get from us combined, from that SNP combined.

And so I think it was -- my understanding is it's more just sort of the way that the marketing materials were developed and less as a prohibition per se. And it's just a limitation for those plans that are actually covering both sets of the Medicare and Medicaid, they can't market it as a joint product.

DR. DEAN: Okay. Another question. And the payment for MA has always been confusing, but for those states that do not have a contract with Medicaid, how does Medicaid pay for this particular plan? Is it fee-for-service or -- I guess I don't understand, if there isn't a specific agreement, how do they do that?

MS. AGUIAR: Right. So at this point, all D-SNPs, in order for them to continue as D-SNPs, have to have a contract with the state.

DR. DEAN: Okay [off microphone].

MS. AGUIAR: The variation is what that contract actually covers, and so it is less likely to cover capitation for that -- the state to give capitated payments to that D-SNP to cover long-term care, behavioral health services, maybe a little bit more likely for them to cover some wrap-around benefits and cost sharing. And then there

are some contracts that really are more sort of an agreement to coordinate across the two benefits, but there's no capitation of services involved.

DR. DEAN: There has to be a contract, but there's no definition about what the contract has to require. Is that --

MS. AGUIAR: No, and there has been some attempt to put a little bit more specificity around what that contract should look like. But sort of there's -- I think neither Congress nor CMS has or perhaps is able to tell the states, you know, you have to contract with these plans for capitated services.

MR. ZARABOZO: Was your question how providers might be paid for services rendered?

DR. DEAN: How the plan [off microphone].

MR. ZARABOZO: Okay.

DR. REDBERG: Thanks. So I wanted to explore the C-SNPs a little bit more because I read this morning that 80 percent of Medicare spending is for the 20 percent of beneficiaries with chronic diseases. So I would like to just -- if you had a better feeling for why these plans didn't perform as well, and also, was there any

differentiation, because there were a lot of different chronic conditions, congestive heart failure and diabetes and dementia and HIV? Were there C-SNPs for all of those and did they all perform at the same level, or were there some that seemed more successful because there's potential.

MR. ZARABOZO: Yeah. There is a big difference in the C-SNP performance indicators between the regional plans. We mentioned a couple times that the C-SNPs that are HMOs perform actually pretty well, and in particular, a couple of organizations do very well on many of the measures.

DR. REDBERG: [Off microphone] -- SNPs for all of those conditions?

MR. ZARABOZO: C-SNPs, there are 15 conditions that they are permitted to offer and then they can do a combination for five more, and then they can do their own, you know, an approved combination of various. Not all permitted conditions are covered. For example, alcohol and drug dependency is one, but there is nobody offering that. Stroke is another one that's available but nobody is offering that. End stage liver disease is another one.

DR. REDBERG: What were the more popular chronic diseases that were offered?

MR. ZARABOZO: Diabetes, congestive heart failure, COPD, lung disorders.

MR. HACKBARTH: Bill, can I just pick up on Rita's question just for a second? So one of the statistics we all hear a lot is what percentage of Medicare spending goes to patients with chronic illness. And in particular, what high percentage goes to patients with multiple chronic illnesses. And so, I just wanted to pick up on what Carlos was just saying. I've had, probably inaccurately, this notion in my head that each of the C-SNPs was specialized in a particular disease, which has always been sort of jarring with me because often the patients come not with one chronic disease, but two or three or four or five.

I thought I heard you say, Carlos, that, in fact, plans, C-SNPs offer combinations of diseases. Did I hear that correctly?

MR. ZARABOZO: Yes, they can offer a combination of diseases, but when they do that, the person has to have at least one. So, for example, they can do diabetes and congestive heart failure. So somebody with CHF can join that plan, somebody with diabetes can join that plan. You don't have to have both conditions to join the plan.

MR. HACKBARTH: Okay. Bill?

DR. HALL: Kind of like a Chinese menu.

MR. HACKBARTH: Right.

DR. HALL: Help me understand how it would work if we allowed the legislation to expire and current D-SNP people are told that you can join the regular MA plan. Most of them, by the time they're in that plan, have kind of special needs. They're not like the large number of people in the MA plans. Would they suddenly have to start paying premiums, or do you think this would be a no-premium insurance product?

MR. ZARABOZO: It depends on the -- sorry about that. It depends on the area. For example, many areas of the country have always had very low premium plans, zero premium plans, rich benefit packages. So there are areas where premiums had been charged historically, and so it's possible that people would -- that what is left is a situation where the plan has to charge a premium, which potentially means -- unless the state is willing to pay the premium for these people, then that may be a problem.

DR. HALL: So I guess to sort of drop this down a little bit more, D-SNPs and variants of D-SNPs like Unlock,

the PACE programs, are very much a work in progress, it seems to me. There are tremendous administrative barriers even in the best of circumstances to coordinate all of the benefits from two paying agencies, or sometimes even more than that.

The benefits that -- the innovative benefits that are offered are often somewhat unconventional. Not many MA enrollees, for example, think of getting bused to a day care center as a benefit that they wish to pay for. They'd much rather go to a health fair or something.

But I think ultimately, some form of this is going to become an important component of the health care system for Medicare patients. I'm not sure what it's going to be called. Of course, we have to hold the D-SNPs to the same quality standards, but I guess I like the option -- maybe I'll leave this for Round 2 -- but I think there are some -- let me just say this.

I think to abandon the program now and turn it over to kind of an optional plan that doesn't have more coordination might be a mistake in the long run. And so, I guess the options of allowing a temporary period here for better quality measurements kind of appeals to me, but I'll

maybe talk more about that later.

MR. GEORGE MILLER: Yes. Fascinating reading and thought you all did an excellent job. Thank you very much for this material. One of my questions, and I've got two first round questions, deals with quality outcome data and its impact on other providers' data. For example, is there any indication that the SNPs have had, because of SNPs or a coordinated plan, has had an impact on hospital data like readmission rates?

And without the SNP for that population of patients, the example I used was readmission rates, would have been higher or different or has it made a difference? Is there any studies to look at a coordination of how a totally integrated plan would work because of the SNP being available?

MR. ZARABOZO: Well, we did look. That does happen to be a measure that is collected, the readmission rates, and as noted in the material, the I-SNPs in particular perform very well on the readmission rates.

MR. GEORGE MILLER: Okay.

MR. ZARABOZO: Some C-SNPs also and some D-SNPs also, but there's a lot of variation, again, in the plans.

MR. GEORGE MILLER: But to follow Bill's point then, if we let the authorization expire and there would not be any C-SNPs -- be any SNPs -- then it could have an impact on downstream quality measures or readmission rates in COPD. Is that fair?

MR. ZARABOZO: Well, if, for example, this -- let's say everybody continued in a general MA plan and the general MA plan performed as well as the SNP plan did for the people that were already enrolled in that plan, then you would presume that they will perform -- or would hope that they would perform just as well for these populations.

MR. GEORGE MILLER: Okay. Well, then a follow up then. What we heard reported on the PACE program, it seems that that population did a much better job of coordinating care because they could uphold the benefits of both Medicare and Medicaid and use resources -- use their resources for things that are not covered and expand it.

So I guess as we evaluate this, one of my questions would be, what value do we put on coordination of care, case management, social service and those things as we evaluate this program outside of the quality outcome measures that we're talking about.

DR. MARK MILLER: See, I think the difficulty in answering the question is this kind of -- you're asking the counter-factual, like if we let this go, then shouldn't we anticipate some impact? And I think why we're stymied in answering the question is, is the one fact point that we can see in the quality data so far, and particularly as it relates to readmissions, which is what motivate -- or part of your question --

MR. GEORGE MILLER: Yeah, yeah.

DR. MARK MILLER: -- the I-SNPs seem to have some evidence of that.

MR. GEORGE MILLER: Some?

DR. MARK MILLER: Right. Everywhere else -- and again, there's all kinds of arguments, it's not the right measures, you haven't got -- but so far, it doesn't seem that the SNPs more broadly distinguish themselves from MA. So I think what Carlos is saying -- we'll see -- was that one, you know, hypothesis is, something is going on here and there's good things happening, but we can't measure it yet.

And by the way, that's what a lot of people are arguing why you need the demonstration, is because somebody needs to examine evidence and see what's going on. And we

have all kinds of issues there, but just let's pretend and move past that for a minute.

The other thing that I think Carlos is saying is, is one of the likely things to happen if this goes away is that the person drops into MA, and his point is, is if MA performs as well as the SNP did for these particular populations, then you may be worse off. But then, of course, there's the whole sets of issues that we've talked about, is how much flexibility does MA have to go in and tailor those programs, and that's yet another unknown.

MR. HACKBARTH: So on the performance issue, if Mike were still here, I think one thing -- an observation that he would make is that we're trying to compare two categories, the regular MA plan and the SNPs.

DR. MARK MILLER: Right.

MR. HACKBARTH: And within each of those categories, there's lot of variation in performance. There's some outstanding performers and some poor performers. And so, we're looking at averages around which there's a lot of variation. And so, in all likelihood, there's probably more overlap in performance than the averages -- looking at the averages from up high.

MR. GEORGE MILLER: Well, to that point --

MR. HACKBARTH: So it makes it difficult to assess how much are we losing if this goes away.

MR. GEORGE MILLER: No, no, that's a very good point. And the last part of my question is, have you noticed if there are -- do we see the same variation across MA -- excuse me -- across SNP plans that we've seen in other areas that we've studied with regional variation as far as the quality outcomes are concerned?

MR. ZARABOZO: There's a lot of regional variation, but within a region, there's variation among plans.

MR. GEORGE MILLER: Okay. And still a problem.

MR. HACKBARTH: So let me try to nail down a couple other points. Bill, in his comment, talked about some non-SNP plans like PACE organizations that care for, you know, potentially overlapping populations, and one of their distinctive characteristic is that they combine medical and social services.

My recollection is that for the special needs plans and other MA plans, there are restrictions on our ability to use Medicare dollars for non-medical services.

Am I correct?

MR. ZARABOZO: That's correct, yes. There's a little bit of leeway for the fully integrated dual eligible SNP plans to use those dollars, but very limited.

MR. HACKBARTH: Okay. So I just wanted to make sure of that. A second clarification I need, so what I hear is that there are two principle differences between being a SNP and being a regular MA plan. You're paid the same, but there are different enrollment rules and there are different rules about how you can structure your benefit package.

On the enrollment side, what I understand to be the differences is that there's continuous open enrollment. It doesn't just happen once a year. It can happen month by month. And plans can also establish limits, capacity-type limits on their enrollment. Are those the basic enrollment rule differences?

MR. ZARABOZO: The open enrollment for duals and other low-income people applies to any MA plan, so the D-SNPs. But the thing about D-SNPs is they have a benefit package that is tailored for these people, and therefore, presumably duals would be more attracted to that kind of plan. But there are 900,000 duals in regular MA plans,

however. Those are not --

MR. HACKBARTH: Yeah. So the C-SNPs, there, there is continuous open enrollment, but not for Medicare Advantage plan people that have chronic illnesses?

MR. ZARABOZO: The C-SNP situation is that if you have one of the conditions, you may enroll at any time. You have an open enrollment opportunity if you have a condition to enroll in the C-SNP. But it's a one-time opportunity only. So you can --

MR. HACKBARTH: A one-time opportunity?

MR. ZARABOZO: Yes. You can enroll in July outside of the open because you're a diabetic, you go to the C-SNP, you're enrolling in July. You have -- that's your end of any open enrollment.

MR. HACKBARTH: Okay.

DR. MARK MILLER: Can you dis-enroll?

MR. ZARABOZO: No, you have to wait for the --

DR. MARK MILLER: You're locked in?

MR. ZARABOZO: You're locked in. You have to wait for the open enrollment period to change.

DR. MARK MILLER: And the same rules for the I-SNP?

MR. ZARABOZO: The I-SNP, no. Institutionalized people can enroll on a month-to-month basis.

MR. HACKBARTH: So what I'm trying to get at in these questions is, how much of an advantage is there, in fact, conferred by these special rules? Do we know about how many people, for example, diabetics, enroll off-cycle, take advantage of that feature? Do we know anything about how much benefit is derived from these special rules?

MR. ZARABOZO: We don't know that, but I think we can find that out. I mean, it is an interesting question, how many people are enrolling under the special enrollment provision. So we can attempt to find that out.

MR. HACKBARTH: And then on the benefits side, I like the way Cori characterized it. It's sort of like, Well, want to have VBID sort of flexibility, and the way we're choosing to do that is by creating a whole new type of plan as opposed to giving more flexibility to standard Medicare Advantage plans. It seems like a rather kludgey, awkward approach to achieving a desirable goal.

Why don't we just offer Medicare Advantage plans more flexibility to do value-based insurance design?

MR. ZARABOZO: I assume that's a rhetorical

question.

[Laughter.]

MR. HACKBARTH: Yes.

MR. ZARABOZO: I'd like to use that language, you know.

MR. HACKBARTH: Okay, Scott?

MR. ARMSTRONG: Okay. So to be frank, I'm not exactly sure what the question is that I'm answering here except to comment on the policy options that have been laid out, in that I guess what I would just tell you is that I don't have much advice for you that would improve on or change the approach that you're describing taking, but I know what you were hoping for was some limitation on a really broad range of questions that you plan to answer and I'm having difficulty sort of narrowing the scope. I have to be frank.

I'm an advocate for MA, Medicare Advantage plans and SNPs seem to be a great vehicle for expanding our experience and expanding the benefits of these plans to beneficiaries in the Medicare program, but we've just described a whole series of real issues that are kind of confounding and it's difficult to know.

I have to disclose my own experiences that I run a big Medicare Advantage plan, but I have also been running a C-SNP that has top, top quality scores that we will be closing January 1st because we've decided, for a variety of different reasons, but we've decided that really through our MA plans, we are better able to serve the patients' needs and the benefit flexibility doesn't outweigh other issues, in particular, the risk of very small enrollment in some real extraordinarily expensive patients.

And so, I'm confounded. I wish -- I like the idea of SNPs. The other point I would make is that D-SNPs seem to be a very different thing from a policy point of view than the rest and maybe we need to just declare that and we'll kind of approach these questions about what our recommendations might be for D-SNPs separate from all this other stuff.

So I regret the fact that I can't offer more kind of a focus to the ongoing work, but generally speaking, I think they're exactly the right questions we should be asking.

MR. GRADISON: I'm pretty sure -- I'm pretty close to what Scott just said. Conceptually, I think of these

plans as true demonstrations or experiments not intended to be permanent, but to inform MA plans and others how they can better serve these populations without necessarily having them in separate categories.

I worry sometimes, too, about whether there are folks that may have very similar chronic illnesses, for example, as the ones that are in the C-SNPs but aren't in them. I mean, they develop these things, but choose just to stay under the regular plans. It's almost like the MA plans are running two different tracks with these people with very similar, maybe even identical, needs and conditions.

So I'm certainly open to recommendations on this, but I do think it would be well to think of this as a transition towards folding these into the general MA arrangements.

DR. NAYLOR: I, first of all, think that this is a really important time to pause and learn all that you can and we can from what's going on with SNP, the kind of lessons that came, advance the demos and so on, and I don't think that these realize the expectations, at least as the data would suggest. PACE is a clinically and financially integrated program. And so, the fact that so few of these

are that is something that I think we need to focus on.

That said, I think, you know, the care coordination component which you describe which has already been a part of the care management of those that are enrolled in especially the D-SNPs, but I assume all SNPs, is something that I am concerned about moving or transitioning those individuals from.

And so, what I think I would lean toward at this point is on the D-SNPs, a time limited re-authorization that gives us a chance to learn from demos, that gives us a chance to learn what those groups that are really looking at quality measures for dual eligibles are doing, and at the same point, I would not be -- I think that we would not transition the people that are on the current programs to something else until we know what the something else is, better.

DR. MARK MILLER: Just for one second, in case this helps you, because I realize there was a lot of things put up and, you know, we even had a summary slide at the end trying to say there's all this. So maybe this will help you. Okay? And if not, I apologize.

You know, you could think about this a couple of -

- in a broad, couple of broad stroke ways. There's not a lot of evidence to Glenn's point. There's so much variation between MA and SNPs that may -- and, you know, the money involved is not insignificant, but it's not large, that maybe you say, they go on because maybe there's still something to be learned here and maybe the Commission says, Not a lot to say, but, you know, let them go on either time limited, whatever the case may be.

Another area you could be thinking about, and this is not mutually exclusive with the third thing I'm going to say, is you could trigger this question of VBID inside or VBID outside, and should we be thinking about MA and the flexibility with inside MA to tailor to specific populations? That could be another path to go down.

The third way to organize information is to say, Okay, well, maybe they do continue, but you try and get some narrowing of focus on them. So on I-SNPs, to George's point, there is some evidence here, so maybe there's something going on there.

For D-SNPs, there is another policy consideration. It brings together these Medicare and Medicaid integration that we kind of like and maybe we could talk a bit about

what integration means and say, You can let them go forward if they at least do -- and we figure out how to fill in the blank.

C-SNPs, we would admit and it seems is the hardest to track on. One thought there in terms of narrowing is, is the list of diseases. You know, these are diseases that are so generalized throughout the rest of the MA population, and I can handle them in my own plan anyway, maybe there's not a lot of distinction there and it's more an issue of, well, for ESRD or AIDS or something where you have a clear population that's driven very hard by their condition, not unlike the I-SNP situation, you say, Okay, we go forward on that basis.

So one more time and quick, but there's not enough information here. You just let them go. Two, we focus on MA and we think about the rules of the road in there or within the three categories, is there some way to narrow some of the things that are going on. That's at least the way I kind of organized it in my head.

DR. NAYLOR: It sounds like a path to integration. I mean, we also have people that may leave this to go to fee-for-service. So it's not -- I mean, we don't know what

decisions will be made. So I think, thinking about a path that a program is responsible for people over time, and their needs change over time, whatever path we have that gets to that I think makes sense.

MR. HACKBARTH: Alice?

DR. COOMBS: Mark, that was very helpful.

DR. MARK MILLER: I don't see how, but okay.

[Laughter.]

DR. COOMBS: So as I mentioned before, I'm listening to the discussion and what I want to walk away with is some kind of pro/con analysis of what this big picture means. If he could package it for me, put it on a plate, and deliver it, it would help out tremendously.

I do think, after hearing the discussion, you really have to treat each one and tailor some of the recommendations to the D-SNPs, the C-SNPs, and I-SNPs differently. It's actually based some of the demands and requirements for each one of them. I think they're characteristically different enough that they require a different kind of solution. So that's what I would recommend.

MR. BUTLER: So having read and listened, I would

lean towards letting it expire like current law, although I'm open to something gentler. But if I were to flip it the other way and said, All we have are MA plans, what would you do in addition? Would you do I-SNP? Would you -- which one of these would you start up now if we didn't already have them? And I'm not sure I would start one of them up, which is another way of looking at it.

So are we hanging on because we're looking for a glide path to combining or are we pretty darn sure that, you know, if you started over again you would put one of these in place? And I'm not convinced you would.

MR. HACKBARTH: Okay. So let me just push on that using Mark's framework a little bit. And you would say that even about the dually eligible SNPs, which they have this unique characteristic of trying to bring together people that are covered under two separate insurance programs?

MR. BUTLER: But not convincingly, even in my own mind. So I'm not putting a big stake in the ground.

MR. HACKBARTH: Well, certainly if they've fallen short of hopes in terms of achieving that integration.

MR. BUTLER: Yeah. And that's why I'm not convinced that it had a shot.

MR. HACKBARTH: Yeah. Okay. Craig?

DR. SAMITT: I had trouble sort of painting all three groups with a common brush, and I tried to think of it as are any of these truly distinct enough populations that we would seek to preserve it, either because we want to see if something innovative can be generated or that the population truly is distinct enough. And, you know, I came up with a preference for three different scenarios for these three different groups.

My sense is I probably would reauthorize I-SNPs because they seem distinct enough. For C-SNPs, I would let it expire because I guess, similar to Scott's, our group's experience is that, you know, what's good for the C-SNP population is really good for all of MA population. And even if you narrow the disease states a little bit further, you have a substantive enough population that you would imagine you'd raise all boats if you practiced one form for both the general MA as well as C-SNPs. So for C-SNPs, I would let it expire and have chronic disease be an expertise that MA plans really should develop for their entire beneficiary group.

MR. HACKBARTH: Craig, just in the interest of

full disclosure, so you have an MA plan?

DR. SAMITT: We don't have an MA plan; however, we've experienced, even in the world of ACO, that to seek to design a special care model for a subset of your population, we're finding that that really doesn't make a lot of sense, that we would want to apply the principles that we generate for a subpopulation to the entire population. Otherwise, you miss an opportunity in those that are not in this narrower group. And so we're not an MA plan, yet at least, but that has been our experience nonetheless with Medicare.

And then for D-SNPs, this is the one that I really like the notion of only reauthorizing those who can demonstrate integration, because I think it's forward compatible with where we want to go. I also think this is a distinct enough population that I'd want to give it a little bit more time to see if there is creativity and innovation that cares for a very distinct needy population. And to fold it into general MA, I'd be a little concerned that we would lose the opportunity to develop new skill sets there.

MR. HACKBARTH: In that same vein, obviously we're entering into a period with lots of experimentation, joint federal-state experimentation around the duals, and

potentially keeping D-SNPs alive as a vehicle for that as that experience unfolds. There may be a case for that.

DR. BAICKER: I wish I had a better handle on why the plans that aren't working aren't working so well. It's a very different story to say, you know, there are these great ideas that work well for a C-SNP population but actually work well for everyone, and the reason the C-SNP isn't working is because we're working -- you know, it's a giant success in some other program so we don't need it, versus these tools just aren't working and no one's using them at all. And that to me has pretty different implications for the hope of a lot of the bigger picture strategies for driving towards, you know, higher-value care, more coordinated care, et cetera.

So I'm torn. If you had asked me ahead of time would a C-SNP work, I would have thought that if you could have some special tools to manage diabetics that you couldn't tailor to that population in a general MA plan, if you have these -- you know, if you can change the co-payments to really tailor to the kind of care that's of particular value for diabetic patients, you should be able to do a better job -- we hope you should be able to do a

better job in delivering high-quality care to them, and if it didn't work or it wasn't attractive to enrollees, is there something about the -- you know, are the risk adjusters not right, or are the patients not getting the information they need, or are the tools not developed yet and they could work, or is this whole endeavor just doomed and that's not the right way to go to try to get higher-value care for them?

Without having a better sense of answers there, I don't know whether to -- which direction to go, so I feel conflicted on that front.

I hope that was helpful.

[Laughter.]

DR. SAMITT: Can I also just clarify? For me, for C-SNPs, it really would be Option 4 that I would want versus Option 2, which is to allow the MA plans flexibility to develop disease-specific benefit designs. So it wouldn't just be allowing the authority to expire, but also allow MA plans to do as Kate described, a little bit more freedom to do innovative things.

MS. UCCELLO: Yeah, I'm frustrated as well with this, and I'm going to sound whiny, but it's -- if none of

them worked well, it would be an easy decision, right? But there's so much variation, and so some plans are doing quite well. And so if we just said no more, you know, what happens to those people? Are they going to, if they move into another MA plan, really continue doing well or not? And it's not clear.

I like Craig's idea of just thinking of the three different SNP types differently. And with the D-SNPs, I think, you know, if we move forward with a reauthorization, tightening up the requirements regarding integration I think is important.

The C-SNPs, you know, I don't know. And if Scott's experience is it just doesn't make sense to have a separate plan, well, then maybe -- I think, regardless, we need to think more about how to allow just general MA plans to have some kinds of different benefit designs, flexibility.

And for the I-SNPs, it looks like they do have some very positive outcomes, so, you know, I worry about just getting right of them.

That's my thought at this point.

DR. HOADLEY: I feel like in a sense I'm saying

"ditto" because I think everything I was going to say has been mentioned somewhere, and I think I agree with a whole lot of what has been said. I'll just go through several things really quickly.

I definitely like the idea of thinking of the three in different ways. With the C-SNPs, one of the things I keep focusing on is there's only 220,000 people, and it's just -- it's not a lot going on there. So, I mean, getting rid of them isn't a huge impact. It's not like there's this whole body of people that has to be moved around.

And the idea of sort of focusing only on ESRD and AIDS, from your table there are 4,000 people enrolled in plans for those two diseases, so, you know, that could be a fine thing for those 4,000 people, but, again, it's a really, really tiny thing. With the I-SNPs, again, it's 50,000 people. So if they're working, you know, that's great and, again, it's not going to have a big cost impact sort of anywhere because even though they're expensive people, there are just not many of them.

I definitely like the idea of figuring out a way to get the value-based insurance design principles that are, in theory at least, being tested here but not probably very

tested, given the small numbers of people. And I think about that also in the context of the drug benefit side of this where all that repeats again.

And then on the D-SNPs, again, the two concepts that struck me is, one, thinking about how this interacts with the dual demos and not throwing it out if there's an opportunity to let that -- here we got real people because we're over a million people. It's something like one in six of all the duals, if my arithmetic is right. But also to do it in some way that insists on some level of integration makes a lot of sense. To just allow a D-SNP to be a D-SNP and not really do much, then have this sort of token contract doesn't seem to make much sense. So pushing them all to do better on that would make sense if we're going to -- I mean, that would be a good tradeoff in a reauthorization.

DR. DEAN: Just like Jack, probably everything I have to say has already been said. But my first reaction was very similar to Peter's, that, you know, this is so unclear, you really wonder are we really accomplishing anything. And I guess the basic question is: Is there something unique about the SNP structure that really can

solve some problems for us? And the data so far is, you know, mixed at best.

I guess my inclination, I don't see much justification for the C-SNPs. Those are things -- those are such broad populations and such a basic part of good care for the elderly, I just don't see where it has a role.

Maybe if -- you know, I guess I could support the idea that maybe integration for the duals, that's something that we clearly haven't accomplished very well, and maybe there's some potential here, and so maybe that's worth pursuing. But I guess, you know, I think there's just not much here that's very convincing.

DR. REDBERG: I certainly also agree with a lot of what has been said. The fact that -- I mean, they seem like good ideas, but it seems so difficult to administer and difficult to understand. And the fact that enrollment is so low, I just wonder if it was hard for beneficiaries to have so many choices and figure out what was the right plan, too. And so, in particular for the C-SNPs, it seems that it might be better just strengthening, certainly from what we've heard, Medicare Advantage to give them more flexibility and address that really important population with chronic

diseases and then perhaps continuing the I-SNPs and integrating the D-SNPs just seemed like good ideas. In theory, it all seems good. Just in practice it's hard -- it seems they got very hard to evaluate and implement.

DR. HALL: Well, I've been very much informed by the written materials. I really appreciate the analysis you put together and also the discussion here.

I guess what I've taken away from it so far is that a lot that is involved in C-SNPs has become part of basic good medical practice. Maybe it wasn't when these were put into place, so that that would make logical sense, as Scott has said, and many others, to put them back into a regular MA.

I do have trouble with the D's only in the sense that I guess my lens on Medicare from a clinical standpoint is that there isn't a typical Medicare patient. It's a little like saying that children are just little adults. We have a large, robust segment of people over age 65, but then we have an increasing, almost a tsunami proportion of individuals into their 80s and 90s that we will be living with for 30 to 50 years -- many of us will be hopefully joining that population someday. We don't know how to take

care of these patients. What we do know is that they need a different kind of integration and care management than we've been able to effect so far, and not only from the clinical standpoint but from the many social aspects and the multiple payment sources that may or may not be available to them.

So I come down saying that I think we should find some way to preserve the D-SNP program for a limited period of time, put whatever sort of quality benchmarks there to make sure that we're heading in the right direction, but I think to abandon it now after so much work has gone into figuring out, at least partially, how to deal with this, the population that MedPAC 20 years from now is going to be spending all their time on, I think we would be shortsighted.

MR. GEORGE MILLER: I want to echo what a great job the staff has done, and the information was very enlightening, and I join my colleagues that have all spoken eloquently before me. I have just a couple of things.

I do agree with Craig about dividing these into three groups. I agree that the C-SNPs can be integrated. I think we should reauthorize I-SNPs. And I am still in favor of keeping D-SNPs, but I can be persuaded. But the reason I

would be persuaded to keep D-SNPs and try to fold them into an integrated model is because of the complexity of the program and the information we've read. And having someone fully navigate and integrate and make sure that population takes advantage of all the benefits and services in a coordinated and integrated way I think would be beneficial and have some benefit in the long term.

I'll leave it at that.

MR. HACKBARTH: Actually, I heard more sort of agreement on general direction than I thought we might at this point, so that's good.

Just two quick questions, observations. A number of people said -- and I agree with this -- well, if we're going to have D-SNPs, they really ought to do something in terms of integrating the Medicare and Medicaid benefits. That was the stance we took a number of years ago.

What ensued was less than we had hoped, and my perception is the reason that's challenging is that it's not just a matter of Congress passing a law or CMS writing a rule, because it involves another party -- namely, state government. And the demo approach tries to deal with that in a very different way, engage the states actively as

partners and setting up demos. I'm still not entirely clear how outside the demo approach we bring this other party, the state, into this active agreement to integrate, fully integrate, under the D-SNPs. So that's one question. And we don't need to answer it now, but I want to learn more about that.

The other idea is a small one that I want to also think a little bit more about. We had observed that -- Bill did mention it earlier -- there are plans that have the ability to combine medical and social services. There are restrictions on Medicare Advantage plans' ability to do that. It has never been entirely clear to me why we should restrict Medicare Advantage plans in that way. If they are fully responsible for the patient, both financials and clinically, why shouldn't we give them the flexibility to say, you know, I want to pay for your transportation if that helps assure that you get to the right place when you need the care. Why the rules? Why do we care how the dollars are spent if they have full financial and clinical responsibility? And so if we were to clear out that sort of -- some of that regulatory underbrush in Medicare Advantage, restrictions on benefit design, restrictions on the use of

dollars, we may be able to accomplish some of the good that we're trying to accomplish with the SNPs more readily in basic Medicare Advantage.

Okay? All right. Thank you very much. Good work, Christine and Carlos. So we are now on to our last session, which is on Medicare payment for ambulance services. And as the staff come to the table to present, let me apologize to people in the audience who have been inconvenienced by my decision to move this from the first item today to the last item. And as I said in our morning session, send the e-mails to me, the complaints to me, not to Mark. This is my doing.

MR. HACKBARTH: And David, Zach, you can begin whenever you are ready.

MR. GAUMER: Okay. Good afternoon. This session is the third presentation of our work in response to a Congressional mandate to report on Medicare payment policy for ambulance services.

At our April and September meetings, we discussed Medicare ambulance coverage and payment policy. We walked through the results of our claims analysis and also discussed a variety of policy options.

In today's presentation, we will briefly review the framework the Commission has applied in evaluating policy options for all three of the mandated reports required by Congress. We will provide responses to a number of questions Commissioners have raised at our September meeting. We will then go over the key policy issues raised by our analysis and present a set of draft recommendations developed by the Chairman for the Commission's discussion.

To evaluate policy options for this report, the Commission will apply a framework consisting of four basic questions. These are the same as the ones you saw earlier in the day. Under the framework, we consider how the policy option would impact Medicare program spending above the current law baseline. We also consider whether the policy will improve beneficiaries' access to care, whether it will improve the quality of care beneficiaries receive, and, finally, whether the policy will advance payment reform away from the current fee-for-service system and towards a more integrated delivery system.

As a part of our mandate, in February, the Congress directed the Commission to conduct a study of the Medicare ambulance fee schedule and specifically required

the Commission to examine the three temporary ambulance add-on policies, including their appropriateness and their effect on ambulance suppliers' and providers' Medicare margins, and also required the Commission to consider whether there is a need to reform the ambulance fee schedule generally.

The formal due date for this report is June 15, 2013. However, the temporary add-on policies will expire under current law at the end of this year. Therefore, the Commission has been working towards giving the Congress the information it needs to make a decision about whether to end, extend, or amend these policies by the end of 2012.

At our September meeting, you asked several follow-up questions in response to our findings. More detailed responses to these questions are included in your October mailing materials and I would be happy to discuss these more specifically on question. But for now, I will just provide you with a brief summary of what we have brought back to you.

First, Rita, Bill, and others inquired about the characteristics of dialysis beneficiaries. Overall, more than half of dialysis beneficiaries had at least one

ambulance transport in 2011, and the growth rate in dialysis-related transports was faster for beneficiaries age 80 or older.

Herb, Glenn, and others inquired about beneficiaries who were dually eligible for both Medicare and Medicaid. We found that duals were more likely than non-duals to use ambulance services and even more likely than non-duals to have a dialysis-related transport. In addition, the share of dialysis-related transports that were attributed to duals varied considerably by State.

Alice, you asked us to evaluate whether high-spending States might be associated with an absence of a Medicaid transportation benefit. As it turns out, Medicaid transportation benefits are present in both low- and high-spending States. However, it is unclear the extent to which these transportation benefits are used in each State.

Kate and others asked us to compare State-level ambulance spending to other State-level utilization measures, such as inpatient use and hemodialysis treatments. What we found is that States in the lowest levels of ambulance spending for dialysis beneficiaries in 2009 also tended to have low levels of utilization in these other

measures. However, States with high ambulance spending did not have consistently high levels of utilization in these other measures.

Glenn and others inquired about the characteristics of dialysis beneficiaries. Dialysis-related transports were shorter than other types of transports in terms of their average distance traveled. And further, over the last five years, dialysis transports have become shorter while the distance of other types of transports have remained relatively constant.

In addition, the average payment for a round-trip dialysis transport was two times higher than the standard bundled base payment rate a dialysis facility receives for a single dialysis treatment.

Now, finally, you asked for an update on the 2012 GAO report on ambulance industry margins. GAO's report was released Monday of this week and it concluded that the median ambulance supplier and provider margin for 2010 was negative one percent, excluding the temporary add-on payments. This finding represents an improvement of approximately five percentage points from their 2007 report, which found a Medicare margin of negative six percent.

In addition, their 2012 estimate of the median margin -- Medicare margin, excuse me -- without the add-on payments ranged from about negative eight percent to positive nine percent, a wide range including both positive and negative margins.

We will now turn to the four specific ambulance policy issues at hand. As a part of each issue, we will provide you with a description and a summary analysis of the issue itself, the Chairman's draft recommendation, and the implications of the stated recommendation.

The first issue concerns the three temporary add-on policies now in effect and whether or not these should be extended or allowed to expire. To remind you, these add-ons are supplemental to the fee schedule, and mechanically how this works is that they are increased, either the base payment or the mileage payment of a given transport. One of the temporary add-ons supplements payments to all ground transports. A second supplements payments for urban air transports that were grandfathered as being rural. And one supplements payments for ground transports originating in areas that are designated as super-rural. These temporary add-ons expire at the end of 2012 and extending any of them

will increase spending relative to current law.

To extend the temporary add-ons and increase spending beyond the baseline in current law, we would need clear evidence that doing so is required to ensure access and improve quality. On the contrary, in regard to the first ground ambulance add-on, we found no evidence of access problems. We observed growth in spending on ambulance transports and growth in the use of ambulance services per beneficiary. However, much of this growth is in the BLS non-emergency transports, and we want to ensure access to emergency transports. We discussed one way to do this on the next few slides.

In addition, we observed growth in the number of ambulance suppliers overall, and particularly for-profit suppliers. We also observed the recent entry of private equity firms into this industry. In addition, the new GAO report concluded that industry margins were higher than in previous reports. Taken together, there does not seem to be clear evidence to increase payments for ground transports.

Second, the super-rural add-on increases a real need, the fact that in areas with low population density the volume of transports may be low and may lead to higher costs

per transport. In these isolated areas, higher costs may be, to a certain extent, beyond the control of the supplier. But the super-rural add-on does not perfectly target isolated low-volume areas. This problem requires a better and more permanent solution, and we will talk about this later in the presentation.

Third, the air ambulance add-on was meant to transition payments following the redesignation of some counties from rural to urban status by the Office of Management and Budget back in 2006. By now, providers should have had time to adjust to those redesignations.

A second issue is that basic life support non-emergency transports appear mis-valued. Over the course of the last two public meetings, we've provided you with a variety of statistics concluding that in recent years, BLS non-emergency transports have grown more rapidly than other types of ground transports, particularly for dialysis-related transports.

In addition, we have concluded that a relatively small group of suppliers and providers focused almost exclusively on BLS non-emergency transports. These entities accounted for a disproportionately large share of all BLS

non-emergency transports. Further, we also found that suppliers and providers that began billing Medicare for ambulance transports between 2008 and 2011 -- these are the newest suppliers, the newest providers -- were more likely to provide BLS non-emergency transports than established entities.

In addition, in recent years, for-profit suppliers have entered the ambulance industry at twice the rate of nonprofit suppliers. And in 2011, three large private equity firms made significant investments in the ambulance industry. The entry of for-profits and private equity is particularly interesting in light of GAO's estimate of 2010 Medicare margins, which have improved from negative six to negative one percent.

Eventually, one solution to addressing this issue of mis-valued BLS non-emergency transports would be to gather current industry-wide cost data from the ambulance industry and then rebase the ambulance RVU scale using those more current data. However, in the absence of these data, CMS could proceed to rebalance existing ambulance RVUs by reducing the RVU for BLS non-emergency transports by a set percentage and increasing the RVUs for all other types of

transports by a set percentage. In doing so, CMS could effectively reduce payments for all BLS non-emergency and hold harmless aggregate payments for all other types of transports. Specifically, this would preserve payment levels for emergency transports consistent with current levels that include all permanent and temporary add-on payments. This policy would be designed to be budget neutral. Also, the impact of this policy would be to reduce the growth in BLS non-emergency transports and reduce the incentive of suppliers and providers to focus on these services instead of emergency ambulance transports.

Therefore, the effort to rebalance the ambulance fee schedules RVUs simultaneously addresses the issue of mis-valued BLS non-emergency services as well as concerns about preserving access to emergency services, which may have arisen from the expiration of the temporary add-ons.

In the subsequent section of this presentation, we also address any concerns that may exist about access to ambulance services in isolated low-volume areas.

Combining the two stated issues at hand, the Chairman's draft recommendation one reads: The Congress should allow the three temporary ambulance add-on policies

to expire and direct the Secretary to rebalance the relative values for ambulance services from BLS non-emergency to other ground transports. Rebalancing should be budget neutral and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on.

Looking at the implications of recommendation one in reference to our framework, we anticipate no overall effect on spending with regard to the expiration of the three temporary add-ons. Further, rebalancing the ambulance RVUs is budget neutral by design. When coupled with recommendation number two, which you'll hear about in a moment, we believe this recommendation results in no net impact on beneficiary access to ambulance services. We anticipate no implications for quality of care and no implications in regards to transitioning away from fee-for-service and towards a more integrated delivery system.

David will now guide us through the next recommendations.

MR. GLASS: Thank you, Zach.

The next issue is protecting access by directing payments to transports from isolated low-volume areas. The

GAO found, not surprisingly, that isolated rural areas with low population density generated fewer ambulance transports than more densely populated areas, and they also found that providers with a low volume of transports had higher costs per transport.

We observed that the permanent short mileage ground add-on policy is not well targeted to help isolated low-volume areas. Current policy increases the mileage rate of all rural transports by 50 percent if the distance of the transport is between one and 17 miles. This add-on broadly increases payments across rural areas and ends up both excluding approximately 220,000 super-rural transports with a mileage greater than 17 miles, which are arguably the ones from the most isolated areas, and at the same time it includes over two million transports from rural areas that are not super-rural. In 2011, this policy accounted for $42 million in spending.

There may be a better method of directing payments to isolated low-volume areas, and we look at one possibility on the next slide. This slide illustrates what we mean by a better policy to deal with the problem of high costs arising from low volume and isolation. The basic issue is how to

better direct higher payments to areas where conditions create higher costs per transport. We illustrate a four-step process.

The first step is to determine the cost function, that is, how much cost increases as volume decreases. From the GAO reports, it appears that a lower volume of transports leads to higher costs and that costs go up noticeably below about 600 to 700 transports a year, so that is less than two a day.

The second step is to define the area as some set radius -- eight, ten, or 15 miles -- around a zip code, or if the zip code area is large enough, you could just look at the population density within the zip code.

The third step is to compute the population in the area and the number of ambulance transports that population would generate, assuming use of the national average.

And finally, if the number of transports would be below the volume threshold, then to increase the payments by some amount.

Whether or not the policy would increase or decrease spending depends on how much is added for low-volume areas and what the low-volume threshold is. In

developing an illustrative policy, we would use areas for definition rather than providers because ambulances are mobile and zip codes are the areas used in the payment system. We would not want to look at supplier location to determine the isolation or the individual volume because, for example, there could be two small providers next door to each other causing each to have a low volume of transports. This policy is designed to replace the current rural short milage payment add-on.

The Chairman's second draft recommendation is as follows. In order to target payments in rural areas to protect access, the Congress should replace the permanent rural short mileage add-on for ground ambulance transports with a new adjustment directing increased payments to ground transports originating in geographically isolated low-volume areas. This would replace the permanent add-on, which adds 50 percent to the ground ambulance mileage rate if the transport starts in a rural zip code and is between one and 17 miles, with one that better directs additional payments to geographically isolated low-volume areas because providers serving those areas face circumstances beyond their control that increase their cost. In other words, it

would better direct extra payments to areas that need them.

Looking at the implications of this recommendation, the design of the new low-volume policy will determine its effect on spending. It may cost the same as the current $42 million short mileage add-on or it could be less if more focused on areas that need the help, because by definition, those areas have very few transports. So even if the add-on is relatively high, it won't be applied very often.

Key variables of the add-on: Percentage, the low-volume threshold, and the determination of payment areas and population density.

The recommendation should maintain access in isolated areas with low population density where suppliers face circumstances that increase their average cost per transport. And we see no implications for quality or payment reform.

DR. MARK MILLER: [Off microphone.] Dave, can I hold you for just a second?

MR. GLASS: Sure.

DR. MARK MILLER: I just want to pause here for a second and pick up with a conversation that some of you were

having earlier, you know, the notion that concerns about unintended consequences and a heavy focus on access, and Alice, you were making some of these points. But it was on everybody's mind.

You can look at data and try and figure out whether access is affected or not, but the other way you can go at it is through policy. And the reason I wanted to stop it here is just to draw your attention to two things here. So if the add-ons go away, there's a natural concern of what happens with access, and there's two things in here to keep track of.

One is the rates for the emergency transports and the ALS non-emergency would be held at their current rates as of today. And so if we aren't experiencing access problems, and we've had no indication of that, that should not be compromised. And the rate that we're taking down to take into account the removal of the add-ons is the non-emergency transports, and we can talk about that more on question.

And the second piece to assure access is take the dollars that are currently for rural areas and better -- for short mileage -- and better target them to the providers who

are truly serving isolated areas and make that add-on actually larger so that the actual profitability -- or they can overcome their fixed cost and have a better shot at being a profitable provider.

And so the point here -- I wanted to pause because we're about to shift gears and get into some program integrity stuff. But in trying to focus on access, these things are being built into the recommendations and the policies directly. And this is something that was on your mind earlier and I wanted to make sure it got back to you.

MR. GLASS: Thank you, Mark.

Well, the last issue is the rapid increase in dialysis-related transports and inappropriate billing for non-emergency transports in general. You remember from September this graph and the fact that transports to dialysis have been growing twice as fast as other transports. We presented some new information in response to your questions but are still left with the finding that there is tremendous unexplained variation across the States and Medicare spending for ambulance services for beneficiaries on dialysis, and we've isolated the six States with the highest spending in red, the ones in the middle in

yellow, and the ones at or below the median in green.

We note that there has been high growth of transports to dialysis relative to other kinds of transports, roughly double the growth rate. We found wide variation across States, as shown on the previous graph. The spending in some States is three times the national average and 20 times that of the lowest-spending States.

There are continued IG findings of inappropriate billings for transports that do not meet medical necessity requirements and prosecutions for fraudulent billing.

And finally, there is a need to resolve inconsistent local claims as it's used by the claims processors.

You suggested that one approach would be to more clearly define the circumstances under which ambulance transport to dialysis facilities are medically necessary, hence, the Chairman's draft recommendation three. The Congress should direct the Secretary to develop and promulgate national guidelines to more precisely define medical necessity requirements for both recurring and non-recurring, non-emergency ground ambulance transport services. To support those guidelines, the Secretary should

develop a set of edits to be used by all claims processors.

But this recommendation by itself is unlikely to solve the problem of inappropriate billing and wide variation, hence the Chairman's draft recommendation number four. The Congress should direct the Secretary to identify aberrant patterns of use by geographic areas and provider, and then use his or her statutory authority to address clinically inappropriate use of basic life support non-emergency ground ambulance transports with an emphasis on transports to and from dialysis facilities. This directs the Secretary to use all of her authorities to eliminate clinically inappropriate use. The Secretary could look at patterns of use and concentrate on areas or providers with aberrant patterns of use. We emphasize transports to dialysis facilities, but transports to other facilities, such as community mental health clinics, have also been the subject of IG investigations.

We look at the implications of recommendation three and four together. We would expect these recommendations to save money. We estimate reducing spending for transports to dialysis facilities in high-spending States at the level of the national median would

save over $400 million a year. Curtailing inappropriate transports to other facilities would result in additional savings. Appropriate access would be maintained, and we did not see implications for the elements of the framework.

We can respond to questions or clarifications of the analysis and look forward to your discussion of the Chairman's draft recommendations.

MR. HACKBARTH: Okay. Thank you, David and Zach.

Let me -- for those of you who just joined us in the audience, let me just say a word about the process and our framework for looking at these issues. So you've heard draft recommendations that I'm offering to the Commission. We'll talk about the draft recommendations today. Between this meeting and our November meeting, we'll make any necessary modification in those draft recommendations and then have our final votes at the November meeting.

In examining this issue on ambulances and two other reports that Congress has asked us to do, one on the physician payment system and the other on outpatient therapy, we are trying to apply a consistent framework which says that if we are to recommend expenditures above the current law baseline in these three areas, we should do so

based on evidence that the increased expenditure would result in improved access to care, improved quality of care, or facilitate movement to new payment systems. So that's the basic test we're applying across each of the three areas where Congress has asked us to do reports.

So let me kick off the clarifying questions with one of my own, and that is for you, Zach. You talked about potential for rebalancing the rates for non-emergency and emergency transport. If the goal is to maintain the rates at the current level, including the temporary add-ons for emergency transport, how much, roughly, would the non-emergency rate have to decline?

MR. GAUMER: In terms of percentage, we'd be looking at about a 5.7 percent decline in the BLS non-emergency transport. And on average, across all of the other services, ground services, there would be an increase, an offsetting increase of about 2.8 percent. So that would include all the emergency as well as ALS non-emergency. So it's BLS emergency and all other.

MR. HACKBARTH: So let me just make sure, because we have the payment levels that exist as we speak with the temporary add-ons, and then we have payment levels that

would exist on January 1, after the expiration. I just want to make sure we don't get confused.

So when you say an increase in the emergency transport, you're referring to an increase relative to the January 1 rate that would otherwise apply.

MR. GAUMER: What we're doing is we're looking at rates currently with the add-on, and so those non-BLS non-emergency, everything else, their payments would get raised up to a level that would include the temporary ground add-on that essentially would be expiring. Now, the super-rural would expire. The air add-on doesn't apply in this case.

MR. HACKBARTH: Yeah --

MR. GLASS: If I may, what we're manipulating is the RVUs.

MR. HACKBARTH: Yes.

MR. GLASS: So we reduce the RVU for BLS non-emergency --

MR. HACKBARTH: Yeah --

MR. GLASS: -- by 5.7, and then the other, have to increase the RVUs for the other ground transports, and by doing so, their payments will be the same as they were before the --

MR. HACKBARTH: And that last phrase is the one I want to zero in on and just make sure that we're all using the terminology the same. So, currently, we have -- the major temporary add-on is the three percent rural, two percent urban add-on to the rates, and my recollection is that accounts for, like, $134 million of a total of roughly $190 million in all of the temporary add-ons together. So it's the big hitter. That's where the money is in the temporary add-ons that we're reviewing.

And what I think David just said is that the reconfiguration, the rebalancing of the relative values would allow us to keep the emergency rates at the level that they are with the three and two percent add-ons, and then that would be made budget neutral relative to current law on January 1 by taking down the non-emergency relative values by 5.7 percent. Are we saying the same --

MR. GLASS: Yes. That is correct.

MR. HACKBARTH: Okay. George, clarifying questions.

MR. GEORGE MILLER: I'm glad you cleared that up. That was very helpful, to explain that.

And I was just wondering, based on your draft

recommendations, if we had looked at how do we determine it's an emergency. Although you would you change the payments to -- for emergencies. But, how do we determine it's an emergency?

And this is anecdotal information. Our ER sometimes gets busy, and folks wait, patients can figure out how they can get above the line by calling 911 and being brought in. Now in my mind that's not an emergency, but because they get called by EMS that becomes an emergency.

So, in this discussion I would like to maybe make a suggestion that -- and Tom is not going to like this statement, but maybe we should have an ER or ED position attest that that is truly an emergency.

DR. DEAN: You're right, George.

MR. GEORGE MILLER: So, we have integrity.

I mean, again, I'm not saying the EMS would do anything wrong, but if a patient calls and the local statute requires no matter who calls you've got to go pick them up, not a national standard but the local statute. They pick them up and bring them, and they've got a hang toenail. They get to go directly in the back and bypass everybody in the ED. That is not an emergency, but based on this current

recommendation we'd have to pay for that.

My suggestion is that we have the ED position attest that it was truly an emergency, then the EMS company would be able to bill if it's truly an emergency. And, if it's not, then they go down to the rate we're talking about in this proposal.

MR. HACKBARTH: Zach or David, do you want to address what the rules are for qualifying for emergency transport?

MR. GAUMER: Yeah, there are a couple of steps along the way where this can be determined or revised -- the emergency status. A 911 call is usually what initiates a -- which goes to a dispatcher, and the dispatcher says yes, this is an emergency; I cannot deny. And the ambulance goes out.

When the crew -- at that point, an ALS emergency crew, advance life support, is usually sent out, and at the scene it can also be determined whether or not this is an ALS emergency or BLS emergency or nonemergency. So it can be revised at that point. So nothing has been billed at that point.

The ambulance supplier will then bill based upon

those two points of determination. But, then there is a MAC -- the Medicare administrative contractors -- who will also think, is this an emergency or not an emergency? And sometimes the claim will get, you know, hung up in there, and the status might get changed again.

MR. GEORGE MILLER: Yeah, even if there's either a state or local statute that says that you have to respond to everything, then they can bill as emergency; those still -- those two steps you just described still oversee?

MR. GAUMER: The state and the local is what determines the standard for emergency. So, in the Medicare regulation, it says, you know, the state and the local rules will determine, you know, what defines emergency. So it does vary.

MR. GEORGE MILLER: Okay.

MR. GAUMER: And, if the EMS crew gets out there and decides this is person doesn't need transport --

MR. GEORGE MILLER: Right.

MR. GAUMER: -- then they don't have to get them, and they don't transport them, and there's no bill to Medicare.

MR. GEORGE MILLER: Okay.

MR. KUHN: Can I ask just a follow-up on that?

You said the MAC would look at this as well, but is also this in the scope of work for the recovery audit contractors? Are they looking at these claims as well?

MR. GAUMER: We did talk to some folks over there, and the RACs do not have this on their radar at the moment. They look at Part A ambulance claims, but they do not right now look at Part B ambulance claims. It was told to me that this might be something they're going to do soon, but they look at this as a Part A-Part B decision.

DR. MARK MILLER: And if you thought it was important, you know, you should bring it up because a push from here could also move that along or move it in one direction or another.

DR. HALL: Apropos to George's inquiry, I'm sort of pessimistic on the idea of trying to control emergency use by making somebody responsible to certify, honestly. I think that there's not much of an incentive for an emergency room doctor to do this, frankly. It just adds on more time and more pressure on their life.

MR. GEORGE MILLER: Check box.

DR. HALL: I know. And, if that's all it is, is a

checked box, then it's meaningless.

I think we just have to change the incentives for the providers of the ambulance services, and I think this is starting to go in that -- very strongly in that direction.

DR. DEAN: Maybe you already answered that, but I mean I had some of the same questions that George did.

Right now, the medical necessity criteria is basically met based on local rules. Is that what you're saying?

MR. GAUMER: Yes, there can be local coverage determinations that are made to define medical necessity.

DR. DEAN: So there's no national guideline.

MR. GAUMER: There is a very broad definition of this nationally, and the local coverage determinations do not consistently weigh in on the definition of medical necessity and some other key items.

DR. DEAN: Do we have any information about especially the dialysis transports; are those actual ambulance transports, or are they vans?

I mean, I suppose it changes a lot with the service, but I mean is it truly an ambulance transport?

MR. GAUMER: You know, under the Medicare

definition, they are ambulance transports, but they're an ambulance transport by a different severity level. You know. Usually, the vast majority of them are basic life support, nonemergency transports, maybe 97, 98 percent of them.

DR. DEAN: Just the vehicle and equipment.

MR. GAUMER: There are some differences. I'm sure that there are --

MR. GLASS: But, they have to be certified as a BLS.

MR. GAUMER: Right. It's really a labor difference. So, ALS staff versus BLS staff.

DR. REDBERG: What you would call an ambulette?

MR. GAUMER: Those are sometimes referred to as ambulettes, but Medicare does not see it as an ambulette if it's an ambulance.

DR. MARK MILLER: Unless it's truly outright fraud, it is an ambulance that's carrying this person. Otherwise, then they're really billing fraudulently.

DR. REDBERG: It's a nonemergency ambulance. It's very confusing to me.

DR. SAMITT: I have two quick questions.

In the briefing materials, this is actually specifically focused on the Chairman's recommendation 2. It talks about the low-volume add-on policy, and it references issues that might reduce or increase actually the cost of this policy.

I just wanted to make sure -- it listed a number of things: the number of transports, estimated utilization rate per capita -- whether we're pretty assured that we could develop a methodology that would lower the cost as opposed to increase it because it seemed as if there were a number of variables that could actually drive it up, not down.

MR. GLASS: Yeah, you could -- but, you could -- we're pretty sure that you can design it, and we've done a few estimates.

DR. SAMITT: So, design the modeling or the --

MR. GLASS: Yeah, we've done some estimates on this, that we think you can design one that is budget neutral to, or even less if you want.

DR. SAMITT: And my second question is I was surprised that--

MR. HACKBARTH: So, Craig, just on that one, my

initial concept was to say let's take -- I think it's like $42 million

MR. GLASS: Correct.

MR. HACKBARTH: -- in the short mileage, permanent add-on. Let's take that 42 million and redesign it and, by definition, do it in a budget neutral way.

DR. SAMITT: My second question, I was struck in the draft recommendations 3 and 4 that there wasn't reference to the notion of actually adjusting RVUs related to dialysis transport even further downward. So, if we're adjusting emergency versus nonemergency BLS, would we ever consider the notion of even saying a dialysis transport RVU would be even less than nonemergency BLS and whether that was considered?

MR. GLASS: So, create a separate RVU for dialysis transports.

DR. SAMITT: Yes.

MR. GLASS: We haven't thought of that.

DR. MARK MILLER: And the only thing I would say -- you know. We are working with, you know given our timeline and everything else, with what the current structure is, the four different vectors and then how to

adjust the RVUs.

The other thing to keep in mind is even though dialysis jumps out the most and there's been a lot of focus on it, we also circulated a couple of articles to you guys in your handouts. I mean, there have been other examples of like partial hospitalization where nonemergency recurrent transportation -- even though dialysis is what jumps out the most, it's probably not the only thing that's going on.

Fair enough?

MR. GLASS: We wouldn't want to see use migrate over to yet a new flavor of the month kind of thing.

MR. BUTLER: So you cited that this week the GAO produced profitability numbers. So, cite those again for me.

You said 1 percent negative margin on Medicare only.

MR. GAUMER: And that's without the add-on payments in there.

MR. BUTLER: Without the add-on.

Then it's a 5 percent improvement. I mean, it was negative 5 percent at when? At what point?

MR. GAUMER: So it was in 2007. In their 2007

report, GAO modeled 2010 Medicare margins, and they came up with a number that was negative 6 percent across the industry.

Okay, there are a lot of caveats to it that I can say in a moment.

But then in 2012, in that report, they also did 2010 margins, using Medicare margins, using cost and payment data from 2010, less of an estimate, more of actual number for -- to get at a number that was negative 1 percent, median.

MR. BUTLER: So my -- you can guess what I would ask next. Well, how about the for-profit consolidated companies versus the more rural, publically and municipally supported ambulances versus the -- is there any -- or, the really effective ones versus the less.

I mean, you go down the whole path, but any striking patterns?

MR. GLASS: Well, I think the most interesting thing from that point of view is that the sampling frame remained unchanged between these reports. So they were looking at established providers, if you will, and so any recent entrants aren't in their sampling frame.

So, since we've shown that the recent ones, or entrants, more interested in the BLS nonemergency and concentrating on that, that minus 1 percent number doesn't include margins for these new providers that are concentrating on BLS nonemergency.

MR. GAUMER: And when David says new, that's really from 2004-on. So that covers a broad range.

And we had shown you some other data that the new providers, which we defined as those from 2008-on, had different transport use patterns, you know, more BLS than emergency, that type of a thing.

So, we wonder what's in there too.

And the other thing --

MR. BUTLER: Well, but -- okay. Obviously, they're doing right overall or they wouldn't be growing, and there would be an access --

MR. GAUMER: Right.

MR. BUTLER: I understand that. I'm just trying to say, is there evidence that maybe they're also more efficient and they're maybe even making money off of Medicare because they just run more efficiently?

MR. GLASS: We're saying we don't have margin data

on those providers in the GAO report, but one would expect that their margins would be higher than the ones that are reported in the GAO report.

MR. BUTLER: Why? I mean, they maybe have more commercial business that's offsetting the Medicare losses.

MR. GLASS: Well, because they're doing BLS nonemergency predominantly and those are much lower cost transports. The GAO report looking at their sample; they found that the higher the percentage of BLS nonemergency to other -- to emergency, the higher the margin.

MR. GAUMER: And one other thing that you asked about, Peter, was stratifying the margin, were we able to get at different types of organizations?

And the answer to that, unfortunately, is no, because the sample size was so small. They were looking at about 150 providers or suppliers in both of these analyses. In the 2012 version and the 2007 version, less than 200 entities were involved. So there's not a lot of stratification by type or that sort of thing.

DR. COOMBS: So I really appreciate you going around and answering all the questions we had the last time. You did a great job. And I think because of that I feel

very comfortable with the information that is presented here.

I just wanted to talk about one specific -- actually, a couple scenarios that I've seen in my practice, and one is the transfer from day surgery to the hospital from a freestanding facility when patients have pain that's not controlled, or nausea and vomiting, and they need to be admitted for an observation visit.

So those are kind of different than the dialysis patients in the sense that the more you do outpatient surgery you may see an increase in that group. Right now, I think it's incredibly rare and that that's not something that is a cost driver, but I think going forward it is something that we should probably just kind of look at very carefully.

And I like the fact that the other question you asked was in terms of low-cost and high-cost areas in terms of geographic variation, that it was uncoupled in the high-cost area, except I saw on that graph that you had Massachusetts way up there and that seems to be well matched.

MR. HACKBARTH: So let me just follow up on

Alice's question. My recollection from the slides last time that laid out the different RVUs was that there was one that -- the cited example was a transfer from one hospital to the other, to another hospital, and it qualified as advance life support, nonemergency.

MR. GAUMER: Yeah. Specialty care transport, I think, is the highest level. It's like -- I think the RVU is over 3, yeah. Is that what you mean?

MR. HACKBARTH: Well, that's my question. So Alice's situation is not the hospital but the ambulatory surgery center to hospital. Any idea where that fits in the scheme of things?

MR. GAUMER: In terms of its growth rate?

MR. HACKBARTH: No, in terms of the RVU.

MR. GLASS: I

MR. GAUMER: Oh, right. Yeah, so it would be high on the RVU scale.

So, if it's a specialty care transport that requires, you know, a doctor to ride in the cab or something -- a patient that's extremely ill coming out of surgery -- that's likely going to be an ALS emergency or a specialty care transport.

And we have seen the specialty care transports. Although they make up a very small proportion of all ambulance transports, they are on the rise.

DR. COOMBS: So -- and I say that only because we are shifting from hospital-based kind of procedures and going to day surgery for a lot of it.

But, it's only an ACLS because if I monitor that patient in the PACU I got them on an EKG so that the ACLS is needed for someone who is going to be watched in the same context in one facility as the other facility. However, if you would wait for one hour, that patient may be getting dressed and going home with, you know, their daughter or son.

MR. HACKBARTH: So, within the framework of the draft recommendations, since that qualifies as emergency transport, it would not be taken down by the reduction in RVUs that's inherent in the draft recommendation. It would be protected at the higher level.

Any clarifying questions? Herb?

MR. KUHN: Thanks. Just a couple.

One, just to make sure I'm clear -- kind of as Glenn started out on the numbers, just to make sure I'm

clear on the numbers on the baseline. So, with the expiring authority at the end of the year, if Congress were to reauthorize, it would basically cost them 192 million in these 3 temporary add-ons. Is that essentially correct?

MR. GAUMER: That's correct.

MR. KUHN: Okay. So it's basically no additional spending based on the recommendations, the 4 recommendations, except for 3 and 4; there might be some potential savings that could be modeled sometime in the future.

MR. GAUMER: That's right.

MR. KUHN: Okay. Second thing, on the GAO report -- and I know that just came out. So we haven't had a chance to spend a lot of time looking at it, and I certainly haven't had a chance to read it yet. But from the 2007 to the 2010 update did GAO use the same methodology for both? So, is it a true apples to apples comparison, or is it -- or are they different?

MR. GLASS: Apparently, it's not precisely the same, and it has something to do with the median versus the average.

MR. GAUMER: There are some differences. I think

they tried to make the regression analyses and those types of things very similar, and they kept the sampling frame almost exactly the same. So there was an effort to be consistent, but it looks like there are some differences, slight ones, to consider.

MR. KUHN: Do we know why they might have chosen a different methodology so that, you know, it's hard to get a true comparison, why they would have changed it in the process?

Do they think it's just more accurate the way they did it now?

MR. GAUMER: I'm not exactly sure what their rationale would be.

You know, we did talk to the GAO early in this whole process to understand the 2007 report, and the vibe we got was that there are just improvements in statistics over the time period, that they might have gotten smarter about certain things and changed their processes.

MR. GLASS: But, if you would like, we can come back next month with the specifics.

DR. MARK MILLER: And, that's what I would say. In the midst of all this preparation, we were also trying to

read this.

MR. GLASS: Right.

DR. MARK MILLER: You know, at night. You know, before you go to sleep, that type of thing. And so, I think we should spend some time with it and answer your question.

MR. KUHN: I thought you all staff were superhuman. You've just now deflated my view of all of you.

MR. HACKBARTH: That's just pathetic.

MR. GLASS: Herb, I never sleep.

DR. MARK MILLER: Also, I'm moving to strike vibe from the transcript here.

MR. HACKBARTH: Bill.

MR. GRADISON: I'm going to wait for the next round, but at that point I really want to focus a fair amount of detail on the dialysis part, which I think needs much more emphasis than is in the current draft of your recommendations.

MR. HACKBARTH: Round 2. And let me also remind you since we have a draft recommendation here and we need to finalize a recommendation for a vote, in particular, in round 2 I would like you to comment specifically on anything -- whether you like the draft recommendations and, if not,

what you would like to see changed.

MR. GEORGE MILLER: All right, fair enough. I like the draft recommendation 1.

MR. HACKBARTH: Okay, we're done.

[Laughter.]

MR. GEORGE MILLER: However, it's not clear to me yet -- and maybe I'll listen and here more as we -- do you want us to comment on all four of them together or individually?

MR. HACKBARTH: I think in the interest of time let's do them all together. I'm sure people will want to focus on one or other. So, let's just try to get it all in one round.

MR. GEORGE MILLER: Okay. In general, I support them, but I am concerned about the word we've all used today -- the unintended consequences. I'm not quite clear yet how this would affect rural providers, particularly some that have gone from rural to urban. And I can talk to staff a little bit later to flesh that out.

But, I'm also concerned that maybe one solution would be to integrate a preauthorization for some of the concerns of fraud, that maybe our recommendation should deal

with that specifically. Maybe we should have preauthorization, maybe on the renal dialysis side, and maybe even put a moratorium on those suppliers until the Secretary can come up with a better methodology in determination.

So, I would like to maybe recommend those two parts of the -- or one facet of your four recommendations, to give specificity to the Secretary on how to deal particularly with the fraud and abuse issues.

DR. HALL: I think we've made enormous progress in trying to dissect out a very difficult and arcane system of payment, and I'm fully in favor of all the recommendations.

DR. REDBERG: And I also am in favor of all of the recommendations. And, you know, I'm very pleased with recommendation 3, to try to define the emergency and nonemergency ground ambulance transport requirements because I think we had a lot of discussion last time over that issue.

And I would also echo -- I think what Herb suggested is that we should look in particular perhaps at those very high-use states and for areas, what's going on there, because there are certainly suggestions that there's

inappropriate use and fraud.

DR. DEAN: Yeah, I support the recommendations, the direction that they're in. I need to look at them a little more in detail, just about the wording, but basically I think they're in the right direction.

A couple of comments. I would -- I mean Bill made the comment, it's hard to define emergencies. It really is. I mean, I think if -- I was in our emergency room at 2:00 in the morning about a week ago for a young guy that was dizzy, and he was perfectly stable. And by -- in any kind of retrospective analysis, it would not be judged an emergency.

And yet, this was a family. This guy came down with a bunch of systems that were frightening. And you know, I didn't particularly like to be there at 2:00 in the morning. On the other hand, they -- to them, it really was an emergency, and I think to deny that is a little hard. I think we've got to be cautious.

And also, I mean, to George's comment about certifying them, we already have to do that. At least with the Medicaid program, we are asked: Was this an emergency? Could this have been handled as an outpatient?

And we have to make a judgment about that. We

already do that. I don't like doing it, but we already -- and I understand the reason, but I'm not sure it's very effective.

There's no question that transportation is a very important part of care, and I think that's the thing we can't lose sight of. I think paying for it through this manner obviously is not appropriate.

But it's very clear -- you know, dialysis is a good example. There are lots of other services that if people don't show up and don't give that care on a regular basis, they get worse and usually the costs go way up to. So there is a good reason for providing transportation.

The question is, how do you get it to people in an appropriate way?

And I wonder if there's -- you know. We need to think about rolling the payment for that into the payment for, whether it should be part of the dialysis payment.

I talked to the administrator of one of the nursing homes I go to, just this week, and they have a van that's on the road a large part of the time because they're in a community that doesn't have any other local services. So, every time one of their residents needs an appointment

with their physician, they provide it.

I said, do you get paid for this?

No, they don't get paid for it. It's just part of the services they provide.

And so, I think there are precedents for these kinds of things. They do it because it needs to be done and it's part of the service.

So, I mean, I think we're -- we need to look at it. It's a bundling issue, basically.

MR. HACKBARTH: Thanks for raising that, Tom.

We spent actually a fair amount of our discussion at the last meeting on that point. And I think in the text of our report on this one we should flag that as an issue. It is beyond the scope of --

DR. DEAN: Yeah.

MR. HACKBARTH: -- what we can reasonably take on for this report because we're on such a tight schedule mandated by Congress, but I think we can flag that as an issue.

DR. DEAN: This one last point is that in my area we do have some potential access problems, but they don't have to do with dollars. They have to do with the fact --

with very low-volume services that rely on volunteer EMTs to staff them and the increasing demands that are placed on the EMTs because of state regulatory requirements, state certification requirements and also employers.

You know, if you've got a service that makes two, three, four runs a week, which is more in keeping with what ours does, that's not enough where there's any possibility you can hire full-time people.

On the other hand, if you're an employer and your employees are taking off two or three times a week for an hour or two at a time, that's something that employers -- you know. Even if they're trying to be cooperative, it's a burden.

And so, again, that's way beyond the scope of this, but I'm just saying there are other things that lead to access problems beyond just the payment. So, yeah.

DR. HOADLEY: Yeah, I think these are good recommendations, and I'm in favor of them. I particularly like on 2 the point that Mark made earlier, that this is a good way to target access and not just sort of leave things as they are and try to be more creative in targeting.

MS. UCCELLO: Yeah, I'm supportive of all these

recommendations.

And I want to second what Tom said about how transportation is needed for these people to get to dialysis. It's important that they get it, but doing this through the ambulance systems seems like overtreatment, especially when the costs are double what the dialysis treatment is. So, finding another way to do that is appropriate.

DR. MARK MILLER: And I'll just remind you all of a point that came up last time that we talked about this, which is within the bundled payment for the dialysis providers, do we start to talk about the notion of opening the door to them providing transport.

DR. REDBERG: I think that's a great idea.

MR. GLASS: Yeah, in the paper, we briefly outline the idea of simply not prohibiting dialysis facilities from providing transport. Rather than putting payment for it in the bundle, just not prohibit them from doing it.

MR. HACKBARTH: Prohibition now is sort of based on the fraud and abuse idea. It's an inducement to use a particular --

MR. GLASS: Yeah, correct.

DR. BAICKER: Yes, I'm supportive of the recommendations, and I think thinking more carefully about how to build this into a bundle would be a great way to promote a higher value means of transporting people. And the transportation is vital, but there are clearly many more efficient ways to do it.

DR. SAMITT: I'd support all the recommendations as well.

The only one that I would have questions about is Recommendation 4, and I'd wonder whether it's too specific. And, it referenced a little bit of the discussion that we had. What I'd hate to see is that we look for clinically inappropriate use, specifically of dialysis, and then all of a sudden we're back at the table again looking at clinically inappropriate use of something else.

I also would wonder about, you know, will we see a shift with the changes due to the other recommendations from BLS back to other forms of transport, and that should be observed as well. So I wonder whether it goes beyond just inappropriate use of BLS and just inappropriate use of dialysis and whether it should be a bit broader than that.

MR. HACKBARTH: So, let me pick up on that. In

fact, this is an issue that Kate raised when we talked on the phone.

So one boundary that we focus on is when is it appropriate to use an ambulance for nonemergency transport. The guidelines are evidently not very clear or very strong on that. So we've got a lot of growth.

Another issue that I think Craig is just raising, and Kate had raised with me, is particularly if you change the RVUs and increase the spread between the rates we pay for emergency and nonemergency, there might be a temptation to try to recategorize more things as emergency. And so, that's a boundary, that you have to pay attention to how clearly do we define the requirements for emergency payment. Level payment.

DR. SAMITT: And that's, in essence, what I was referencing. And it may be just word-smithing this recommendation, but we may want to broaden it.

MR. BUTLER: So I'm not going to make additional suggestions other than what's been made to these recommendations, but I have a need to say two things.

One is that somehow I'm still troubled on the nonemergency. If you -- in a perfect world, if you had a

co-pay, if you had the consumer engaged in this, they might find alternatives to the transportation that is provided by the federal Medicare dollars. And we've been down the path on beneficiary engagement, but the supplemental insurance, you know, just removes the consumer from this decision altogether.

MR. HACKBARTH: These are Part B services. So there's already the Part B deductible and 20 percent co-insurance. So, there are co-pays. This is not like the --

MR. BUTLER: Well, 90 percent with supplemental insurance --

MR. HACKBARTH: Exactly.

MR. BUTLER: -- is just invisible for the most part. I can't work it into this recommendation. It's an observation.

The second is that this sounds cold-hearted to the rural community, and I don't mean to be that way, but it sounds as if we're going to say we'll pay -- we'll do the cost analysis and whatever it takes. And it feels a little bit that way.

And these communities right now have a lot of public dollars or volunteers or something. And, again, are

we going to remove any of the local incentive, and are we going to -- where does it end?

You could say, well, the ERs also ought to have this, and they ought to have a neurosurgeon. Where do you draw the line in terms of what that standard of access should be if you're living in one of these remote areas?

And, if Mitra were here, she'd be saying the same thing.

What happens if you happen to be in some high-rise in a downtown urban area and you need support to get from here to there in an emergency? What about those folks?

So it's just -- there's just a little uneasiness about the federal government providing guarantees for certain kinds of access in some of these areas that are just tough no matter what the cost.

MR. HACKBARTH: Your point is well taken, Peter, and it's one of the reasons why I think it's important to take advantage of the bright red line that exists that are $42 million. And, we'll design it around that budget.

We're not saying, oh, there's now an open-ended commitment to federal money to achieve new levels of access. We're saying, let's just use the current money better.

MR. BUTLER: That's why I did not change the recommendations, but I needed a little therapy.

[Laughter.]

DR. COOMBS: Yes, I support all four recommendations, and I especially like recommendation 2 where you took in account this 2 percent increase that will address some of the standby capacity for areas where, you know, there may be a short distance.

But the other piece of it is that they may not have a neurosurgeon, and they can get to one if we make sure there's an allowance for that transport to get them there and get them to the right place for time-sensitive therapy, as we discussed before, like code stroke and code AMIs and things like that.

So I think these recommendations really have addressed the needs of different communities.

And for the dialysis -- there was one other entity, and I think we talked about it the last time, and that was transport for BLS nonemergent to the doctor's office. And that was the other thing that I think we mentioned the last time, which was another --

DR. NAYLOR: So I also support the recommendations

and hope the text will add the opportunity here to develop quality measures that really help us to -- I mean, I think we have a great benchmark here. I do think it needs to be -- the whole program needs to be monitored. And I really do think there should be -- even though it's not directly related to this -- an attention to the critical importance of quality measures to go forward.

MR. KUHN: I, too, am generally supportive of the recommendations although, as we talked about earlier in the GAO report and trying to understand that, I think having that information would just give me more comfort with the final vote next month. So I appreciate Mark and Zach and everybody, David, coming back with more information on that. That will be helpful.

Earlier, I'd asked the question about the recovery audit contractors, and Mark made the observation of I'd like to make a recommendation on that. I don't think so. I have some specific concerns with the performance of the RACs overall right now. I think the strength of recommendations 3 and 4 are sufficient.

MR. GRADISON: I support all the recommendations.

I do want to take a very close look at whatever

language we write with regard to recommendation 4. I certainly don't want to suggest that all the players in that area are breaking the rules nor do I want to suggest that dialysis should be our only concern. But, for example, the chart that we had up there that showed the levels by state -- it's just interesting that the one press clip we got which had to do with a major recovery, millions of dollars, caused by a whistleblower, was not in one of those top states. It was Kentucky and Alabama, mostly, for that particular group of companies.

The potential here for -- the potential for fraud is extraordinary. The transportation costs, as we know from the data that's here -- the transportation costs round-trip for each dialysis session are approximately double the amount of money that the dialysis center gets for the care that it provides. Now that doesn't mean that it's wrong, but I think it does raise some interesting questions in itself.

Just to take an extreme example -- and I'm not saying that this would apply in many cases, if any. A typical dialysis patient goes in three times a week. That's 3 round trips for 50 weeks. That's 150 round trips.

According to the data we have, the transportation average payment is $454 per round trip. That's $70,000 a year per patient.

You wouldn't have to sign up very many in a particular dialysis center, particularly with the average distance in the urban setting is six, seven miles or something, to have a pretty good thing going.

So I know we all know everything. I'm just repeating, but I just am looking for some language there that indicates that this particular area is -- needs more attention that it appears to be getting from an enforcement point of view.

MR. HACKBARTH: The numbers that you cite, Bill, on the magnitude of the transport payment relative to the dialysis payment caught my eye as well, and my immediate reaction was, well, the dialysis people would like to see this folded into their bundle. This would change the whole dynamic of the dialysis business.

DR. HALL: The remarkable thing to me is that a higher proportion of dialysis patients aren't coming by ambulances right now.

MR. HACKBARTH: Right, right. So, again, an

important area. We need to look at some options of which bundling may be one albeit at a lower rate.

MR. ARMSTRONG: I, too, support the recommendations. The one -- for many reasons already made.

One additional point, it's just worth acknowledging that a relatively small spend -- you know, 5.5 billion. We're actually taking that trend down as we're pulling out this $190 million, and yet we're also, inside of this smaller envelope, rationalizing the way in which the payment policy really works.

And so, I think it's a really, really nice combination of recommendations.

MR. HACKBARTH: Thank you all.

Thanks, Zach and David.

We will now have our public comment period.

Before you begin, sir, could I see -- either line up if you have a comment to make, or let me see your hands so I've got a sense of how many commenters we have in total. Anybody else joining the line? Okay. So we've got two.

So here are the ground rules for the public comment period. First, begin by identifying yourself and your organization, and I'm going to ask you to keep your

comments to just a couple minutes. When this red light comes back on, that's the end of your time period. And I would remind everybody that this isn't your only or even your best opportunity to provide input on the work of the Commission. The best opportunity is directly to the staff. A second opportunity is to communicate with Commissioners by letter, and we do read them. Then the third opportunity is to place comments on our website where there's a place where you can for each meeting file comments.

So, with that introduction, sir?

MR. WILLIAMSON: Good afternoon, Commissioners. My name is Stephen Williamson, and I am speaking on behalf of the American Ambulance Association, which represents ambulance providers and suppliers who provide coverage for more than 75 percent of the population of the United States, both in emergency and non-emergency transports.

We appreciate the proposal basically to maintain the current rates in emergency and non-emergency ALS. However, we're very concerned that all BLS non-emergency providers would experience lower rates.

While there are clearly problems related to dialysis transports, and while GAO numbers did move up from

2007 to 2012, the GAO also stated that it was not appropriate to draw conclusions that margins actually improves.

In addition, the margin -- again, as GAO noted -- is higher than it would be today. We estimate that as a calculation the margin would be lower by 1.6 percent.

We agree that the system should be reformed, but we also believe a more appropriate approach would be based on reform that was based on data collection to identify what aspects BLS non-emergency may be problematic and if any of these things, including dialysis, could be looked at. We recommend this much more direct approach to reduce fraud in dialysis transports. This includes prior authorization and a moratorium on new providers in high-fraud areas. This approach would result in substantial savings, and this would offset retaining the BLS non-emergency -- legitimate BLS non-emergency transports.

There should be good data. This target or reform effort -- and repeat -- and not repeat the mistakes of the past by guessing what the right answers should be. We are working quickly to provide you with a tool to accomplish this effort in collecting the data.

Thank you.

MR. NORTH: Good afternoon. My name is Tristan North. I am also with the American Ambulance Association. I'm on their staff and just thought I could provide maybe some clarification on the GAO report that just came out. Obviously, it did just come out on Monday, so not a lot of time for everyone to digest it. We were fortunate enough to provide information and data to the GAO and assist in their report over the past year. And a lot of the reason why you see them going from a mean back in 2007 to a median is, like yourselves, they are under a very tight deadline. Theirs was actually shorter. Obviously, they had to have a report out by Monday. So we actually had Chris Hogan, our data analyst who was in with us, acknowledge their justification in using a median rather than a mean. However, had actually stated that it was more of a time constraint than anything else.

And looking to page 24 and 25 of the report, they do state that you can't compare the two reports, that by using a median over a mean as well as such a statistically small sample size and different providers, that it is difficult to compare and say that there has been an

improvement since the data of the 2007 report being 2005 data, moving to the 2012 being 2010 data.

They were also good enough to report some of our issues that we had raised as far as it being a negative 1 percent when you removed the add-on. While they did remove just the 2 percent, 3 percent in the super-rural bonus payments, the typical ambulance add-ons, in the year that they captured data, 2010, ambulance services also got an approximately 1.6-percent bump that year as a result in the change of the practice expense component of the physician fee schedule. The practice expense component is essentially the GPCI for the ambulance service and Medicare reimbursement. So that was not taken into consideration.

Also, if you note in their comments on page 24 and 25, there have been increases in cost for ambulance services over the past two years as well as changes in Medicare policy that have reduced reimbursement, one being fractional mileage in which CMS changed the policy in which they reimburse for miles that are not whole miles. They now go to the exact fractional mileage, the tenth, rather than rounding up. So CMS, within its proposed and final rule, acknowledged that about $50 to $80 million is being taken

out of the system. We determined that it's about a 0.8-percent reduction in reimbursement, as well as other changes in reimbursements since then.

So I just wanted to provide a little clarification on why the GAO may not have looked at means this time around, as well as changes in Medicare reimbursement and costs since then. So thank you very much.

MR. HACKBARTH: Okay. Thank you, and we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:53 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, October 5, 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, October 5, 2012
8:30 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:30 a.m.]

MR. HACKBARTH: Okay. Good morning. This morning, we begin with the third of the Congressionally requested reports, this one on outpatient therapy.

For the people in the audience, let me just say a word about the process and where we are. We've been asked to provide recommendations to the Congress on three issues, outpatient therapy, the physician work geographic adjustment, and ambulance services, and to make final recommendations by our November meeting. And so today, we will be reviewing draft recommendations on outpatient therapy, and after the discussion today, we'll make any modifications necessary for a final recommendation and vote at our meeting in November.

With that, let me turn it over to Adaeze. Are you going first?

DR. AKAMIGBO: Good morning. The Middle Class Tax Relief and Job Creation Act of 2012 requires MedPAC to study the payment system for outpatient therapy services and to address how it can be reformed to reflect the therapy needs of the patient. We would like to thank Lauren Matayer, our RA, for her assistance on this project.

The mandate requires MedPAC to come up with recommendations on how to reform the payment system under Part B and to evaluate how therapy services are managed in the private sector. Some of the policies we will discuss will expire at the end of this year. For those recommendations to be useful to the Congress, they need to be produced before the provisions expire. The mandated report is due June 2013.

You've already seen this in two presentations in our mandated studies yesterday, but just as a reminder, this is the framework we use to evaluate potential policy changes. We ask, how does the policy impact Medicare program spending? Will it improve beneficiary access to care? Will it improve the quality of care Medicare beneficiaries receive? And will the policy advance payment reform? And here we mean, does it move us away from fee-for-service and encourage a more integrated delivery system? Each recommendation or draft recommendation is evaluated using these four criteria.

Today, we will begin with a few Commissioner questions from the September meeting that the staff have addressed. We won't have time to present on each of them,

but Herb, an answer to your question on existing national and local coverage determinations relevant to therapy services was included in the mailing materials. Also, Herb and George, you asked about how the VA manages the benefit and we wrote up a section in the mailing materials. We can certainly take additional questions on that today if there are any.

I'll take a minute to address Mary's question about additional evidence to support the benefits of outpatient therapy services. Then we will briefly review the issues with outpatient therapy services and Medicare, such as spending, growth, regional variation, and the paucity of needed information to determine the need for therapy services in Medicare. And then we will review the Chairman's draft recommendations to address outpatient therapy services.

So there is some evidence in the literature to support the use of outpatient therapy services. For example, physical therapy, often used for patients who are recovering from knee or hip surgery or low back pain, has been shown to improve muscle function, improve posture and balance, and improve patients' ability to transfer, and

that's such as moving yourself from one position to another, as well as prevent falls. In the same vein, occupational therapy interventions have been shown to improve the ability to independently perform activities of daily living, such as transferring or feeding one's self. It has also been shown to be effective in improving IADLs, or instrumental activities of daily living, for people recovering from stroke.

Now, for speech language pathology, some of the clinical conditions we may find there are aphasia, which sis an impairment of language affecting the production and comprehension of speech, and the ability to read or write, and dysphasia, a swallowing disorder that can affect eating and communicating. Speech pathology interventions for these two conditions have been shown to improve speech and communications functions.

But despite the benefits, the strength of the evidence around these interventions varies from study to study due to the size of the population studied and the design of the studies. There's also a concern in the literature about the lack of targeting treatments to the right patients, especially in the outpatient setting.

This brings us to some of the larger concerns about the outpatient therapy benefit under Medicare. Provision of therapy services is sensitive to payment policy. Utilization is sensitive to changes in caps on annual amounts specific to therapy, for example. And we've seen many shifts in utilization in other payment settings, such as SNF and home health.

Second, there's wide regional variation in the use of therapy services and they remain after adjusting for health status. Most importantly, there's almost no information available to CMS to judge whether therapy services are appropriately indicated for the patients who get them, what type of therapy and how much they should get, and once they get therapy, no information to determine their functional outcomes or improvement as a result of therapy services.

Now, let me talk very briefly about each of these concerns.

We presented much of the detail on spending growth in your mailing materials in March and in September, but just as a quick refresher, this chart shows that spending has been growing rapidly since 1999 despite policy changes

to the caps, which are indicated at the top, and changes to the exceptions process, indicated at the bottom of the chart in yellow.

Caps first took effect in 1999, and as we see, spending dropped that year. But from 2000 through 2005, when there were no caps except for a three-month period in 2003, spending increased dramatically according to the years for which we have data. Caps were reintroduced in 2006. The exceptions process was introduced that year, although it was a manual process at first. Spending dropped that year relative to 2004. But after the exceptions process became automatic with the KX modifier, spending has increased every year since.

As we see on this chart, adjusting for health status, mean per user spending among the top ten counties is over $2,800, while it is $477 among the ten lowest spending counties. Counties in the Southeast region, States like Louisiana, Texas, and Mississippi, and two large counties in New York, are among the highest spending areas in the country. The lowest spending counties are concentrated in the Midwest, States like Iowa, Minnesota, and North Dakota.

In the face of spending growth and geographic

variation in spending, there are no functional status data for outpatient therapy beneficiaries at baseline, at discharge, or at any time during the course of therapy. Providers have not been required to report standardized data on functional status at any point to be reimbursed. This makes it difficult to determine the progress patients make, in essence, their functional outcomes once therapy is initiated. Diagnosis codes are not clear and do not provide clear information about the clinical condition of the patient.

Now, the Commission discussed all of these concerns and some policy options to address them back in September. For instance, the Commission discussed the option to develop outpatient therapy episodes and pay on an episode basis. But the lack of good data that would support this approach in the near term and the concern that providers could simply generate more episodes led the Commission to consider other administrative tools.

With the overarching goal of preserving access to therapy services while strengthening CMS's ability to manage the benefit, the Commission discussed other options, and some are listed here.

The Commission discussed including therapy services received in hospital outpatient departments under therapy caps. HOPDs had not been included under the caps but will be from October through December this year. The Commission discussed making this permanent.

The Commission discussed reducing the certification period for the therapy plan of care from 90 days to 45 days. The average episode lasts about 32 days, so this would still accommodate most beneficiaries, but would encourage physician engagement over the plan of care.

The Commission discussed implementing a manual review process for claims that request exceptions to spend above caps limits in order to introduce some scrutiny over the medical necessity of additional therapy services.

And the Commission discussed the option of implementing payment edits to screen for implausible amounts of therapy delivered to beneficiaries. For example, some MACs would screen for more than five units or 75 minutes of therapy in the outpatient setting per day.

The Commission also discussed an option to collect functional status information using a standardized tool across all therapy types.

Ariel will now discuss additional administrative tools to manage spending.

MR. WINTER: Okay. So we're going to talk now about some administrative tools to manage the therapy benefit that we did not talk about in September.

One important management tool is payment accuracy, which has long been a priority of the Commission. In a moment, I'll talk about the multiple procedure payment reduction, which could be used to improve payment accuracy for a combination of therapy services provided in the same session.

In addition, there are other expenditure controls that you may want to consider. One idea would be to reduce the level of the caps and another idea would be to reduce payment rates for individual therapy services.

Medicare currently applies the multiple procedure payment reduction to the practice expense portion of the payment when multiple therapy services are provided to the same patient on the same day. Now, the practice expense covers the clinical labor, which, for example, a physical therapy assistant who's involved in the service, as well as the supplies that are used for the service. Now, the MPPR,

or the multiple procedure reduction, does not apply to the work RVU portion of the payment, which is what covers the work of the therapist, and the rationale for this policy is that there are efficiencies when multiple services are provided in a single session because certain activities are not performed twice, such as greeting and gowning the patient, patient education, and obtaining patient measurements. And, in fact, there are also some efficiencies in supplies.

CMS found that these efficiencies are often not reflected in the practice expense values for therapy services. CMS examined high-volume pairs of therapy codes that are billed in a single session and found that the efficiencies justified reducing the practice expense payments for the lower-paid service by 28 percent to 56 percent.

So based on this analysis, CMS initially proposed a 50 percent reduction for multiple therapy services beginning in 2011, but there was significant opposition from providers to this proposal. And in the final rule, CMS adopted a 25 percent reduction as what they called a conservative first step.

A short time later, Congress intervened and set the reduction at 20 percent for services provided in non-facility settings and 25 percent for services in facility settings.

So under the option we're talking about here on this slide, Congress could increase the reduction to 50 percent in all settings and require that the savings be used to reduce Medicare spending. This would also reduce financial incentives for providers to furnish additional therapy services within the same session.

And now, we'll return to Adaeze.

DR. AKAMIGBO: The Commission could also discuss the option to reduce therapy caps to a lower point on the outpatient therapy spending distribution. The Medicare outpatient therapy benefit includes annual caps on per beneficiary spending. There are two caps limits, one for physical therapy and speech pathology combined, and another for occupational therapy. Therapy caps are adjusted annually for inflation, and for the 2012 spending year, the cap is $1,880.

The mean spending per user under each cap was a little over $1,000 in 2011, but the median program spending

by each cap was closer to $600. Overall, mean spending for all therapy was $1,173, and the median was $629.

In 2011, 19 percent of therapy users exceeded the PT speech pathology cap and 22 percent exceeded the occupational therapy cap, and this has grown over time. Reducing the cap amounts to a level that accommodates the needs of most beneficiaries combined with a manual exceptions process that reviews requests for medical necessity could assure access to needed care, strengthen the effectiveness of caps as a cost management tool, and provide some scrutiny for additional services for medical necessity.

This brings us to the Chairman's draft recommendations for outpatient therapy services. First, to assure program integrity of the outpatient therapy benefit, the Congress should direct the Secretary to reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days and use PPACA-granted authorities to target high-use geographic areas and aberrant providers.

Now, PPACA granted the Secretary new authority to address fraud and abuse in geographic areas and among providers who exhibit aberrant patterns that suggest fraudulent billing. Under this new authority, the Secretary

could place a temporary moratorium on enrollment of new providers, require providers to re-enroll, or suspend payments for services that show a high risk of fraud.

Third, the Congress should direct the Secretary to implement payment edits at the national level that target implausible amounts of therapy.

The spending implications of this draft recommendation would be budget neutral or could lead to a decrease in program spending. This draft recommendation would preserve beneficiaries' access to needed services. And the effect on quality of care is unclear because quality measures are currently not available for the Medicare outpatient therapy benefit. This draft recommendation does not move us from fee-for-service to a more integrated delivery system.

For the Chairman's second draft recommendation, aimed to assure access to needed outpatient therapy services while managing Medicare spending, the Congress should, first, reduce therapy caps for physical therapy and speech language pathology services combined and for occupational therapy, and implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for

this purpose. The Congress should include services delivered in hospital outpatient departments under therapy caps and apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same therapy on the same day.

The components of the second draft recommendation just described are necessary to effectively manage the benefit and associated costs while maintaining access to needed care. The options, however, may result in spending above current law. If spending is projected to be above current law and the Congress wishes to reduce spending on outpatient therapy services to current law levels, the Congress could employ any of these mechanisms. They could lower the therapy caps levels further. They could lower payment rates. Or they could increase beneficiary cost sharing.

Now, for implications. If all components of this draft recommendation are implementing, spending would likely increase relative to current law. This draft recommendation would preserve beneficiaries' access to needed services. We do expect lower use of services among the highest users, but

with the manual exceptions review process, beneficiaries who legitimately need additional services will be able to get them. The effect on quality is less clear because, again, quality measures are currently not available for the Medicare outpatient therapy benefit. This draft recommendation does not move us from fee-for-service to a more integrated delivery system, so there would be no implications for payment reform.

For the Chairman's third draft recommendation, to improve management of the benefit in the longer term, the Congress should direct the Secretary to prohibit the use of V-codes as a principal diagnosis on outpatient therapy claims and collect functional status information on therapy users using a streamlined standardized assessment tool that reflects demographic, diagnosis, biomedication, surgery, and functional limitations to classify patients across all therapy types and use the information collected using this tool to measure the impact of therapy services on functional status and provide the basis for global payment approaches in the future.

As discussed before, there is a prototype for such a tool that was part of a CMS study. And as we discussed

with a panel of researchers and practitioners this summer, additional data elements to that prototype would serve as a good start towards developing such an instrument for payment purposes.

The spending implications of this third draft recommendation would include some administrative costs to develop the tool and collect the data, but no direct impact on program spending. This draft recommendation would not impact beneficiaries' access to therapy services. With respect to quality, the goal is that the functional status information collected using this tool and better clinical data would lead to an improved ability to measure and deliver quality care. The use of a standardized instrument that facilitates the classification of patients by severity and measures improvement over time would facilitate moving from a fee-for-service system to a more bundled payment approach in the future.

To wrap up, we would like your reactions and guidance on these draft recommendations. Some of the policies we've discussed expire at the end of the year and Congress has required MedPAC to make recommendations in this report. For those recommendations to be useful, they need

to be produced before the provisions expire.

And with that, I'll turn it back over to Glenn.

MR. HACKBARTH: Thank you, Adaeze and Ariel. Very well done.

Before we begin the round one questions, let me just say a few additional words about how I thought about this issue and why I framed the draft recommendations in this way.

The approach that we agreed on for evaluating these three issues--outpatient therapy, the physician work GPCI, and ambulance--is that we should not recommend increased spending above current law unless we believe there's evidence that doing so would improve access to care, quality, or support movement to new payment systems. Here, we're talking about a package of recommendations that would increase spending above current law levels. So the obvious question is, why, and I believe that going to a system -- returning to a system of hard caps, no exceptions, would, in fact, impede access to needed care for Medicare beneficiaries. So I think it meets that test.

Having said that, I think it's still incumbent upon us to help Congress find ways to keep that additional

expenditure as reasonable as possible and as targeted on the beneficiaries who most need the services as possible.

Adaeze, could you put up Slide 14 for a second. So as was pointed out in the presentation, right now, we have roughly 20 percent of the people over the caps. And if you put up the bar graph, Adaeze, the one with the spending -- there we go. So we're talking roughly $6 billion in expenditures in 2011. About 20 percent of that represents spending over the cap. So we're talking about roughly a billion dollars or a little bit more than a billion dollars in additional spending if we don't revert to hard caps. And so there's a big potential increase in Medicare spending above the current law baseline if we don't revert to hard caps.

So is that clear? The current law says hard caps, no exceptions. That would reduce spending by a little over a billion dollars. And so if we recommend no hard caps, that's the number that we're trying to work with and reduce it, make sure it's properly used to assure care for Medicare beneficiaries.

And it's in that context that I offer the specific recommendations about -- and I'm not going to go through all

of those, they were well presented -- it's in that context that I recommended some things that otherwise might be a little jarring.

So let me just cite one example. My draft recommendation proposes reducing the caps, and my thinking on that is that if we reduce the cap but still have exceptions, albeit manual exceptions, effectively, what we are doing is saying people can still get access to care if on manual review it's deemed appropriate, where it's simply increasing the proportion of beneficiaries who are going to have their need reviewed before Medicare agrees to pay. So we're sort of putting a different cut point in the distribution. It seems to me that's a way to assure access to needed care while minimizing the budget score with the approach. I won't go through all of the other specific elements of the recommendations, but I just wanted to make sure my thinking, the underlying thinking in my approach was clear.

So with that, let's turn to clarifying questions. Tom looks ready to clarify.

DR. DEAN: Or looks confused.

[Laughter.]

DR. DEAN: Do we know why P.T. and speech were combined? I mean, that seems -- how that came about? It may not relate directly to this. I was just curious.

DR. AKAMIGBO: There's no good reason.

DR. DEAN: That's what I thought.

DR. AKAMIGBO: And there's talk that it was based on just a missed comma. I'm not sure how. It doesn't sound right, but there's no good reason.

DR. DEAN: P.T. and O.T. are often prescribed together.

DR. AKAMIGBO: P.T. and O.T. are much more related, yes.

DR. DEAN: Yeah.

DR. AKAMIGBO: So the combination of the P.T./speech cap is not clear.

DR. DEAN: And the review process, do we have a sense of how that would work? I mean, would they have to get authorization before they'd go ahead with additional treatments? I mean, obviously that's something that CMS would have to arrange, I suppose.

DR. AKAMIGBO: So CMS is actually doing this right now at the $3,700 threshold level, and also in the same law,

the Middle Class Tax Relief and Job Creation Act, CMS was required to implement a manual review process once benes spent $3,700 for the P.T./speech combined cap or separately for O.T..

And as part of that process, once -- if you're a provider and you have a patient who has reached or is approaching that level, you can submit to your MAC, and they have pretty clear guidance on what you should submit, information on the plan of care, the referring physician, their NPIs, the reason why you -- the reason for additional therapy above that $3,700 level.

And at that point, it's a manual review. It's someone at the MAC level looking through that information, and in some cases, they may come back and request information from the medical record to see if there is true justification for medical necessity. So they are doing that. They just started October 1st.

DR. DEAN: I guess the concern with me, I mean, what's the time frame for all this and how long -- I mean, if you have a therapy in progress, is this going to be a quick turn-around so it doesn't interfere with the therapy or are they going to have to wait two or three weeks or

whatever to get a ruling, or are they just going to go ahead and hope they get paid?

DR. AKAMIGBO: So this is a pre-payment review. It's up to the provider to, I suppose, make the decision as to whether they want to provide the service and then hope for, you know, that it would pass muster. But it is a pre-payment review.

As the rules state right now for that $3,700 level, the MAC has ten days to approve or deny. So they have ten days to issue a decision. It is incumbent upon the provider to submit that as early as possible. Certainly these appointments are made ahead of time and they can track. They know how much their patients are spending at any given time.

So it seems to me it would be in their benefit to submit that request at the $3,700 level as soon as they know that their patients are going to need additional therapy services.

So I guess what I'm saying is, it's been designed right now to prevent, as much as possible, any delays or discontinuations in therapy.

DR. DEAN: Thank you.

DR. HOADLEY: Two quick follow-ups on those questions. The speech therapy is much, much smaller than the other two categories. Isn't that right? So, I mean, just quantitatively in terms of its impact on the cap, it's got a lot less. So, I mean, that's certainly something to keep in mind, it seems like.

And on this question of the timing of the review, which I think is an interesting one, I wonder if that's going to trigger the need for or common use of advance beneficiary notices in terms of, you know, warning the beneficiary that they may not -- that they may be responsible for the cost of this in these situations.

DR. AKAMIGBO: That's a good point. They have done that. As of September 1st, CMS sent a letter to beneficiaries and then the letter, they basically informed them of four things. These are beneficiaries who had spent $1,700 between January 1st and August 31st.

And so the letter says, You've spent this much on therapy to date. There is a cap, by the way, and you're approaching that cap. And any additional expenses above that cap that are deemed to be medically -- for services that are deemed to be medically unnecessary, you are

responsible for. There's also this manual review process should you approach the $3,700 threshold.

This caused some confusion, concern. Lots of beneficiaries called CMS. They called their MACs. They called the providers. They cancelled appointments because they were afraid of, you know, being responsible if this were deemed to be medically unnecessary. So it's not the kind of correspondence they're used to getting from Medicare.

DR. HOADLEY: But that's actually different than the kind of notice the provider would say that you're going to be responsible. Is there any evidence of that kind of notices?

DR. AKAMIGBO: ABNs on that?

DR. HOADLEY: Yeah, ABNs.

DR. AKAMIGBO: I have not heard, but I can check.

DR. HOADLEY: Or whether it might under this kind of --

DR. AKAMIGBO: Yeah.

DR. HOADLEY: And I guess the other question is, in the rule for this round from CMS, they've got some data collection. Then they put some data collection requirements

in the rule this time. Can you say anything about that?

DR. AKAMIGBO: The proposed rule?

DR. HOADLEY: Proposed rules, right.

DR. AKAMIGBO: There is some data collection requirement in the proposed rule. So CMS is required to collect functional status information from the Middle Class Tax Relief and Job Creation Act. The proposed rule came out in June, I think.

DR. HOADLEY: Summer.

DR. AKAMIGBO: Summer. And CMS put forth a plan on how -- a proposed plan on how they would do that. And just to not get mired in details --

DR. HOADLEY: Sure.

DR. AKAMIGBO: -- basically it says, We're going to use a series of g-codes to collect functional status at baseline, or once therapy is initiated at some point during the course of therapy, and hopefully, if the patient were to come back for discharge -- for discharge instructions, you could then complete an assessment and have some discharge level function.

But it's a series of g-codes not rooted in any particular -- it's not rooted in any particular instrument.

There's no consistency in how the patient would be -- and how different patients would be assessed, for instance, and it seemed to have a great deal of burden, I think, placed on the provider to determine whether the patient is functioning at 10 percent versus 90 percent and how that would be standardized in reporting back and how it's reported back to CMS.

So I think the general agreement -- not agreement, but the general sense from the folks who read this and had something to say, is that this probably will not work well as it was put forth.

DR. HOADLEY: And when is the final rule -- it's any time now, right?

MR. WINTER: End of this month, early next month.

DR. HOADLEY: Okay.

MR. WINTER: We didn't talk about our concerns in our comment letter on the proposed rule.

DR. HOADLEY: And obviously related to whatever our recommendations are, if there's anything left in the final rule.

DR. MARK MILLER: At the time, obviously, we didn't have a recommendation, and I think what I would just

say is, in our comment letter, we were concerned that you would have a bunch of data, but you wouldn't have much standardization and that it wouldn't lead you to a place. And then now we've come through with this process, and if you are all on-board with a different data collection, then that would be the hope to get to something that's standardized in general and across modality.

To be really clear in answering your question, this would be saying to CMS, What you're doing shouldn't be happening. This is what we would prefer to happen.

DR. HOADLEY: Okay, good. Thanks.

MS. UCCELO: So the reaction that beneficiaries had to those letters suggests that they were unaware that caps existed, didn't know that from Medicare materials or from their providers. So this is just something that they're just not even aware of. And the exceptions process was something that went on that they didn't know about?

DR. AKAMIGBO: Yeah. So the extent to which beneficiaries would log on to MyMedicare.gov or Medicare.gov to get it to access information, the extent to which they do that I can guess, but I won't. I would -- but it is out there. So this information is out there. It is in the --

they receive, once a year, I believe in the fall, they receive a Medicare new handbook. I believe this is in there.

It's on the web site through different -- on the therapy pages, different, you know, sources, different documents. So it's not that this was hidden, but I suspect many would not know the details of therapy caps, especially with the exceptions process. It's not like their providers have to inform them about this.

DR. MARK MILLER: I think that's more of the point. I mean, the therapist could put the KX modifier on the claim and continue the process. So again, I'm not really clear what happens on the ground either, but I'm not sure it needs to involve the beneficiary in making that decision. And I think that speaks to your point.

MS. UCCELO: Yes. And another question kind of following up on what Tom said, and I just don't know enough about the differences between P.T. and O.T., but looking at the materials from last month, or last time we talked about this, there is overlap on some of the conditions that each of these groups of patients are treated for. I'm wondering, is there ever, Okay, I'm approaching the P.T. cap, can I re-

categorize this to O.T.? Is there --

DR. AKAMIGBO: So I've spoken to many providers, both physical therapists and occupational therapists, and I would -- they wouldn't -- it doesn't strike me that they would make decisions based on what type of therapy you should get based upon whether you're approaching one cap versus the other.

It seems that at the point of referral, when the physician is saying, You need O.T. because you need specific assistance with a specific ADL or IADL, you would be seeing an O.T. versus, you know, if you have a total knee replacement and you need physical therapy to strengthen maybe the muscles or, you know, to help you with balance, you would be seeing a physical therapist.

So I have not come across decisions based upon, you know, whether you're approaching one cap versus the other.

MS. UCCELO: Thank you.

DR. SAMITT: Great presentation. Thank you. My question is about Slide 20, which would be the longer term recommendations. In the advance materials, you talk about the work you had done to speak with private plans. And one

of the pieces of information was that most private plans do not require the use of a standard tool to collect functional status either.

So I guess, did you get it? Why? So if this recommendation is going to include collection of information for functional status, private plans are not doing that either. So is it an operational challenge? You know, what is the reason why they're not collecting it today?

DR. AKAMIGBO: There's deep concern, I think, when you talk to the different providers, you know, when you talk to speech pathologists versus physical therapists. Each group is wedded to whatever instrument they deem to be more valuable for their services, and it captures either clinical improvement or functional disability or impairment more accurately for their patients.

And so, I think what we find in Medicare is reflected in the private sector as well. And essentially, it sounds to me like plans that have backed away, also, from saying, You must use this or you must use that, and they've just adopted other more administrative tools rather than requiring the use of, you know, certain instruments to collect functional. It didn't sound like they saw that as

something that was worthwhile given the barriers across the different providers.

DR. MARK MILLER: If I could, one of the things in all of our conversations that came out to me, and this is all consistent, you have different modalities, different tools across modality, and within modality different tools even. And so, sort of bringing some order to that, you know, for the last 20 years has been the challenge.

Underlying this, since there's not a lot of evidence-based guidelines that drive things really clearly, it's really hard to bring this together. But nonetheless, one of the things that helped me start to think about it is, what do you need for planning for any given patient? What do you need for payment?

My sense is for purposes of payment, the private sector has said, I'm just moving to administrative arrangements here. I'm going to set visit limits and then ask people to produce evidence, and if you want to use these different tools to try and produce evidence in the medical record, fine.

And I also want to be clear, from our point of view in the data that we're talking about here, this would

help Medicare move towards a common payment and understanding what's happening with its payment. But the providers could still be free to use their different tools for their own planning purposes.

I found that kind of a convenient line to divide my thinking. What do you need for payment? What do you need to plan and do their services or their plan of care? So we wouldn't be saying, You can't use any of your other tools, but this is the information we need in order to understand payment in the future. I don't know if that helps you.

MR. HACKBARTH: It might be worth, if you're an individual private payer dealing with this context where there's a lack of agreement, it may feel like, I simply don't have the leverage to alter this situation. And so, they don't try. It might be a different question, do they think it should be different than this, and if Medicare were to try to create some common tools, would that be something that they would value.

So it's a difference between what they would like to have and what they think is reasonable for them as individual payers to accomplish. I don't know the answer to

that, but it might be worth talking to some private payers about that question. Do you disagree with that, Craig? You look like you're --

DR. SAMITT: No, I agree with that. I took it several steps further, which is, this whole concept is applicable to many other areas as well. I'm, in particular, thinking about quality measurement. If a common litmus test is created, it would be wonderful for commercial plans, private plans to adopt the same. And so, hopefully we would see that same momentum in other scenarios beyond this one. But otherwise, I agree with your assessment.

MR. BUTLER: My first question is on the regional variation. You have upper Midwest being light, the Southeast and pockets in New York being heavy. I suspect in the upper Midwest it might just be supply, the services, the therapists aren't there. I don't know. But in the Southeast and New York, there may be some suspicious relationships between those who are ordering the services and those who are supplying the services.

But I'm not sure what those look like. Are they typically maybe nursing home-based services? Are they ones that are related to home? Is there some way you would

categorize the kinds of relationships that you would look at if you were trying to explain the variation, the high utilization areas?

DR. AKAMIGBO: If I can just step back or maybe restate what I think I'm understanding, is this being driven by particular settings? Is the variations, particularly in a high use area, is being driven by a particular -- or services delivered --

MR. BUTLER: So if you steer somebody to say, Go find out why these things are so high in utilizing, would you go to look in nursing homes and home care agencies, and what kinds of relationships would tend to kind of fuel the utilization that would be questionable?

DR. AKAMIGBO: So maybe I'll let you speak to the self-referral in a second, but services delivered in nursing facilities account for about 40 percent of spending. Services delivered by physical therapists in private practice account for about 30 percent. And there's some question as to what really constitutes a physical therapist in private practice. There are about three different types of scenarios that we've unpacked so far.

But I would look at those two as driving. There's

a lot of the utilization we see anywhere, but particularly in the high use areas. Per bene spending in nursing facilities is about $2,400 per beneficiary, and HOPDs is about $600. So that's a huge differential.

DR. MARK MILLER: Can I ask this just before it goes to Ariel? Would it answer -- if I understand your question, would it answer your question if we were able to cut the data by the proportions of services and setting in the high and the low areas? It sounds like that's what you're asking.

MR. BUTLER: It might. You might find that, yeah, the nursing home utilization is three times as high in the Southeast as it is in the upper Midwest. It might help lend your way to where you might even apply caps.

DR. MARK MILLER: I hear you.

DR. AKAMIGBO: Yes, we can.

DR. MARK MILLER: We haven't, but we can.

DR. AKAMIGBO: Yeah.

MR. BUTLER: Okay. My second question is on Slide 7. So my first part of it is simple. Underneath the left-hand side, you have no exceptions. Well, when there are no caps, there are automatically no exceptions, right? Is that

-- so that really --

DR. AKAMIGBO: I was just trying to make a distinction between when we had exceptions and when we didn't have exceptions in those --

MR. BUTLER: With the noted except in 1999, which says that these hard caps might work, right?

DR. AKAMIGBO: Yes.

MR. BUTLER: So there's an important lesson right there. They work when you don't have exceptions.

MR. HACKBARTH: If your only goal is to reduce expenditures, yes, they work. They work on any service.

MR. BUTLER: But you're getting a little ahead to Round 2, though. Just because you lower the cap to automatically take some money off the top, it doesn't necessarily change the trajectory going forward.

Now, back to the private plans, which Craig noted you had in the chapter and I did, too, but it didn't look like there was many lessons -- they're struggling with it in the private plans as well.

DR. AKAMIGBO: Yes.

MR. BUTLER: Yet they have typically hard caps, if I read it right, of a round number of visits and then co-

pays?

DR. AKAMIGBO: Yes.

MR. BUTLER: Which we typically don't have, at least in a meaningful way in this. But my guess is that this chart and the private plans, even though they're struggling with it, I'm guessing -- maybe you know or don't know -- is the trajectory in spending in the private plans. My guess, because of either co-pays or maybe their caps have fewer exceptions, that the trajectory is less than it is for Medicare spending.

DR. AKAMIGBO: I think so. Depending on where they are located, the plans we spoke with, they have experienced some spending, some over-utilization issues in the outpatient therapy setting, which triggered a closer look at what tools they could use to manage the benefit. So their trajectory would look very different, but they've already done something about it, and that's by saying, you know, You have 20 visits for the year after which you either get no more or you are subjected to extensive review, and you have $25 co-pays, and in some cases $50 co-pay per visit. So for those two reasons alone, their trajectory would look quite different.

DR. MARK MILLER: And the only clarification I would put in here is, this is when a conversation about a given employer, whether the data generally in the -- you know, if you had it that looked across the private sector looked differently, I'd be much less certain of what to say. In our conversations where somebody said, I took action and this is what I did, of course the assertion is, and it changed the trajectory for my, you know, covered lives. But that data in the private sector, if you had that trend, I don't know what it would look like across.

MR. BUTLER: I bet you a billion dollars down in 1999 versus six billion in 2011 is a pretty healthy increase. I don't know if it's gone up. My guess is it hasn't gone up that fast in the non-Medicare population.

DR. MARK MILLER: Again, we have some private data. We may be able to look at that. I just didn't want to say it flat out without having looked at it, and I'm not going to bet you a billion dollars because you already took half of that off of me.

DR. COOMBS: So one out of five, roughly, are exceeders of the cap overall. In the high cost areas, it looks like there's some top diagnosis other than the v-codes

and it may be more like one out of two, one out of three, would you say, in those high cost areas?

DR. AKAMIGBO: I think I'd try to get back to you on that. So the share of users who exceed the caps in the top spending counties is what you're asking?

DR. COOMBS: Right.

DR. AKAMIGBO: I don't have that data.

DR. COOMBS: Because that makes it real -- that's important for the recommendation that Glenn has offered for shortening the time span from the 90 to the 45, because the average is 32, and if that is indeed the case, it would be a disincentive for the high spending areas, which would work in some respect, and to preserve some fiscal determination for areas in which there might be patients with need.

And then the other question I have is for either Glenn or you. The no-cost for introducing a functionality tool, are we redirecting costs from one area to another? Because I was just interested in that. There was no increase in spending on that one, on Recommendation 2.

MR. HACKBARTH: Could you put up Recommendation 2?

DR. COOMBS: Recommendation 3. I'm sorry. Elimination of v-codes, Slide 20.

DR. MARK MILLER: So, Alice, and your question is?

DR. COOMBS: There's no direct spending, but there must be some implementation. Do you include that? Are you speaking specifically according to billing only for Medicare services?

DR. MARK MILLER: I think if I'm following your question, and redirect --

MR. HACKBARTH: I think I understand Alice's question. So this calls for the creation of new tools in collecting information, which of course always has a cost attached to it. Yet the spending line and the implications say no impact on program spending. That's what you're focused on, Alice?

And so, there will be some additional cost for doing these things. I think maybe what the spending line is referring to is that there's no projected impact on utilization of services and program spending in that sense. Am I interpreting it correctly? So there would be administrative costs, which is -- and I think maybe we discussed this on the phone.

It is always an issue for CMS when we say, Oh, there needs to be more intensive review. Herb can speak to

this better than I can. Those things cost money and they cost money in a part of the CMS budget that is really tightly constrained. They don't come out of the entitlement spending. They come out of the program operations budget which is annually appropriated. And if I'm saying anything wrong, Herb, jump in and correct me.

And so, they have this really tightly constrained appropriations budget, and when more requirements are put in there and they've got to do more stuff, it poses real issues for them.

DR. COOMBS: So my question is, if there are savings accrued because of what you're doing, eradicating the V codes and that, is that -- that's a hard ask to redirect that to the area where you develop a functionality to assess functionality.

MR. HACKBARTH: I'm not sure I followed.

DR. COOMBS: So you just can't redirect that -- in other words, because this is on one side of -- this is one category. You can't redirect the savings --

MR. HACKBARTH: You can't use savings from entitlement spending --

DR. COOMBS: Right.

MR. HACKBARTH: -- to finance operations, unless there's a specific congressional provision that allows you to do that.

DR. COOMBS: Okay

DR. MARK MILLER: And I just want to take -- because this is employed, just reinforce this. On the manual review recommendation, we're also explicit in the language of saying to the Congress that if you -- you need to give the administrative dollars to CMS on this because for this to work -- I mean, in a sense, think of what the private sector does. It says here's your cap visit. Then you have to present evidence to go beyond that, and they fund it. They have somebody who reviews that evidence and makes that decision. And we're saying here, you know, to the Congress that if you want this manual review and have some oversight on the exceptions process, you have to fund the carriers actually having that view. It's back to this point of them having the resources to do it.

DR. COOMBS: So it might be a good idea maybe to tack something else on, like this piece as well.

DR. MARK MILLER: But the only thing I would say here is in a sense what we're saying here on 3 and why --

and we can do that, but the reason we didn't directly go to that is CMS is expending administrative resources now to administer the benefit. We're sort of saying continue to administer the benefit, use a different instrument. There will be some resources in developing the new tool, but that may not involve a completely new operation like the manual review, which is a very intensive oversight. And that's why we sort of spoke to resources in one case. Here it might be more reprogramming of resources that they have already. But if people feel strongly about this, we can obviously speak to that.

MR. WINTER: There is a one-page form that CMS has developed as part of a research project, which we think could be a template for collecting the kind of standardized functional status information that we're talking about in this draft recommendation. So there's been some work that could be -- you know, that has already been done that could be applied to get at the goal of this recommendation, draft recommendation.

DR. MARK MILLER: He said it better. They have a running start [off microphone].

MR. HACKBARTH: Right.

DR. NAYLOR: I wonder if we could look at Slide 14. I just want to make sure that I understand. The recommendation is to now move from annual per beneficiary caps of 1,880 to -- are we recommending to the mean?

DR. AKAMIGBO: I'll let Glenn take that.

DR. NAYLOR: Okay. I'm trying to figure out -- so it's just an overall recommendation with data provided about mean and median. Yes, okay.

MR. HACKBARTH: Lowered the caps as a way to reduce the potential cost of this.

DR. NAYLOR: Okay. So it's not what --

MR. HACKBARTH: But we have not, at this point at least, said lower it to a specific number.

DR. NAYLOR: Okay. And I was wondering if -- and this I think probably may be addressed by Peter, what you're doing in response to Peter's question, but trying to understand not just those that exceed the caps but those -- what's the profile of people that are above the mean and median in terms of understanding do they look -- and I know -- I understand from your paper that's really hard to do. But do they look very different than those that are below the mean? And so as we're making decisions about reducing a

cap, we have a pretty good understanding of what the difference is in needs and so on. So I don't know. Can you at all help to uncover --

DR. AKAMIGBO: We've tried, you know, but remember, at this point we --

DR. NAYLOR: Have no functional data.

DR. AKAMIGBO: We have no functional data. We're relying on ICD-9 codes that look the same across the board.

DR. NAYLOR: Got it.

DR. AKAMIGBO: So I don't know that we can bring more --

DR. NAYLOR: So it's not even above the mean or -- you don't see those kinds of differences?

DR. AKAMIGBO: You don't see huge -- no.

DR. NAYLOR: So maybe it's going to be then helping to uncover where the service use is, et cetera.

And the last thing I'm wondering is the issue about when to trigger the mandated review. I'm wondering why it isn't being triggered at cap now. I mean, it's double the cap that's required.

DR. AKAMIGBO: The $3,700 threshold, that was just a matter -- that was what was in the law, and $3,700 is in

reference to the -- that's the 95th percentile, exactly.

DR. NAYLOR: I guess my question is whether or not triggering that --

DR. MARK MILLER: Earlier [off microphone].

DR. NAYLOR: -- much earlier wouldn't have resulted in something different. I know that's what we're working toward, but how it would affect what we're observing here.

MR. KUHN: Before I get to my kind of two technical questions, just to react a little bit to Peter's question about kind of the variation and maybe a little bit more nuanced than we need. But going back, I think it was either in 2005 or in 2006 when CMS discovered that athletic trainers were actually delivering these services and billing for these services. And under the law, athletic trainers are not a recognized provider with the PTs, OTs, and speech language pathologists, so CMS stopped that. But it seemed like they were collected pretty heavily in the Midwest and Upper Midwest that was out there.

So one of the reasons we might see a decrease in that area is the fact that there were a whole set of providers out there delivering care that were no longer

permitted to deliver care in 2005 and 2006 out there. So just a little bit of a nuance on that.

First of all, thank you both for including the information in the written materials on the VA and the NCD, LCD process. That was helpful. One question on that, on the NCD, LCD. You indicated in the paper that there are very few NCDs, but there seems to be an awful lot of LCDs. I didn't go through and look at all the various Medicare administrative contractors. I just don't have that much time. But I looked at a couple, and I kind of scrolled down the page in terms of the LCDs, and just based on those two looks, and if you multiply that by the others, it appears to me that there's literally hundreds of LCDs out there. Is that an inaccurate assumption on my part, do you think?

MR. WINTER: There are many LCDs. I'm not sure if there are hundreds. I'm looking to Lauren actually --26? Okay, 26 LCDs. And that includes Part A and Part B?

DR. AKAMIGBO: Yes.

MR. WINTER: Okay. So we found 26. Lauren looked through all of them, and she's really the expert on this. But what we found is -- she's not the expert? Okay.

[Laughter.]

MR. WINTER: Among the three of us, she probably has the most expertise.

What we generally found is that they're very similar and they're modeled after the Medicare Coverage Manual in terms of outpatient therapy. There are a couple of wrinkles. There are some MACs that have limits on the number of time services that can be provided to a patient on ACO given day or within a given month, for example, five 15-minute services in OT or PT per day, without going through medical review. A couple of MACs have that limitation. The rest of them -- most of them do not. But, generally, very similar, very broad coverage. There are a couple of exceptions for things like therapeutic ultrasound, which is a modality that's sometimes used, but generally similar and pretty broad.

MR. KUHN: Thanks for that research and that clarification. That's helpful.

The second thing I had a question on was the manual review, a little bit where people have talked about it, and really kind of looking at the capacity issue for CMS to do this. So as we show on Slide 14, we've got 19 percent that exceed the cap for PT and speech language pathology and

22 percent for OT. So how many kind of manual reviews are we talking about here? What's the order of magnitude? Do we have any sense of what we'd be looking at?

DR. MARK MILLER: Do you have a sense of the total service counts [off microphone] or visits that are provided?

DR. AKAMIGBO: It would be at the -- I can get back to you on that.

MR. KUHN: I guess what I'm just trying to think about is capacity within the MACs and how many FTEs they would need to do this, to do it, as Tom was kind of -- and Jack, you know, talking about making sure that it's done in a timely way and what would be the army of contractors that would need to be hired to kind of manage something like this.

DR. MARK MILLER: And we can put some thought in this, and this is a dynamic that, you know, might help you think about this, and it may also relate to some things that Mary was saying a second ago. There's probably a situation where, as you bring the cap down, the percentage of services subject to review goes up, and there's probably a point -- and you could talk about I want to put the cap at this point in the distribution, but there's probably an administrative

point after which your capacity to review begins to stop, and that may be the point where the cap sort of settles in a sense, because at some point your capacity to do this will just kind of fade away.

MR. KUHN: Yeah, that makes sense, and I think -- and as Glenn, I think, when he was responding to Alice's question, you laid it out very accurately in terms of, you know, administrative funds that they have and how they would be able to contract this. So I think it's a good recommendation. I guess I'm trying to think about the practicality and feasibility of it. So if there's some refinements that we can think in that, that might be useful. But it does make sense that that's something that probably needs to be done. Just how do we help the agency accomplish that goal I think is part of our stewardship responsibility here.

MR. GRADISON: I, too, have been concerned about the manual review process, and in particular, I'm very aware of the limitations because of the requirement of an appropriation for certain of these processes. I think these dollars are going to become harder to get, especially if there's division within the Congress about various parts of

the new health care law. It would be helpful to me and perhaps to others to have a short memorandum at some point which just took a look at what are the MACs doing with these dollars, that is to say, what kinds of activities, and in particular, to focus on areas that have to do with manual review. This isn't the first time I think we've talked about a part of the Medicare program where there's at least talk, if not action, about having a review process, often perhaps before care is provided. And so I'd like to personally get a better feel for how this fits into the larger picture of what these reviews are intended to accomplish and the reality about how much can actually be done along these lines. Even if it would be a good idea and even if there is a break point, the constraint of dollars alone could be a very important overriding element. So that's just a general request.

Do we yet have any data from the MACs about the approval or denial ratios in this area?

DR. AKAMIGBO: At the cap level, we don't have data, but we've spoken with a few medical directors from MACs across the country. The denial rates have been classified as low. The denial rates have been classified as

relatively low. And this again implicates the fact that there are few guidelines to help them make a decision about whether something is truly medically unnecessary.

We don't have data at the $3,700 threshold. That just started October 1st. The submission of requests to spend above that threshold started September 18th, so we -- and I was on the call, the CMS call last week, and so we have a sense of how many -- what those requests have looked like, and they haven't had the kind of information the MACs were hoping for. So it's still being refined, but no data.

MR. GRADISON: That's really so critical, I think, to trying to figure out the role of the review process, because if the word gets out most of them are going to be approved anyway, it could actually increase the number of requests. And just the reverse is true, too. I can see situations in which a provider might like to avoid being turned down consistently because that might look like an outlier that would involve further investigation of the way they're conducting their activities and requesting reimbursement.

Thank you.

MR. HACKBARTH: Let me just follow on Bill's

questions to help me understand this. Forget the new $3,700 provision that's just now being implemented. Before that, we have got nominal caps, but basically we've got automatic exceptions that are granted based on the provider just putting a certain code on the claim. So I guess if I am a contractor, the signal that I'm getting from the current law is we don't want you to really seriously review this stuff. Am I missing something?

DR. AKAMIGBO: No, you're not. That's --

MR. HACKBARTH: And so past experience of review, when these are the signals that are being sent, may not be indicative of the future productivity of review if very different signals are being sent.

MR. ARMSTRONG: Bill, I'm glad you asked that point. It was a point I wanted to make, and I won't elaborate too much on it. But there have been times when we've had required caps for reviews and discovered that 98 percent of the time we approved them and decided the administrative investment wasn't worth it. But so there's two reasons for this review. One is to prevent requests from coming forward that would obviously be denied, and we don't know how much of that happens, but I think that's a

good reason for this cap and this review process. But then, second, if we're going to review these, we should review them with an expectation and then a system built so that we can actually deny them if they don't meet our standards, and that requires clear standards and so forth. So, anyway, I think those are excellent points.

Just one other point to comments that had come up earlier. Part of the difficulty in comparing this experience with private plans is that the plans' benefits vary so significantly depending upon what the employers are looking for as well. And even in many systems like our own, our review process and the caps, in fact, depend not just on the benefit structure but also on where the care is being provided. We will review against caps when care is provided outside of our own network, but we won't when it's within our own network. And so, I mean, I can really imagine how that would be a difficult point of comparison.

Craig didn't ask this, but it would be very interesting to be able to look at how this compares to Medicare Advantage plan experience, so for the record, I will say that.

[Inaudible comment off microphone.]

MR. ARMSTRONG: And I guess that's all I'll say.

MR. GEORGE MILLER: Yeah, again, thank you, both of you, for the work on this. This was outstanding, and I really appreciate the information about the VA. I knew literally nothing about the VA process, and it was very helpful to read that.

On Slide 7, just a technical question. You probably covered this in September and I just forgot, but why was there no data for 2005?

DR. AKAMIGBO: So for earlier years, we relied on CMS contractor reports for a lot of this data, and there just wasn't a report for that year.

MR. GEORGE MILLER: All right. And then on Slide 13, help me understand why the difference for 25 percent in a facility setting and only a 20-percent reduction in non-facility settings. What was the rationale thinking for the differences?

MR. WINTER: I'm not exactly sure what -- so Congress came in and when CMS initially finalized their proposal, it was 25 percent across the board. Congress came in and said we're going to reduce the hit on non-facility settings, like therapists in private practice, take it down

from 25 percent to 20 percent, but we're going to keep it the same 25 percent in facility settings. There was no explicit -- I don't believe there was an explicit rationale for why there was that distinction.

But one of the other things they did that's really important is the initial policy was budget neutral as it applied to the non-facility setting. So the money that was saved as redistributed to other physician fee schedule services. And when Congress made this change, they took that money basically out of the physician fee schedule and used it -- part of the legislation was also to prevent a steep reduction in the conversion factor under the -- as a part of the SGR. I forgot if they held it, you know, if the update was zero percent or a small increase. They had to pay for it, right? So this is -- making the savings not budget neutral was a way to pay for some of the cost of avoiding a steep reduction in the conversion factor.

MR. HACKBARTH: So it was based on careful analysis.

[Laughter.]

MR. GEORGE MILLER: Yeah, yeah. Or should I play back the tape from yesterday, what I said?

[Laughter.]

MR. GEORGE MILLER: All right. I'll accept that explanation and breathe deeply.

MR. WINTER: The option we're talking about would be uniform across settings.

MR. GEORGE MILLER: I understand.

[Laughter.]

MR. GEORGE MILLER: Help me understand the high-spend area, if you could put that slide up, the top ten, please. And I appreciate the Chairman's recommendation. I guess I'm just a little bit concerned -- well, let me ask, in the recommendations do they include the average, if you lower the caps to a mean, the question Mary asked about where the mean's going to be, so if they include the high-spend areas, my question would be: Are we penalizing -- and I guess it would average over -- I think I just answered my own question.

MR. HACKBARTH: So, to be clear, as I said to Mary, I have not at this point proposed a specific --

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: -- for lowering the cap.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: There is this interaction that we've been focused on where, if you lower the cap, you're increasing potentially the proportion of claims that are subject to review, and that creates some administrative burden, and how many claims can we realistically review, effectively review. And I'll want to come back to that when we get to round two.

MR. GEORGE MILLER: I will, too. I'll cover it in round two. Just one quick point. It seems that with these high-spend areas that's one of the reasons for the cap being driven down, which makes perfect sense. But I'm just wondering if we're penalizing some that may be at the appropriate level but that cap --

MR. HACKBARTH: You know, one inference from this is that in some parts of the country a lower cap would not result in any review at all.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: In other parts of the country, you'd be talking about a high percentage of users being subject to review.

MR. GEORGE MILLER: Right, yeah.

DR. MARK MILLER: The only quick thing I would add

here is the program integrity recommendations, number one, also would presumably come in and have greater effect on the left-hand side of the slide. And so if there were national edits that said this many services in this time period don't make a lot of sense, maybe some of that gets worked down, and the cap is still likely to have a greater effect there, but maybe some of the real aberrant services are cleared out through that kind of process.

MR. GEORGE MILLER: And I'm sorry, just one quick thing. In the paper, I was just curious, in your recommendation for a tool, an assessment tool, why was not either ethnic or race included in the demographic information so that we could measure disparities?

DR. MARK MILLER: I don't think it was an explicit decision to exclude it. We were trying to repeat the information that's on this basic instrument that, you know, as a starting point for where they could start to collect information.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: To just quickly go back to George's first question about the multiple procedure discount, and he asked about the difference between the 25

and 20 percent discount for facility and non-facility-based, and that was in legislation. We were all sort of making light of that, that it was probably not based on, you know, a real careful analysis. My understanding, though, is that there was a significant piece of analysis for the initial CMS proposal for a multiple procedure discount.

MR. WINTER: Yes. If you go back to Slide 12, you'll see we summarize that.

MR. HACKBARTH: Yeah, so I just don't want our making light of the one to undermine confidence in the other. Okay.

DR. HALL: Wonderful job on this. Can we go back to 7 again? This is total Medicare spending on services. So it doesn't distinguish between the actual amount per recipient versus volume. Is that correct? I just want to make sure I understand that. This would just be the whole lump annualized amount that's spent on services. So do we have any way of knowing whether in some of these cases, particularly since, say, 2005, that one of the phenomena here is just an increase in the number of recipients of services as opposed to increased spending on average per --

DR. AKAMIGBO: In September we had the per

beneficiary table.

DR. HALL: Right, I saw that.

DR. AKAMIGBO: And so that basically accounts for the increase. It takes that out as a factor, the increase in the number of users. We're just looking at spending per user. And it essentially follows the same trajectory.

DR. HALL: The same, it explains all of it, because, you know, there have been so many services that have been introduced since, say, the last ten years that almost automatically generate physical therapy services. A good example would be knee replacement. It's doubled over ten years, and virtually 100 percent of those patients have rehab services.

Anyway, I guess what I'm getting at is whether we still have a comprehensive picture of this whole very heterogeneous group of providers -- I mean of service recipients. You mentioned, Adaeze, that 40 percent of the services were provided in nursing homes. Do I have that right?

DR. AKAMIGBO: It was about 38 percent, yeah, 40.

DR. HALL: Near enough for government work. And 30 percent were in private practice settings or ambulatory

settings.

DR. AKAMIGBO: Physical therapy.

DR. HALL: Physical therapy. That's what I'm really concentrating on. Where was the other 30 percent spent?

DR. AKAMIGBO: In a variety of settings, so about 10 percent were -- 10 percent of spending occurs in outpatient rehab facilities. Hospital outpatient departments account for about maybe another 16 percent, so that's 26. And then physician's offices account for about 4 percent.

DR. HALL: So almost half of these services are in one venue, nursing homes; is that right?

DR. AKAMIGBO: Essentially, yes.

DR. HALL: I guess the one thing I'm concerned about, without this kind of more focused view of the population, is whether by any system of caps or constraints on utilization that we might penalize a lot of groups that don't really need to be penalized, and maybe there's more bang for the buck if we concentrate in areas where there seems to be clear-cut issues. We won't say anything about Queens and Brooklyn County -- or Kings County. I don't know

whether that would be of use to us, but it may come up in round two as well.

DR. AKAMIGBO: Okay.

MR. HACKBARTH: Bill, let me ask about the first comment. What would be the policy implications if we were, for the sake of discussion, to find that an increase in the number of users as opposed to use per beneficiary was an important driver of the increase?

DR. HALL: Well, I think it would have multiple causation. Let's just stay with knee surgery for a moment. There has been some recent commentary in some of the medical literature about this increase, and we really don't have any good data on quality of outcomes to justify whether even the procedure itself is a good one. Well, that's for another discussion.

But I guess I always worry when there has been such an increase in the use of anything, predominantly technology, but even maybe services like this that are more related to increased volume of recipients. That's a different question than how much we're spending per recipient, I think.

MR. HACKBARTH: We've got, unfortunately, this

very tight deadline.

DR. HALL: I know. Right.

MR. HACKBARTH: And we have to make a recommendation. We've got a certain number of policy tools, you know, the dollar value of the cap, manual review, multiple procedure discounts and the like. I'm trying to connect the issue that you're raising, which I think is an important and valid one, and what it might mean for the configuration of policy options that we recommend to the Congress.

DR. HALL: Well, let's say we found that a lot of this is due to medical procedures that weren't there, let's say, in the year 1996 or something like that. I would say one counter of health care systems might be, well, look, if you want us to keep these people in the hospital longer rather than get them out with rehab, fine, but then you're going to have to pay for this -- or we're going to have to pay for it, or someone is.

I guess I'm more thinking down the line when we really start pushing, if we do bundling of payments. A lot of these bundled services, by the way, have a lot to do with physical and occupational therapy. I hope we don't create

problems for ourselves as we go down the road on this. I don't want to overemphasize that point.

DR. MARK MILLER: One thing about your comment on differential caps which seemed to be --

DR. HALL: Maybe.

DR. MARK MILLER: Okay, because then I suspect that you could just be back at this table five years from now and, you know, the growth has all moved out from under that cap and moved to the one where there was -- where it was looser.

DR. REDBERG: Thank you for an excellent report.

On Slide 20, on the Chairman's draft recommendation three, I just wanted to clarify. I think the tool certainly is a good idea, but is the idea that when it says we'll provide the basis for global payment approaches that the payment is going to be pegged to the improvement on the tool or would it be a collecting tool just to know how it's doing? I wasn't sure what that meant.

DR. AKAMIGBO: I think I understand your question. So the idea is that the tool would be used to do a couple of things, to collect information on functional status over time, so from the time the beneficiary starts getting

therapy to the time they are discharged, and that based on that -- so based on what we've learned about their improvement or their outcomes, we would then be able to -- should we move to an episode base or some more bundled payment approach, we would have the necessary information that would -- to help sort of move into that payment framework. Because I think for a bundled payment, you need to know --

MR. WINTER: [Off microphone.]

DR. AKAMIGBO: Yes, essentially how to classify patients by function -- by severity, by function, by risk. And so that's what the -- go ahead, Mark.

DR. MARK MILLER: I think there's, in a perfect world -- which, you know, we can all pause for a minute and decide what that is -- this might do two things, okay. One is if you were still in a fee-for-service environment, maybe it gives you another metric to judge whether you continue. So there's a continued improvement here. I'm hitting a point. Let's imagine a world in which there are not caps and that kind of thing and you're sort of saying, look, there's improvement here. This patient should continue. This has plateaued and so we're -- maybe. And I want to say

that's a real reach.

I think what the statement about the bundling and those kinds of things, we're trying to capture what the Commissioners were saying last time, which is if you wanted to try and build this into bundles or help an ACO manage and you could organize people consistently into more identifiable groups -- knee replacement surgery, this appears to be the average amount and the distribution around that amount -- it might help in constructing either bigger bundles around a post-acute care period, or alternatively, an ACO in trying to manage its populations. We drew that out of conversation that we thought you guys were having.

DR. REDBERG: My other question is, can you tell me, and maybe I missed it, how much does the usual PT or OT episode cost and is there a lot of variability? I'm just trying to understand how many episodes these caps would actually cover.

DR. AKAMIGBO: So the per visit payment is around $73, and there are, on average, 16 visits per year. So someone can do the -- it's about a little bit over $1,000, I think. So that's roughly how much it costs per episode.

MR. HACKBARTH: Okay, so we're to round two and

we've got a lot of work to accomplish here in this round. This has been a very rich discussion. People have raised important and valid issues, but we need to get to a recommendation for next month's meeting. That's not optional. So I'm going to try to really structure this second round so that we come away with a clear sense of direction in formulating the final recommendation. So everybody take out your pen and paper. That's good, but I'm going to actually break it down to a little bit more granular level.

And the way this is organized in my mind is like a decision tree. The first decision is do we recommend the hard caps or not. Current law is, January 1st, we revert to a system of hard dollar caps, no exceptions.

If your answer is, no, we should not revert to a system of hard dollar caps, if we have no caps and do nothing else, we're talking about an increased Medicare expenditure above the current law baseline of roughly $1 billion a year, $10 billion over ten years.

If you don't want to incur that cost -- recommend to the Congress that they incur that cost -- which tools do you support using to reduce that cost? And, frankly, we are

not going to be able to eliminate the cost. We are talking about reducing the budget score for not going back to hard caps.

The items on the table are reduce the cap, the effect of which would be to mean that more users would be subject to review.

A second tool is intense manual review of all claims above whatever the new dollar cap is.

A third is the multiple procedure discount in the payment rate.

And so those are the ones that are incorporated in my recommendations, and I'm setting aside -- I haven't sensed any disagreement about the program integrity pieces of this.

I think, based on the September discussion, I assumed everybody wanted to put the hospital outpatient departments under the cap. It didn't make sense to treat them differently than anybody else, and so I'm not going to ask for people on that.

So we've got three major tools -- lower cap, manual review, multiple procedure discount -- that I've incorporated in my recommendations.

Then we have the passage that we would add to the text that says, although this isn't part of the MedPAC recommendation, if Congress decides that it is unwilling to accept whatever residual score is left after whatever we embrace, they, of course, could lower the payment rate to providers and/or increase beneficiary cost sharing on services. Those are the other two tools that I did not incorporate in my recommendations, but they are logical additional tools.

So, again, the questions are -- I have answered the questions. I don't think we ought to go to hard caps. I'm unwilling to accept a billion dollars a year in additional expenditure. To try to reduce that cost, I'm willing to support a lower dollar cap, manual review of claims above that cap, and a multiple procedure discount. I have not been willing to endorse just an across-the-board reduction in payment rates or increasing beneficiary cost sharing.

So when you go through, if you can sort of structure, this is what I support and this is what I don't support, that'll help me in formulating the final recommendation. And Tom, you are up first.

DR. COOMBS: One question I have. The V-codes, elimination of V-codes, are we going to incorporate that into our analysis, as well?

MR. HACKBARTH: To me, frankly, that's sort of an obvious one. The V-codes, they ought to be eliminated. I'm trying to focus the discussion on what I think are the really major issues that have financial implications, as well as major access implications. For me, the V-code thing is a pretty obvious one, frankly.

Tom.

DR. DEAN: I have another question that probably really should have been in round one. When these claims are submitted, is there any attestation about the need for continued therapy? I mean, does the therapist have to document their belief that there has been progress and evidence of continued progress?

DR. AKAMIGBO: Yes. The answer is that the KX modifier, that is what the KX modifier is attesting to, that there has been -- that there's necessity to continue to receive therapy services above the cap and that that's been documented in the medical record by the therapist.

DR. DEAN: And they have to sign a statement to

that effect, or --

DR. AKAMIGBO: That's essentially what that modifier represents on the claim.

DR. DEAN: I'm just wondering if there is a clear statement that they are responsible for stating that?

DR. AKAMIGBO: In the medical record?

DR. DEAN: Yes.

DR. AKAMIGBO: Yeah. It's essentially --

DR. DEAN: Is it just implied or is it --

DR. AKAMIGBO: So let me make the finer distinction --

DR. DEAN: -- because if this is reviewed or audited, is there a way to trace that back to the individual that made that judgment, or --

DR. AKAMIGBO: Yes.

DR. MARK MILLER: Tom, are you asking under the current situation --

DR. DEAN: Yes, current.

DR. MARK MILLER: -- or the new situation?

DR. DEAN: Well, either one. I mean, I was asking under the current situation, and if it isn't, is that something that we ought to consider, I guess.

DR. MARK MILLER: The only thing I would say about the new situation is this. If a person comes up to the cap and says, I want approval to go beyond the cap, in a sense, they have to justify that to -- not in a sense, they have to justify that to the MAC. And so, presumably, the therapist is providing that information, and if the decision to go ahead is given, then it has been accepted as a valid service. And so I don't know whether the attestation is still necessary at that point. That would --

DR. AKAMIGBO: This is -- you're speaking, Mark, you're speaking to current --

DR. MARK MILLER: No.

DR. AKAMIGBO: This is --

DR. MARK MILLER: The future.

DR. AKAMIGBO: -- in the future --

DR. MARK MILLER: Because I think you're asking the question as it relates to --

DR. DEAN: Just if these are challenged, is there someone that would be required to take responsibility for making that judgment, just to make sure that -- you know, obviously, we do this and we may get challenged, and I think it's reasonable that if we're saying that there is a reason

to move on, somebody should have the responsibility of saying that, yes, that it was necessary.

MR. HACKBARTH: So just to pick up on what Mark is saying, so if you're applying for services above the cap, there is, for all practical purposes, an attestation that I, the therapist, think these are needed services, and then that request is subject to review. For services below the cap, there is a requirement that there be a plan of care developed by the therapist, and I don't know that there's a formal attestation requirement where you swear at the bottom that this is an accurate statement. But there does need to be a plan of care, as I understand this.

DR. AKAMIGBO: Yes.

MR. WINTER: The plan of care applies to services both below and above the cap.

MR. HACKBARTH: Yes.

MR. WINTER: It applies to all services.

DR. AKAMIGBO: All therapy services.

MR. HACKBARTH: Right. So how much of an impact on utilization you would get from a formal attestation requirement, I'm not sure that it would be a whole lot of additional benefit from that.

DR. DEAN: Okay. Well, I guess that was the question. It's just relatively easy to do, that's the thing. So beyond that, I support the recommendations. I think the three approaches you suggested make sense and I would support those.

DR. HOADLEY: So I, too, agree with the basic framing of the recommendation. I guess I would make two comments.

One is the issue we talked about earlier on the question of manual review and burden and its influence on the level of the cap. And the one thing I do remember from one of the private payers was, or perhaps one of the private benefit managers had developed sort of an automated process that could handle some set of reviews that were relatively routine, and then ones that made it through the automated would go to a more truly manual, you know, hands-on human review, and it may be worth talking about something like that just sort of as a partial way to help address the burden issue and be able to deal with that.

The other thing I do remember from the private plan experience is some of the interest in per visit payment and whether that serves as an alternative to the multiple

procedure reductions. I realize there's a work been done on that, so it probably doesn't make sense to go a different route within the recommendation, but it may be worth at least a comment that that is an alternative thing that could address some of the multiple procedures on the same visit, just a flat per visit rate rather than the per code rates.

MS. UCCELLO: I agree with the recommendations as they're stated. I think you've done a great job kind of making order out of chaos.

One comment on whether -- if we do say something about where to set the new cap, I would think we would want to do this in terms of percentiles instead of the mean. If we think about it, it's now at the 80th percentile, so how far down from that do we want to go? But I think percentiles rather than means make more sense.

DR. BAICKER: So I also agree with the direction of the recommendations wholeheartedly. Imposing strict caps would inhibit access, so that's no good. But then we need some of these tools. And I think the combination of lowering the cap and the manual review makes a lot of sense.

Scott's point is well taken, that it's hard to judge the success of manual review by denials. In some

sense, if you never have to deny anyone, that is a success because people have moderated the use that would be denied. So it's going to be hard to know how to set the cap and the cost of the manual review that a lower cap would trigger. That's a balancing act that clearly needs more exploration, but that seems like the right way to go. And the multiple procedure adjustment clearly seems very sensible to me.

I think there is great potential in the variable beneficiary cost sharing that you outlined, and I understand the reasons for not pushing that forward now, and I'm glad we at least discussed those options, realizing that their effectiveness is hampered by the current Medigap environment and that some of our other recommendations about ensuring that Medigap plans don't push additional costs onto the main program. If those were in place, then I think there would be even more potential for that cost sharing to be successful. But given that the world doesn't do everything that we say, which seems shocking, I think it's reasonable to have structured it the way that we have.

DR. MARK MILLER: That little discussion that you just went through could certainly be built into the chapter and I think would --

DR. SAMITT: I also fully approve the recommendations. I certainly wouldn't want to see hard caps. There would be untoward consequences there.

I do have two small concerns. One pertains to what we talked about earlier regarding the communication to beneficiaries of reaching or coming close to a cap, and I'm worried that beneficiaries would individually choose not to receive therapy services, even though should they go to manual review they would be approved. So I'm not sure how we reconcile that issue. I don't know whether there can be a prevention of balance billing to beneficiaries. The providers would fully bear that cost if there isn't medical necessity. So I feel a little bit uncomfortable about that because it could lead to under-utilization of necessary services per the beneficiaries' choice.

I'm also a little bit worried about the manual review and the burden associated with it. Sometimes in our organization, what we would consider doing, and I don't know whether there's any precedent here, we'd consider a gold carding methodology. So either providers who currently routinely fall below the cap are gold carded in that there isn't a manual review process. It's monitored offline, but

there isn't a manual review. Or that the manual review applies to all, but after a period of time, should people never seek out an approval or a manual review, that they are then gold carded. So that may be a slight modification that could help to some degree some of the burden.

MR. HACKBARTH: And as with Kate's comment, I think each of these concerns are important things that we should raise in the text. I'm not sure how we could properly handle them in boldface recommendation, but that would be my approach to these issues. Is that okay?

Peter.

MR. BUTLER: So, actually, I would, surprisingly, support hard caps, but you didn't make that an option, I think.

MR. HACKBARTH: I want to hear that. I just laid out my own analysis.

MR. BUTLER: And I actually would support cost sharing, not necessarily because the beneficiary would now have skin in the game, but we have to remember that Medicare and supplemental insurance -- what's not covered -- not everything that is needed is covered by the benefit package now, necessarily, and so simply to say the value of this is,

you know, you could have 50 percent or something covered or something along those lines and say, why is it -- was this the next best benefit enhancement? I'm not sure. We limit the number of SNF days, for example, that are covered by Medicare now, right? And we don't say they're not needed, but it's not something that's within the Medicare expenditures overall. So it's another way of looking at the cost sharing, not just getting consumers engaged in it, but is this the value service that we think it should be.

But back to the more specific answer. So I guess my first choice would be a hard cap, but alternatively, if we have -- I'm supportive of the multiple procedure discount. So I could support, certainly, the exceptions, but I'm not really supportive of manual process. I just don't think it's going to be worth the time and effort.

So I'm probably not as clear as you want me to be --

MR. HACKBARTH: Actually, if you support --

MR. BUTLER: -- as a tool --

MR. HACKBARTH: -- hard caps, there's no budget score to work off.

MR. BUTLER: But alternatively, I would definitely

support a cap plus the multiple -- I want to do it through pricing. I think that the success of trying to intervene in exceptions process, wherever they are, is laborious and not all that good. So I'd be happy if you just left the same exception process in place, had multiple discounts, multiple procedure discounts, and a lower cap.

MR. HACKBARTH: Yes. So I'm not trying to talk you out of it, push back, I'm just trying to understand. So on the one hand, you're saying hard caps --

MR. BUTLER: That's my first choice.

MR. HACKBARTH: But then if we don't have hard caps, you're saying, well, the only one you really feel comfortable with -- or only ones are cost sharing and the multiple procedure discount. Am I --

MR. BUTLER: But you took cost sharing a little bit off the table.

MR. HACKBARTH: Well, again, I laid out the menu and I'm trying to understand as explicitly as possible where all of you stand. I told you my personal choice, but I want to understand yours --

MR. BUTLER: Yeah.

MR. HACKBARTH: -- and I just want to make sure

I'm understanding yours correctly. Your first choice is hard caps. If there are not hard caps --

MR. BUTLER: Then I'd do a combination of the cap, permit the exceptions process, but I wouldn't make it manual, and I would include coinsurance for going over the cap plus the multiple procedure discount.

MR. HACKBARTH: Okay. Okay.

DR. COOMBS: I support the recommendations and I'm glad you don't have cost sharing and I think that there's a point where if it's really, you know, deemed necessary for an extension, that that may, indeed, alter the course for a patient and get a patient in a better physical status and decrease morbidity, follow-up morbidity.

So I think, for me, the process of having the manual review in place increases the integrity of the program and I think it's more important to get the best product at the end for the patient. I'm more willing to give on the other end than on the patient cost end because I think -- I have to believe that there's something good that's going to result in a better outcome for the patient in the big picture, even for the less cost burden on the patient, which makes sense for me.

MR. HACKBARTH: Perhaps I should just say another little bit about cost sharing and why I put it where I did. I guess my first point would be, in some ways, I think this is like home health, where there is a significant discretionary component to it, and all other things being equal, that says to me cost sharing is an appropriate tool to consider.

I ended up in a different place for two reasons. One is, unlike home health, there already is cost sharing in this service. There's a Part B deductible and 20 percent coinsurance, so we're not starting from zero. But that wouldn't rule out the possibility that you could have a restructured cost sharing with higher cost sharing later in the potentially more discretionary end of the continuum.

But then I bump up against the Kate issue. You know, in the world of our redefined Medicare benefit package, including the charge on supplemental coverage, that's a recommendation that would make a lot of sense. That is not the environment that we're in for purposes of this recommendation. We're in an environment where whatever we do on cost sharing is going to just flow through the supplemental insurance system and it's not going to affect

utilization. It's just going to be a straight cost shift to beneficiaries. It flows through the premiums of supplemental plans. So I don't see the gain.

So that's how I got to -- it's not that I'm in principle opposed to cost sharing. I just don't see it working in this context.

DR. NAYLOR: Thank you both, and all the team, for another exceptional report and the update.

So I do not support hard caps. In terms of the tools, two and three listed there, multiple procedure payment and including services in hospital outpatient department, I support.

I am concerned about decreasing caps, and I -- so let me just say that the framework we're using is what do we know about potential impact on access and quality and obviously on cost. And I think the evidence, albeit imperfect, points in the direction that we have opportunities here, and opportunities in improving function that could have -- are they upstream -- really important impacts in terms of use of more costly resources downstream.

And so I would like to think that maybe we could also explore keeping the cap where it is, but putting the

mandated reviews right in place to see, at least for the short term as these functional status measures are -- I mean, that, to me, is the ultimate gain, to get a functional status measure that's linked to performance, and payment is linked to performance.

So that's where I'd go. If we go with reducing caps, the idea of percentiles makes a great more sense to me than thinking about means and medians.

And let me just say that this is one area that Medicare beneficiaries have been really loud and clear about. As they look to the future, the thing they care most about is their independence. It's function. And so I just want to make sure that we get to the right kind of solutions that are really aligned with what people think are most important to them.

MR. HACKBARTH: You said that at the September meeting, Mary, and I personally found that very persuasive and it's one of my most important reasons for not wanting to do hard caps.

DR. NAYLOR: Thank you.

MR. HACKBARTH: I think in terms of the quality of life for Medicare beneficiaries, the ability to get around

and be independent, I think they serve often very, very important services. Herb?

MR. KUHN: Glenn, I want to thank you again and all the staff for the hard work here, and I think pulling together a lot of diverse ideas and getting us to a position where we're looking at these three recommendations. So having said that, I think the recommendations are in the framework and they work for me. So I'm generally supportive of those.

The manual review, you know, I've raised some questions about that. I think we'll get some more information in terms of the resources needed, but it's pretty clear that the KX modifier is on auto-pilot and something needs to be done. And short of manual review, I don't know what other option exists out there to grapple with that.

And on the multiple procedure discount, I'm a huge fan of that. I was part of that at CMS when we did it on imaging. I just think that makes a lot of sense. So I think that's going to work real well.

But I would like to kind of ask if we could think collectively about maybe another option or a refinement of

some of the options we have here. You know, as we heard from Adaeze in her presentation, there are a lot of concerns about the outpatient therapy benefit under Medicare. As she kind of rolled out in the slides that she presented, CMS lacks a lot of basic information in terms of who should get the benefit, what type, and for how long, and really, we don't have any information about improvement or level of improvement that's out there.

We also heard today about the fact that there are very few NCDs in this area, and there are a moderate number of LCDs. So perhaps I'm over-interpreting this, but it sure seems to me that the contractors are struggling with managing this benefit or else they wouldn't be issuing these LCDs as they go forward.

I also know from our conversations, both last meeting and this meeting, that therapists treat patients with many different conditions. So it's a complicated issue and it's in many different settings.

So having said that, I was encouraged yesterday when we were going through the ambulance set of recommendations and Recommendation Number 3 where we put forward some national guidelines to kind of more precisely

define the medical necessity requirements, so I think there's a bit of a framework or a precedent here.

So the NCD is a blunt instrument. It's difficult to kind of manage and I just think that would be cumbersome and difficult for CMS. So maybe an alternative that we could think about, and the reason why I want to think about this alternative, because we have these wonderful set of recommendations, but if we place them on top of a shaky foundation, I don't think we've accomplished much.

So I think we need to kind of move in parallel here to kind of shore up the foundation a little bit, kind of like we did on the ambulance recommendation yesterday. So what I would think about is maybe that we could suggest, encourage, or even direct the Secretary to ask CMS to kind of examine the language regarding coverage, and refine it through a systematic process of reviewing the Medicare benefit policy manual.

I think by looking at the manual, going through a systematic process, updating the manual, I think that gives us a better foundation so that as we add these new kind of activities related to this benefit, it might serve us well in just performance overall.

MR. HACKBARTH: So, Adaeze, could you put up Recommendation 3? It seems like that could fit in this context of certain longer term improvements.

MR. KUHN: Like I said, it could be another one or it could be subsumed under that, but either way, I think that's just the way I look at it.

MR. HACKBARTH: Yes. So we'll talk more about that, but this is where I would be inclined to place it.

MR. KUHN: To place it.

MR. HACKBARTH: Yes.

MR. KUHN: Thank you.

MR. HACKBARTH: Bill?

MR. GRADISON: I support the recommendations. I have this nagging concern about hard caps and I want to explain why. For a time, I served as the director of a rather large national managed care plan that focused on worker's comp. And, of course, the circumstances were different. The population was different in general from the Medicare population, although as an aside, I think we're going to see a growing proportion of Medicare beneficiaries who are working in the future, especially younger Medicare beneficiaries because of the inadequacy of retirement

benefits that we can already anticipate and see happening.

What was going on, and it's true today, I believe, still in the worker's comp area, that they found that by incurring much heavier costs at the outset, more frequent physical therapy, more hours a day, more days a week, that they were able to get people back to work quicker. And that was the trade-off, because from the point of view of the employer, they were balancing higher medical costs against the wage costs.

Now, again, that is not exactly our situation, but the reason I find that that helps inform my thinking about it is that in a sense, one could argue that the programs have the same goal, which is to restore maximum functional status, and even though there isn't the employment tie-in, in most cases, for Medicare. So that's why the hard caps at this stage of my thinking don't have much appeal. I think that's all I want to say on it. I'm supporting.

MR. ARMSTRONG: First, I, too, would say I support the recommendations the way that you laid them out. We're trying to solve this problem where we know, because of our benefit structure and our payment policy, that we're spending who knows how much, but maybe a billion dollars

more on this and it's not a good investment of our beneficiaries -- of the program dollars.

But at the same time, there are people who need way more than the cap, and it's good care, and so we're trying to strike that balance and I think this does a nice job of that.

Around reducing the cap, in particular, there have been some concerns about, you know, should we reduce it, what's the right level. I think it should be reduced and that the real question is, do you have confidence in the process by which you can manage that lower cap level, and it's not that hard. We should be able to figure out how to do that.

I think the last point I would make is that while I support this, I do think we should be fleshing out kind of those options that describe, if you really want to make this budget neutral, what would you need to do. I think I believe, like many other Commissioners, that the supplemental plans really mess up the incentives for the beneficiaries in ways that hurt us.

I believe that there should be more out-of-pocket costs that influence our beneficiaries' decisions than there

are given the MediGap plans. I don't know the solution specific to these outpatient services, however, but I think we need to use this as another chance to make the point that there's a real problem in the way MediGap plans disconnect patients from financial incentives that they should be connected to, and let's push that.

I guess the last point I would make is that the staff probably get this, but for me, I'm not clear enough as I could be about how we deal with a whole series of these ambulatory services and the payment policies and benefits associated with them. We've referenced home health with outpatient services and there are many others. It just seems to me that, at least from my point of view, we come into each one of them kind of separately and there's like an emerging set of principles about how we want those benefits to evolve.

I would really benefit, I think, some time from a little bit of time to put them all in front of us and say, What's the consistency in how we approach payment policy that we want to apply to all these different areas? And so, that that, too, I think, will really help us understand how each one of these sets of recommendations are actually

contributing to the advancement, you know, to a more reformed payment system.

MR. GEORGE MILLER: Yeah, I think Scott just mentioned one of the points I had on my paper to make. We're again dealing with a silo versus comprehensive health care reform, and so when you look at just one silo, this makes sense and I support the recommendation. It makes sense in that framework.

But I do question the billion dollar statement. I understand we need to reduce that. But if we looked at by reducing that, does it have a downstream impact somewhere else where someone may not get care and then go into the hospital? And again, Scott made a very good point about looking at it comprehensively.

But since we don't have it on the table today, I do support the recommendations. I would prefer not to have hard caps, and then the three things that you illustrated are important. For today in the context, I believe this may be the right kind of solution for what we're dealing with. I want to echo again Mary's point about the quality of life and giving beneficiaries the option to choose and how to be very, very active. I believe this set of recommendations

move into that context.

But I again want to emphasize, when we look at comprehensive, the entire package, we may look how it impacts each other. At first, until I read the paper -- and I'm very pleased with the paper -- was concerned about increasing co-pays, but I noticed in the paper the VA does have co-pays and, you know, we already have a payment. Again, Scott just illustrated the point about the MediGap payments that kind of blinds -- not blinds -- but doesn't have the same impact as paying really out-of-pocket because 90 percent of it is covered. So anyway, I support the recommendation.

DR. HALL: Well, I'll join the chorus on this recommendation as we've said with the plan. I just emphasize again what Mary and Bill and George said about the importance of encouraging development of functional measures.

I tried to find a little bit more from a very cursory reading of the various associations that represent the deliverers of these services. I was surprised that they haven't really gotten on board on this and taken the lead in developing functional assessment tools. They have, but not

really linking it so much to a potential payment system. I think there's just such a crying need for this, so it can't just be a little one-liner in the text, but has to have some emphasis.

DR. REDBERG: I'll support the recommendations and I just wanted to add, you know, in particular in thinking about, you know, our patient-centered focus, we're really talking about patients so much. It's not treatments. If you look at what most -- a lot of these therapy services are used for, a lot of them are back pain and joint pains. And I think we should kind of apply the whole concept we're talking about here in looking at functional status to all of the other treatments we also have for back pains and joint pains.

For one example, we have a lot of back pain surgical procedures that have never undergone these kind of tests. They don't show any improvements in quality of life, and in fact, they probably do -- they do a lot of harms to our Medicare beneficiaries. For example, we spend -- well, in 2008, we spent one billion dollars on vestibuloplasty and keratoplasty which, you know, in a SHM controlled trial in the New England Journal had no improvement over SHM. And

most of that was Medicare beneficiaries and those are done for back pain.

And so, if we're going to apply these kind of tools for a $73 dollar an episode physical therapy, which I think we all think is a good thing for our beneficiaries, we should also apply those to the other things we do for back pain. And that, I think, would make it very budget neutral, budget favorable, and also be a win for beneficiaries because they would not be subject to harmful procedures that don't help them and get more of these physical therapy services which do help them.

And the other big pocket I think that contributes to a lot of these diseases that lead to joint pains and back pains is obesity. So if we did more on reducing obesity in the Medicare population, I think that overall would be a win-win again.

MR. HACKBARTH: Okay. Thank you very much and I appreciate your willingness to fit your comments into my structure. More on this. I'll be talking to each of you about this recommendation and the recommendations on the physician work payment and ambulance before the November meeting. Adaeze, thank you, and Ariel, thank you very much.

Good work.

Now we will turn to our concluding session on population-based measures of ambulatory quality.

Whenever you're ready, Nancy.

MS. RAY: Good morning.

Fee-for-service payment systems reward for more care and more complex care with little regard to the quality of that care. In addition, fee-for-service systems create provider-specific payment silos and do little to encourage coordination across the silos. The Commission has discussed various approaches over the years to address these problems -- accountable care organizations, medical homes, and bundling, for example.

This presentation will explore using indicators of preventable admissions and preventable emergency department use as population-based quality measures.

And let me just pause for a moment and say that Sara and I will be using the acronym PPAs to stand for potentially preventable admissions and PPVs for potentially preventable emergency department visits.

These indicators are intended to reflect access to and the value of a region's ambulatory care system. Rather

than evaluating the performance of providers by silo, they allow a more comprehensive view of care in the community from a patient-centered perspective.

We last presented on this topic in October 2011. Today's presentation consists of three parts. First, I will provide some background on these indicators as population-based quality measures. Second, Sara will present findings of our analysis of 2006-2008 Medicare claims data that measure rates of potentially preventable admissions and emergency department visits across and within regions. This analysis was conducted under contract to MedPAC by 3M Health Information Systems. Sara will conclude the presentation by discussing next steps.

Potentially preventable admissions and emergency department visits are population-based quality indicators that measure rates of admissions and ED visits for conditions that could have been managed and treated in less costly ambulatory care sites rather than the ED or inpatient setting. These indicators are not intended to measure hospital quality. Rather, they reflect access to and the quality of a region's ambulatory care system. Comparatively high rates of potentially preventable events, when risk-

adjusted for variation in the underlying population mix, identify opportunities for improvement in a region's ambulatory care system.

PPAs measure rates of admissions that involve the treatment of ambulatory care sensitive conditions like diabetes, congestive heart failure, and asthma. Ambulatory care sensitive conditions are conditions for which timely, appropriate primary care can prevent or reduce the likelihood of preventable admissions.

The use of PPAs by policymakers and researchers as population-based quality measures is fairly well developed. For example, AHRQ's PPA indicators consist of 14 ambulatory care sensitive conditions.

For our data analysis, we have used 3M's PPA definition. It also based on ambulatory care sensitive conditions but is more comprehensive than AHRQ's. For example, 3M's definition includes admissions for conditions that could have been prevented by using coordinated care.

The paper, your briefing materials, provides more information about this indicator, and we would be happy to answer any questions you might have.

PPVs are ED visits that might have been furnished

in less costly ambulatory care settings. Like potentially preventable admissions, potentially preventable ED visits may result from lack of access to ambulatory care. There is also literature that other factors such as the convenience of the ED is also a factor contributing to the use of EDs when other ambulatory care sites could have been used.

While researchers and policymakers have begun using PPV rates as population-based quality indicators, their use is less developed than PPAs.

For our analysis, we used 3M's definition of PPVs. It is based on the ambulatory care sensitive conditions but exclude visits that resulted in a hospital admission. Those could potentially be captured in the indicator measuring potentially preventable admissions. 3M's definition of PPVs also excludes surgical procedures.

Now Sara will report on the findings of our analysis.

MS. SADOWNIK: I'm going to talk about our methods, results, and next steps. We conducted two analyses. The first measures rates across hospital referral regions, or HRRs, for a 5-percent sample of fee-for-service beneficiaries nationally. The second analysis begins to

look at variation within HRRs by analyzing data for 100 percent of fee-for-service beneficiaries residing in six markets. This analysis looks at the variation of rates for hospital service areas within hospital referral regions.

So let's talk about the difference between a hospital referral region, or HRR, and a hospital service area, or HSA. Created by the Dartmouth Atlas, HRRs capture larger regional markets for tertiary medical care that require a major referral center. By comparison, HSAs are local markets for hospital care. They represent where the majority of the Medicare residents in an area are admitted. Most, but not all, HSAs contain only one hospital.

For both analyses, PPA and PPV rates are risk-adjusted using 3M's clinical risk groups which account for underlying comorbidities and beneficiary age.

We also performed a regression analysis to look at how different factors impacted the rates. We looked at population characteristics of gender, race, disability, dual eligibility, ESRD status, and the extent to which beneficiary place of residence is rural, as well as hospital occupancy rates. The impact of the population's demographic characteristics is evaluated at the individual beneficiary

level, not at the HRR level. For example, for dual eligibility, we looked at the association between event rates in beneficiaries who are dually eligible versus those who are not, as opposed to evaluating the percentage of dually eligible beneficiaries in a given hospital referral region.

I'm now going to talk about what we found. We found that PPAs and PPVs accounted for a substantial proportion of all admissions and ED visits. PPAs accounted for one-quarter of all initial hospital admissions. The annual PPA rate was approximately 94 cases per 1,000 beneficiaries, and heart failure was the primary clinical reason.

PPVs accounted for almost 60 percent of all treat-and-release ED visits; that is, 60 percent of ED visits that did not result in a hospital admission. The PPV rate was around 158 per 1,000 beneficiaries. The most frequent reason for PPV was the category of "infections of the upper respiratory tract."

Rates of PPAs and PPVs varied widely by HRR. For both PPAs and PPVs, the table here shows cases per thousand, risk-adjusted for age and severity of illness. The values

represent the average of the HRR rates in the top- and bottom-performing quartiles. For potentially preventable admissions, the values across all HRRs ranged from about 37 cases per 1,000 to 107 cases per 1,000 beneficiaries. For potentially preventable emergency department visits, the HRR values ranged from 14 cases per 1,000 to about 66 cases per 1,000 beneficiaries.

To start to look at whether it would be better to measure and evaluate quality at a more local level than HRRs, we did a preliminary analysis of the performance of HSAs within larger HRRs. There are typically many HSAs within each HRR. While any system-level evaluation will have higher- and lower-performing providers, evaluating quality at the HRR level requires averaging the performance of numerous and diverse hospital systems. Focusing on performance at more local levels than HRRs may be more effective for quality improvement. Providers that make up an HSA may be able to more easily coordinate and implement initiatives to improve quality. However, evaluating performance at the HSA level has the challenge of accounting for patients who live in one HSA, but travel to other HSAs for care. In addition, inferring differences between HSAs

requires greater caution than between the larger HRRs because random variation is more likely to factor with small populations.

So for our exploration of how HSA rates vary within HRRs, we looked at six markets. These markets were Boston, Massachusetts; Orange County, California; Miami, Florida; Minneapolis, Minnesota; Phoenix, Arizona; and Greenville, South Carolina.

For both PPA and PPV rates, we found considerable variation between the highest- and lowest-performing HSAs within each market. Note here that Minneapolis and Orange County have similar risk-adjusted PPA rates -- that is, 51.7 for Orange County and 52.1 for Minneapolis -- but their underlying HSAs show very different patterns: Minneapolis' HSAs range from 36.1 to 112.2, while Orange County's HSAs range from 42.9 to 60.8.

HRRs often encompass highly diverse HSAs. For example, among the HSAs that make up the HRR for Minneapolis, one particular HSA has seven hospitals and a Medicare population of almost 93,000 while another particular HSA in that same HRR has one hospital with less than 100 beds and a Medicare population of around 1,000.

We also looked at how different factors might impact rates of PPAs and PPVs. A regression analysis showed that the effect sizes for all of the variables that we considered was relatively small. However, some notable results did emerge. We found that some factors impacted PPA and PPV rates differently. In particular, disability status and being over 85 years old were two factors tied most strongly to higher rates of potentially preventable admissions. However, this age category had no significant association with potentially preventable emergency department visit rates, and disability status had only a small positive association. African Americans had higher rates of potentially preventable emergency department visits, but had no significant association with potentially preventable admissions. Beneficiaries who reside in urban regions -- both metropolitan and micropolitan -- had lower rates of potentially preventable admissions than beneficiaries who reside in rural areas, but slightly higher rates of potentially preventable emergency department visits.

Some factors did impact PPA and PPV rates in the same direction. Being dually eligible was associated with

higher rates of both. Looking at occupancy rates, we found that as hospital occupancy rates decreased, the rates of both PPAs and PPVs increased. With respect to PPVs, hospitals with higher occupancy may have busier EDs which may crowd out the PPV cases, that is, the nonurgent and primary care cases, whether through patient selection or hospital strategy. In the context of a population-based measure, we note that hospitals represent only one of many providers in a community that affect PPA and PPV rates, with the ambulatory system feeding into hospitals.

In addition, importantly, we saw that while population characteristics appear to impact the rates for PPAs and PPVs, variation between regions with similar characteristics suggests opportunities for improvement.

We have also started to look at how access to ambulatory care in an area impacts that area's rates of PPAs and PPVs. In conceiving of PPA and PPV rates as community outcome measures, it is important to be able to consider different communities' resource availability as well as whether beneficiaries can and do access these resources. Firstly, we may continue to look at what services beneficiaries used in the days directly preceding a

potentially preventable event, as well as how care use patterns may differ in areas with high versus low event rates. Secondly, we need to define indicators of access to care in the community. These indicators could include the number of primary care physicians and specialists in an area, the number of other community providers, such as federally qualified health centers or urgent care clinics, or some measure that does not rely on number of providers, such as measuring the distribution of where beneficiaries receive their care. Research should track with a patient perspective of the beneficiary's ability to have timely, regular access to a provider.

So we've presented early results on how PPA and PPV rates vary by region and some determinants of these rates, in considering the use of PPAs and PPVs as population-based measures of ambulatory care quality. We have also discussed areas for further research that would be important in honing the use of PPA and PPV rates as community measures, in particular, one, measurement and evaluation at the HSA level, or at a different more granular level than HRRs; and, two, more robust research on access to ambulatory care prior to these events.

We anticipate that the material reviewed today will feed into a chapter in the June 2013 report. We plan to incorporate examples from groups that may be using these measures and add additional research with guidance from the Commission. Today we look forward to the Commission's input regarding the use of PPA and PPV rates to assess the adequacy of care in a region, as well as directions for additional research or refinements, particularly on defining access to ambulatory care.

This concludes our presentation, and we look forward to your questions.

MR. HACKBARTH: Okay. Thank you, Nancy, Sara. Very well done. Rita, do you want to lead off the clarifying questions?

DR. REDBERG: I just wanted to understand a little better the methodology, because I think the concept of looking at PPAs and PPVs are good, but I couldn't really get how they were doing it. And one related to that in particular, if a PPV was associated with an admission, then it could not be called a PPA, right? Is that correct?

MS. RAY: If a beneficiary went to the emergency department and it resulted in an admission, then that

encounter would be considered as a potentially preventable event on the PPA side. If the beneficiary went to the emergency department visit and it did not result in an admission, then that encounter would be considered in the PPV analysis.

DR. REDBERG: Having just read through, it wasn't really clear to me what -- I mean, I understood that they were saying -- or it seemed 3M was saying if there were more care on asthma care and more care on diabetes care, then it wouldn't necessarily have to go to the ED. But it wasn't clear to me how they actually established their criteria for potentially preventable visits. And I'll let you answer that, but as a cardiologist, a lot of what I see in potentially preventable visits is for chest pain, and often when those -- and they're actually, in my opinion, potentially preventable visits that turn into admissions, because then I go down and see them, and they have very funny kind of chest pain that I don't think even warrants -- you know, normal EKG is not the kind of thing I would admit. And I say, "Well, did you call your doctor?" And often they might have tried to call their doctor, but they got a triage nurse, and triage nurses are just told, "If you hear chest

pain, even if it's right-sided chest pain that happens when you shower, just tell them to go to the ED."

And so I would have considered that a potentially preventable visit and admission, but it doesn't sound like it would have met it in the 3M criteria.

MS. RAY: Okay. So let me try to address your comments. So the premise behind both potentially preventable admissions and ED visits, they primarily consist of what is called these ambulatory care sensitive conditions, and these are conditions, like asthma, like congestive heart failure, like diabetes, where ambulatory primary care, regular access to high-quality regular ambulatory care could have prevented some of the ED visits and some of the admissions. But the premise behind this analysis is that not every ED visit and not every admission can be avoidable, and that's why it's very important why we calculate rates of PPVs and rates of admissions and then risk-adjust for the underlying comorbidity of the population.

So there is not the expectation in this analysis that every admission and every ED visit for these ambulatory care sensitive conditions will go away. But there is the

potential for a reduction due to better ambulatory care.

DR. REDBERG: So did 3M have like a list of criteria that we could look at? And was it being done by physicians or nurses, or who was doing their --

MS. RAY: Right, so 3M's process did use clinical panels, and we could provide you with a list of the conditions that are considered potentially preventable ED visits and admissions. They are based on AHRQ's 14 ambulatory care sensitive conditions, but there's more conditions on 3M's list. There was a table in your briefing materials that provided some examples, but we can definitely follow up with you.

MR. GEORGE MILLER: Yes, this was fascinating reading, and as you probably discovered, it's complex. I've got two quick technical questions, and one is, did you factor in if a patient was brought in by EMS versus someone who may have just walked in? Was there a differential between that in your analysis?

MS. SADOWNIK: No, we didn't consider those two sources differently.

MR. GEORGE MILLER: Okay. And just on the top of my mind, wouldn't those be different? If someone was

brought in by an EMS and it was not a -- or it was an avoidable event, it would seem to me that there would be a difference. And maybe not. Maybe just in my mind.

And then the second question I have, did you stratify the information to look at where the numbers are falling on a safety net provider or teaching hospital versus maybe a suburban hospital to see if there's a difference, a measurable difference?

MS. SADOWNIK: We did not look at that. We can try to look at that.

MR. GEORGE MILLER: I am just curious.

MS. RAY: Well, and I guess -- the analysis focuses at the regional level, not at any given hospital level.

MR. GEORGE MILLER: No, I understand that. But I'm wondering if a safety net provider or a teaching hospital that in theory may have a different demographic would have a difference in these two areas versus a suburban hospital, or one that would not have the same general characteristics of a safety net hospital or a teaching hospital. I'm just curious.

DR. MARK MILLER: You know, and I do understand --

I think I understand what you're saying, and I'll redirect it if not. This will be a little bit different than -- and maybe in some ways it addresses comments that people have been making about, you know, silos versus not silos. This analysis comes at things a little bit differently, and where we ultimately want to be, assuming all these steps work out, and the methods, and we're very much in a developmental stage. Think of the hospital service area, and there might be one hospital, but there may be multiple hospitals. What we're really trying to focus on is what's happening around those hospitals that creates these events. And then we would be coming back, at least at first blush, and reporting how different HSAs behave or seem to shake out, with the underlying question being what's going on with the ambulatory care in that area that's resulted in these events at the hospital. Even though it is -- we're talking about hospital admissions and emergency rooms. In a sense, it's sort of focusing outside of the hospital in the area around it.

Now, we can try and tease out where do these people end up and do they end up more in one type of provider or another. But the first-blush orientation,

notwithstanding that we keep saying hospital, is really about the ambulatory setting.

MR. GEORGE MILLER: I think I got that, and that's a very good explanation. Then maybe it will modify my question just a little bit. Would the HSAs have either safety net hospitals in them and/or teaching hospitals compared to an HSA that did not?

DR. MARK MILLER: And maybe we can begin to -- you know, once we get the actual widget defined, maybe we can begin to contrast that.

MR. GEORGE MILLER: Right, and I'll tell you why. In my mind, with no research, no data, there are many factors that deal with both a patient coming to the ED and/or getting admitted. And I'm not sure if the data shake that out at this point, but I'd love to see that. I think there are social factors, there are a whole host of issues -- support, transportation, just a whole number of issues that -- all of this is looking at one segment. I think there are a lot of other factors that you just described, and I'm just curious how this is going to tease out. It's fascinating, though.

MR. HACKBARTH: So just to amplify on Mark's

point, this is one of those efforts where we try to break out of the silos and look more at system issues, which is good. It's further removed from policy recommendations in the sense that we're talking about community characteristics that, as care is currently organized, there aren't accountable parties for the -- at least in most cases, for the community care delivery system. So this is not research that we typically do, which is really directly related to a policy tool and a policy option, but a sort of more basic understanding of care delivery dynamics.

MR. ARMSTRONG: Yeah, frankly, for that reason, I love this analysis, and it's going to be very interesting to see where this goes.

By the way, I'll just get it out of the way, I think this is one of those places where if we could compare fee-for-service to what's actually happening in the MA plans, and I think --

[Laughter.]

MR. ARMSTRONG: I actually think you could on some of these outcomes, you know, some of these high population rates of, you know, days per 1,000, ED visits per 1,000, maybe even PPVs per 1,000. We may be able to do some of

that. The tricky part, to your point, is this is a symptom of a system that's either working well or not. Well, how do you start to then kind of figure out, well, what are the key variables that drive that outcome? That is, I think, going to be really interesting, and I know that's not a technical question, but that's going to raise a lot of questions as we go forward.

DR. MARK MILLER: It is, and it's not unrelated to what George was saying, because one of the reasons -- I'll be very quick -- that we're trying to grapple with what goes on before these events, because what if somebody is regularly seeking their care at a hospital. You know, it's because it's the safety net. Then how does that influence this? Should we expect to see more of these? I think that is in a sense one of the versions of what you're asking.

MR. GEORGE MILLER: Sure, and just briefly, or in some communities the physicians drive patients to the hospital after hours or tell them to go there. There's a lot of factors. That's just one example.

DR. REDBERG: And nursing homes, I just wanted to -- and they did note that in the written materials, but --

MR. ARMSTRONG: Just a question I have about the

definition of potentially preventable either visits or admissions. So I assume, first of all, that the numbers that are labeled PPAs -- let's just stick with hospital admissions -- is actually a subset of what you would consider to be inappropriate or unnecessary admissions. And if there's other reasons why someone would be in a hospital bed inappropriately, then because it was a potentially preventable admission -- is that right?

MS. SADOWNIK: I think --

MR. ARMSTRONG: For example, someone has a social issue and goes to the emergency room and gets admitted. Is that a potentially preventable admission, which would be more like they're not controlling their diabetes and so they actually should be admitted, but -- and it's appropriate -- but it was potentially preventable?

MS. SADOWNIK: Right. Exactly. At the potentially preventable admissions, it's -- we're looking at events that could have been clinically prevented with better primary care, better care coordination, things of that nature. It's not a -- rather than a comment that the care itself should not be delivered at that point in time.

MR. ARMSTRONG: Okay. Good.

MS. SADOWNIK: It's quite the opposite. Yeah.

MS. UCCELLO: I'm sorry, can I come in here? Does it also include, though, things that could have been treated in other settings?

MR. GEORGE MILLER: [Off microphone.] Whether it was available or not.

MS. SADOWNIK: For the PPVs, the potentially preventable emergency department visits, it's referring to care that could have been treated at a different setting. But PPAs are talking about something a little bit different, which is that the care could have been prevented with better primary care.

MR. ARMSTRONG: Yeah. I think, just as we go forward, we'll really want to sort through some of the definitions of these. First, I was thinking PPAs were kind of the same thing as inappropriate admissions or unnecessary admissions and I think they really are different things, but they're kind of overlapping and very -- and we'll just want to be really clear about that.

The last question I had was, these are spectacular rates. I mean, 25 percent of all hospital admissions are preventable, and 60 percent of ED visits were potentially

preventable. Now, are those -- what's the denominator? So we've identified -- you know, you've identified diagnostic categories of populations of patients -- congestive heart failure, diabetes, and so forth. So is that 60 percent of patients in those diagnostic categories would have been avoidable visits, or is it 60 percent of all ED visits were potentially preventable?

MS. RAY: Sixty percent of all treat and release ED visits are potentially preventable.

MR. ARMSTRONG: Okay.

MS. RAY: Right.

MR. ARMSTRONG: So that's an even more spectacular number.

MS. RAY: Right.

MR. ARMSTRONG: Okay. And there, again, as we go through this, we'll want to really nail down our understanding of some of these statistics.

DR. MARK MILLER: And that would be just the other thing I'd bring into this conversation. This research is still very much in progress. So we're making statements like this on the basis of something that we're still in the process of defining and kind of coming to some consensus on.

So I wouldn't carry that number to the bank and all of that. But at least so far in the work, that's what's coming out of it. That's the only caution I would put.

And, by the way, two-to-one on the MA stuff. So you've got to step up.

MR. HACKBARTH: I think I saw Craig raising his hand over there.

DR. MARK MILLER: Was he trying? All right. We'll give him a half-a-point.

MR. HACKBARTH: He wanted to launch a preemptive strike.

[Laughter.]

MR. HACKBARTH: Okay. Bill.

MR. GRADISON: A minor point which may have to do more with hospital readmissions. How do you characterize in studies of this kind planned readmissions, which is not uncommon, I gather. Somebody is being treated, but it is fully expected at the time of discharge that they'll be coming back in two weeks or whatever for something -- within 30 days for some additional procedure.

DR. MARK MILLER: From what I followed in the research and that we've gone through in our meetings, that's

precisely the types of things that were tried to be taken out of the definition. So a condition for which you would expect admissions. Now, you said readmissions, but --

MR. GRADISON: Well --

DR. MARK MILLER: -- I'm assuming you meant broadly, if an admission was planned --

MR. GRADISON: If at the time of initial hospital treatment, when the patient is discharged, if there were a determination at that point that this patient is expected to be back in the hospital within 30 days, that's what I'm really trying to -- I mean, I don't think that ought to count, but I just don't know whether it does or it doesn't. We don't need to get into it now, but maybe later. I'd like to learn a little bit more about this. I'm getting increasingly concerned about the practical fairness of some of these calculations on hospital readmissions. Thank you.

DR. MARK MILLER: I will say this about our work on readmissions, and we, MedPAC -- and there are other definitions floating around -- have focused on potentially preventable readmissions, and I want to understand, that's not the conversation we're having here. We have specifically tried to make sure that the definitions deal

with cases like that.

MR. GRADISON: Thank you.

MS. RAY: And I just want to clarify that in this analysis, most -- the analysis excludes readmissions following the index admission. I want to be very clear about that. So if a person was hospitalized on January 1st for a potentially preventable condition and then was admitted again on January 15th, that admission on January 15th was not counted in this analysis. So this, again, it's -- these are preliminary results, but we based it just on the index admission.

MR. GRADISON: I think, then, I want to come back to perhaps not understanding clearly the response to Scott's question. My understanding is that a very high proportion of admits are through the ED, and, indeed, that the percentage has been rising and it may be close to 90 percent, I have heard, in some cases to date. My understanding is that if the admit does take place, then that's excluded from any consideration of the denominator.

DR. MARK MILLER: No, I think I would say it differently.

MR. GRADISON: How does it work?

DR. MARK MILLER: If you come through the ED and you are admitted, then you could be in the denominator of the PPA, but it doesn't necessarily mean that was potentially avoidable. But you would go into the denominator. And in a sense, I think with the rules that they were saying is in defining the denominators for them in turn computing the potentially preventable, the admission then passes through the ED and then becomes an admission, moves over to the denominator on the admission, and then you ask the question, was this potentially avoidable -- or a potentially preventable admission. Is that --

MS. SADOWNIK: Right.

DR. MARK MILLER: Okay. Because I think I'm done for the day now. I don't think I can do anything else.

[Laughter.]

MS. SADOWNIK: That's exactly right. And the admission is counted whether it was through the ED or whether it was planned or through EMS or any, you know, however they got to be admitted. We did find that of all potentially preventable admissions, we found that 60 percent did come through the ED.

MR. GRADISON: But say a little bit more about --

that's pretty remarkable. In other words, the ED within the same institution was not doing an appropriate job of screening whether an admit was required?

DR. MARK MILLER: No, I think that's not what's being said. So imagine a patient comes in with diabetes out of control, and this is the distinction in Scott's question that we were driving at. At that point, it may be appropriate to admit that person. The question is, is had they had better care up to that point, could that whole event, you know, however they got to the admission, been avoided.

MS. SADOWNIK: Sorry, and it was -- I said 60. It was actually 70 percent.

MR. KUHN: I, too, want to let you both know this is really some terrific work and it was fun to read the paper. And I think what's kind of exciting about this work is that it starts to paint a statistical picture of the multiple tiers of actions out there and care, and I think that'll be fun for us to look at when we put out the information next year.

I did have some questions about the read ahead material, and particularly on pages 13 and 14 when we talked

about some of the definitions. So kind of three questions in this area.

So the first one talked about the 3M definitions of PPVs and it talked about the five leading conditions, and it listed upper respiratory tract infection, lumbar disc disease, abdominal pain, and respiratory diagnosis. But the other one, the fifth one, said signs, symptoms, and other factors influencing health status.

So as I think about these things, I think about actionable items for prevention. So what's the actionable items against other factors influencing health status? Any granularity there you could share?

MS. RAY: Uhh -- we'll get back to you on that.

[Laughter.]

MR. KUHN: Okay. So going on down that page, then it comes down to McDonald and the work that he did for AHRQ in 2009 and presented at the conference. And on that one, going on to page 14, it talks about motor vehicle collisions and drownings. So I'm looking at kind of prevention things related to that a little bit, or if you can help me understand a little bit more what we're talking about there.

MS. RAY: Right. Now, that, I just included that

in the paper just to give a feel for how other researchers have defined these potentially preventable events --

MR. KUHN: Okay. Thank you.

MS. RAY: -- ED visits.

DR. MARK MILLER: Just so you know, internally, we had a conversation about this very point, because it's how do you prevent drowning --

MR. KUHN: Yeah. I mean, this one really jumped out at me as I was reading it.

DR. MARK MILLER: And we decided to go ahead and put it in because it's some of the research out there, but we had the same hang-up.

MR. KUHN: Good. That's kind of what I thought, but I just wanted to be sure.

And then, finally, I would just make the observation here that the New York University information, I thought, had real logic and predictability. I thought that was really interesting work and that might be something we could look at further. So thanks.

DR. NAYLOR: So this is such important work and a terrific paper, briefing. So one thing that it raises is, conceptually, how do you measure population health, and you

have looked at all of those elements. I understood on page 19 that you were going to do analyses that included both 3M's definition of potentially preventable admissions as well as -- which excludes readmissions and what happens in the 30 days -- as well as including that. And I'm wondering if you have done that and whether or not those findings would change -- I mean, am I wrong?

MS. SADOWNIK: We did do both of those. We focused on the initial admissions here. We did -- there were some individual factors that -- where we did notice some difference, but the big picture was really strikingly quite similar --

DR. NAYLOR: So the major findings you listed would not have changed dramatically in terms of the factors that we're trying to uncover that contribute. The reason I think that this is important is that, conceptually, population health is all in. It's everything that's happening to a population. And so the capacity to go beyond even where others have gone, to think about both including and not including what happens from admission and readmission. You're looking also at ambulatory care as what happens before, and so the chance here is also to look at

what happens after and get the real trajectory, so --

DR. MARK MILLER: I just want to say, and I think, in some ways, I ended up driving us to this, because there was a concern that we were presenting so much information, it was hard -- the definitional issues alone were hard to get into people's heads, and then to have multiple definitions. So I suggested focusing on the initial admission as just at least a way to bring everybody through it one time. There has been work including the readmissions.

The other reason that I thought that that made sense is we have other issues kind of focused on readmissions and readmissions can begin to enter, well, what did the hospital do in that process. It still could be an ambulatory issue, but it could be a hospital issue.

But we have this. We can work it into the analysis and bring it forward. This was really just a presentation, you know, what to focus on kind of decision.

DR. NAYLOR: I think it's terrific. I just think that the opportunities here are -- you know, this language of admission and readmission may be changing, and 30 days is not carved in stone anywhere, so I think that this is a real

chance to think about different --

DR. MARK MILLER: And there were a few differences in the regression work that fell out on those two different measures and we can crank through that and make sure that that's clear to you guys in the next round of this.

DR. NAYLOR: One last question on the table that began to really uncover the associations, disability and older age, et cetera. SES, is that a part of the kind of -- we talked about that at the last meeting, but is that one of the measures that's being looked at here in the regression?

MS. SADOWNIK: We didn't look at -- we didn't define or look at SES in an explicit way. You know, we had, right, a dual-eligible where you can begin to look at that, so -- but, yeah.

DR. NAYLOR: [Off microphone.] Thank you.

DR. COOMBS: So I work with the Boston Health Disparities Council and two years ago, we actually did an analysis of ED visits, and what we found was that the greatest peak for ED visits -- those were preventable ED visits, and we didn't include surgical, we didn't include overdoses, we included medical diagnosis, and I noticed the overlap between 3M and AHRQ in terms of what they have

classified as preventable admissions. We found that the preventable visits to the emergency room occurred between nine and five and that that was the simultaneous results that we got in conjunction with the workforce results of the Mass Medical Society to look at what are the areas and specialties in terms of primary care and various specialties that were having critical levels of workforce issues.

And it turns out that one of the things that we assume from that is that the ED functioned as a decompression device, that when the office was overwhelmed and they couldn't get a visit within the office. We looked at critical time periods for when it took for a patient to actually get in the office, and if it wasn't going to be in the next two to three days, that the patient was going to show up on your doorsteps to the ED.

So that was a very, very important piece of this, the timing for which the peak ED preventable visits occurred. Most of us thought that the visits would occur three to 11 or even in the night, but nobody comes in in the dead of the night. They usually come in on the three to 11 shift. That's what we thought.

And that's -- it was very interesting, because we

looked at public payers and private payers. Although the public payers were slightly increased, the private payers followed the same course in many respects.

The other thing, as I looked through this, some of the classifications, such as, I guess, in AHRQ is a perforated appendix. And so perforated appendix is one of those diagnoses that I think most doctors would say is not preventable or avoidable.

The intervention of -- the timely intervention is directly related to resources that are available in the immediate area. So if they are community health clinics, neighborhood health clinics, I would look at that, the number of neighborhood health clinics in close proximity to hospital areas, and I don't think that Elliott Fisher and those guys looked at those kind of things.

Then the total number of hospital beds, that is key. That is huge. In New York, New York has X-number of beds that are readily available, and I think you guys looked at occupancy, which is another factor.

So as I think about the admissions, though, I think about some of the other features of the admissions, and the admissions actually are the criteria that they use

for admissions, it's -- I think George kind of alluded to this. The threshold for which someone admits someone has to do with a lot of things with the inter-hospital dynamics. And so occupancies is one of those things, and certainly -- but you have to look at for-profit hospitals and not-for-profit hospitals in terms of what the benchmarks for admissions are.

There are some ones in which they would say, let's refer this to an ambulatory clinic and they'll follow up in 24 hours. There have been people to actually treat a febrile neutropenic patient as an outpatient, which I think is really different. But the follow-up is very good in terms of the ambulatory setting and they'll give antibiotics in that setting. There are other people who would admit someone with a headache and say, I'm going to watch them for, you know, maybe they have a subarachnoid bleed, I'm not sure, whatever. We don't have access to other technological things that we'd like to do to study.

So I think the capacity of the institution in terms of handling things immediately, whether it be interventions such that you want to do a work up and you don't want that patient to come back as an outpatient. So I

think the hospital capacity is really important.

So there are a number of things that I -- and I can talk with you later about some of the other things that we found as a result.

The African-American status, and as Mary has talked about, the socio-economic status, those are very important parameters, but you will find that some of those things are through the lens of the emergency room in terms of what happens in the emergency room. For instance, there are a number of iatrogenic things that occur in the emergency room, such as volume overload, things that happen in the emergency room to say, I watched this patient for four hours and we have a drug reaction because I gave this drug and things like that. I don't know what that percentage is, but I know that when I'm in the ICU, I'll get a reaction to a drug that was given in the emergency room and so that the patient getting there was unavoidable, but what happened when they got there had a lot to do with what we did to them once they hit the door. So I think those are the kind of important things that I would look at.

MS. SADOWNIK: That's a whole new level of something to look at.

MR. BUTLER: So I'm not sure what round we're on and what the lateness of the hour is. I realize that we don't have a --

MR. HACKBARTH: Yeah. I think, because of the exceptional thoroughness of our round one questions, we have lapsed into round two, and we're roughly 20 minutes from our end time. So feel free to do two as well as one.

MR. BUTLER: All right. I'll still try to be efficient.

So I actually think this topic is more important than readmissions, because here, particularly, you have situations where I think Rita would say we do things to particularly fragile elderly when we bring them into the hospital and they leave worse off than when they came in, often, in some of these situations. So the more it can be managed -- unlike readmissions, it's a little more difficult, though, for a hospital to kind of be the -- begin to say the hospitals can determine where their post-acute care goes to some extent. They have less -- so who and how we engage at the front end is a different exercise here. So this is something to be aware of.

Now, it is great work and the first time, I think,

Herb, I've heard the work described as fun.

[Laughter.]

MR. BUTLER: Fascinating, intriguing, fun. But, anyway, it is something that is important, for sure.

So of your two next steps up there, you've focused on regions and HSAs. I've been in, like, three different markets and very different institutions and I would say that my own anecdotes would say it's much more an intra-region issue. You will learn less by looking at regional differences than what's going on within the region. Now, there are big exceptions. If you're a smaller community and, say, you go to a town and you look at all the players and understand, as Glenn was describing, or Mark, that's one thing. But when you're in a major urban area, it's probably less helpful to look at a region.

So the quick examples I would say is, in one situation I was in, you had a private nursing home literally across the street that would kind of at the flip of the switch send somebody over when they were in trouble. That's documented in here and you'd see that.

Another situation, 25 years ago I was in, where you had a very highly incented, primary care motivated,

capitated Medicare product that they literally -- the ER doctors called the participating primary care physician to come in and they would permit them to see them before it registered an ED visit to help avoid the admission. It was almost -- it was over the top. And if they didn't get there within the 20 minutes, it converted to an ED visit. I mean, it literally was that kind of management, suggesting the payer incentives do make a difference, to an extreme in that situation.

The third situation, I was in a large capitated system. We actually had chest pain clinics set up in ED, not to attract unnecessary -- but to manage the capitated business to help avoid the admission. Again, payment helps to align the appropriate use of these things.

And then the last example was, I think is also cited here, where you have either a busy physician office or an after-hours, not just nine-to-five, say go to the ER, that's my back-up. And so how you kind of think about those things and say, okay, how do you change that behavior to help incentivize this gets the focus on the second bullet to me being more important and trying to kind of say, where were they sitting before they came in? Can we bucket those

in a way that would help identify some of these patterns of utilization that we're seeing?

DR. SAMITT: So thank you for this. I love this stuff. This is great. What would only make it better is if we included MA information in it as well.

[Laughter.]

MR. HACKBARTH: Partial credit [off microphone].

[Laughter.]

DR. SAMITT: All right, partial. You know, I have a question about where to measure this, you know, because I agree that the region's not the right level. I'm not even sure the HSA is the right level. I think what you will find is intra-HSA variation, and I guess where I would start the analysis, I mean, I think we should mine for the top performers and where the lowest PPA and PPV rates are, because I'm not sure we'll really understand what to look for, for variables that drive the differences until we see some of these high-performing areas. My guess is you will find in these high-performing areas wide ranges of demographics and other changes. And I think what Mark said earlier, it's what's happen on the outpatient side primarily in some of these groups or physician offices or what have

you that are very much influencing this.

So I don't know where to suggest you should look, but obviously there are integrated delivery systems, capitated groups, yes, some MA plans but not all of them. I think if we can find those that truly have the lowest rates -- and you already demonstrated you can measure variation within an HRR. I'd even go deeper to say, Where are the lowest performance levels, and what is it that's different about these groups or these markets that we should then study and compare to see if there's correlation for performance?

The other thing I would say is I think this has tremendous merit as a quality measure if we can get this right. In fact, I would argue that this is a measure that should apply to ACOs. It certainly should be one of the things that would qualify as high performing, you know, if this is the 34th measure, if it is possible to get this right, because measurement only gets us so far, we then want to tie the measurement to some form of incentive or other way to encourage these organizations to do more of what reduces these inappropriate admission and visit rates.

DR. BAICKER: So these data I think are really

informative, and you've outlined some new steps that you'll take. I'd love to see a more formal decomposition of the within versus between variation at the HRR level versus the HSA level once you have -- I know you've only done the HSA drill-down in select communities thus far, but with the universe we could really see where most of the variability was. And I'm as big a fan of the Medicare Advantage encounter data as anyone, but here's one instance where, in fact, there are alternative data sources that you could compare both MA populations and commercially insured populations from hospital discharge data where we have the universe of hospital discharges in the HCUP for some states, and so you could look at the share of those that are not -- you know, you can do those sort of AHRQ PQA, prevention quality indicators, ambulatory care sensitive condition type. So it's not going to match exactly this, but it would have the universe of hospital discharges with enough granularity that you could have a pretty comparable measure of ambulatory care sensitive condition discharges. And then you could take the measures you have and further correlate them with general spending on Medicare in different bins of types of care to start to see how this maps into the right

system level mix of care and how that can or can't avoid these kinds of potentially avoidable admissions and visits.

So I'd love to see how these measures correlate with spending in different areas on prescription drugs, on outpatient visits, on physician services, on hospitalizations generally. So there's all sorts of richness that can be layered on to what you've already developed.

MS. UCCELLO: Well, I don't think I'm going to say I love it, but I am very excited about this work. It's very important, and I think it's a really nice complement to the work we're doing on readmissions. In that work, especially when we're thinking about these vulnerable communities, this work can really help us understand that better about, when people leave the hospital, what kinds of supports they're getting.

I'm just wondering, you mentioned about looking at where people are receiving care in the days before their PPV or PPA, is there going to be an opportunity to look back a longer period prior to these events to understand more if and where these people have regular sources of care. And I think looking at a longer period can help a little more than

just looking at a few days.

DR. HOADLEY: Well, I would echo that this is very thought-provoking, great work. I'm struck by a couple things. One, sort of inspired by George and Alice's comments, I mean, there really is a little bit of a measurement issue on the dependent variable side of -- and I'm thinking of the PPAs. It's an admission that's potentially preventable from the point of view of what's happened before. But it is somewhat contaminated in a statistical sense by decisions that are occurring at the point of admission to hospitals, whether it's occupancy or social circumstances or special programs to help prevent it. So, I mean, I don't know if there's anything you can do about that, but it is definitely something to stay aware of.

I think more interesting are some of the things to think about on the prediction side, and you've talked about a lot of them, and some of them clearly are sort of person-level things going on, which we were just talking about, and then community-level things, which you've also talked about. And I'm struck by, putting my prescription drug hat on, you know, drug adherence obviously is going to be a factor for a bunch of these kinds of conditions, pretty important. I'm

not quite sure what's the right way to think about measuring that, and I can try to think more about that. But obviously if there's something we can measure about adherence going on, you know, either at a geographical level or at an individual level, that would be really interesting to look at.

Things that you raised about presence of urgent care centers, I also think about some of these kind of off-site emergency facilities and even retail clinics. I mean, those are things that really are quite different from one community to another, and it really would be interesting to see -- I don't know if it's good or bad results always, but what roles those different kinds -- and community health centers and the other things people have talked about, how that's playing in.

And then some of the things that have come up that I think are a lot harder to measure -- I mean, those you can actually go and count what's in the community, but the sort of -- this example of what do the primary care doctors do when somebody calls off hours or when there's no time, and we've seen in the site visits over the years, you know, does the message on the phone machine say, "If this is urgent, go

to the ER"? Or does it say, "If this is urgent, press this, and we'll have a doctor call you back within 15 minutes"? And that alone -- again, it's not on a data set anywhere, but that kind of thing may drive some of these results, and then lots of other things like those, and it may be useful to do -- you know, when you're looking at a pair of communities like you focused on in the slides to try to go back and do something more qualitative to see what are other things going on, being done to try to improve the stories. A lot of good stuff.

DR. DEAN: I would as well echo the interest. This is interesting and important stuff to try to figure out how we can use resources in the most appropriate way.

A question, just a couple of parameters that I know have affected my decision to admit people that might well fall in the category of potentially preventable. One has to do with caregivers at home. Is that a piece of data that you have access to? It may be hard to get. But there are certainly conditions where, if there was somebody at home that could look after this usually elderly person, they really don't need to be in the hospital. On the other hand, they shouldn't be home by themselves. And that comes up

fairly often in my practice, and I don't know if there's any way to get that information. But it is a common factor.

The other one in a similar category is how far away do they live, because there's the same situation, if somebody lives across the street and they have a condition that's stable for the moment but could get worse in a hurry, if they're across the street, I'm okay. If they're 30 miles away, then I'm uncomfortable. And I might well put them in the hospital, but it would probably fall in the category of, because their clinical status at the time they go in, they're stable.

So, you know, these are just situations that are just -- they don't fit in the model real well, and yet -- you know, not to criticize the model because it's a good model, but there are some places where those judgments might be made, and yet there'd still be a perfectly legitimate reason for these people to be in the hospital.

DR. REDBERG: Maybe that's signs and symptoms influencing health status.

[Laughter.]

DR. BAICKER: Can I jump in with just one quick general methodological point? One of the reasons I like

looking at these population-based measures is any individual case, you could definitely say, well, in this instance this was appropriate, even though it falls in this general bin, this was an exception; and so applying these measures at an individual level is pretty fraught. Whereas, when you're looking at a population measure meant to sort of capture the quality of care the system is delivering, these things are going to balance out in a lot of cases.

Now, distance to the hospital might not. You might want to have an area-level measure of how far away the population lives or something like that. But on an individual level, if you think that these individual preferences or idiosyncracies of particular cases average out over big populations, then these measures are really valuable and aren't so sensitive to individual wrinkles as individual cases would be.

DR. DEAN: The other comment I would make is we definitely do not send people to the emergency room if our clinic is busy because then I've got to leave the clinic and go to the ER and see them.

[Laughter.]

DR. DEAN: So we do not do that.

MR. HACKBARTH: So here's a half-baked idea. These measures sort of get to the state, the quality of a community health care delivery system. We spend, on the other hand, a lot of time, as people pointed out, talking about readmissions, and readmissions are challenging because in some cases they may be within the control of the hospital and, you know, that's part of the idea for having a hospital-related penalty. But other cases they are reflective of what's going on in the community and the ambulatory resources that are available for post-admission care.

It would be interesting to look at the ratios. You know, if you have a hospital that has a really good readmission rate relative to the community, that might be a meaningful indicator. On the other hand, if you have a hospital with a very high readmission rate in a community that has lots of good resources, those ratios may be intriguing to look at.

DR. COOMBS: I just wanted to say one thing. It might be better for us to shrink the number of preventable in both categories just so you can get your arms around it and it would correct for some of the other issues. I'll bet

you your diagnosis wasn't congestive heart failure or anything that remotely relates to that. But it might be a good idea to maybe do a top ten or a top six or whatever.

MR. HACKBARTH: Just to complete my thought about this, you'll recall at our last meeting when we talked about readmissions, and we talked about socioeconomic status, and one of the options that we put on the table was to say, well, what we ought to be doing is comparing readmission rates among peer groups. This could be -- and I don't know if all the analysis and data can work out. This would maybe even be better than peer groups, because the peer groups could be very different community circumstances. You could say, you know, teaching hospitals are in all sorts of different community circumstances or even public hospitals. Here, if you could have a ratio between readmission performance and community characteristics that are really relevant, it would be sort of an interesting comparison to make.

MR. ARMSTRONG: One other thought on this, too, is in a way a PPV rate or PPA rate is kind of a sub-variable within kind of broader population goals, and that we may also just think about, you know, total days per thousand in

a community or in a system.

The other thing I was thinking about was that we're presuming -- we're kind of thinking about this as a quality indicator, but what we're looking for are quality outcomes that actually drive lower total costs as well. And so to see if there's any relationship between kind of your cost trends and these lower PPAs or PPVs would also be kind of an interesting question for us.

DR. HALL: Are we starting round two [off microphone]?

MR. HACKBARTH: Well, we are actually at a time -- what I was going to do is for the people who were very disciplined in truly only doing round one, give you a chance to make any additional comments.

DR. HALL: Thank you. So I loved this too, but I think there was something that was bothering me, and I guess I understand now what it was, and that has to do with our obligation to the Medicare population as opposed to all of humanity.

So if we look at this whole issue of preventable admissions and inappropriate ED admissions, I think I would parse that out as there are two main causes. One is there's

a cohort of the population that simply does not have access to what we would consider good quality care. So a mother from the inner city brings her child in every time they get the sniffles to the emergency room. Well, what else is she to do? Or brings in her husband with influenza to find out he didn't have an influenza vaccination. Now we're getting a little -- the older population. But they didn't know how to do it, so access still exists in this country as one of the issues for inappropriate use, but much less so in the Medicare population because this is, guess what, the only form of universal health care that exists.

There I think we should -- if we're going to really take this somewhere, we have to look at what I would call -- I'm trying to use a politically correct term here -- what might be called "inappropriate standards of care" in a community. Let's do it gently that way. So one of this could be that there may be elements, and even in the Medicare population, of real limitations in health literacy, people who don't speak English as a primary language, people who really don't read, even -- there's still that possibility -- or live in an environment where nobody can help them with reading and all the rest. So that's one

whole problem. But I would say that's a relatively small problem.

The real problem is that there are levels -- there are sort of standards of convenience in any community, in any health care system, and many of them were mentioned as we went around the room here. Well, the patient was sent to the emergency room because the doctor, let's say, on a Saturday night said this is the standard of care in our community and that's accepted. And for many hospitals, that's quite acceptable because maybe, let's face it, their admissions aren't that great and maybe they want to do something about that. It gets very complicated from that point on. And there are many other examples of convenience here.

So if we were to look at, strictly speaking, the Medicare population, people who in theory have access to health care, have a means provided to them for a whole variety of different services, and it doesn't work out, I would really want to target the standards of care in a community or in a health care system that allow that to happen. We know that 10 percent of admissions of Medicare patients are due to some drug misadventure. That didn't

happen by accident. That's just a good example of that.

So as we move forward into this, I hope we don't sort of take on the whole world, because while it's a very laudable cause, we can't die for all the worthwhile causes in a day and a half a month.

MR. HACKBARTH: I'm tempted to say that's the concluding note, but is there anybody else who wants --

MR. KUHN: I'll send you my comments in an e-mail.

MR. HACKBARTH: Okay. It is the concluding note then, Bill. Okay. Thank you, Nancy and Sara. Very well done.

We'll now have our public comment period.

And if you wish to make a comment, would you please get in line so I can see how many are there? So we've got what, five, five people? Okay. So for five comments, I'm going to be really strict about the time limit. I'll give you each two minutes. Please begin by stating your name and your organization.

And as always, I will remind people this isn't your only or your best opportunity to provide input on the Commission's work. The best opportunity is to meet with the staff. Next best is to send letters to Commissioners, which

we do read. And then there's also the opportunity to present comments on our web site. So when the light comes back on, your time is up.

MS. LEE: Okay. I'm Gayle Lee and I'm here today speaking on behalf of the American Physical Therapy Association. We appreciate the thorough discussion today on outpatient therapy and we commend the Commissioners for your recognition that a hard cap would be a serious problem. As a number of you stated, therapy is an extremely important service for Medicare beneficiaries and it ultimately reduces costs downstream and improves the quality of life.

We also strongly support development and use of a standardized core data items that would measure function and be used for payment ultimately. We are taking a lead on developing such core data items as well as on development of an alternative payment system for outpatient physical therapy.

We have serious concerns with implementation of an MPPR reduction of 50 percent. We identified serious flaws in CMS methodology used to determine if the MPPR reduction was warranted back in 2011. In particular, the practice that expends values of these codes were already reduced when

these codes were valued through the RUC process. These additional reductions would get to the point that the cost of care exceeds payment amounts, and we believe that that will ultimately impact access to these services.

We also have serious concerns with reducing the therapy cap dollar amount and setting prior authorization at that lower level. I want to emphasize that to conduct these reviews takes a considerable amount of resources from CMS and its contractors and would result in significant delays in care. We are already seeing major challenges with implementation of this manual medical review process at the $3,700 threshold.

We will submit more detailed written comments to you, and once again, thank you for your thorough discussion of this topic.

MS. HITCHON: I'm Jennifer Hitchon with the American Occupational Therapy Association. We agree with many of you in rejecting a hard cap that would make medically necessity outpatient services inaccessible and ultimately increase costs, particularly at an institutional level.

We also disagree with a lot of the discussions

here about the multiple procedure payment reduction for the same reasons that APTA mentioned, that the redundancies in payment for practice expense have already been reduced by the AMA RUC. And I would like to emphasize some points related to the manual medical review process that we're already seeing, and that this body is considering recommending above and beyond a therapy cap, which would be lowered, apparently.

We are seeing that some providers are having problems getting faxes received by their carriers, that mail can take a long time. It's not simply just a ten-day waiting period that also includes shipping, and providers don't always get receipt, get proof that their requests have been received by the carrier.

The carriers all have different forms. Their practices are varied across the line. They can be inconsistent. The burden for providers in providing the necessary materials and for the carriers in making these administrative decisions are high. Some providers, when they see a patient for the first time, it may be a second episode in one calendar year. Then after completing the evaluation, have to submit a request for prior authorization

at that time and then wait ten-plus days to begin treatment.

I also want to emphasize that these -- that the manual medical reviews happening now are, like Gayle said, at the $3,700 level, and this was a level that Congress determined. It's the 95th percentile. Congress determined that this was really the level at which it was feasible, administratively possible for the carriers to even do.

So by reducing that level, I think it would -- the data seems to suggest that that would become an even more administrative burdensome process. Thanks.

MS. MORTON: Hi. I'm Cynthia Morton. I represent the National Association for the Support of Long-Term Care. We are the therapy companies and the therapists providing therapy primarily in nursing homes. The patients in nursing homes are subject to the caps and the manual medical review more acutely than the rest of the beneficiaries getting therapy.

So when the Commission looks at general data and not by setting, the data really masks the impact to beneficiaries, especially in the nursing home setting. For our patients, the cap is arbitrary, and especially by geographic location. And what I mean is, a patient treated

in Massachusetts gets less therapy because of the GPCI, the high cost labor market there, than a patient, say, in Alabama. So as is, the cap is very uneven.

Our patients in nursing homes are older, more medically complex, and have more co-morbidities. Because of these demographics and their conditions, our patients tend to need P.T. and O.T. together and some all three disciplines. So they are seriously harmed by the MPPR. Because of their low tolerance, they can only tolerate therapy sometimes in several doses in one day. So that's multiple times in one day.

A word about the manual medical review. We're on day five of MMR over $3,700 and you're considering lowering that amount. It's a chaotic mess already on day five. The MAC have issued denials with no detail for denial, and the detail is required in the transmittal, so that the provider doesn't know what to do. They've just spent ten hours faxing in that medical record and they don't know how to alter it to seek the review that the doc has said is -- for the therapy that the doc has said is necessary.

One therapist -- and I've heard this several times -- took 14 hours to get the multiple documents through the

fax into the MAC. The MACs just aren't set up to -- they've required so many documents which is fine for them to do, but they're not set up to receive them. In fact, one MAC requires all documents by U.S. mail. Nothing is done by email. It's fax or U.S. mail.

We've also heard that the MACs have rejected a medical record, you know, for pre-authorization sent in because they couldn't see the same claim experience that the facility knew about and they said it was too early for pre-authorization.

My most important point to you is that the nursing home setting, the patients receiving therapy in the nursing home setting, is different than when you look at the balance of patients receiving therapy. And so, your analysis really should pull data out and pull patients out by setting, because otherwise, your recommendations are going to have an obscuring impact to the patients, especially for those that receive therapy in a nursing home setting. Thank you.

MS. LUCAS: Hi. I'm Ingrid Lucas with the American Speech Language Hearing Association and wanted to echo a lot of the comments that have already been made by the colleagues in the other therapy professions. Two things

that I'd like to address with the Commission is, one, there was a comment made earlier about whether or not groups were developing their own functional outcomes measurement system, and we have spoken with the Commission and the staff before.

ASHA has over 15 years of data on functional outcomes measures for speech language pathology services through out national outcomes measurement system and continued to offer that data and anything that we can provide with that for speech language pathology services to the Commission.

We understand your desire to reduce inappropriate utilization of therapy services and support that and are very happy to hear that you're not going to support a hard cap. But in your deliberations and as you're discussing things, we would ask that the Commissioners review what would happen lowering the therapy caps and also putting the therapy caps on the hospital outpatient departments and what that would do with Congressional scoring.

We have a fear that there might be some unintended consequences of not only increasing the score to extend the therapy cap exceptions process, and also in repealing and replacing the caps with an alternative payment policy.

Additionally, as you're looking at hospital outpatient departments being under the therapy caps, historically they were excluded from the therapy caps as a patient safety net. So if the therapy caps were ever to come back into place and the hospital outpatient departments were under the therapy cap, then the patients would be losing a safety net. Thank you.

MR. CONNOLLY: Hello. I'm Jerry Connolly. I'm representing the private practice of physical therapists across the country. There's over 4,200 of them. I also represent PTPN which is a national network of private practice physical therapists, occupational therapists, and speech language pathologists.

In addition, I represent Focus on Therapeutic Outcomes which is a national outcomes database in business for over 19 years. It has functional outcomes status measures on over three million episodes of care and much of these measures that they have developed, which are valid, reliable, responsive, are supported in the literature and are available at no charge. So they're in the public domain.

Personally, I've been a physical therapist for

over 40 years. I was in private practice for 25 years. The length of time that you spent on Round 1 today tells me that I think you were kind of struggling with trying to figure out the benefits, what physical therapy, occupational therapy, speech does, how those are provided, and where they are provided.

And the provision of particularly private practice therapy is very well stipulated in the law and in the regs, and I think that it would really be helpful for all the Commissioners to have a good grasp and an understanding of how those services are provided and where they are in the statute.

For example, the combination of the P.T. and SLP cap is not a drafting error. It is specifically where the statute was amended, that provision of the statute happened to combine P.T. and speech and not O.T. in there. So it wasn't a drafting error, and this is something that I think the Commission really has to consider.

You know, Congress, as we've said, doesn't carefully analyze things. They really want the Commission to do these kinds of things. And the Commission didn't really spend any time today in talking about, well, should

the P.T. speech benefit or cap be divided? And I think that's something that you should really delve into.

The benefits of therapy, I think, were cursively provided in Slide 5. P.T., for example, is much more than Parkinsonism, total knee, and low back. And the education and research and practice of therapies are abundantly supported in the literature and I think it's incumbent upon the Commissioners to understand that before you make decisions or recommendations that could have a dramatic effect on the beneficiaries.

So I would ask that rather than urge -- I'd urge you, rather than to hasten this report, the report isn't due until June --

MR. HACKBARTH: False.

MR. CONNOLLY: I think you need to work in --

MR. HACKBARTH: You're finished. Thank you.

MR. CONNOLLY: Thank you very much. Delay the report until June and gather this information.

MR. HACKBARTH: Okay. Thank you very much. We're adjourned until our November meeting.

[Whereupon, at 12:02 p.m., the meeting was adjourned.]