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 6, 2011
9:57 a.m.

COMMISSIONERS PRESENT:
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ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
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MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:57 a.m.]

MR. HACKBARTH: Okay. It is time for us to get started. I apologize to those of you who are standing. Our space is what it is.

So today, our first and only item on the agenda before lunch is physician payment and the Sustainable Growth Rate system. We will have final votes on four recommendations at today's meeting. The recommendations that we will vote on are fundamentally the same as what we considered at the September meeting. There have been some modifications, but fundamentally, they are the same.

Once the staff have completed their presentation, I will have some other comments to make. Before we begin the staff presentation, I want to thank Kevin and Cristina and Kate for their work on this. This has been a fairly intense effort to do a lot of complicated things over a relatively short period, and thank you for your hard work and excellent work and your patience. It is much appreciated.

So, Cristina, are you leading off?

MS. BOCCUTI: Well, the Commission has spent several meetings discussing ways to move forward from the

Sustainable Growth Rate system, known, of course, as the SGR. So today, Kevin, Kate, and I are going to summarize the principles that you have discussed and present some draft recommendations on the topic for your votes.

We start here on this slide with three principles that have guided the Commission's work on resolving the SGR. First, the Commission determined that it was essential to sever the formulaic link between annual updates and cumulative expenditures for fee schedule services.

The second principle that guided the Commission was to protect beneficiary access to care.

And the third was to offer a fiscally responsible policy to replace the SGR.

Under the first principle, the Commission determined that the SGR's formula of basing annual updates on expenditure targets created significant problems. It has failed to restrain volume growth and may have, in fact, exacerbated it. Although the presence of the SGR may have maintained fiscal pressure on the updates over the last decade, this pressure has disproportionately burdened providers in specialties that cannot easily increase their volume. And finally, numerous temporary stop-gap fixes to

override the SGR are undermining Medicare's credibility and engendering uncertainty for providers and anxiety for beneficiaries.

Under the second principle, protecting access to care, research suggests that the greatest threat to access over the next decade is concentrated in primary care. Indeed, MedPAC's patient survey -- in that survey, both Medicare and privately insured individuals report that they are more likely to encounter problems finding a primary care physician than a specialist. In surveys of physicians, those in primary care are less likely than specialists to accept new Medicare and privately insured patients. So, again, in the surveys of physicians, it is the primary care physicians that are more likely to not accept new patients. We include more details on these surveys in the materials that you have received and I can, of course, answer any questions.

So considering these access differences, the Commission is proposing a significant realignment of fee schedule payments to support primary care. By realignment, I mean that payments for non-primary care services would be reduced while fees for primary care would remain at current

levels. To define primary care, we considered a two-part definition of primary care that takes both specialty and practice pattern into account.

So going back to the principle of access, another feature of the Commission's work on the SGR was to ensure that annual Medicare spending on fee schedule services would continue to grow. Such growth is attributable to both growth in beneficiary enrollment and per beneficiary service use.

And finally, on the last bullet in the slide, we want to underscore the crucial need to annually review access to fee schedule services. This assessment should use the most timely data available in order to capture the earliest signs of any problems if they occur.

This next slide illustrates how implementation of the legislative updates would occur. Aiming for a policy that has a score of about $200 billion over ten years and freezes primary care rates at their current levels, the reductions in the conversion factor for non-primary care services, shown here as the orange line, would be 5.9 percent each year for three years. That means that over the next three years, the conversion factor would go down from

its current level, which is about $34, to about $28, and then stay at that level for the remaining seven years of the budget window, which is here ten years. In this scenario, the conversion factor for primary care would remain as $34 for the entire ten years.

Despite the reductions for non-primary care services, Medicare spending, which is shown here on the top line, would continue to increase. Over the next ten years, fee schedule spending would go from $64 billion to $121 billion. About two-thirds of the spending growth would be attributable to increasing numbers of beneficiaries enrolled in Medicare and the other one-third would be due to growth in beneficiary service use, and this, of course, is measured in both the number of services and the intensity of services.

To estimate this per beneficiary growth, we used average annual volume growth from 2004 to 2009. Matched with these update paths, we estimate that spending per beneficiary would increase at an average rate of about two percent per year.

To be clear, under these update paths, not every practitioner would see this increase. It is an average

increase across all practitioners for the ten years.

Going back to the Commission's principles for resolving the SGR, the third driving consideration was to offer a fiscally responsible policy to replace the SGR, recognizing that repealing the SGR has a high budgetary cost. A ten-year freeze across all services is estimated to cost approximately $300 billion. So SGR repeal requires significant offsets.

Kate here to my left is going to discuss potential offset options in more detail later on in this presentation, but let me review some of the main considerations.

If the Congress chooses to offset the costs of repealing the SGR within Medicare, then the Commission is offering options that share the costs across physicians, other health professionals, providers in other sectors, and beneficiaries. To be clear, offsetting the costs within Medicare compels difficult choices, both in offsets and in fee reductions, that MedPAC may not support outside of the context of repealing the SGR system.

MR. HACKBARTH: Cristina, could I just interrupt for a second --

MS. BOCCUTI: Sure.

MR. HACKBARTH: -- just to clarify a point for the audience. We will be voting on four recommendations. We will not be voting on individual offset items. We will talk more about that later, but I think some people may be here because they expect that we are voting on offset items. We are not, so go ahead.

MS. BOCCUTI: So, then, this brings us to the first draft recommendation. I will read it aloud for the record.

The Congress should repeal the Sustainable Growth Rate system and replace it with a ten-year path of statutory fee schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the costs of repealing the SGR system within the Medicare program.

Repeal of the SGR and replacing it with the update path in this recommendation is expected to score about $200 billion over ten years. This recommendation, because it has differential payments by provider, would have differential

effects on providers. It would also have differential effects on beneficiary cost sharing, depending on their service use. While cost sharing for non-primary care services would decline more than that for primary care, primary care services are typically less expensive. And as stated earlier, it will be essential to monitor beneficiary access to care.

DR. MARK MILLER: And if I could just say one clarification there, that will be something that we -- that is something that we do every year and something that we would be coming back each year to readdress in the Commission.

MS. BOCCUTI: So I am turning the next section over to Kevin.

DR. HAYES: Thank you. This next slide addresses the issue of data needed to improve payment accuracy. The concern is that the Secretary lacks current objective data needed to set the fee schedule's RVUs for practitioner work and practice expense. The proposal is that the Secretary could collect data on a recurring basis from a cohort of practitioner offices and other settings where practitioners work. When the Secretary adjusts RVUs with the data

collected, the RVU changes would be budget neutral.

A draft recommendation on this reads as follows. The Congress should direct the Secretary to regularly collect data, including service volume and work time, to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

On the spending implications of the recommendation, any payment changes resulting from this data collection would be budget neutral, so the recommendation, just from the standpoint of the RVU changes, would have no impact on program spending. However, the Congress would have to provide the necessary funding for the data collection activity to occur.

The data collection would have no impact on beneficiaries. For providers, there may be some administrative burden for those in the cohort participating in the data collection.

Moving forward from the SGR could also include a

change in the process for identifying overpriced services in the Physician Fee Schedule. The Commission has considered the evidence that some services are overpriced. To address this issue, there is a process in place now for reviewing potentially misvalued services. However, it is time consuming and has inherent conflicts. The conflicts arise because the process relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the RVUs assigned to services.

To accelerate and better target the process, the Secretary could be directed to analyze the data collected under recommendation number two, identify overpriced services, and adjust RVUs of those services. Further, to accelerate the current review process, the Congress could direct the Secretary to achieve an annual numeric goal equivalent to, say, one percent of fee schedule spending. This would be a goal for reducing the RVUs of overpriced services. As is the case now, the RVU changes would be budget neutral and, therefore, would redistribute payments to underpriced services.

A draft recommendation on this would read as follows. The Congress should direct the Secretary to

identify overpriced fee schedule services and reduce their RVUs accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in Draft Recommendation 2. These reductions would be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal for each of five consecutive years of at least one percent of fee schedule spending.

The RVU changes would be budget neutral, so the spending implications of this recommendation are that it would have no impact on program spending. For beneficiaries and providers, there would be a redistribution of payments from overpriced services to other services. And more accurate RVUs would make payments more equitable for physicians and other professionals.

Now, we will shift gears and Cristina will talk about options for accelerating delivery system reform.

MS. BOCCUTI: The Commission has stated on many occasions that Medicare must implement payment policies that will accelerate changes in our delivery system to improve quality and efficiency. The current fee-for-service system is inherently flawed. It rewards volume growth. It

penalizes providers who constrain unnecessary spending and provides no accountability for care quality.

It is important, therefore, for delivery system reforms to shift Medicare payments away from fee-for-service. New payment models, such as ACOs and bundled payments, can potentially improve accountability for efficient use of resources and care quality. Repealing the SGR may provide an opportunity for Medicare to encourage providers to move towards these models and make fee-for-service less attractive. Additionally, to achieve widespread delivery system reform, beneficiary incentives must also be aligned with these objectives.

So in thinking about policies to accelerate delivery system reforms, we next consider ways to align payment for fee schedule services with incentives for improving quality and prudent resource use. Looking at the ACO program, for example, Medicare could create incentives for physicians and other health professionals to join or lead ACOs. One way would be to allow greater opportunity for shared savings to those physicians and health professionals who join or lead two-sided risk ACOs, and I am defining here two-sided risk ACOs are those that are subject

to penalties or bonuses based on performance. That is in contrast to bonus-only models in which they are not subject to financial penalties for poor performance.

The greater opportunity for shared savings under this policy would come from calculating the two-sided risk ACO spending benchmark using higher overall fee schedule growth rates. So under this policy, of overall fee schedule rates are reduced, two-sided risk ACOs could be measured against a freeze and would, therefore, have a better chance of coming in under the benchmark. So these ACOs would have a greater opportunity for shared savings.

And we try to embody that in this recommendation here, which reads, under the ten-year update path specified in Draft Recommendation 1, the Secretary should increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk ACOs. The Secretary should compute spending benchmarks for two-sided risk ACOs using the 2011 fee schedule rates.

For here, we have the spending implications as indeterminate because the ACO regulations are not yet final. We can talk about that a little more if you have questions, but we will leave it at that for this purpose here.

For the beneficiary and provider implications here, we have that it could increase the willingness of physicians and other health professionals to join or lead two-sided risk ACOs and could increase provider accountability for health care quality and spending.

So these are the four draft recommendations, but Kate is going to talk a little bit now about the list of options included for offsets.

MS. BLONIARZ: The Commission's draft recommendation for updating physician fees will cost approximately $200 billion over ten years. Because MedPAC was established to advise the Congress on Medicare payment policies, the Commission is offering a list of savings options within Medicare that Congress may use to offset the cost of repealing the SGR and replacing it with specified legislated updates over ten years. The Congress may, of course, seek offsets for repealing the SGR inside or outside of the Medicare program, and the Commission does not necessarily recommend that the Congress offset the repeal of the SGR entirely through Medicare offsets.

A key principle for forming the recommendation and selecting potential offset options is to strike a balance

between ensuring beneficiary access to care and sharing the cost of repeal among physicians and other health professionals, other Medicare providers, and beneficiaries. Offsetting the cost within Medicare only compels the Commission to make difficult choices, including the conversion factor reductions for non-primary care services as well as offset options that the Commission might not otherwise support.

The package of offset options that the Commission has developed now sums to approximately $220 billion over ten years. You have seen the draft list of offset options and it has been posted to the web. We have revised the estimates and refined some proposals in the offset options package. To remind you of the shape of the package, the pie on the slide shows the direct effect of the package by sector or group. The beneficiary and provider implications of the offset options are that payments to some providers would go down as compared with current law and beneficiaries could face higher cost sharing. The effects on payments to providers could also effect providers' willingness to take Medicare beneficiaries. Furthermore, the indirect effects could be significant and we would monitor the effect of

these offset options to determine how they are affecting beneficiaries' access to care.

Overall, the total package includes about $50 billion in Tier I, which are MedPAC recommendations, and about $168 billion in Tier II, which are options derived from other sources or MedPAC analysis. The inclusion of items on Tier II are not to be construed as MedPAC recommendations, but are offered to assist the Congress in resolving the SGR problem.

It is also important to note that Tier II is not an exhaustive list of options that people have offered to reduce Medicare spending, for example, increasing the age of eligibility, requiring higher contributions from beneficiaries with higher than average incomes, or premium support. The exclusion of such policies should not be construed as a statement of the Commission's position on these policies. Such policies raise complex issues that are beyond the scope of Tier II offsets.

So that concludes our presentation and we will now turn it over to you for your discussion.

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

I wanted to address three questions at the

beginning. The three questions are, first, why is it important to repeal SGR now? The second is, who should pay for repeal of SGR? And the third is, how should we protect access to care for Medicare beneficiaries?

The first question, why is it important to repeal SGR now. Since 2001, MedPAC has been on record supporting repeal of SGR. In the spring of 2011, we decided that being on the record was not sufficient. We should make a proposal that would have a chance of actually accomplishing the goal of repeal of SGR. Why now? Why, after ten years, is it important to try to accomplish repeal now?

There are three reasons in my mind. First, the cost of repeal will only grow. Second, the likelihood of repeal without offsets to pay for it is probably declining in the current economic and political environment. Third, Medicare savings, which could be used as potential offsets for repeal of SGR, are being used for other purposes, whether for expansion of coverage under the Affordable Care Act or for deficit reduction.

In my mind, perhaps a better question than why now is why didn't we push for this seven or eight years ago when the cost of repeal would have been much smaller and the

pain, the discomfort from offsets, therefore, less? I don't have a good answer to that question. I ask myself that repeatedly and I regret that we did not push down this path earlier.

So my second question is, who should pay for repeal of SGR? Congress, not us, will decide whether to offset the cost of repeal of SGR and who should pay for it. Frankly, Congress doesn't look to MedPAC for advice on these questions. Whether the cost of repeal should be offset is a question about what size of deficit is acceptable. That's not our call, that's the Congress's call. Who should pay for offsets potentially raises questions that go well beyond Medicare, issues of tax policy, spending on other programs, whether it be defense or education, and the like. Again, Congress does not look to MedPAC for advice on that question.

The pertinent question for MedPAC, or pertinent questions for MedPAC are, then, do we recommend repeal of SGR even if the cost must be offset within Medicare? And if so, how would we allocate the cost of repeal across the participants in the Medicare system? These are the questions that we are striving to answer.

This is a really crucial point. It should be clear to everyone who is listening today or reads our recommendations that we are not necessarily recommending the Congress fully offset the cost of SGR repeal within Medicare. We are saying that if Congress elects to do that, this is how we would approach it and a set of options for them to consider.

It is not necessarily the first choice of any Commissioner to approach financing repeal of SGR in this way, whether it's specific offset items or cuts in the conversion factor. What we are saying is that if Congress decides that the offset -- the cost of repeal must be fully offset within Congress, we think they should still go ahead and here is our recommended approach for doing that.

The third question is, how will we protect access to care for Medicare beneficiaries? The recommendations would do two principal things to try to reduce the risk of impeded access to care. First of all is the different treatment for primary care as opposed to specialty services. Cristina in her presentation outlined why we are particularly concerned about access to primary care.

The second thing we do will be to review payment

adequacy for physicians each year in the future as we have in the past. Each year, we will make a recommendation to the Congress about whether payments to physicians are adequate to assure access to care for Medicare beneficiaries.

Let's assume for the sake of discussion that in year two, we conclude that the risk of impeded access to care is escalating and that we think that Congress should not follow the ten-year schedule of conversion factors that has been described. In year two, say, we don't want to go forward with the second 5.9 percent cut and we want to freeze rates in year two. How much would it cost? What would be the rough score of that intervention, that pause, foregoing the second year cut in the schedule? And I want to be clear here that if Congress were to adopt our recommendation and enact this ten-year schedule of conversion factors, any departure from it would require new legislation and carry with it a CBO score.

If Congress were to choose to intervene in year two and say, we want to stop and assess the effect on access, our staff -- and this is not a CBO estimate, but our staff estimate is that the cost of that intervention would

have a ten-year cost of about $10 billion. Currently, to intervene, for example, at the end of this calendar year, to stop the scheduled SGR cut for January 1 has a ten-year cost of about $22 billion. So there are a couple points that I want to emphasize here.

The first is that this is not like taking a step off a cliff and once you have left the cliff, there's no opportunity to reassess. We will each year reassess payment adequacy for physicians. It will have a cost if the Congress decides to depart from the path, but it can depart from the path.

In terms of the CBO score for departing, it is, as I say, roughly in the magnitude of $10 billion over ten years if they intervene in year two.

So those are the three questions that I wanted to address at the outset. Now, I would like to open the discussion to the other Commissioners. What I propose we do is simply do one round of comments, not our usual approach of a round of clarifying questions and then comments. Having discussed this several times already, I think we ought to reserve the maximum amount of time for comments, and Karen, I will begin with you.

DR. BORMAN: In the interest of full disclosure, I remind everyone that I am a general surgeon, although I hope that you will understand that my comments are made through my thinking as a Commissioner and with those priorities in mind and not driven by any professional association to which I belong.

Secondly, I would say that as a subject, this is about as near and dear to my heart as it gets since our recent work last year on graduate medical education since the two areas of focus that I think I probably perhaps add to the Commission relate to physician reimbursement and graduate medical education and workforce. So please feel free to take my comments in those lights.

I think we can all agree that the SGR is a fiscal policy tool that's been poorly suited to lead us toward the high quality, reliable, high performing, and sustainable system that we would like for Medicare beneficiaries, and by inference, because of Medicare's position in the health care Medicare, because of the interdigitation of Medicare's fee schedules with other payers, by inference, we impact the sons, daughters, and grandchildren of Medicare beneficiaries by what we do, and the SGR is a tool poorly suited to help

all of them.

Through years of hard work and people that preceded me in this room, people that are here, and people that will come after, I believe this Commission has become a trusted soul in terms of advising Medicare and has been built -- advising the Congress and has demonstrated qualities of being built to last, focused on Medicare's sustainability going forward. And I think everyone in this room needs to be proud of that.

I think we have done that in a way that, by and large, has articulated principles and auctions and relatively seldom, if ever, wandered into essentially creating draft legislation. And I think that perhaps we are coming close this time for many reasons, I think as Glenn has outlined, but also perhaps at our peril, and I would want to just highlight that a bit, that I hope that this change in our role or our approach does not have consequences for its going forward that we don't intend, just as the SGR did.

I think we are advancing a complex -- or the Commission is advancing, not me personally -- a complex and complicated proposal, some of whose provisions have not gone

through the entirety of our usual evaluation process. And while we can be very careful and nuance language to say, yes, some of these are not necessarily our ideas but we think they might be good ones and they have these offsets, inevitably, these will become associated with us and appear to bear our imprimatur even though we may not have given it. And I think, again, there is some peril.

I also think that despite the wonderful monitoring -- and I appreciate Glenn's comments very much because they certainly address some of my concerns, as he knows -- of the impact of these, just like the SGR has been so difficult to unwind, I think it will be dauntingly difficult to intervene, certainly in year two if not in subsequent years of this package. And so I think we need to have considerable confidence about what we recommend.

I believe, also, that we perpetuate -- although what we are doing is abolishing the SGR and offering an alternative, I think that it is very difficult not to hold us to some of the standards that we are to fix, so we are criticizing about the SGR. So does this proposal move us toward more quality, more efficiency, more sustainability? Arguably, perhaps, sustainability by the fiscal effects, but

certainly toward quality, efficiency, rewarding providers at a meaningful individual level for what they do?

I think this begs those issues and we may not be able to address them in a home run, but again, I think that we are, in fact, not addressing those things, and I think even as our letters and statements about those have made, there's comments that people can make things up in volume and that's exactly the behaviors that we're very concerned about have been incentivized under the SGR. So I have great concerns from that standpoint.

Also, I think that we have supported thoughtful review of what is needed in the way of workforce composition to do what we want to do going forward, and there is a National Workforce Commission. We have recommended a task force to review GME allocations. And I think that our discussions would be much better informed if we had at least some projection of the workforce, including non-physician providers who are increasingly important to our care delivery, what our needs are going forward before we think we know we're incentivizing necessarily the right segments in the right ways.

In terms of things that relate a bit more perhaps

toward the second and third recommendations, because they relate to relative value scales and how they are constructed and implemented, I would say that we are de facto creating a second relative value scale by a differential among specialties and that what is the interdigitation, if any, of that second relative value scale with the one that exists? How will this play out in Medicaid payments who often tee off the Medicare fee schedule or other payer systems who do? For example, what does the MACPAC have to say about any Medicaid implications of this activity? But again, a thoughtful consideration of those implications and interdigitations just really hasn't been allowed for in a relatively rapid time line.

Also, this relative value scale that's created, I'd be happy to look at the data on which it's based in terms of its number. How do we know that this is the appropriate differential and how do we know that it will begin to reward the things that we hope to reward, the things that drive people into their choice of practice? The venue and the specialty are multi-factorial. Income is certainly one. But the nature of the work, work life, lifestyle balance is a huge issue for today's young

physicians, and the issue of young physicians is hugely important because about 40 percent of practitioners now are 55 or older. I, frankly, think the bigger workforce challenge here, even beyond the primary care workforce, is just the physician workforce. Physicians who are nearing that age, certainly one of their options here is to clearly hope they've made good retirement investments and leave the field entirely in facing this challenge. So I think that we need to be thoughtful about the workforce implications that we have.

Also, I think the piece about creating a second Relative Value Scale does a disservice to the mechanisms that already exist. We've been fairly active in criticizing the RUC. I think perhaps we've been less good than we could be about applauding some of the very fine work that it does on a voluntary basis. And any of you that have been privy to some of the outputs of the Research Subcommittee, for example, I think could acknowledge that some of the work there is worthy of some of the fine work that our staff does in bringing us some other insights into the RUC. I would much prefer seeing us, rather than trying to set arbitrary targets for valuations of services and some of these other

approaches, I would rather see us put more time into making an existing Relative Value Scale that was build on a fair amount of very significant public health researcher experience and has a long track record be done better.

And as a Commission, I would encourage us to do better in that regard as opposed to just having the "my eyes glaze over" response when we start to talk about practice expense or work RVUs. I think we deserve to give that a little more justice than perhaps we had in the past if we're going to undertake these major interventions like creating a second Relative Value Scale.

Finally, or in that vein, my last point would be that there have been a number of interventions over the last five years, certainly, in terms of in the 15-year review, the major increase in evaluation of management services, that move $4 billion into those services from everyone else. There have been the practice expense redistributions that have been the equivalent of payments to four surgical specialties that have moved away from those. And so where have we seen what the summative change has been in the five-year time, and I have not seen that comparison presented to us.

I would note that certainly if we look back over the entire RVS system, that the E&M services have gone up substantially, whereas cataract surgery and knee replacement, some of those other things have gone down substantially.

My final comment would be that I think we need to be careful in this time where we are committed to abolishing the SGR that we be fully confident that we are not merely substituting something that has inherent flaws and is likely to have as many unintended and perverse consequences as what currently exists.

I appreciate the time to share my views with you and certainly, I think it is probably pretty clear, I do not support Recommendation Number 1 and, therefore, Recommendation Number 4 that follows along with it.

DR. CASTELLANOS: Thank you, and Karen, thank you. I appreciate your comments.

I guess under full disclosure, I have to say it also. I'm a urologist. I'm the only physician on the Commission that's in private practice. I don't work for the government and I don't work for any health care organization.

I think we all agree that we need to get rid of the SGR. That's not the question. We should have done that a long time ago, and I was very -- I advocated to do it and Glenn was also. Did we miss an opportunity? Probably, but we do have the opportunity now and I don't want to miss it at this time.

Anytime you do something, you have good benefits and you have some unintended consequences, and what I'd like to do is focus mainly in some of the unintended consequences.

Now, I'm a specialist. I'm a urologist. And one of the unintended consequences is the message that's going to be given by this 5.9 percent cut for three years and then a freeze, and I'll be very honest and show you that a Nurse Practitioner, who I value tremendously -- I have Nurse Practitioners and I have PAs in my practice and I value them. They are an integral part of the delivery care system. However, after 2014, a Nurse Practitioner seeing the same patient I do with the same code and same risk will get paid more than a specialist. That, to me, is extremely disturbing. A urologist like myself has somewhere between 15,000 and 17,000 hours of training. A Nurse Practitioner

has somewhere between 750 and 1,500 hours. I have a difficult time philosophically accepting that, but that is one of the consequences of what we call an unintended effect of this pay scale.

We talked about access to care, and I'm very concerned about it and so is the Commission, and we're going to look at it very, very, very carefully. In my world, 40 percent of the physicians in the United States today are 55 years or older, and in some specialties, like urology, myself, psychiatry, and pathology, 50 percent are over 55. In my State, Florida, 50 percent of the urologists are 55 or older.

With the potential of other risks, to include penalties for e-prescription, PQRS penalties, EMR, going forward, it's going to make a big difference. Is it worth it for me to stay in practice? Is it worth it for me to have to go through these hoops of these unintended regulations? Is it worth it to me to see a patient where I know when I hire a practitioner or a Nurse Practitioner, she is going to get paid more than I am? I think there are going to be a lot of doctors like myself who are going to say, it's just not worth it anymore. I enjoy the practice

of medicine. That is the real privilege and pleasure I have in life. But I don't enjoy a lot of the regulatory burdens that are forced on me.

So what's going to happen when we have this? Well, we've seen it already. We've seen it a couple -- we just saw it last fall with the cardiologists, when CMS took their ancillaries out of their office. What did the cardiologists do? They used a different business model that went to the hospital. And what did that do? It caused increased costs to Medicare and to the beneficiary. Cost sharing for the beneficiary went up. Cost sharing for Medicare went up. And what was accomplished? I am not sure. I am really not sure.

We know, 20 or 30 years ago, and Bill, you can tell me this. When you were in Congress, I think it was under Nixon, we had a freeze for physician fees and it was called the WIN thing, Whip Inflation Now. And what did it do? It did the same thing that Glenn has already said we're going to have done here. It is going to increase volume. And what did Karen say? That's the last thing we want done. That's an unintended consequence.

I keep saying, and I'm going to repeat it now, I'm

in private practice. I need to be in -- I have 80 to 90 employees. I have a large payroll. If I'm not in business today, I can't take care of my patients today or tomorrow. And I'm going to be honest with you. With the financial issues, I'm going to look -- George, I'm going to come knocking on your door, or Peter, I'm going to come knocking on your door and say, hey, is there a job for me? This is an unintended consequence.

More important, it's a workforce problem. Contrary -- and we're really looking at workforce, and as Karen said, and Glenn is going to a meeting this afternoon concerning the workforce issues and graduate medical education -- we have a shortage of specialists today, too, not just primary care. And if I drop out now, and a lot of my colleagues drop out now, that's not going to show up until it's too late. We're going to look at it each year, but to replace me, it's going to take a doctor somewhere between ten and 12 years of postgraduate training and we don't have it set up now. We don't have the residency caps changed. So I think there is a real significant problem.

One of the concerns I have, and I really believe this, I think we really need to look at primary care and we

really need to pay them appropriately for what they do. By that, I mean care coordination, telephone calls, e-mails, et cetera. By doing this and changing the reimbursement on conversions, we haven't changed one thing with primary care. We have not solved that problem.

I'd like to specifically talk about the other -- so I'm going to go on record. I cannot vote for this. I cannot vote for Recommendation Number 1.

Draft Recommendation Number 2, the only problem I have there is the -- not the diagnosis, but the definition of an efficient provider, and as you know, the devil is always in the details.

Draft Recommendation Number 3, we talk about an annual numeric goal. Boy, if that doesn't sound like the SGR, I don't know what it sounds like.

As far as ACOs go, I really -- you know, a year ago, nine months ago, I was very enthusiastic. I thought, God, this is just what the Commission wants. This is just what the delivery of care changes we want. Subsequently, with all the regulatory burdens, with no funding for up-start or start-up costs, and with this decrease in income, and even though we show an increased revenue to the

practice, that is not income. That is cost of providing care. I have very strong concerns about a risk model ACO. At my age, I don't take risks in my portfolio. Why should I take risks in the care of my practice? I don't see any -- you know, I'm talking about generational. Now, the younger guys coming up may feel differently.

So I have a lot of concerns over this. I, quite honestly, like Karen, am very concerned and I, sitting here today, cannot support Recommendation 1. Recommendation 2, 3, and 4, I can support with some concerns. Thank you.

MR. GRADISON: Thank you, Glenn. I support these recommendations. I certainly don't do it in the spirit of saving that they are perfect. I am definitely influenced by the question of timing. The window of opportunity actually might open because of the overall budgetary issues which are being considered by the Congress, and I think it would be a real tragedy if we limp along for years with the SGR for failure to seize what may turn out to be an opportunity to come up with something better.

So the notion of repealing and replacing definitely has some charm to me. I think it's possible that the consideration of acting now on the SGR might happen

anyway, or might have happened anyway, even if MedPAC has nothing to say on this subject. But I'm not at all sure about that.

Not only do I think we have a responsibility to the Congress which created us because they wanted our advice on this subject, but I also think that the opportunity here is to at least start a discussion. I know there are many people who have filled our email boxes -- and thank you, and I mean that -- with well-considered concerns about what we have recommended.

And I think, in a sense, that's very healthy. To the extent that we foster constructive exploration of alternatives, we will have served the public and the Congress very well. That is not to suggest walking away from what we're recommending.

It is, however, on my part, a very strong suggestion to those who don't like what we're doing, is to get in and play the game. Put your recommendations forward. If you've got a better way to finance this than you think we have, let the world know about it. I think if that kind of a fervor were developed, I would feel that we had accomplished what we were set up to accomplish.

MR. GEORGE MILLER: Thank you, Glenn. And certainly I would like to weigh on this with my views, but I certainly respect both Ron and Karen's perspective. I think just as Bill said, this is healthy that we have this discussion. These issues are very complicated, they're complex, and our discussions, deliberations are, quite frankly, going to be painful.

But I do land on the principle of access to care as one of our driving principles in dealing with this issue. As Ron said, and he may come knock on my door, but I'm a hospital administrator and one of the challenges that we have as hospitals and one of the challenges this proposal deals with is that we employ a great number of physicians across America.

And so we have a stake in this issue as well because it would affect us, quite frankly, twice. We employ physicians and then we're going to take the cut. But with that said, my role as a Commissioner I take very seriously and our job is somewhat larger than our individual responsibilities to make the right decision to the best of our ability for the Medicare beneficiaries and to make sure that we do what we think is right.

I am concerned, though, by some of the implications that Ron mentioned about the unintended consequences, especially if I employ both a nurse practitioner and a urologist or physician where the physician payments under the current proposal will be -- for a physician will be less than a nurse practitioner.

And I may understand it as an unintended consequences, but some things are -- what is right is right and that is a concern. So I want to acknowledge what Ron talked about as a concern.

But overall, in this environment, we're dealing with a very complex issue. I believe I tend to support all four of the recommendations, but with some caveats and concerns as has been outlined. And I certainly want to compliment both Glenn and the staff. These are very difficult issues and they've done a tremendous amount of work as we are brought to this place at this time.

And finally, again, dealing with the access to care, I believe that the principles and draft recommendations to assure that the program provides that over the long term, to make sure we have access to care, and certainly I support the fact that we're trying to address

that issue along with the primary care physicians concern.

DR. STUART: This is easily the most difficult series of votes that I've had while I've been on the Commission, and the interest in this issue is reflected in the size of the audience and the emails and mail and conversations that we've all gone through over the last month or so.

So I do not look at this casually. I think this is a hugely important series of votes that we have. Ron and I actually are on record as having recommended -- I can't remember whether it was this spring or last fall, that we just simply write it off, that SGR, make it go away.

Recognize that the increase in the debt is there, it's a real debt, it should be recorded, and leave it at that. What we're faced today is with the necessity of that choice of either going forward with SGR or coming up with some reasonable mechanisms by which we can pay off that debt.

And I agree with the Chairman that we owe it to Congress to come up with a framework of recommendations as opposed to necessarily specific recommendations that would be approved by each member of the Commission.

So in my mind, it really comes down to, what are we better off doing? Are we better off saying, Well, even though we're opposed to SGR, we're not going to do anything to help Congress actually effectuate the repeal of SGR, or are we going to accept the necessity of dealing with it straight-forwardly, and in my own mind, I'm convinced, based upon arguments that I've heard over the five years that I've been on the Commission, that the cost of maintaining continuing SGR are unsustainable and we really do need to make a decision now.

And so I do support the recommendations. And I guess my recommendation also would be, in terms of those who are reviewing what we have done here, obviously that chart on Tier 1 and Tier 2 savings is hugely important and something that we must examine, as well as the freeze and the reduction in physician fees.

And I think it's important to note that it's not just the 5.9 percent reduction in specialty fees over the first three years that is the only pain that physicians will face under this. The freeze itself is the most important thing. I mean, if one were to look at the rate of growth in physician fees over the past ten years, it certainly is

above zero.

And so, looking forward ten years with no increase at all is probably the most painful of all of the recommendations here. So I think that what we need to do then is to ask ourselves, Well, here's the pain, here's the blackness of the cloud. Where is the silver lining, if there is any, and what are the opportunities in terms of having to manage policy under these circumstances.

And here is where I think the recommendations two through four are important, and if we had a year to do this, I think we probably, as a Commission, would come up with some other set, more refined mechanisms here. But I think the purpose of these recommendations two through four is to use this as an opportunity to improve the program.

And every one of these is going to improve the -- I think has a strong probability of improving the long-term sustainability of the Medicare program. And I think it's also important to note that none of them is scored. I mean, some are budget neutral. I mean, they don't have to be budget neutral. I mean, it could be that Congress could say, All right, well, if there are savings in terms of overpriced procedures, well, we'll take those and we'll ask

CBO to score them and we'll add that to the mix.

But I think what it does is it gives us an opportunity to change what we all believe is a fundamentally flawed system that rewards additional volume and puts us on this unsustainable track. And ironically, I kind of argue the opposite of what Karen did. I can see that if you weren't to do anything, that reducing fees might provide additional incentives to push volume in those specialties where that could be done.

But I think that clearly, the intent of this is to move away from that as far as the overall emphasis of payment under the system being fee-for-service. And so, I leave that and maybe it's more of a wish than -- a wish and a hope than a necessarily reasoned expectation. But I think that it's important that we're on record for making these recommendations two through four.

And on the basis of that, I support one in the context of also supporting two through four.

DR. NAYLOR: So I'd like to start by thanking the leadership of our Commission and the staff and all the Commissioners. I have enormous respect for the diverse perspectives that really get us to a path going forward, and

I appreciate the real honesty that each member brings here.

I look at this as even though it's individual recommendations, I look at it as a set. I look it as collectively a path forward. And as much as we critically know the importance and everybody recognizes the importance of repealing SGR, we're also talking about a path forward that helps us get to a delivery system that really ultimately gets to higher value for the people that we, on this Commission, are to serve, and that's to support the Medicare beneficiaries.

I support all four recommendations. I think that they need to be thought of in the context of the existing payment system, the opportunities to get to more meaningful data, the opportunities to use that data to get to the right pricing, and collectively, the opportunities to create the care systems we need.

I really also support the principles that guided this work, and the attention to primary care, particularly in the context of access. So we know right now the SGR system really is a major threat to access because of the uncertainty it creates.

And we also know that we're moving as a country to

primary care systems that are really trying to embrace what primary care is all about: Comprehensive care delivery, coordinated care delivery, collaborative care delivery, all on behalf of getting to higher value. We have a pretty evidence base that if we do that right, we do increase access, we do improve quality, and use well our increasingly finite resources.

So I think the emphasis on that and the emphasis on the beneficiaries we serve that really are the hallmark of these, and underpin all of these recommendations, are what make very difficult decisions, I think, help us to understand how we can support them.

I do have an appreciation that this is an extraordinary change. I have an appreciation from the work that you've done about its potential consequences on beneficiaries and certainly we've heard on the providers of care. But I'm comforted by the notion of the monitoring that is also the hallmark of the Commission, which is staff bringing us data constantly on the impact of these kinds of transformations, and I think that that's a critical part of all this.

I appreciate, also, that the offsets, many of them

have been a part of the recommendations for many years in the ten years that you've been attempting to think about how to get SGR repealed. We have $52 billion worth of these recommendations that are grounded in the work of this Commission and the others that offer a set of potential opportunities so, you know, informed by Commissions, the MedPAC staff and others.

So I think this is a time that calls for really important leadership, and that is not easy, but I think if we keep the focus on the people today and the growing number of people who are going to be served by Medicare tomorrow and into the foreseeable future, that this represents the best path to get us toward accessible, high-value care.

DR. HALL: Thank you, Glenn. I'm going to be speaking in favor of these four segments of our proposal. I have the considerable disadvantage of being one of the newest members of the Commission so I don't have nearly the experience and expertise of most of my fellow Commissioners on this.

What I do bring to the table, I hope, though, is a lot of professional experience. I work at an academic medical center in upstate New York where I'm a geriatrician,

and about half my professional time is spent with Medicare recipients. Virtually 100 percent of my clinical work has been in Medicare and Medicaid for the past 20 years.

The rest of my time is spent in helping to shape the educational agenda for young health care providers who will be taking care of the next generation of Medicare recipients, and that has, I'm sure, influenced my points of view on many of these aspects.

As I mentioned in September, there are no easy answers here. There is so much pain to be passed around here and we shouldn't minimize that. From the standpoint of physicians and other health care providers, while some concerns have to do with economics, personal economics, I don't think we should under-estimate the almost heart-wrenching aspect of seeing changes in the medical care system that put many barriers between the relationship between the provider and the patient.

It's much harder to articulate that rather than just what a salary would be or what reimbursement for a service would be. So when you hear health care providers say they have concerns about this proposal and other proposals like this, it's not entirely financially

motivated, but it has to do with, what has happened to the nature of the healing relationship that we all feel used to exist in the health care system, and how can we best preserve that now and in the future? So hats off to Ron, Karen, and others who have made remarks, recognize where that's coming from.

So in situations like this, what I try to do is say, Well, what are the guiding principles? What are my values? What's really important as we go through some of this discussion? And can I weigh this proposal against some of those values?

So there are three of them, basically, that I'd just like to quickly mention. As has been pointed out several times, we will get nowhere in terms of Medicare reform, particularly specifically SGR, unless we embrace the notion that the system is broken and needs fixing. Almost everybody has said that in the course of this morning so far, and I suspect we'll hear more of that as we go around.

Proposal after proposal has been put forward. We've had a lot of constructive criticism from various bodies in the last month, and one of the common denominators there, however, is that the proposals for change always put

the fiscal responsibility on somebody else. Somebody has to break that chain.

And I'm convinced that the proposal that we've put forward here, painful as it is, is at least one attempt to say, This is what the painful cost of health care reform and an SGR revision is going to take. The report also -- the proposal also, very clearly, points out that it's not the only way that this could be solved, that Congress has the ability and the responsibility to find other sources to pay for SGR reform.

But we're saying if, in fact, as we are being asked, if, in fact, this burden has to be put on providers, here is one concrete example of how it could be done. And again, as others have said, if you've got a better way of doing it, why don't you bring it forward. That's what we've been missing in this whole thing.

And I would agree with Bill that there's just a slight chance that we are at one of those critical points in history, very close to the brink of chaos, where really good ideas will actually result in something. I know something in the back of my head says that never happens, but maybe this is one of those times when something like that could

happen.

So I believe that we have to approach fiscal solvency as we approach SGR. I believe we have to present ideas that may be controversial, and if they're controversial, that's good. And recognize that we are only responding to one specific aspect of this: How would the providers help pay for this? We're not saying that's the only way it can be done. So I'm happy in that sense.

The second principle that I think is important is for my vision of how I want to be cared for in a few years in Medicare and the future generations, how my children will be cared for, is there has to be access to care, both on the front end when people are trying to find a health care provider when they reach Medicare eligibility, whatever that turns out to be, that age. But also for people who are beset with chronic illness and run the risk of perceiving that they have problems with access.

We've put the data out pretty clearly and the arguments why access to primary care is perhaps a much greater challenge than specialty care, but also access to primary care and preservation of primary care is probably the only part of the proposal, or anyone's proposal, that's

going to allow us to move quickly to alternative forms of care based on a whole different mechanism other than fee-for-service.

Without primary care providers in the system -- and believe me, we're training -- in medical schools, we're training precious few of them these days -- we're going to have a much harder time getting to whether it's in the broadest sense, any kind of accountable care organization.

I've been impressed that the MedPAC staff has very carefully looked at this problem of access, and again, nothing is written in stone here. There's going to be active and careful surveillance on a yearly basis of access to care and appropriate revision of recommendations if that goes forward.

So we talk about a ten-year plan, but there is plenty of opportunity and room here for us to make sure that you and I and future generations will have access to care as the SGR is reformed and we move to a different system.

And then finally, I just have to basically say that as an educator, I really want primary care to be a laudable profession to, again, attract the best and the brightest and in no denigrate specialty services. My

previous life was as a critical care specialist until I decided that geriatrics was where I wanted to go.

But we do need these primary care providers, and this is the first proposal that I've ever seen that actually puts some teeth into that. And one can find holes in here and there, but it's a very solid foundation. So that's where I come forward on all four parts of this.

MR. KUHN: Glenn, thanks again for your leadership and for the hard work of the staff on this. This has been a lot of good work in a very short period of time. Let me make three points. The first one, I just want to thank all those organizations that did send comment letters, that provided information and reaction to the proposals that were advanced at the September meeting. They were helpful, they were instructive.

But just one observation is that as I looked at all that material, I got a very good understanding of what people opposed or what they were against. I didn't get a very good grasp in terms of what they were so. And so, just on a go-forward basis, I think as this advances to Congress, this issue, for people to really kind of also share what they're for, what they can support, I think, is helpful to

the dialogue as well, and would just encourage that on a go-forward basis.

The second issue is just my general feel about the SGR. It's hopelessly broken. It undermines the integrity of the Medicare system and it should be repealed. In fact, let me restate that and be a little bit stronger. It must be repealed. It just is -- it's wrong and needs to be taken care of.

As Glenn indicated, we're now kind of entering our second decade at MedPAC of recommendations for repealing the SGR. Let's hope that the second decade is more successful than the first decade as we go forward, because above all else, physicians deserve predictability and stability in the system. Beneficiaries, as Bill and others have articulated, deserve unfettered access to care and we need to strive towards those principles as we continue to go forward.

The third point I would just mention deals with the offsets, and I think Glenn set this up very nice as, understand the constraints that we operated under here. We are looking only at the Medicare program, and I think that's key for people to really understand. We also have to understand there's real pain here as we go forward.

But the real sense of the set of offsets that are there is that they are potential options, they're not written in stone. They're potential options. There's two tiers. The first tier are ones that MedPAC has opined on in the past. The others are advanced by other organizations that are out there for people to look at.

There shouldn't be anything new here. I think these are all things that people have seen before. I would just point out that I thought some of the groups that sent comments about some of the options were well-done. One I would just mention in particular is the fact that if you look at the Tier 1 options, most of them, except for three, most of them are more recent options by the Commission. Three of them date back to 2003, one dealing with rehab facilities and the 75 percent rule.

I thought some of the folks in their comment letters provided some good observations that the marketplace has changed much since that set of recommendations. That's good information that ought to be considered on a go-forward basis, and so very helpful.

In that regard, right now I'm in a position to support all four of the recommendations and look forward to

our continued deliberations, and ultimately follow-up monitoring of physician payment.

DR. BERENSON: Thank you. I share my respect for the Chairman's leadership and for the staff work in this area. I support all four recommendations and want to take my time commenting on a few of the comment letters that we've received to try to, I think, correct some misunderstanding that I think is out there, or at least as reflected in the letters.

I share with Bill and Herb that it was very good to get these letters and, in fact, there were many constructive, helpful observations and suggestions. But I want to talk about one or two, specifically where I think there's some problems that are important to understand.

So I'm reading from a sentence in a letter signed by 43, as I counted them, specialty societies representing virtually all physicians. I did note a couple of significant absentees of signatories. The sentence says, Today Medicare payments are just 4 percent higher than in 2001, but physician practice cost as measured by the MEI or 24 percent higher.

Well, the accurate statement would have been

payment rates are 4 percent higher, not payments. And I think it's important to understand the difference between payment rates and payments. Indeed, my observation has been that the medical profession has really never taken responsibility for the volume growth problem that is essentially at the center of physician spending increases, and in many cases, increasingly, I believe, the volume growth doesn't help patients, but is really there to generate revenue.

So I've asked, knowing that I was going to talk about this, I've actually asked Kevin to prepare, I guess, two slides to sort of illustrate the point that I'm trying to make here. Kevin, I'm going to turn it over to you. The point here is to clarify the difference between payment rates and payments. If you would?

DR. HAYES: Sure, sure, sure. So just briefly, we see on the bottom line, the yellow line, the updates that have occurred since 2000, and the white line represents changes in the Medicare Economic Index, which is a measure of changes in input prices for physician services, practitioner services.

And so we see that indeed the updates have been

lower than the changes in the MEI. Just the numbers briefly, the updates have totaled 8 percent, the changes in the MEI 22 percent. But the thing, as Bob pointed out, the thing that's left out of that is just how spending has changed. So the red line you see there is changes in spending per beneficiary. And that wide margin between the updates and the red line, the spending per beneficiary, represents the growth in the volume of services, and you've seen here, we've been doing the analyses over the years.

You've seen what that means, that there are some categories of services that are growing at rates two or three times the rates of others. So that's just something to keep in mind when interpreting the kinds of things that Bob is talking about. And just briefly, another slide with just some of the numbers here.

The slide that I just showed, the chart, the red line was growth in spending per beneficiary. This is just the total numbers, you know, going in 2000 from $37 billion up to $64 billion, a total growth of 72 percent. And then the next set of numbers there shows the growth in spending per beneficiary, the numbers that were shown on the slide, going from $1,200 to $2,000.

DR. BERENSON: Thank you, Kevin. So to just take the last line there, in fact, spending per beneficiary to physicians has gone up 5 percent a year. It is because of volume growth.

And I share the concern about fees being frozen and now we're recommending actually reductions. But, in fact, physicians have not been worse off over the past decade, and even the projections are that, on a per-beneficiary basis, will continue -- payments to physicians will continue to go up at 2.2 percent.

Now, as Kevin said and I have said many times in the past, and as I think most of the Commissioners agree, the fact that total payments are going up still is not -- well, we shouldn't take any comfort in that because they're not going up in the right places.

They vary by type of service, so major procedures, major surgical procedures aren't going up. E&M services actually are not increasing very fast. They are concentrated in tests and imaging and minor procedures which presumably do no harm to patients, but are a way to generate revenues in some cases.

There's variations by geography. There's

variations by specialty, and most problematic for me is that this kind of a payment system rewards physicians who generate unnecessary and often inappropriate services and it penalizes a large number of physicians who are prudently providing medical care and not paying attention to their bottom lines, and as a result, are suffering -- I wouldn't say suffering, but are experiencing financial pressures that I would say are inherent in a fee-for-service system.

To me, the real conclusion here or the policy implication is that we need to fundamentally alter the payment method and get on with moving off of fee-for-service. Having said that, I think we still need to improve the physician fee schedule.

I support recommendations two and three. I observe in the letters that I received -- in fact, there's a lot of disagreement across the specialties about whether the current process for establishing fees works well. Some are very supportive of the current method. Some other specialties wanted to jump in in the primary care boat and did not oppose the idea that there would be differential payments. They just wanted to be included.

The anesthesiologists have a special problem that

they've got. There's a lot of work to be done and if we come out -- whatever we do with this proposal, we and in particular CMS and the RUC have a lot of work to do to work through this fee schedule, because it will take time to get these other payment systems in place.

Just a few other points and I'll stop. Clearly, this distinction in payment between primary care services and all the rest does provide a sort of special protection for primary care. It sure doesn't solve the primary care problem that we've got which is sort of urgent. I mean, this is sort of a dealing with the SGR problem.

I personally oppose the idea that some had suggested that, Well, we should also let the primary care docs ancillary services be exempt from payment cuts. I don't think we should be encouraging any physicians to make up for shortfalls in their payment by doing tests on patients.

I'm encouraged by the leadership and the initiative that the CMS seems to be taking through the Innovation Center in coming up with models of primary care re-engineering, trying to work with private payers, and I think that should be supported and expedited.

Just wanted to make two or three more comments and finish. There was one other comment here in the letter that I do want to get to. It basically said, The SGR repeal policy supported by our groups calls for a period of payment stability to see which of these new models weren't followed by the adoption of those that do.

I've now been doing this off and on for about 35 years, regrettably it's that much at this point. I guess Bill has me beat some, but other than that, I'm sort of one of the senior people around the table.

My observation is that stability basically equals complacency. You provide stability and everybody is more than happy with preserving the status quo and not getting on with the kind of change that we're talking about. As we all have said, it would be better if we did not have to go here in terms of a new fee schedule that involves significant reductions.

But I think, in fact, I'm quite suspicious of a notion that, Oh, if we just give everybody MEI then we'll be more than happy to work with all these new payments models, I guess I'm now from Missouri. Here, I don't know if people from Missouri want to accept me, but --

MR. KUHN: Missroua.

DR. BERENSON: Missoura, yeah. Show me.

[Laughter.]

DR. BERENSON: Two more and then I will stop. I wanted to address one point that Ron made about the nurse practitioner in his office getting paid more. I mean, that is an anomaly that I think is unfortunate. The way I would solve it I'm not sure would make you happy, which would be to not pay her extra in your practice, because I think we should work on the primary care definition because I don't think that's what we had in mind.

But more, you brought up the notion of return on educational investment as a major factor in determining what physicians' incomes or professionals', clinicians' income should be. We now have a payment system in which family physicians, in general, internal medicine docs do three years of post-graduate education, as do radiologists and dermatologists, if I've got my data correct.

The difference in hourly income across those specialties is two to two-and-a-half times. This has never been a criterion. It might be something we would want to look at, but not just in this context. It has never been

something we have looked at.

We have accepted, in the current physician fee schedule, in my view, unacceptable variations in return on investment, and that's what I think number two and number three are getting at, is to try to correct distortions in the payment system that contribute to that.

And the final point I would want to make is about, a few people have said, Karen and Ron and others, that if you put pressure on fee-for-service rates, you get just a volume increase, so it's self-defeating. I think the evidence around that is much more mixed, I think, the fee-for-service system producing the incentive to generate volume.

The actuaries, I guess, do have a behavioral offset, but recently the Congress passed legislation to significantly reduce the payment rates for advanced imaging services and the response was not an increase in those advanced imaging services. It was a moderation of the increase in imaging services. It's actually a complex mix of responses. It varies by the type of service. It varies by the type of practice.

And so, I just think that the problem here is the

volume-inducing incentives of fee-for-service and we need to get on, and I don't think we need a time of stability or complacency at this time.

MS. BEHROOZI: Well, thanks. Tough act to follow. I don't have 35 or 40 years working on this.

MR. HACKBARTH: Like Bob.

MS. BEHROOZI: No, no, no. He was deferring to others on the Commission who might have had a little more. And it's taken me all of my whatever, five years, having been here to kind of start to get it about the SGR, and while the rest of you were all dealing with many letters and emails from, I guess, you know, the advocacy folks and the specialty societies and the various interest groups that have people who specialize in this stuff, you know, I got some of those, too, but I got a lot of people saying to me, Now, what is this SGR and why does it cost money? But wait, it's a cut, so what is this thing?

So I explained it, I don't know, enough times for me to realize that maybe I was kind of getting it. It still feels a little surreal. You know, you're talking about paying doctors more or not, usually. I mean, when we pay doctors, you know, in my world as a payer, it's whether we

pay them more and how much more we pay them. That's all. Not how much -- you know, how deep is the hole out of which we are now appearing to pay them a buck extra.

But thanks to the patients and guidance of the staff and Mark and especially you, Glenn, thank you so much for all the time that you have spent talking with all of us, and not only helping me as an individual understand, but I think really shaping an approach that overcomes that feeling of surreality, whatever the word would be if there was such a word, to the reality that I recognize that Congress has to deal with, and that's who we're advising.

So while in my life as a citizen I might be advocating different choices about how society's resources should be distributed, as a member of MedPAC, I recognize that I have to answer the question that you asked, which I think is the important question.

Do we recommend repeal of SGR even if it means that it must be offset within Medicare, because that is the hardest question. I think I have to answer it yes, even though I am not advocating that it all should be offset within Medicare. But posing the question in its hardest form, I think the answer has to be yes because of the issues

identified about the fact that it just doesn't make any sense.

I would love to be able to say, Oh, just make it go away and start over, and I've tried to say that in the past, but obviously that doesn't work. I think the recommendation one, the part of the recommendation that recommends the freezing of primary care rates and a reduction in the conversion factor for specialty rates, I look at that not so much as a new system of payment, but really a way of lowering the cost from $300 billion to $200 billion.

It's not the right way to do it. It's not the best way to do it. It's a way to do it that protects against further erosion of the primary care base maybe. I don't think specialists need to be whacked. I don't think they're undeserving or bad people or anything like that, but if you want to take a $100 billion chunk out of this $300 billion cost, that's a way to do it that I can agree with.

I think that there really isn't a way. I'm not an economist, but the time I've spent here and just reading conflicting views that don't really seem reconcilable, I don't think there is a way to control volume in a fee-for-

service system solely by payment.

And I've made the case here for other kinds of management tools that the program ought to have because I think, you know, as Bob just said, you have all kinds of behavior resulting from payment reductions or payment increases, for that matter.

So I think that all of the other policies that we've talking about, the policy recommendations that we've made and will yet make are the things that are the really important system changing paths toward a better delivery system and a better way to pay for it.

So that brings me to the offsets. The proposals, the Tier 2 proposals in particular, they need to be there because, you know, I've already answered that tough question, that if it has to be offset within Medicare, we have to be the ones to deal with it or we have to be among those dealing with it.

I'm not endorsing all of the Tier 2 elements. There really are a couple, even though I agree with Herb, I've sort of heard of pretty much all of them. I think actually there's one or two that I don't understand as expressed, so maybe there's some language that could make

them clearer.

But particularly, I'm concerned about their impact on beneficiaries, and in the pie chart, Kate told us that 15 percent of the burden of the $220 billion burden, would be borne by beneficiaries. And so, I think that it's very important to understand exactly how that will work in each of those cases, because access is not meaningful if someone can find a doctor, but then can't afford to go to the doctor, or can afford to go to the doctor once, but not the second time that they need to go for the follow-up.

So I think that it's really important and we'll talk about it more in the benefit design discussion tomorrow and in many of the other discussions, to make sure that access is meaningful, that where there are cost shifts that are necessary because of the sustainability of the program or because of whatever other reason, that they happen in such a way that people can make high-value choices, high value to themselves and high value to the Medicare program, and avoid those costs that otherwise would block them from seeking that high value care.

So I think that that's pretty much all the things that I want to say. I would agree with others, and I would

certainly support the other recommendations, two through four, which I think do go more toward improving the payment system.

DR. CHERNEW: So regardless of how long one has been doing this, it feels like 35 or 40 years.

[Laughter.]

DR. CHERNEW: I want to start by saying something about how we got to the 5.9 and emphasize that at least it's my understanding -- I can be corrected -- that basically we had estimates that repealing the SGR would cost $300 billion, and there was a list of offsets that have been discussed. And if you look at the $300 billion and you add up all the offsets, you don't get quite there. And if you want to make it essentially completely financed within Medicare -- and it's not clear that we do, but if you want to finance it completely within Medicare, you end up with a number that's equivalent to 5.9-percent cuts. And I would say as an academic that that 5.9 percent is not right in any particular analytic sense, and I doubt we would have come up with it independently if we had to do that. It's just the numbers that make the system balance.

I also would say that with regards to the offset,

particularly the Tier II offsets, we haven't spoken of them in great detail, and so I don't think that they're necessarily advisable, and I want it to be clear that when I vote for these -- and I will -- that we're not recommending them or voting for the particular offsets. We're voting for this whole package, and I wouldn't consider this an endorsement of any individual offsets which we have discussed.

In the spirit of Bob's comments, I'd like to say something about some of the arguments that have been made. The first one relates to this argument about the fee cuts, the proposed recommendation, reducing access, and I will talk simultaneously about the one where we say that's going to increase -- the fee cuts will increase volume. So those might be right, but it's hard to hold both of those as being right on behalf. In other words, if volume goes up, I wouldn't worry a lot about access. If access goes down, I wouldn't worry a lot about the volume. So I find it difficult, if you want to make both of those arguments, to maintain -- you know, you better be a little more nuanced than, "No, it's more volume," "No, it's less volume." Right? It's going to be one. It might be in some cases one

and one the other, but there's some need for consistency, and I think that shouldn't detract from the point that I actually think many of the critiques in the letters that were sent were right. And, in fact, I don't come down exactly where Bob does on the income-revenue thing. I think the point is the payment rate should be compared to the unit costs, and the total amount of payments should be compared to the total amount of expenses. You don't know where those are all going to play out.

That said, I think the argument related to that would have a lot more credibility if knew something about the value of all those extra services, which we don't. So I'm not phenomenally sympathetic to the fact that costs aren't matching -- that revenues aren't matching costs because I'm not sure all the costs are justified, and that's a broader question.

So despite all of this rambling, I think the basic point remains that we can't ignore the need to repeal the SGR, which is the one thing we agree on, or the fiscal realities. And, therefore, I am going to support Recommendation 1 and the other recommendations.

I would say that I would prefer a rewording of

Recommendation 1 to reflect Slide 6, which I thought was outstanding, incidentally. I don't think the wording actually captures or that or Glenn's intro, which I also thought was outstanding in your comments, Glenn, which I also don't think exactly -- the current wording doesn't reflect that exactly, and in part because I think the "if" in the recommendation could be more prominent, as it is in the slide and as it was in your comments. And I think it could apply to the 5.9 as well as to the other offsets.

But even given all of that, I do support this, and I think I feel obliged, at least to myself, to justify why. And so I will just say that I think there's a number of safety valves in the system. Once of them is ACOs. I'll say something about that in a minute. Another one is MA plans. And another one is this ability to monitor and revise this.

So to those people that say in some way we are killing the fee-for-service system and we won't be able to function, and the fee-for-service system will have to run to bigger organizations, I say, yes, that's true, that is right, and I personally am not so ashamed that that may be where this recommendation takes us. And unless we can find

away to build a system that is fiscally sustainable in providing high-quality care -- and I am doubtful that fee-for-service is the way to go in that regard -- or unless we want to put a lot more money into the system, which is where I think the status quo might have taken us, I think it's reasonable to have these outlets and have a recommendation, and with these outlets and the continued monitoring, I think it's a reasonable way to go, although, as I said, analytically I'm not sure it's exactly where I would have come out.

So that's my comment on 1. I won't say much about 2 or 3, although I support them, and say a little bit about Recommendation 4. You may have inferred from my previous comments that I'm a supporter of alternative payment systems and ACOs. I would add that in the recommendation we should say "ACO or ACO-like things" because ACOs are changing and different types of things are getting other names.

But in any case, despite that support, I worry about the unintended consequences of Recommendation 4 as worded. I don't know how much I should worry. I wish I did. But it does some unintended things. It creates a gap between the ACO and the MA payment rates because the MA

payment rates are based on fee-for-service. If not everyone is in the ACO, there's a gap between these things. And I worry about what that gap might do. I worry it might weaken the fiscal impact of ACOs because now ACOs are rising a lot faster, the 2011 price as opposed to the current law prices. And a lot, although not all, of those savings accrue to the ACOs depending on exactly what model of the ACOs we have. And as was pointed out, we don't know for sure if the ACO regs are under development. But I worry that if we're supporting ACOs because of their ability to control spending and we put them on a faster trajectory of spending growth, then our zeal to support the fiscally constraining system will be compromised by our desire them more, as our zeal to support fiscally constraining MA plans was compromised by our policies that paid them more. So I think we have to think about that.

I am worried more specifically that the recommendation as worded weakens the budgetary neutrality of our recommendations, but since I don't know the details of ACOs or how it's all going to play out, I'm not sure how the ACO Recommendation 4 influences the budget neutrality or the within-Medicare neutrality of our recommendations. But

since I'm not necessarily a fan of the financing within Medicare anyway, I will still hitch on.

And, finally, I will say -- and, again, this just requires some more thought -- there are some nuances in the law about people, particularly the Office of the Actuary, certifying ACOs as saving money before they can diffuse widely. And I worry that if we set this up in a way where the payment rates for ACOs are higher than the payment rates in some other baseline, that when we want them to diffuse and it has to be scored by someone as saving money, that while we think this recommendation is to support ACOs - and I may have mentioned I support the idea behind ACOs - I'm not sure that the wording of this recommendation will, in fact, do that when it's interpreted in the context of all the other requirements about what it's going to take to support ACOs.

So I support all these recommendations. I do so with no joy of the position we're put in. And I say to all of those who criticize them, of which there are many, I think the solution must involve how to move to a better system as opposed to just we want to repeal the SGR and move forward. Because if we just end up with more volume or more

money, we're going to come back here later in a much, much worse place. So we might as well get along and work to a better system.

DR. DEAN: Thank you. I would certainly echo the comments that have been made about appreciating all the work that has gone into this. The SGR has been a frustration of mine for many years, and we have seen a number of, you know, various efforts to try and deal with it, most of which have had no effect. And I really do support this effort as much as anything because I think it's the most comprehensive way to say we really have to deal with this thing and we have to deal with it now. So for all the problems with these proposals -- and there certainly are -- I think we need to move.

I obviously wish we did not have to face the alternatives that are in these proposals, but they're there, and not to do so I think the problem only gets worse if we don't deal with it now. It, unfortunately, I think is just a testament to the failure of our political process that it has gotten to this point and that it has not been dealt with, because it has been obvious for a long time that this was a system that was not working.

It's a painful issue. The degree of pain that is encompassed or included in these proposals I think is just a measure of how deep the problem is. And like I say, I guess I've already said that as bad and as tough as some of the impact of these proposals may be, to back away from it I think only means that it's going to be worse when we come back to it another time, which we inevitably will. So I really do appreciate the efforts that have been made to come up with a comprehensive approach.

Having said that, there are obviously things that I wish we could improve, but I don't have a good answer to that. I wish that we could make the cuts more well focused and really if they could be directed more specifically to the areas where the rapid growth has occurred and, you know, where the problems really have originated from. I think, you know -- I guess it was Bob, I think, that said that, for instance, the issue of major procedures, the numbers have not gone up. That's probably not an area. And yet they would end up receiving some substantial cuts under this structure.

Obviously, as a primary care physician, I support the efforts to protect primary care, but I think having said

that, I would in the next breath say that this is not nearly -- this is still a crude instrument. It's probably the best that we can do right now, and hopefully the other recommendations are in there and, if they play out, will help us to focus it more precisely as time goes on.

I guess finally I would say that we don't want -- I don't at least -- in any way to let the message go out that this is somehow a correction or a solution to the primary care "problem." I think Bob also mentioned that. This does not even begin to address the real issues of inappropriate mechanisms for payment for primary care services. That's a different issue. The structure that's in this proposal makes some important moves to try to keep that from getting worse, but it doesn't begin to correct it. And so just for the record, I think -- because I'm sure some people will take that as this is a solution to the primary care problem, and it very obviously isn't.

So having said that, I do support all four recommendations. I do so with some hesitation. Like I said, I wish we didn't have to face these kinds of painful alternatives. But, on the other hand, not to do so now I think would only result in worse things down the line.

DR. BAICKER: As you pointed out in your opening remarks, this is a problem that clearly gets worse and worse and worse every day, so I'm strongly in favor of doing something about it now and support the recommendations.

Clearly, there are a lot of details that are subject to debate in the package of offsets, in what share of the burden should be borne by providers versus other segments of the market. And I think it's important to take into account in that pie chart of which share of the burden is being borne by which sector that the cut in physician payments is part of that picture, that the baseline could be seen as the full 300 not as zero. And so I interpret all of those in that light.

The fact that we have so much trouble focusing on the details of the payments and the points about the values not necessarily being aligned with high-value care and layering on additional payment differentials may not be exactly right just highlights the importance of Mike's point about moving in the long run towards a non-fee-for-service system, towards a payment system that truly lines up the payments with the high-value care that we want beneficiaries to get. So in the long run, I think anything that pushes us

in that direction is a very good thing, and we can't hold ourselves to the standard in the short run of having perfect prices because that will never work. And this is a step in the right direction for the intermediate term. In the long term, a broader overhaul seems warrant.

MS. UCCELLO: I want to echo everyone else's thanks to Glenn for his leadership and staff for all their hard work on this. As a relative newbie, I really appreciate this.

I support the set of recommendations, and I want to say that I think it's vital that we move beyond just the recommendation to eliminate the SGR and step up and offer replacements and offsets. I think to not do so would have been irresponsible. And I would even go further and say, given the concerns about the sustainability of the Medicare program, overall that it is important for the payments for this to come from the Medicare program.

I do appreciate Ron and Karen's input. I think they've made very valuable comments on things that we need to keep in mind as we move forward. That said, I think that we did -- we have offered a package that strikes an appropriate balance. It's not perfect, in part because

there's no such thing as perfect with this problem. However, there are elements in this package that do move the program more toward one that focuses on value. I think those elements are especially important.

I will echo some of Mike's concerns regarding ACOs. While we want to encourage them, we don't want to ultimately end up in a place where we are overpaying them. But I think with just the access issue, with the ACO issue, I think we have appropriate safeguards that, moving forward, as we monitor things, we can recommend changes as appropriate moving forward.

That's it. So, again, I support all of these recommendations, and, again, they're not perfect, but I think they are appropriate and balanced.

MR. BUTLER: I'll comment on Recommendations 1, 4, offsets briefly, and the March Update Chapter, which you'll understand in a minute.

With respect to Recommendation 1, I won't reiterate things, but, you know, this is a tough pill to swallow, and it should be. It's not supposed to prop up and continue income and the fee-for-service system that has existed that we are trying to move people away from. So I

don't think we need to really apologize about that.

And similar to the comment that Mike made and in response to Ron, if it does aggregate physicians and other providers or systems of care in ways that can coordinate care better, I think that that, frankly, is a good thing. I think it's going to be very, very difficult for very small groups to independently operate and make the kind of impact that we need to make in the health care system in the future. I just don't think it's going to work.

With respect to the 5.9, I have angst. Mike indicated that we kind of backed into that based on the Tier I and Tier II offsets, which we never really kind of discussed at any great length. I'm not sure if that's the reason, but whatever the reason is, it's arbitrary for sure. And I think our biggest test and concern is what's the right number to make sure that access is not a problem. I think that's what I'm most worried about.

So I have been an advocate of the 3.1 percent over 10 years as a more defendable way of looking at this, or put it this way, smoothing it rather than front-end-loading it, with the acknowledgment that there are other tradeoffs in doing that. But I do see primary care physicians,

psychiatrists, specialists -- I admit it's not boatloads, but I can point to specific examples where they have bailed out of Medicare and said they're working not as hard and making more. And so, you know, we need to worry about that for sure.

While we are putting a footnote in the letter that there are alternative ways of doing this, I'd rather have that footnote bolder and say, you know, there are ways to smooth this out.

With respect to Recommendation 4, I'm very supportive of ACOs. I think the way it is framed, though, is it makes it look like we're betting the ranch on ACOs. It's the only thing that is mentioned. And I understand ACOs are upon us. I understand that they come closer to coordinating the entire capitated dollar where other mechanisms of risk sharing are at a lower level and don't quit get you there. But it looks like we're banking on ACOs as the solution the way the recommendation reads. And, frankly, I think whether it's health systems or individual doctors, they're not kind of lining up in great numbers for ACOs at this time. But I know my colleagues are all hot to trot a bit on trying bundled payments and other things. And

so think that, you know, it's just an ACO world that we're trying to support I think is not right.

So I would rather see bundled payments and, for that matter, other forms of risk sharing in the recommendation itself, even though I understand that's not the way it is worded at this time.

The fact is we're trying to paint a picture between a fee-for-service world that doesn't work and an engaged group of providers and physicians and caregivers in a world that we're trying to lean toward. So when it's just a recommendation that addresses ACOs, it sounds like that's the only mechanism to participate. So I'd rather have a stronger statement around that general philosophy of painting the world we're trying to leave behind and the world we're trying to go do.

With respect to offsets, I think actually the list isn't too bad, even though I, too, would not individually support some of them. I think it has been brought up by some of our Commissioners that things like tort reform and age eligibility may be good candidates as well, and we recognize some of those are not within our purview. That's okay. We can mention them anyway even though that's not

always a congressional action.

I do think the benefit design and beneficiary sharing is in our purview, and I would encourage us to continue to look at that, as we will be doing tomorrow.

Finally, why do I mention the March Update Chapter? I think we shouldn't miss this opportunity to kind of -- I won't say return to our roots, but I would say make sure we begin to have disciplined modeling, disciplined monitoring of the consequences of what we're about to do. But more important, I said at last month's meeting that our real customers are Congress and the beneficiaries, but this month I'll say they're also doctors. They don't have to contract with the Medicare program. They are customers. And I think we need to recast the chapter a little bit with the idea of painting the picture of the full menu of ways that physicians can engage and be rewarded for engaging in the reform of the system. So, again, it kind of gets back to the ACO. We have ACOs. We have bundled payments. The hospitals will be looking at readmission rates, electronic records, value-based purchasing. We need physicians to participate in that, and so we need to paint a picture that not just says here's 6 percent or 5.9 and, you know, move

away from fee-for-service. We have to paint a picture of the rewards and the opportunities in the partnerships, and we ought to pull out the demonstration projects and the other things that represent the full list, and say: You know what? If you join this way, it is a good way to deliver care. You can be rewarded some, and it's not so bad.

MR. ARMSTRONG: Thank you. Thanks, Glenn. Being the 17th Commissioner means there aren't very many points that haven't been made already. But I will just make a few fairly briefly just so you hear them in my own words.

First, I want to just say I support these recommendations, each one of them, and in particular as a package, I think that they represent a responsible approach to dealing with a major problem. And, frankly, I'm proud to be a Commissioner at a time when we're taking this on. And, actually, I think that this positions MedPAC very well to deal with a future where we're going to have conversations that I think are even more intense than this one as we take responsibility for making sure our Medicare program -- which is, I believe, going to benefit from these recommendations, but that we'll still need some tough choices in front of us.

In fact, to that point, we've talked a lot about context, whether it's the federal budget or the economy. Indeed, let's remember that the Medicare program right now is dealing with a future that does not look very good, and that, in fact, these are hard choices with unpredictable and real consequences. They're just the beginning. This is just actually a set of incremental steps that we know -- I think to Peter's points and many others -- that the rest of our agenda is as important, if not more important, in dealing with all of the different levers that we have influence over that need to be aligned toward achieving a very different level of performance than our actual experience has been in the last couple of years. And, in particular, we know that leveraging fee schedules, like this recommendation does, may not be -- in fact, I believe is likely not to be the most powerful level that we will have in the years ahead because it doesn't deal with the continuity of care and the management of overall health of populations over the course of time.

And so I support these recommendations with that context in mind, but I also do just want to emphasize that I think these recommendations do a great job of advancing a

series of policy goals that we have been working on and advocating for for a long time. I think we do a nice and responsible job of using this opportunity to push forward, advancing primary care as just one example. And, by the way, I would say we haven't amplified the fact that it's one of the few investments we make in these recommendations that actually is not just about reducing costs or cutting costs. It's about how we expect a return on that investment that should lower our expense trends in ways we don't even try to take any credit for.

I won't iterate some of the other policy goals that we take this opportunity to advance.

My final point would be I recognize the concerns that have been expressed, I think very well, about whether MedPAC is going to beyond the scope of focus that it should have or moving too quickly to lay out recommendations. I know we've spent a lot of time in our comments talking about how do we couch Tier II ideas and so forth appropriately, and I am concerned about that. But I would also just say that our pace in the past, which we're all very proud of, and our analytic approach and so forth, I doubt is adequate to deal with the problems of the future; and that I think

that we need to become more comfortable moving more quickly. Frankly, these decisions are going to be made in the next few years. I have more confidence in MedPAC moving quickly with recommendations than any other body moving at whatever pace they would be moving at. And so let's recognize that this is different, but that it's still a process by which we are really coming up with, I think, the best solutions and recommendations anyone could.

MR. HACKBARTH: Okay. Just a couple concluding observations.

I want to lift our gaze for a second from the details of the specific proposals to think about the broader context, the broader implications, the broader message here.

In the way that we've addressed SGR, trying to not just propose repeal but also figure out how to pay for it, we've undertaken a novel approach for MedPAC. This is not our usual way of doing things. And for that, some people have criticized me and warned that this could have unintended consequences. They may prove correct in that.

But there's a message in the approach. Set aside the details of the recommendations. There's a message in the approach. And what is that message?

The first message is urgency, how urgent we think it is to repeal SGR. This was not the easy path for the Commission to take. The easy path would have been to reiterate our 2001 recommendation to repeal SGR and say nothing more and say, well, we don't normally talk about offsets and we will continue our past practice. That would have been the easy path, and I thank the Commissioners for their willingness to depart from the easy path and put ourselves in the position of the Congress, the Congress being our ultimate customer. They need to worry about not just, oh, repeal SGR, but how do we make this work in an increasingly stringent fiscal environment.

So maybe this will have untoward consequences, this novel approach, but the spirit in which it has been done is to try to put ourselves in the position of the Congress and serve what is our most basic mission: to help Congress think about the decisions it needs to make on Medicare policy.

The second key message here -- again, setting aside the details for a second -- is that if Congress elects -- and it's their decision. If Congress elects to try to finance SGR repeal solely out of Medicare, it's a tough

path. If we have accomplished nothing else through this exercise other than to systematically work through it and make it clear to the Congress what the implications of that policy choice are, that's an important thing in its own right.

So whatever people might think about the particulars, I think those two messages -- the one of urgency about the repeal of SGR, and the difficulty of the path of trying to finance it solely out of Medicare -- those are messages that I dare say even though Ron and Karen have made it clear that they oppose the particulars of the recommendation, they would concur, I think, in the message about the urgency of repeal of SGR, and that if you go down the Medicare financing route, if that's where you look for all the savings, it's a tough, tough path.

So with those concluding observations, it's time to vote, so would you put up Recommendation 1, please? All in favor of Recommendation 1, please raise your hand.

[Hands raised.]

MR. HACKBARTH: You've got it?

DR. MARK MILLER: Yes, I've got it.

MR. HACKBARTH: Recommendation 2, all in favor?

[Hands raised.]

MR. HACKBARTH: Okay. I think everybody's up.

Recommendation 3?

[Hands raised.]

DR. MARK MILLER: I got it.

MR. HACKBARTH: And Recommendation 4?

[Hands raised.]

DR. STUART: Glenn, are you going to distinguish between abstentions and no votes?

MR. HACKBARTH: I will allow people to distinguish if they want. Right now if you didn't raise your hand, you're counted as a no vote. If you want the record to show otherwise, say so. Speak up.

DR. CHERNEW: I'm abstaining from 4.

MR. HACKBARTH: Okay. Any others?

[No response.]

MR. HACKBARTH: Okay. We are finished.

We will now have our public comment period.

We are eight minutes behind schedule right now. I suspect we will have a number of people wanting to comment, so let me repeat the ground rules here.

Please begin by identifying yourself and your

organization. I'm going to strictly limit comments to two minutes, so when this red lights comes back on, that signifies the end of your two minutes. As you can tell from the discussion we just had, Commissioners have carefully read the many, many comment letters that we have received. The public comment period is never the only opportunity to influence MedPAC's work, nor is it even anywhere near the top of the list of the best opportunities to influence our work. Using letters, meeting with the staff, putting comments on our website, all are far superior and far more useful to the Commission than the public comment period.

Having said that, you have the microphone, sir. When the light comes back on, please finish your comments.

DR. LAING: Thank you and good afternoon. I'm Dr. Tim Laing. I'm here on behalf of the American College of Rheumatology. I'm the current Chair of the Government Affairs Committee.

While rheumatologists in the ACR are very appreciative of the focus MedPAC is giving to moving beyond the Sustainable Growth Rate System, we cannot support the current recommendations you endorsed today. We believe that implementation of that plan will be just as threatening to

patient access to rheumatology as the 29.5-percent cut scheduled to go into effect on January 1st of next year.

Two points, quickly.

First, we appreciate the attention MedPAC has given recently to addressing the very real need to protect access to rheumatologists and other cognitive care specialists who share much in common with primary care. Ensuring an adequate supply of these practitioners is important to the nation's health care system and to millions of people with arthritis, rheumatic, and musculoskeletal conditions.

Like primary care services, rheumatology currently faces potential physician shortages, lack of new medical students going into the subspecialty, longer waiting times for appointments, generally lower pay rates than more procedurally oriented specialists, and a growing and aging population that needs our help.

The current recommendation does not follow the Commission's previous recommendations to help ensure an adequate supply of practitioners in cognitive specialties who focus on managing patients with chronic conditions. In fact, it does the opposite and would seriously harm access

to practitioners in cognitive specialties such as rheumatology.

Please remember that in many cases a rheumatologist or other cognitive specialist is de facto the primary care provider for managing patients' conditions over the long term and providing patient evaluation management services as a majority of their services rather than performing procedures.

While rheumatologists serve populations with complex, chronic, and acute conditions that require medical expertise beyond that of traditional primary care physicians, they often provide the same services as those conventional primary care physicians. They also serve to coordinate care for patients who have chronic conditions. In these cases, the rheumatologist serves as the patient's primary care doctor.

Second, we are concerned that the current proposal would limit physicians' options for participating in payment and delivery reforms. Many physicians would be unable to continue seeing Medicare patients, much less be in a position to try various payment reform options. The ACR recommends that any plan recommended by the Commission be

capable of creating an environment that encourages payment and delivery reforms.

MR. HACKBARTH: Okay. Your time is up.

DR. LAING: Thank you.

MR. HACKBARTH: Thank you.

MS. GRAHAM: Good morning. Emily Graham, representing the Alliance of Specialty Medicine, and I'm going to try to do this in 60 seconds or less, so I hope you appreciate that.

First of all, the alliance certainly appreciates MedPAC's repeated calls for repealing the SGR; however, we're extremely disappointed with your recommendations that essentially place a disproportionate share on specialty physicians. As you know, physicians did not create this problem. Congress did. And I think -- and I'm really sorry, Dr. Berenson, but I think it's unfair to suggest that physicians have not taken any responsibility for this problem. I know of a number of groups that are part of the alliance that have actually gone to CMS to share concerns about duplicative payments that they may be receiving as a result of the way the payment system is currently now. And in addition to that, there's a number of groups that have

created appropriateness criteria so that they can get at overutilization and things of that nature.

In addition, we would support all of the things that Dr. Castellanos said in reference to the unintended consequences. There's so many different penalties and things that are coming down the pike that are hitting physicians. It's like a waterfall of cuts that are coming, and it's really unfair. And one that I don't know if he mentioned was the IPAB that is coming fast and furious.

And, Mr. Kuhn, you said that you're interested in knowing what groups support and that that was absent from a lot of the letters. I think one thing we would support would be the idea of Congress just writing this off, which I'm sure a lot of people would probably agree with, and also private contracting, which would empower beneficiaries to use their benefits and have access to any physician of their choice.

Thank you very much.

MS. ZOLLAR: My name is Carolyn Zollar. I'm with the American Medical Rehabilitation Providers Association. We appreciate the acknowledgment of the letter which we saw and which I believe was circulated to the Commissioners and

the acknowledgment of our serious concerns regarding moving the threshold for what's known as the compliance threshold under a Medicare exclusion criteria to 75 percent. That is an old recommendation. It has been vetted over a period of time and we thought settled in 2007.

If that threshold is raised, we do believe serious access problems not only for existing patients but, equally critically, four in the eight years since that recommendation was revisited by the MedPAC of the new and emerging types of patients that we're seeing in rehabilitation who do need and benefit from our care: LVADs, for those of your familiar with them, a number of organ transplant and cancer patients.

So we're also concerned about the quality of care. We deliver, we like to believe, a very high quality of care if you look at discharge to home and community and the increase in functional status of our patients compared to other settings.

The other thing, by moving around the threshold, while it has budgetary appeal, is it does not look at an issue that was being acknowledged earlier kind of on the talking about ACOs, the whole issue of reform, service

delivery reform as well as payment reform, and we have championed the continuing care hospital pilot as a way of looking at post-acute care in, we'll call it, a mini-post-acute care bundle as a way of moving forward towards those objectives, and we urge you again to seek its implementation.

We will also take advantage and appreciate the invitation to give you some other options on what we might be for within an exceedingly difficult environment, and we acknowledge that.

Thank you for your time.

MR. AMERY: Michael Amery. I represent the 24,500 members of the American Academy of Neurology. We all agree that something needs to be done about SGR, but we object strenuously to Recommendation 1 that splits primary care from all other specialties without recognizing at all the actual treatment that physicians provide to patients. Neurologists treating people with Alzheimer's, ALS, Parkinson's, and epilepsy oftentimes become the primary care providers for those patients. They provide actual services that end up coordinating the care for those patients.

Now, we don't believe that the disparities that

you see in physicians are actually between primary care providers and all specialties. You can take that line and you can draw it between non-procedural and procedural specialties. So much like rheumatology, we would ask you to go back to your recommendation from June 2011 that says that the SGR problem gives an opportunity to recognize that there are problems with cognitive care and that you need to take a look at how we increased the numbers of people like rheumatologists, endocrinologists, and neurologists who are doing coordination of care and non-procedural care.

Thank you.

DR. REPKA: Commissioners, my name is Michael Repka. I'm am ophthalmologist from Baltimore and I'm here on behalf of the American Academy of Ophthalmology.

Just a reminder that ophthalmologists are in training for four and today most times five years. They provide, in addition to routine care, care for chronic and debilitating diseases such as macular degeneration, cataract, and glaucoma to Medicare beneficiaries. That, in fact, does require a substantial amount of commitment to coordination.

We also want to point out that, of course, as has

been said by members of the Commission as well as previous public commenters, this is a problem not created by the physicians, not created by MedPAC, but, rather, created in effect by the Congress who recognized it on multiple occasions that, in fact, providers are not responsible for the impact of the SGR but, rather, poor creation of the regulations.

Lastly, the differentiation between specialty and non-specialty or primary care will likely create a great deal of access problems to those providers who are providing care to many Medicare and Medicaid beneficiaries, particularly where they have few options to leverage their care, as was noted in today's New England Journal by Paul Ginsburg.

Thanks very much for your attention.

MS. ERICKSON: Hi. My name is Shari Erickson. I'm the Director of Regulator and Insurer Affairs for the American College of Physicians, and I wanted to note that while ACP appreciates that MedPAC has put forward a comprehensive proposal to address the SGR, we do have some significant concerns that preclude us from supporting the recommendations that were just voted on today.

I want to reiterate a couple of those and then note that we have put forward a proposal to address this issue that was a request to the House Energy and Commerce Committee that is really a comprehensive proposal that we believe would save a substantial amount of money over the longer term.

Our concerns are that, as Dr. Berenson noted, many primary care physicians who would qualify under the MedPAC proposal also provide ancillary services that would be subject to the nearly 17-percent cut over the next three years. It's also unclear if their hospital visits would be defined as primary care services or subject to the nearly 17-percent cut. And while many smaller practices need to provide these services in order to stay in practice and provide access to their patients, in addition to which for patients it provides some convenient one-stop shopping for t in those practices, so we don't agree that it is something that is always intended to result in more testing. It's actually intended to provide access and also allow patients to receive the services that they may need.

With regard to specialists, the nearly 17-percent cut in payments to non-primary care specialists will

adversely affect patient access to care to physicians in every other specialty, including those specialties that are facing substantial workforce shortages, and without any evidence really to justify that a cut is merited or appropriate. This cut goes into effect no matter how efficient or effective the care is that they provide, whether or not they're in a high- or low-cost area of the country, and whether or not their specialty is projected to face a shortage.

In addition, as noted earlier by some of the other commenters, there are several subspecialties that principally provide cognitive services such as endocrinology, rheumatology, infectious diseases, and others that would be particularly affected by these cuts.

Finally, the MedPAC proposal we believe will unintentionally undermine the goal of transitioning to new payment models aligned with value. Primary care physicians and subspecialists that are interested in transforming their practices to provide more comprehensive and coordinated care won't have the resources in order to do that to participate in tests of models, such as the patient-center medical home, ACOs, bundled payments, et cetera. So for these reasons,

ACP is opposed to the recommendations that were just approved by MedPAC. However, we do believe that --

MR. HACKBARTH: Your time is up.

MS. ERICKSON: -- physicians should contribute to moving forward in the deficit reduction and reducing it through real cost drivers.

Thank you.

MR. HACKBARTH: Thank you.

MS. HILL: Thank you. I am Catherine Hill with the American Association of Neurological Surgeons, and organized neurosurgery supports the repeal of the SGR but opposes the proposed update reductions for specialty physicians that come on the heels of other cuts and reductions to specialty procedures.

Neurosurgery is deeply concerned about access and workforce issues in the future. Neurosurgeons train for seven years after medical school, and many are close to retirement age. Organized neurosurgery supports legislative changes to allow physicians and patients to enter into private contracts for payments for certain procedures.

Thank you.

MS. TOMAR: And, finally, I'm Barbara Tomar from

the College of Emergency Physicians, and I really just wanted to make a couple of general comments.

I think for almost everybody in this room, it's been kind of a disheartening morning, and I think everybody in this room also agrees that there's a tremendous urgency to doing something about the problem. And I think we all realize that this isn't the Balanced Budget Act of 1997. This is a whole different world, and we're going to have to make some shared sacrifice.

One of the things that I think you all are overestimating some enthusiasm about -- I think it was echoed by Mike Chernew and Mr. Butler -- was that this whole rush to the new delivery system is sort of somewhere over the rainbow still, and I think in an era where you're going to be either flatlining or reducing payments, there's a tremendous amount of investment that's going to have to go into getting from where we are today to getting into this value-based purchasing. And I think, you know, for most physician groups, the whole ACO draft regulation at least was very disheartening in terms of just the amount of start-up costs that would be involved for physician groups to get in the game.

The last comment I'd like to make particularly on behalf of emergency medicine is that coverage does not equal access, and I hope you think about working with us, because as more and more -- if these cuts go through and as more and more docs reduce the number of Medicare patients they're going to take, let alone the new Medicaid coverage folks that are coming along in a couple of years -- and there's no night, weekend, extra access, where do you think they're all going to go? To those expensive, inefficient emergency rooms. So just keep that in mind. We can be the canary in the coal mine in terms of finding out what's happening.

Thank you.

MR. HACKBARTH: Okay. Thank -- oh, Sharon.

MS. McILRATH: Sorry. I'll make it quick. I do feel like I have to respond about the letter. There was no intention to deceive people and make it look like we were talking about total expenditures on physician services. The sentence preceding the one you quoted talked about payment rates, and we probably should have said "payment rates" a second time, but it was always about payment rates.

On the volume issue, there was a period at the first part of the decade where things were growing rapidly,

going right up into the middle. It's been coming down since then. In 2010 it was 2.4. I think our numbers on the average over time are somewhat smaller than yours. As several people said, the physician community is trying to address those problems. It may be more difficult when the finances are more constrained.

I also wanted to respond to the comment about we always are always just asking for stability and not coming up with solutions. I don't really think that's fair to say when there were a number of us who did support the ACA and supported it despite the fact that it had a lot of pain in it for physicians because it did have reforms and because we are trying to move in that direction. But as many people have said, it isn't easy when the finances are constrained and there is a possibility that this is going to actually derail some of those things that you were trying to do.

I guess the final thing -- our points were made in the letter. I'm not going to reiterate those.

The final thing is that if you were trying to create something that is stable and that offers some comfort to physicians and to beneficiaries, that they're still going to have access to medical care, hospital care, any kind of

care, I don't think that most physicians are going to say that this offers them stability. I mean, a 16.6-percent or a freeze, it's going to leave the primary care physicians 16 percent behind inflation, and it will leave the others 30 percent behind inflation. So, yes, we can try to work on the cost side, but that's a lot to make up.

MR. HACKBARTH: Okay. We will reconvene after lunch at 1:15.

[Whereupon, at 12:27 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:20 p.m.]

MR. HACKBARTH: Okay. It's time to begin the afternoon. The first topic this afternoon is coordinating care for dual-eligible beneficiaries.

MS. AGUIAR: Good afternoon. Today we will continue our discussion on the Program of All-inclusive Care for the Elderly, also known as PACE. As you know, PACE is a provider-based integrated care program that enrolls nursing home-certifiable beneficiaries over the age of 55 with the goal of keeping them in the community.

During the September meeting we discussed finding from site visits and interviews with seven PACE providers, the results of our analysis of the Medicare payment system and quality reporting requirements for PACE, and options for improving PACE. Today I will follow up on your questions from the September meeting, review the key findings from our research, and present draft recommendations for your consideration.

A number of Commissioners asked for more information during the September meeting.

Mary, you asked for us to add more outcomes literature on PACE, and we included summaries of multiple

evaluations that found positive outcomes of PACE when compared to fee-for-service, other integrated care programs, or home and community-based services.

Mike asked for more detail on the magnitude of the reductions in hospitalizations, and while results vary by study, one evaluation for CMS found that PACE enrollees were 50 percent less likely than the comparison group to have had a hospital admission at the six-month follow-up

Kate asked whether selection bias could be impacting the results of this evaluation, and the authors of this study tried to control for selection bias by adjusting for patient demographics and other characteristics at baseline. A more detailed discussion of the literature is included in the Evaluation Section of the mailing materials.

George asked for a map of the location of PACE providers, and that map is included in the Background Section of the mailing materials. George also asked for demographic characteristics of PACE enrollees, and those characteristics are listed on the slide.

Bruce, you asked for the disenrollment rates, and we found that after excluding beneficiaries that died, 5 percent of Medicare beneficiaries disenrolled from PACE in

2009.

Both Bob and Scott asked about the relationship between this work and future work. This analysis has two purposes. The first is to identify ways to improve PACE and encourage enrollment into the program, which is what we will discuss today. The second is to identify characteristics of the PACE program that we will revisit later. We plan to revisit the flexibility that PACE providers have to use Medicare funds to cover non-clinical services and to blend Medicare and Medicaid funds at the provider level in the context of other integrated care programs.

As you remember from the September meeting, based on all of our analyses, we concluded that the PACE model does provide a fully integrated model of care. Multiple evaluations have shown that the model reduces hospitalizations and nursing home use. The PACE model also includes the key components that are most likely to improve care coordination for duals: full integration of all Medicare and Medicaid benefits, capitated payments, and full risk assumed by the PACE providers. As I discussed on the previous slide, PACE providers have the flexibility to blend Medicare and Medicaid funds and to use Medicare funds to

cover non-clinical services. The PACE staff we interviewed reported that these flexibilities enabled them to intervene with any necessary services.

We also identified three areas for improvement to PACE, which are listed on the slide. For the remainder of the presentation, I will review the key findings from our research and the draft recommendations that are related to each of these areas. The goals of the draft recommendations are to more accurately pay PACE providers for the beneficiaries they enroll; to support the growth of the PACE program by improving the payment system and expanding enrollment; and to pay all integrated care programs for dual-eligible beneficiaries through the same payment system.

The first of the three areas for improvement to PACE is the Medicare payment methodology, and this slide reviews our key findings on the payment system. Medicare payments to PACE providers are based on the MA payment system, with exceptions. For one, PPACA revised the county benchmarks for MA plans in order to better align spending on the plans with fee-for-service spending; however PACE providers were exempted from this change and are still paid on the pre-PPACA benchmarks. As a result, in the majority

of counties PACE sites operate in, Medicare spending increases when beneficiaries move from fee-for-service into PACE. We estimate that for 2012 Medicare will spend about 17 percent more on behalf of PACE enrollees than it would spend on these beneficiaries if they were to remain in traditional fee-for-service. Second, PACE providers are also exempted from the MA quality bonus program that was implemented by PPACA and, therefore, they are not able to receive bonus payments. Finally, because of these exceptions, PACE providers are paid differently than integrated care programs that are operated by special needs plans.

Medicare payments to PACE providers are adjusted through the MA risk adjustment system. As Dan discussed during the September meeting, we have found that the current system underpredicts costs for very complex patients, which are the types of patients that PACE providers enroll. Payments to PACE providers are also adjusted for frailty. For example, for providers whose enrollees have on average three to four limitations in their activities of daily living, the monthly Medicare payments for each enrollee are increased by 13.2 percent. Our analyses indicate that the

frailty adjuster helps make up for the underprediction of the risk adjustment system. The frailty adjuster to PACE payments was originally implemented because the MA risk adjustment system does not account for the impact that functional status has on costs.

Finally, under the rural PACE provider grant program that Congress authorized in 2005, new rural PACE sites had access to outlier protection. The protection lasted for the first three years of start-up and could only be used on high acute-care expenditures. PACE providers could not receive more than $500,000 in total outlier payments over 12 months, and they had to exhaust any risk reserves prior to receiving payments from the outlier fund. Staff from the rural sites told us that although most sites did not use the outlier protection, having it available was an incentive to their sponsoring organization to open the site. However, outlier protection is no longer available to any new PACE sites. Some PACE providers purchased reinsurance although CMS does not require PACE providers to do so.

The first draft recommendation is: The Congress should direct the Secretary to improve the Medicare

Advantage risk adjustment system to more accurately predict risk across all MA enrollees. The Congress should direct the Secretary to pay PACE providers based on the MA payment system for setting benchmarks and quality bonuses no later than 2015.

The purpose of the first part of this recommendation is to correct the MA risk adjustment systems underprediction of complex patients and to support growth in PACE by redistributing Medicare spending from MA plans that take less complex patients and towards PACE providers that enroll complex patients. When revising the system, the Secretary should consider using factors such as multiple conditions and functional status. In addition, the amount of the frailty adjuster should be revised because improvements to the risk adjustment system may result in the need for a reduction in size of the frailty adjuster.

Under the second part of the recommendation, payments to PACE providers would be based on the PPACA-revised county benchmarks. This would reduce Medicare spending on PACE and better align it with fee-for-service spending levels. In addition, this recommendation would permit PACE providers to earn bonus payments through the

quality bonus program. These changes would also make the payment system for PACE more consistent with the payment systems of integrated care programs operated by special needs plans.

We estimate that this recommendation would have no effect on federal spending on PACE relative to current law in the first year and would decrease spending by less than $1 billion over five years. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries' access to care. Paying PACE providers on the PPACA-revised benchmarks would lower payments to PACE; however, the improvements to the risk adjustment system and participating in the quality bonus program are anticipated to increase payments to PACE providers. In total, we do not expect these changes to reduce PACE providers' willingness and ability to care for Medicare beneficiaries.

Our second area for improvement for PACE relates to enrollment. This slide is an overview of key findings on enrollment from our interviews with PACE providers. We found that the programs are generally small and enrollment is low. Because sites are small, reaching enrollment targets can help them operate at or above break-even.

PACE staff identified a number of enrollment barriers that we discussed in September and in your mailing materials. But one barrier that I do want to highlight was that PACE providers receive a prospective capitation payment from Medicare and Medicaid at the beginning of each month and do not receive retrospective payment for beneficiaries enrolled after the first of the month. Because of this, sites have not been able to enroll some beneficiaries that are in immediate need of services.

One way to help PACE sites reach their enrollment targets and break-even faster is to enroll nursing home-certifiable Medicare beneficiaries that are under the age of 55 who currently cannot enroll because of their age. Most PACE staff we interviewed were supportive of enrolling the under 55 and noted that they might have to make some changes to their program if they enroll these beneficiaries. Changes included scheduling attendance at the day-care center by age groups or enrollees' conditions and offering separate activities for the younger enrollees.

Over the next few slides, I will present three draft recommendations related to supporting the growth of PACE.

The second draft recommendation is: After the changes in draft recommendation 1 take effect, the Congress should change the age eligibility criteria for PACE to allow nursing home-certifiable Medicare beneficiaries under the age of 55 to enroll.

This draft recommendation would allow, but would not require, PACE providers to enroll nursing home-certifiable Medicare beneficiaries under the age of 55 that are not currently eligible for PACE. It would also help PACE providers increase enrollment to achieve economies of scale faster.

We do not expect this recommendation to result in a large increase in Medicare beneficiaries enrolled in PACE. The reliance on the day-care center constrains the capacity of PACE providers, and the PACE model is not appealing to all beneficiaries. In addition, because PACE is an optional Medicaid benefit, states would still maintain their discretion over whether or not to contract with PACE to enroll the under-55.

Because we do not expect a large enrollment increase into PACE, we expect that the cost to the Medicare program from beneficiaries under 55 enrolling into PACE

would be offset by the savings achieved from paying PACE providers on the PPACA-revised benchmarks. Therefore, we do not expect this recommendation to increase federal spending on PACE relative to current law. We do expect this recommendation to increase access to PACE services for nursing home-certifiable Medicare beneficiaries under the age of 55. This recommendation may also help PACE providers to increase their program enrollment.

The third draft recommendation for your consideration is: After the changes in draft recommendation 1 take effect, the Secretary should provide pro-rated Medicare capitation payments to PACE providers for partial-month enrollees.

This recommendation could help PACE providers to enroll more beneficiaries because it would enable them to receive Medicare payments for partial-month new enrollees. We again do not expect this recommendation to result in a large increase in enrollment into PACE and states would also have to make similar changes to PACE payments in order for the providers to receive a full pro-rated Medicare and Medicaid payment for partial-month enrollees.

Because we do not expect a large enrollment

increase, we expect that the cost to the Medicare program from more beneficiaries being enrolled because of this recommendation would be offset by the savings achieved from paying PACE providers on the PPACA-revised benchmarks. Therefore, we do not expect this recommendation to increase federal spending on PACE relative to current law. We do expect this recommendation to increase access to PACE services for some nursing home-certifiable Medicare beneficiaries. This recommendation may also help PACE providers to increase their program enrollment.

The fourth draft recommendation is: After the changes in draft recommendation 1 take effect, the Secretary should establish an outlier protection policy for new PACE sites to use during the first three years of their programs to help defray the exceptionally high acute-care costs for Medicare beneficiaries.

The Secretary should establish the per enrollee and per provider outlier payment caps so that the costs of draft recommendations 2, 3, and the outlier payments combined do not exceed the savings achieved by the changes in draft recommendation 1.

The intention of this recommendation is to give organizations an incentive to sponsor PACE sites. As under the rural PACE demonstration, the outlier protection would be available for the first three years of the program and could only be used on high acute-care expenditures for Medicare beneficiaries. CMS could structure the outlier protection similar to the one available to the rural PACE sites. In order to not increase total Medicare spending, the Secretary should determine the size and structure of the outlier pool so that the outlier protection, the expansion to enroll beneficiaries under the age of 55, and pro-rating capitated payments for partial-month enrollees can all be completely financed from the changes in the PACE county benchmarks.

With respect to implications, this recommendation would not increase federal spending on PACE relative to current law because the outlier protection would be funded by the reduction in Medicare spending from basing PACE payments on the PPACA-revised benchmarks. In addition, we do not expect this recommendation to have adverse impacts on Medicare beneficiaries' access to care. This recommendation may be an incentive for sponsors to open new PACE sites.

Our final area for improvement is related to quality data. As you recall, CMS monitors PACE providers' quality of care and requires them to report the outcome measures which are listed on the slide. However, this data is not publicly reported.

The final draft recommendation for your consideration is: The Congress should direct the Secretary to publish select quality measures on PACE providers and develop appropriate quality measures to enable PACE providers to participate in the MA quality bonus program by 2015. Publishing quality measures would permit the policy community to evaluate PACE and would help beneficiaries and their families make more informed decisions about joining PACE. In addition, CMS needs to identify which measures will be used for the quality bonus program.

We estimate that this recommendation would not impact federal spending on PACE relative to current law, and this recommendation should not have adverse impacts on PACE providers. We do not expect this recommendation to adversely impact Medicare beneficiaries' access to care, and it could enhance beneficiaries' ability to choose a program that meets their needs.

In total, I have presented five draft recommendations for your consideration. The recommendations are summarized on this slide as a reference for you during your discussion.

I will conclude with topics for your discussion: Are there any additional questions about our analyses of PACE or changes you would like made to the chapter? We would also appreciate your feedback on the draft recommendations.

Thank you.

MR. HACKBARTH: Thanks, Christine. Well done. Can I just ask a clarifying question about draft recommendation 1 to make sure I've got the arithmetic correct here. I think you said that because PACE organizations are not paid the new PPACA rate -- they're paid at rates that are 17 percent higher than PPACA. Is that right?

MS. AGUIAR: No. The 17 percent is higher than fee-for-service.

MR. HACKBARTH: Higher than fee-for-service, okay. That was one clarification.

When we determine whether they're higher than fee-

for-service or not, you would need to make an apples-to-apples comparison, how much these particular high-risk patients would cost in fee-for-service, which assumes a risk adjustment that doesn't yet exist. So just --

MS. AGUIAR: Right, so I'm just going to defer this to Carlos, but what I did say is what we looked at is CMS puts out a spread sheet that shows what the PACE benchmark is in each county, and we compare that to the fee-for-service benchmark within that county. And then we factored in the number of beneficiaries that enrolled in PACE. So we did it that way. We did not on top of that add the PACE risk adjustment, which we've heard from CMS is about 2.4 on average, the risk adjustment factor. So we didn't add that on top of it.

MR. ZARABOZO: But the level of difference would still be 17 percent because you would be adjusting on both sides if you want to do an apples-to-apples comparison. So what this is, this is a 1.0-to-1.0 comparison, which is just the benchmarks -- how do the benchmarks relate to fee-for-service. So if you get twice as much in payment, it's twice as much in fee-for-service compared to twice as much on a benchmark basis.

MR. HACKBARTH: Okay.

MR. ZARABOZO: So that's why it's expressed as a percentage. It's 17 percent more than fee-for-service would be.

MR. HACKBARTH: Okay. So then just one last question in the same vein. If this would decrease spending by $1 billion over five years, to me that implies that we think that the combined effect of the risk adjustment and eligibility for quality bonuses would have a dollar effect of less than the 17 percent, slightly less than the 17 percent. Am I following the math right here?

MS. AGUIAR: I just want to make sure I understand. You're saying could the rest of the recommendations be financed from bringing down the benchmarks?

MR. HACKBARTH: No. I'm trying to make sure I understand the statement that Recommendation 1 by itself would decrease spending --

MS. AGUIAR: Yes.

MR. HACKBARTH: -- by $1 billion over five years. That implies -- there's some give-and-takes here. So the PACE plans would have new benchmarks, which pushes down

their payment.

MS. AGUIAR: Correct.

MR. HACKBARTH: But, on the other hand, they get a risk adjustment that better reflects their population ineligibility for the quality bonus, which go the other way.

MR. ZARABOZO: Right.

MS. AGUIAR: Right.

MR. HACKBARTH: The net of those two effects means that they're still going to end up being paid $1 billion less over five years than they are currently. Am I understanding the arithmetic?

MR. ZARABOZO: That's correct.

MS. AGUIAR: Yes, that's correct.

MR. HACKBARTH: Okay. Then just one last question. I'm sorry, Mark. The $1 billion, can you express that in terms of what kind of a percentage reduction that is in total payments to PACE plans?

DR. MARK MILLER: This is where I want to say something. This $1 billion is -- now we're kind of to our bucket conversation.

MS. AGUIAR: Right, that's what I was going to say.

DR. MARK MILLER: And I know you know this, and just to make sure everybody knows it, so it's not $1 billion.

MR. HACKBARTH: So it's less than --

DR. MARK MILLER: It's no more than $1 billion, and generally what we do in these draft recommendations is we consult with CBO, and they tell us, "You're in the right bucket," but they don't give us a point estimate that I'm aware of.

MS. AGUIAR: And that's exactly how it happens. So when we give CBO our estimates, they are in these broad buckets, and the bucket we have over five years is $1 billion. And so CBO confirmed that it would be within that, but we weren't able to get a definitive answer to where, where within that.

MR. HACKBARTH: That's [off microphone]. Clarifying questions, round one.

MR. ARMSTRONG: A couple of things. There are, what, about a million dual eligibles in the country?

MS. AGUIAR: About 9 million.

MR. ARMSTRONG: Okay, 9 million. So what I was trying to do is -- you can tell I hadn't accomplished this

yet -- get straight with the numbers. So we have 21,000 PACE participants, and you said it's a very small percentage, I think 2 percent, something like that, of the overall dual-eligible population, right?

MS. AGUIAR: Oh, right. The 2 percent -- and maybe you're referred to an earlier document that we wrote. The 2 percent was dual eligibles that are in any integrated care program.

MR. ARMSTRONG: Okay.

MS. AGUIAR: That's PACE, but that's also like managed care base.

MR. ARMSTRONG: So what's the overall enrollment in PACE programs?

MS. AGUIAR: It's close to 21,000.

MR. ARMSTRONG: Okay, 21,000. Have we tried to estimate at all what these strategies to expand enrollment would result in terms of enrollees?

MS. AGUIAR: We did, and we weren't able to get a specific concrete number. We also talked with CBO about this. The first sort of step of that is that we looked at, well, what's basically the size of the under-55 population, and we found that of the under-55 is about 23 percent of

them we think would qualify for being nursing home-certifiable. We used like two plus ADLs with cognitive impairment. And then you have to sort of think then that PACE doesn't operate in every single county.

MR. ARMSTRONG: Right.

MS. AGUIAR: And so we tried to look, okay, what percent of -- you know, sort of like looking at those counties. But beyond that, the reason why we think -- and we confirmed this with CBO. We think it would be really on the margins, maybe a few to maybe a hundred a year, because the PACE providers are constrained by the size of their day-care center, and some states, I believe, do put caps on their enrollment. And the thing that we also tried to highlight is, you know, this is something where -- you know, we heard very strongly from the PACE sites that we interviewed that they really want to -- it pains them to have to turn away someone who is 53, 54, who otherwise could really benefit.

So even though it was something that we think really would be on the margins and we can't exactly quantify that, we thought that it was something still worth pursuing. But the caveat about that is we could fix it on the Medicare

side, but states still have the discretion to say whether or not they would contract with PACE providers to give those under-55 beneficiaries a Medicaid payment. So it could be even smaller.

MR. ARMSTRONG: Okay. So just to clarify then, we know a lot about the PACE program and how it's working and what its costs are and so forth. We're looking for ways to expand the enrollment. We actually are expanding eligibility as one strategy for expanding enrollment.

MS. AGUIAR: Right.

MR. ARMSTRONG: But even that, it's still a really small number.

MS. AGUIAR: It is.

MR. ARMSTRONG: And so that's why another purpose for this evaluation is to understand, well, what is it about PACE that works so that we can consider a much more effective way of applying that to more patients, because that's the real issue we're trying to deal with here, and that is that we're not managing care for dual eligibles very well.

MS. AGUIAR: Right, exactly. That's exactly right, and I think that was your comment that you had asked

the last time. You're exactly right on that. We're looking at what works here and how could we translate that into other programs. And then beyond that, you know, we'll also be looking at -- intend to be looking in the spring about broader expansions into other programs.

MR. ARMSTRONG: Great. Thank you.

MR. BUTLER: So last month I was a little hung up on the outlier issue, and I'm still hung up on it a little bit. In the write-up in the chapter, it mentioned, of course, that the outliers were available to the rural demonstration, right? And yet those same plans bought reinsurance on their own, the ones that you talked to.

MS. AGUIAR: That we spoke with, yes.

MR. BUTLER: Right, and it doesn't mean that all of them did. Tell me a little bit how the outlier policy actually works. Is it just once you exceed a per capita spending level then you get paid what?

MS. AGUIAR: Right -- no, so it's -- I was going to use the word "rigid," but that's probably not the right word. It's not easy to have actually gotten an outlier payment from that policy. First there was a cap that no one -- first, it only applied to acute-care expenditures. And

then there was a cap that no one individual could receive more than, I believe, 100,000 within a 12-month period. Then there was a second cap that no one provider could receive more than 500,000 in a 12-month period. So you sort of had those restrictions. In order for them to even get an outlier payment, they had to have used up some of their own risk reserves. So it really was almost, if you could think about it, like a catastrophic benefit for them.

MR. ARMSTRONG: So then to clarify the fourth recommendation there, we're not advocating any particular methodology, just that money should be set aside to pay for outliers.

MS. AGUIAR: Exactly. What we have said, again, in the rationale below the recommendation, was that it should be temporary, for three years, as was the one under the rural PACE demonstration, that it should only apply to high acute-care costs for the Medicare beneficiaries, because some PACE plans can enroll Medicaid-only beneficiaries and get -- Medicaid pays the Medicare side. So this would only be for the Medicare beneficiaries, and then, you know, so for the three years. And then beyond that, we said that CMS could look to the structure of the

rural one to develop this one.

MS. UCCELLO: Last month, I, too, had some questions about the outlier, but in conversations with you off-line as well as the additional material you put in our mailing really helped clarify that for me, so thank you.

Now I have another question. This 17 percent --

DR. MARK MILLER: [off microphone].

[Laughter.]

MS. UCCELLO: It never ends with me. But this 17 percent, my confusion here is if this is at a 1.0 kind of risk score type person but we're also saying that the risk adjustment really isn't -- it's not getting to where we have to be, then isn't that 17 percent too high if we --

MR. HACKBARTH: [off microphone].

MS. UCCELLO: Yeah.

MR. ZARABOZO: If the risk adjustment is not paying them enough, it would be then less than 17 percent. Is that your --

MS. UCCELLO: That's -- right, right.

MS. AGUIAR: But what I would just only add to that is we tried to make the distinction between the risk adjustment is underpredicting, but the frailty adjuster is

making up for that. So the frailty adjuster from our analyses is making them whole. If you're looking for a risk adjuster that's going to get to a perfect 1.0 predictive risk adjuster, now let's say it's like 0.88, but the frailty adjuster, which is 13 percent, is bringing them close to if not at whole.

MR. HACKBARTH: My follow-up question from that would be then you're saying that the frailty adjuster and a risk adjuster produce the same aggregate level of payments. The fact that you don't think that the frailty adjuster suffices means that you think the distribution will change through an improved risk adjuster. So this is really about redistributing dollars? Am I drawing the correct inference here?

MS. AGUIAR: So you mean the changes to the risk adjustment system?

MR. HACKBARTH: Yes.

MS. AGUIAR: Yes.

MR. HACKBARTH: Let me just make sure I am not misinterpreting your comment. A minute ago you said you think, well, we're underpaying them on risk adjustment.

MS. AGUIAR: Right.

MR. HACKBARTH: But we have this sort of unique feature of the frailty adjustment, and we think that the frailty adjustment offsets the lack of a proper risk adjustment. So then the question is: Well, why do you care, why do you want to go ahead and do a new risk adjustment?

MS. AGUIAR: Right.

MR. HACKBARTH: It must be because you want to redistribute the dollars that go out under the frailty.

MS. AGUIAR: Exactly. And I would say two things. One thing, the risk adjustment recommendation would not apply only to PACE providers, and they're the only ones -- with the exception of a few SNPs, they are the only ones that get the frailty adjuster. So there is that sort of need for the more complex MA plans, you know, just to have that sort of redistribution.

The other thing is, you know, I mean, ideally you would have one risk adjustment system that would be sufficient. The frailty adjuster is based off of a survey, and, you know, even in conversations with other members of the government, they say that that's just not ideal, you know, to have sort of these two -- a survey based and then

the risk adjustment based. So the rationale for the risk adjustment is, you know, it's one sort of system that accurately produces risk, and that would apply beyond PACE as well.

MR. HACKBARTH: I'm sorry, Cori, for interrupting your flow.

MS. UCCELLO: That gets at my question, so thank you.

MR. HACKBARTH: Clarifying questions?

DR. CHERNEW: I have a question about Recommendation 1. Is the quality bonus program the same quality bonus program that was on our list from the earlier discussion we had? That was called quality demonstration on that list.

DR. MARK MILLER: I'll answer that. There's a quality bonus program that was included in the change in law, in PPACA.

DR. CHERNEW: Right.

DR. MARK MILLER: Them CMS came behind that and, using its demonstration authority, added more dollars and added more people to the quality bonus. It is making it easier to qualify, essentially.

The Commission had taken a position a few years before that demonstration authority is supposed to be for demonstrations, not just unilaterally increasing payments. And so it's that piece that we're saying should be rolled back.

DR. CHERNEW: In the earlier discussion -- and this is different, so --

DR. MARK MILLER: Yeah, they would still be eligible for the quality bonus programs that were passed in the original law.

DR. CHERNEW: But that would have a quality demonstration part. Okay. I understand now. Thank you.

MS. BEHROOZI: You talk about the aggregate Medicare spending on PACE beneficiaries, and there was a lot of conversation about that, and I'm not going to reopen that. But is there any study other than by the PACE providers themselves that compares the combined spending, Medicare and Medicaid spending, you know, in the PACE program versus fee-for-service?

MS. AGUIAR: Unfortunately we don't have that. I believe that there was a study that was done in 1998 that was the evaluation of CMS that did look at savings to

Medicare and Medicaid. The thing is, at least from the Medicare side, that was under a different payment system than it is now, and I am not quite sure -- I would imagine there have been changes subsequently on the Medicaid side. But we don't have that data. We have requested the data on total Medicare spending from CMS, but that's just C and D, not on the Medicaid side.

MS. BEHROOZI: Is this something that we know that MACPAC is looking into or somebody else? Is that being done or do we have to try to make it happen?

DR. MARK MILLER: Throughout all of this process, we've kept MACPAC aware of what we're doing here. They saw all of this before, you know, as we were developing it and all of the rest of it. And in some of those discussions, they have said that they're trying to focus on the Medicaid side. So, for example, at least on one of the phone calls we were on, they were saying there were different rates that different states pay, and they were actually in some instances surprised how much Medicaid paid in some of the instances. So I know they have some attention over there to that.

I also know that they're doing some work where

they're trying to look at coordinated care models on the Medicaid side and sort of examine how well they've performed and that type of thing. That's at least a couple things that they're up to.

But we've had those conversations. They're aware of what's going on here.

DR. BERENSON: Actually, my question is a follow-up to that. I know today we're mostly focusing on suggested enhancements to PACE per se, but that other point of what are the lessons for care for the duals more broadly I'm interested in. Since I've got you, I want to ask a question about that.

Earlier this week colleagues of mine at the Urban Institute published what I thought was a pretty compelling paper arguing that Medicare should retain the primary responsibility for oversight of programs for the duals for lots of reasons. I think the last time you presented there was some confusion about where responsibility for oversight of PACE was sort of sitting.

MS. AGUIAR: Right. We figured that out.

DR. BERENSON: So I'll give you a chance to answer. So I think it would be helpful in the chapter that

we do to be real clear about that, but sort of to understand what authority the states have and what authority CMS and Medicare has, or other parts of CMS, Medicaid has, to be real clear about those lines of authority and if there's any way to talk about how that's working out as we go forward and look at where responsibility should reside for programs for the duals. But I'd be more than happy to have you tell me what you've learned.

MR. HACKBARTH: Bob, for the Commissioners who haven't seen Judy Feder's paper, you may want to just say a couple sentences about the nature of her argument that this should be primarily a Medicare responsibility.

DR. BERENSON: Basically, there were a number of arguments, and I can't remember them all, but most fundamentally the money is Medicare's money. There was a worry that the states would sort of cost-shift to Medicare. The potential, I think, for states to use the money for other purposes in a time of great distress -- I don't know how much she emphasized that argument, but I know that argument has been of concern -- would be some. Perhaps you know more of the arguments that were laid out in the paper. It's a short one, so I do recommend it to people.

MR. HACKBARTH: As I recall -- and correct me, Bob, if I've got it wrong -- I think the number they used was that over 80 percent of the dollars for duals are actually Medicare dollars, and please forgive me if I don't have that right.

DR. BERENSON: [off microphone] I don't remember.

MR. HACKBARTH: Does that sound right to you, Christine?

MS. AGUIAR: The numbers I'm remembering are about between 60 to 80 percent, because I think it depends -- the match depends on each state. But that is something, again, we could quickly...

MR. HACKBARTH: Okay. Any clarifying questions?

DR. HALL: In your written report, you mention the impressive savings that appear to be associated with PACE programs in terms of hospitalizations, rehospitalizations, nursing home placements, kind of a gamish of Medicare and Medicaid reimbursable services. Since CMS doesn't release a lot of these data, is there any way you can put a dollar figure on this, savings per thousand PACE enrollees or something like that? Is there any metric that works?

MS. AGUIAR: I think the -- and I'm in a moment

going to turn this over to Carlos to explain this, but I think the tension that we've sort of been seeing is there are these evaluations that have demonstrated that, you know, even relative to fee-for-service, you know, sort of -- okay, before it was on the current payment system, there was a study that showed that it did save, and they attributed that really to the capitation rate because the capitation at the time was set below the fee-for-service spending. And then the PACE providers were able to operate within that capitated rate.

Then there are other studies that have looked at -- you know, sometimes within -- so there's one that looked at PACE versus another integrated care program and were able to sort of say, okay, PACE is better at reducing hospitalizations, things of that sort, than versus another managed care-based integrated care program. Some have looked at it more from the state perspective, you know, how PACE operates compared to home and community-based services or compared to nursing home uses.

I think the problem is that the reason that we think that we aren't able to see those savings is because PACE is on the MA payment system, and that's set relative to

fee-for-service.

DR. HALL: Okay. Well, I just wanted to know yes or no. It sounds like, no, we don't have this kind of dollar figure. So when we start talking about adjusting payment, don't we have to sort of factor in what potential effect any payment adjustment is going to make on this potential to really save a lot of money in terms of higher-end care? Also, that has implications for the wider lessons to be learned from PACE. Presumably all these data are risk adjusted as well as we can and maybe frailty adjusted. I'm not quite sure what that means. So what is the element of PACE that allows them to have lower hospitalizations and SNF placements? It might have something to do with care plans. It might have something to do with volume of people who work there. But if there's any data at all on that, I think it would be very informative.

MS. AGUIAR: Right. And what we've seen from our research personally is that it's the -- there's a day-care center-focused model, so the beneficiaries are there, and you have a multi-interdisciplinary team as well as many other staff.

DR. HALL: Right.

MS. AGUIAR: And so they're constantly monitoring these patients, and they're able to recognize extremely subtle changes. So it's sort of the very intense, very constant monitoring. The ability to get them into the primary care center right away because it's literally in the day-care center, and then they have the flexibility to just blend that pot of Medicare and Medicaid money and to spend the Medicare money on clinical services. And so they're really able to intervene with very these sort of -- I don't want to say minor, but, you know, to pay for services that they wouldn't otherwise be able to, to then avoid the hospitalizations and ER and things like that.

DR. HALL: Let me just give you a very parochial example. Our community has had a PACE program for 20 years now. The best predictor of whether someone was going to be hospitalized or got to a SNF was what the bus driver observed on the way in. It had nothing to do with doctors or anything else.

MR. HACKBARTH: Mary, before I invite your question, I interrupted and Christine did not get a chance to respond to Bob's inquiry about oversight responsibility and where it resides.

MS. AGUIAR: Right. So we did have a call with CMS, and they were extremely helpful and really had to pull in staff from multiple different areas within CMS. And so the group that focuses -- has oversight over Medicare Advantage in general is very heavily involved. There was some staff also more from the quality division, and then we also talked with -- I'm not sure if you want me to give actual names or just sort of --

Okay, so general areas. The staff got really focused on looking at more of the financials and the Medicare -- the MA Risk Adjustment System in general, and then also the financials. So it seems like there's a lot of different groups with CMS that are --

DR. BERENSON: But largely on the Medicare side.

MS. AGUIAR: Yes.

DR. NAYLOR: So I just wanted to follow up on -- I haven't read Judy's report. So for the PACE Program, not dual eligibles overall, what is the ratio of Medicaid to Medicare to the cap rate, on average?

MS. AGUIAR: I just want to make sure I understand.

DR. NAYLOR: So if I'm PACE enrollee in a given

state, how much of the capitation rate per month might I expect to get from Medicaid versus Medicare?

MS. AGUIAR: Got it. So off the top of my head, I'm not sure. I don't want to just throw out a number. But what I can say is the ones that we spoke with, and again, you know, as a sample, the Medicaid rates were higher than the Medicare rates.

The Medicaid PMPMs ranged from about 3,000, some up to 4,000. Whereas, the Medicare PMPMs were more from about 1,700 to like a 2,200.

DR. NAYLOR: So in the context of who's responsible, the states feel very responsible, but I just -- so in this apples to apples issue, in the comparisons, are we talking about comparing 55 and older with nursing home eligible or those receiving home and community-based services when we talk about the 17 percent difference?

MR. ZARABOZO: Well, it would be -- I mean, when we say 1.0 percent, it assumes again that the risk adjustment accounts for all of the factors that would contribute to program expenditures. So if, for example, nursing home status is reflected in the risk adjustment, then yes, and that's why we mentioned that the frailty

adjustment, which bumps up the PACE plan significantly, gets you to the equivalent in fee-for-service for that particular population. The short answer is yes, it should account for all those factors.

DR. STUART: Thank you for addressing the questions that I had last time. I have a new batch for you. You indicate that relatively few people, relatively few patient-enrollees dis-enroll except for death. Do you have information about the duration of enrollment and the proportion of mortality in this population?

MS. AGUIAR: We did look for -- I'm sorry. When we did the analysis, we excluded those that had died, but we could actually email that to you because I know that we do have that.

DR. STUART: The reason I raised that, actually there were two reasons. One is, if the duration is relatively short, then there may be the same issue in PACE that we discussed with respect to hospice, and that is that cost of care is going to be high during the initial month or two, and then is going to drop, and then will be high toward the end.

And the longer the duration of enrollment, then

the less serious that particular issue would be.

MS. AGUIAR: Right. And I apologize because I forgot to answer the first part of that question. Again, there is some literature that has shown survival rates and I believe it's in here. It's either three or five years survival rates. I'm sorry, Mary.

DR. NAYLOR: Four versus three.

MS. AGUIAR: Four versus three. Thank you. And then again, we heard anecdotally -- and again, it depends on the population within a given, you know, sort of -- within a given PACE provider. Some will last three years. I mean, if you have a population that's very heavy and sort of 85 or older, the duration will be longer. Obviously if they were to enroll the under-55, the duration would be much longer.

DR. STUART: So that's not really an issue that I raised. But another real quicky. What happens during the months that the enrollee dies? We were talking about -- one of the issues here is prorating payments. I assume very few patients die on the 1st or the 31st of the month. Do they get paid for the whole month or is it like Social Security where the Government comes back and takes away your check because they pay in advance and then they want their money

back?

MS. AGUIAR: I think it's a full month. We've never directly asked if it was taken back, but I don't believe it is. But we'll fact-check that for you.

MR. HACKBARTH: Carlos, the Medicare Advantage, the check is cut and it's a full month payment?

MR. ZARABOZO: Right.

MR. HACKBARTH: George, clarifying questions?

MR. GEORGE MILLER: Yes, please. First of all, thanks for the demographic information, the map. It is very helpful. I'm struck in looking at the map, there's some pretty large urban areas around the country, particularly in the south, have no PACE. I don't know if you have a reason for that, Houston, Dallas, Atlanta, Georgia. Is there any reason why they would not have any that you could tell?

MS. AGUIAR: I don't know reasons by state --

MR. GEORGE MILLER: Right.

MS. AGUIAR: -- which is why they wouldn't. The two reasons that I know they have to respond to geography is that PACE is an optional Medicaid benefit. So a state has to elect to start the PACE program, or to allow the PACE program to start in their state.

The second reason why you would see them more concentrated around urban areas, that, I think, was one of the driving forces behind this Rural PACE Demonstration, was to see can you get this model to work in rural areas, can you incentivize it.

MR. GEORGE MILLER: Okay, okay. And then the second part, I was very struck by the coordination of care. Do you have quality data that shows that based on that coordination of care, those patient populations would do better with disparity issues than in the general population because of that coordination of care they're getting, better care based on any quality indicators for that population versus the general population?

MS. AGUIAR: I'm just going to rephrase to make sure I understand.

MR. GEORGE MILLER: Okay.

MS. AGUIAR: So is the question that would minority patients be getting better coordinated care in PACE than in other integrated programs?

MR. GEORGE MILLER: Correct, or any patients, for that matter, but certainly those who have suffered through disparities, and that could be minority populations. But it

could be Appalachian whites as an example.

MS. AGUIAR: Right, right, exactly. I don't know exactly the answer to that one. I know that there was a study, again, that we did not include here that did show that outcomes for PACE participants, they were better for the African-Americans than for the white patients.

And it was very interesting, but the author seemed to attribute that possibly to maybe baseline status. They had more of an opportunity -- sort of if they had worse services before the entered in, then they really thrived more in the program.

But, you know, the comparative studies that we found really were looking at outcomes, you know, hospitalizations, ER rates, nursing home use, which you then sort of infer is because of the better care coordination that you would get.

MR. GEORGE MILLER: Okay, thank you.

MR. HACKBARTH: [Off microphone]

MR. ARMSTRONG: So I think fairly briefly, I would just, first of all, say -- let me clarify. Are we voting on the recommendations today or just commenting? Okay.

So I would just say that the recommendations all

are heading in the right direction. I don't have specific suggested changes to any of them in general. I like what we're trying to do and that is move the unique features of a payment structure for PACE much more into an MA-type structure.

Particularly I like that we would be pushing on the quality reporting and creating opportunities for some incentives around achieving high standards with respect to those quality measures. I hope, too, part of that evolution helps us to imagine how perhaps the MA program, but it doesn't have to be, can become more generally a vehicle by which we can serve dual eligibles.

I mean, I feel like we have spent an awful lot of time on a very specific program that seems pretty well run, but serves just a tiny percentage of the patients that we should be worried about, and I kind of want to move on to how we can really expand access for dual eligibles to programs that are going to serve them much better.

The report does a very nice job of helping us understand, so what are the features that we should apply? But I'm eager for MedPAC to move on to some of the bigger questions.

DR. BAICKER: I thought the conversation about the risk adjusters was really helpful because this is something that comes up in lots of other manifestations, lots of the policies we talk about and other aspects hinge crucially on getting the risk adjusters right.

So understanding how the risk adjustment here might interact with risk adjustment in Medicare Advantage or in future ACOs would be helpful, but that seems like a particularly strong part of the recommendation.

MS. BEHROOZI: Yeah. I was thinking a little bit along the lines of what Scott was talking about, that we went from like the whole world, when we were talking about the SGR this morning, to a very sort of rarified group that gets the benefit of this wonderful program, I mean, you know, full disclosure, as we were saying earlier this morning. My father is actually in a PACE program and we encountered a lot of the barriers, and actually Christine and I talked about it, about having to give up his own physician and things like that.

And I don't know that it's always perfect-perfect, but I'm much happier knowing that there are people paying attention to him all the time. So I think it's a wonderful,

really wonderful, valuable program, and as Kate said, I think I said last time, very interested in the risk adjusters being appropriate for this population, both on the payment side and on the quality and assessment side.

But also, I do think that the bigger thing here is not so much to make recommendations to make PACE better, because, you know, these people are really dedicated and what they do, they do well, and they do pretty efficiently so that they can take the money they have and spread it around to the things that really make the most impact on their patients' lives, is really seeing what can be exported from the PACE program.

Like everybody loves to talk about the bus drivers. Well, if you don't have a daycare program that you're transporting people to on a daily basis, okay, that's not immediately transferrable, but maybe there are recommendations about going out into the community to care for chronically-ill patients by MA programs or ACOs or PCMHs or whatever those other manifestations of the best kind of care could be. So I think that's sort of the next level for me.

DR. NAYLOR: First, thank you for all of your

response to all of our questions the last time. This is really terrific background. Just a couple general comments. I really also appreciate the opportunity to learn what we can from the kinds of programs we seem to be trying to move toward, coordinated care programs for high-risk people.

In your work, and especially with Recommendation Number 1, the notion of what's happening in states in terms of dramatic cuts in support for programs like this, either in the forms of reduced their part of the reimbursement or the increasing caps on programs to be able to even grow, I think that the impact of those changes -- and I know that's outside the purview of Medicare, but here we have a Medicare/Medicaid program where the providers think -- they don't think of it that way. They think of it as a chance to use resources to do something on behalf of the people.

So I think that we need to -- I appreciate the fact that you're working with the states to understand what the impact of those changes might be on this program. I'm not sure where a frailty adjustment is. I think it's a really imperfect and imprecise process right now. So I know that a lot of people are working on it. I think it has a long way to go before we can rely on it.

I am concerned about the under-55, not so much because that's not an extraordinarily important group, but many of these -- the PACE programs are Home Health and the full range of services, more than just daycare, and many of them are open six or seven days a week serving the over-55. So the ability to substitute days is not good.

But I like the idea of permission. You know, saying, Do you want to do this? Can you offer the additional services? So I think that's great. And like the outlier policy, and I certainly recommend for pushing for publication of the quality data.

DR. STUART: I have a question on quality data. It's two of the five recommendations here, and this has come up before. I can't remember whether in this context or other contexts. And that has to do with minimum size for having stable estimates of these measures. And one can think, particularly of the small PACE programs, that might bounce around because of just random variation. So what are your thoughts on that?

MR. ZARABOZO: This came up in the quality discussions for MA plans in general, which is the size issue, and it is a problem for PACE. And that's why, I

mean, when we talk about this internally, we think that you may have PACE-specific measures. So it is a concern.

What is the appropriate way of evaluating these plans that enables them to get a quality bonus? It's sort of the eventual goal of that, so it's a difficult issue and we recognize there is this numbers problem, so it cannot be exactly the quality measurement system used for MA. There may have to be, you know, supplemental or other ways of getting around the numbers issues.

MR. HACKBARTH: Remind what the average enrollment is in a PACE program.

MS. AGUIAR: So it ranges from about 11 to, I think, about 2,500, but we found that about half had 300 or under.

MR. HACKBARTH: Yeah. So you're talking about, certainly if you're looking at any sort of an outcome measure, the instability with that sample size is enormous, which may push you almost inevitably more towards process sort of measures that aren't as dependent on large numbers for stability. But that then buys you another set of potential problems or weaknesses.

DR. MARK MILLER: The other thing, and this issue

comes up in other conversations that we've had, you know, even small rural hospitals are multiple years of data where you start to accumulate measures on that basis.

MR. HACKBARTH: Well, if you're talking a few hundred, you're talking about a decade or two worth of data to get the stability in the numbers.

DR. MARK MILLER: Maybe five.

MR. HACKBARTH: Yeah. George.

MR. GEORGE MILLER: Yeah, I want to combine Bill's question of last time and Scott's comment about how do we move this forward, particularly I think what Bill was driving at. It appears that, at least what I read in the chapter and I think you can infer from Bill's question, there's some cost savings to the overall program, to all of the buckets, because the care coordination of the PACE program, and if we're able to expand that to appreciable numbers.

Although the individual sites would be small, it appears that there would be some significant cost savings because of the care coordination. So my question really is, how do we move that forward, which is really what Scott asked? What incentives? What do we need to do to put that

in place to make sure that more beneficiaries are benefitting?

Because again, I'm struck by the care coordination and the quality indicators that appear to seem to say that even the bus driver does an excellent job of making sure that that population is very well taken care of. They know the subtleties.

And there may be a problem if a bus driver or anyone else prevents something from happening. I don't know how you measure that as well, but it appears that they are doing very well. So my question really is, which is Scott's question, how do we move this forward and as quickly as possible?

And one final question while you're thinking about the answer to that question, do you know the margin for the five for-profits versus the rest of the country who are not for-profits? Is there an appreciable difference between those margins as well?

MS. AGUIAR: So the only for-profit PACE sites are operating now under a demonstration, and the only reason that we were able to get some of the profit information was from the site visits and we asked them. So we didn't get

the information from CMS. And I'm not quite sure, actually, if they've been operating long enough.

Usually CMS puts PACE providers under about a three-year sort of period to let them -- recognizing it takes awhile to ramp up to break-even. So I'm not even quite sure if they've been operating long enough to have gotten to that point.

What I would say about the first point, you know, what we've been planning now for the spring is really to be looking at this -- sort of to looking at sort of two other types of integrated care programs. We've been lumping them all up now into the same bucket.

One is these fully-integrated dual eligible SNPs. So they're not just the regular dual SNPs, and there's a bit of a debate in terms of exactly where you set that cut-off, but the most sort of strict definition of them is that they're a DSNP that has a contract with a state to cover all of the Medicaid benefits, and that's all behavioral health, all long-term care.

And there are some programs that say, you know, we cover all long-term care, but not all behavioral health because of factors within our state, so we should be able to

be included. So there's a little bit of controversy around that.

And so they, you know, as of today literally do not have the flexibility to use the Medicare funding to cover non-clinical services, but that is something that CMS actually has just recently proposed. And so that may be taken care of.

The other thing that we were considering looking at for them was this issue of expanding more enrollment into them, and as we had said publicly before, we've looked at this issue of opt-out. So we haven't presented the results of that yet, but we intend to be at least now going into that into the spring.

The other sort of integrated programs are these Medicare and Medicaid demonstration programs that are being run by the Federal Coordinated Health Care Office. I'm sorry. They just changed their name and I was blanking on what it is, but within CMS that was created by PPACA.

And so, there you've got 15 state demonstrations which are very state-driven, as well as two other demonstrations, which one which is a three-way contract between a state, between the CMS and the health plan, and

then there's also another one which is more of like the North Carolina model, if you will. It's like a fee-for-service overlay.

So when we talk about, you know, how we could expand and how we come up with fees, we're really looking at all of those programs. And again, I'll just say, you know, we sort of have this intention now, but again, depending on your interest and your feedback, what we pursue -- we could continue this to the next cycle based on what I'm hearing, if there's more work that you would like.

MR. GRADISON: This is going to be a little pedestrian and I ask you to bear with me and feel free to criticize and tear apart what I say. I think it fair to say that is an article of faith among many of us that fee-for-service results in lower quality at a higher cost; that more coordinated care should result in higher quality and lower cost; that the PACE program moves away from fee-for-service and through more coordinated activities appears to provide higher quality but at a higher cost than fee-for-service.

And further, that our package of recommendations doesn't do anything about the cost factor. It still is plus-17 percent, or thereabouts, and which you have

explained to us.

One could even go further and argue that that same thing is true of a much bigger program called Medicare Advantage which maybe over time will get ratcheted down to a fee-for-service equivalent with adequate risk adjusters. It's, as far as I know, certainly very popular, quarter of the Medicare beneficiaries are in it, but it presumably is providing higher quality, but at higher costs.

Should I continue to have confidence in the article of faith to that moving away from fee-for-service will save us money?

MS. AGUIAR: I'll answer that in terms of fees and then Carlos can answer it in terms of MA.

MR. ZARABOZO: [Off microphone]

MS. AGUIAR: What I would say about -- in terms of PACE, the recommendation to -- Recommendation One to move them to the PPACA-revised benchmarks, that is intended to bring them closer down to the fee-for-service levels because that will -- and so -- and then again, that would make them, that with the bonus, would make them consistent with how MA plans -- more consistent with how MA plans are paid now.

And so, now the issue of how MA is higher than

fee-for-service, I will turn that to Carlos.

MR. HACKBARTH: Carlos, before you go, I think we need to be careful to distinguish between payments and costs incurred in the delivery of care. The 17 percent figure is payments relative to what it would have cost in fee-for-service. It doesn't address one way or another with the actual cost of delivering the care is, and that's where the benefit of better care coordination would show up, on the cost side, not on the payment side.

And what I think I heard Christine say a minute ago is that we really don't know all that much about the costs of PACE organizations. Did I understand you correctly?

MS. AGUIAR: Right, exactly. We asked them about what their payments were for Medicare and Medicaid, but not with their costs. And what we do know about their costs is that some -- most of the ones that we visited were able to manage their costs within their capitated payments, whereas others weren't.

MR. HACKBARTH: I should know this, but the PACE organizations don't do any sort of cost report the way hospitals do?

MS. AGUIAR: No, not in that sense, no. But they do -- CMS does look at their financials. But it's not like a cost report or anything like that.

MR. HACKBARTH: Yeah. So to make a judgment about whether they're truly saving money in care delivery, we need cost information, not just the payment information?

DR. MARK MILLER: And I think the other couple things I would add to it is, is that if they're -- and I wasn't quite sure that I caught what you were saying so I may have misunderstood. If they're saving money relative to fee-for-service, the problem is, is we're losing it on our payment rates. And so, I think that's one statement.

And then your article of faith on fee-for-service versus more coordinated care programs, and there may be other views on this. There seems to be evidence that it improves quality. Whether it saves money is, you know, the evidence on that is less clear, although --

MR. GRADISON: That's the point -- that's exactly the point I was trying to reach.

DR. MARK MILLER: Yeah, that's kind of what I thought you were driving at.

MR. GRADISON: Yes.

DR. MARK MILLER: Although --

MR. GRADISON: And frankly, I could refer back to what we voted on earlier. I didn't want to make a big deal out of it, but the notion of using for two-sides ACOs the 2011 fee schedule rates struck me as having an unnecessary, inflationary bias. But anyway, we've done it and I voted for it.

DR. MARK MILLER: That's what Mike would say.

MR. HACKBARTH: Ron?

DR. CASTELLANOS: My question was answered.

MR. HACKBARTH: Okay, Karen.

DR. BORMAN: Just to bring together, maybe overlap a couple of things that have come up, I, too, am interested in moving on to knowing what we can generalize. And so, my question is, relative to these recommendations and what stands behind them, is there anything in these that if we generalize things about PACE, is there anything here that will start to set a precedent that we want to be careful not to set relative to dual SNPs or any other integrated care model.

Is there something that we could be establishing here that could put us in a box that we don't want to be in,

either in terms of giving out or withholding relative to these other models? And I realize that's a little bit of an ephemeral, you know, crystal ball kind of question, but I would want to think we've examined these in that light.

I mean, it appears to me that publishing quality data probably isn't going to have that kind of implication, other than this whole point of the small sample size and whatever. But, for example, if we start getting into prorating and outlier protection so far, are those things that we're pretty confident we would want to offer to other models because the arguments could be, Well, you did it for this.

So I just want to make sure that we've given that consideration.

MS. AGUIAR: So I would say yes, and we did think about that. You know, again as we said, the first draft recommendations, you know, those really are sort of focused on trying to bring PACE more aligned with the other programs.

Again, we talked about this outlier, you know, and would basically other plans be asking for it. And again, the rationale about that is to try to support growth in

PACE, because it is so small, because the start-up costs are so high, and because it does have -- I mean, it's one of the few that has really demonstrated really good outcomes.

And so, we saw from talking to the rural PACE sites that having this -- you know, albeit was very temporary and very hard to get an outlier protection that really sort of gave the sponsors an incentive to join. And so, you know, that was more of the rationale for that.

DR. BORMAN: The only thing I would say then is maybe let's be enormously careful in supporting language or what ever way we describe this to really emphasize that. I personally, as much as I think this is clearly a wonderful program and does good for its beneficiaries, the odds that this is going to apply to the other couple hundred thousand just doesn't seem to be very large.

And so, I think that there may be reasons to especially support it, but to especially support it because we think it's something we're going to now ramp to a couple hundred thousand people, I think, is probably maybe fallacious reasoning.

And then the other piece would be being careful to say we're doing it specifically for this program given these

characteristics, to give us a little bit to fall back on when somebody else comes forward and says, Well, we should have this too, that they need to be able to demonstrate criteria or characteristics that would qualify them for the same thing.

So I'm just saying, it's going to be in the way we write about it, to capture those things.

MR. HACKBARTH: Your point is a really important one, Karen. Let me just make a conceptual point about outliers, whether you're talking about PACE programs or hospital outliers. A key issue is how you pay for the outliers. So you can have outlier payments that are additional payments, new money into the system, or you can pay for outliers by reducing the base rates, in which case it's sort of like, you might think of it as re-insurance.

Everybody's giving up something under base rate for protection against an event beyond their control. Usually when we talk about outliers, we're talking about the latter model. It's not new money, but, rather, paid for by a reduction in the base rates and everybody is getting basically government-managed re-insurance.

Now, whether that's what we would do in this case

or not, I don't have any idea. But that's the normal way that Medicare approaches outliers.

Jim, let me ask you a process question, a scheduling question. Today we did draft recommendations. At this point, when do you envision that we will come back to consider final recommendations?

DR. MATHEWS: This is tentatively on the schedule for next month, the November meeting.

MR. HACKBARTH: Okay. So if you would, take a look at the draft recommendations and any unresolved issues, questions you have about them, and let us know what they are as quickly as possible. And I'll be checking in with you, one means or another, in the next couple weeks to get your thinking about these as final recommendations. Thank you, Christine, Carlos.

MR. HACKBARTH: So let's see. Next we're on to the Mandated Report on Quality of Care in Rural Areas.

DR. AKAMIGBO: Good afternoon. The Patient Protection and Affordable Care Act of 2010 requires MedPAC to study Medicare payments to rural areas and evaluate access to care and quality of care in rural areas.

In February, we presented findings that showed

that, on average, access to services do not differ between rural and urban beneficiaries. In September, we discussed rural payment adjustments and principles around better targets for sole source providers, empirically justified adjustments and incentives for cost controls.

Today we will present findings on quality of care in rural areas. The next presentation will focus on adequacy of rural payments. For today's presentation, I will provide an overview and discuss the dimensions of quality we evaluated, namely, performance on patient satisfaction, process of care in inpatient and outpatient settings, and quality findings in post-acute and dialysis settings.

Jeff will discuss hospital mortality and the complexities of measuring mortality rates at the hospital level. He will also discuss potential guiding principles to consider for rural quality and potential strategies to improve quality in rural areas.

Rural areas are diverse and should not be lumped into one group, particularly when examining quality of care. Therefore, we consider four types of counties separately. First are urban counties which include suburbs with more

than 50,000 people, and the second are rural micropolitan counties, and these are counties with a town of 10,000 or more people.

The third are rural counties without a city of 10,000, but are adjacent to metropolitan areas. And the fourth are counties that are not adjacent to urban areas and do not have a city of 10,000 people. Finally, we realize that areas with the lowest population densities may face particular challenges, so we also examined frontier counties, and these are counties with less than six people per square mile.

We evaluated the key aspects of quality of care and explain each in detail in your mailing materials. Patient satisfaction measures reflect how patients feel about the quality of care they received and their interactions with the health care system. We use HCAHPS data from Hospital Compare and the Medicare current beneficiary survey to determine satisfaction levels.

Processes of care are clinically relevant, evidence-based activities clinicians ought to do to provide good quality care. We used data from Hospital Compare to determine performance on process measures. Health outcomes

reflect the end results of care such as whether a patient survived or not.

We examined mortality and readmission rates as reported on Hospital Compare and from MedPAC data. Dialysis and post-acute care outcomes are MedPAC analyses of data for those respective sectors.

We found that patient satisfaction levels are largely equal across rural and urban areas. A similar share, about 67 percent of Medicare beneficiaries, rate their hospital highly. A slightly higher share of urban beneficiaries would definitely recommend their hospital, but again, these rates do not differ very much across rural and urban areas.

Medicare beneficiaries were also asked about the quality of follow-up care, their perceptions of their physicians' overall concern about their health, and the quality of the information communicated to them about their health. Results here show that for the most part, urban and rural beneficiaries are satisfied with these proxy measures of physician quality, over 90 percent, as you can, on each measure. And rural non-adjacent beneficiaries tend to have slightly higher rates of satisfaction on these measures.

Now, let's shift gears to discuss our quality findings in post-acute and dialysis settings. We evaluated quality measures in these sectors and show detailed results in your mailing materials. We summarize our findings on this slide.

Essentially, for skilled nursing facilities, a similar share of rural and urban patients are discharged to the community and the rates of potentially avoidable hospitalizations are similar. So again, quality is about equal across rural and urban areas. Home health outcomes, as measured by the rates of discharges to hospitals, are also similar across rural and urban groups. And dialysis outcomes, as measured by hospitalizations per year, dialysis adequacy, and share of patients with catheters all show that there are no urban/rural differences.

Now let's look at a few hospital inpatient process measures. We found that rural providers' performance is generally poor when compared to urban providers. We won't go through every measure, but overall, we found lower shares of patients receive appropriate processes of care for pneumonia, heart failure, heart attacks, and surgical care with few exceptions.

In addition, performance is generally lower as providers become more rural. An important reminder here is that many rural providers have fewer volumes for some of these conditions. Therefore, our expectations for their performance may be moderated by the low volume phenomenon.

Here we show hospital outpatient process measures which are also reported on Hospital Compare. We found that rural providers perform better on a few measures such as average minutes to fibrinolysis or treatment for blood clots. Also, the pattern we found for inpatient process measures were performance degrades as providers become more rural is not evident here. A good example is below that yellow dotted line where we show the share of patients who get aspirin within 24 hours for chest pain. Frontier areas tend to do very well compared to the rest of the groups.

For many measures, however, rural performance was lower than urban. For average minutes for chest pain patients to be transferred, rural hospitals posted longer times than urban hospitals. This result was unexpected given that many rural hospitals transfer patients once they are stabilized, and this is a practice that is well within the scope of most rural providers.

Jeff will now discuss the results on hospital outcomes measures.

DR. STENSLAND: We examined four hospital outcome measures, heart failure readmission, heart failure mortality, pneumonia readmission, and pneumonia mortality. We chose these four metrics for two reasons. First, they're common even among the smallest hospitals. Second, these are services that hospitals choose to provide, unlike emergency services. By focusing on heart failure and pneumonia, we can ask the question, How do rural hospitals perform on the types of services they choose to provide where an alternative source of care often exists.

Our first finding is that readmission rates are roughly equal in rural and urban areas, and this is consistent with the literature. However, we find risk-adjusted 30-day mortality rates are higher in rural areas. We examined mortalities in two methods.

The first is the AHRQ-IQI risk-adjusted mortality. For the question of comparing hospital groups, this is our preferred method. It adjusts for risk factors such as the patient's diagnosis, age, and other factors. The other common metric is the CMS Hospital Compare mortality rates.

Now, this may work when examining individual hospitals, but the data is inappropriate when examining differences among groups as I'll discuss later.

This slide compares the results from the AHRQ and the CMS methods. First note that both methods show higher mortality in rural areas. However, the AHRQ method shows about a 2 percentage point difference while the CMS method shows less than a 1 percentage point difference between rural and urban.

So why is the difference compressed in the CMS data? The CMS measure is designed to avoid the risk of having random variation categorize an individual provider as a poor performer. To accomplish this, CMS presents data that is essentially a blend of the experience of the subject hospital and average experience in the country.

CMS states, In essence, the predicted mortality rate for a hospital with a small number of cases is moved toward the overall U.S. national mortality rate for all hospitals. The net result of this method is to compress reported values toward to the mean.

The AHRQ method we used reports only data from the subject hospital. It does not compress differences across

classes of hospitals. It is therefore more appropriate when comparing aggregate rural and urban quality. Therefore, we focused our attention on the AHRQ results. And that's what we look at in this slide.

In your mailing materials, we show that the more rural an area becomes, the smaller the hospital becomes. And one key question is whether the higher mortality rate in rural areas is purely due to having lower volumes of services in these rural hospitals.

So rather than break things down by the level of rurality, as Adaeze did just a minute ago, we'll focus on the size of the hospital. Start by looking at the first column. This first column shows 30-day risk-adjusted mortality for heart failure patients in rural hospitals. For the smallest hospitals, those with 1,000 to 2,000 discharges -- that's total discharges, not just heart failure -- the risk-adjusted mortality is 13.8 percent.

For the largest hospitals, those with over 8,000 discharges, it is 3 percentage points lower at 10.9 percent. We see this relationship both for heart failure and pneumonia care. We also see it both in rural and urban hospitals, but this should not be surprising. Keeler found

the same result in his 1992 paper on hospital mortality that looked at rural mortality.

We also found it again in our analysis of 2003 data when we did our report on Critical Access Hospitals, and a recent JAMA paper found the same thing looking at 2008 and 2009 data. So it should not be a surprise that we see a volume outcomes relationship when we look at 2010 data.

However, even within each volume category, rural providers tend to have slightly higher mortality. Therefore, the patient volume appears to partially, but not fully, explain the rural/urban differences in reported risk-adjusted mortality.

Now, this slide I'm showing you right now is limited to PPS hospitals, but we see the same thing with Critical Access Hospitals where CAHs with larger medical staffs tend to have lower risk-adjusted mortality than CAHs with smaller medical staffs. This suggests that physicians and nurses may benefit from having colleagues to discuss issues with and may benefit from having practice with similar cases.

This raises the question of whether quality could improve if two CAHs that are 10 or 15 miles apart merged.

While the closure of one or two neighboring facilities may improve outcomes, the hospital boards in the two neighboring communities often cannot agree on which community should lose their hospital. And the result, in recent years at least, is that both hospitals often stay open, but this may not be the best result for patient outcomes.

One long-standing hope is that small hospitals would do better if they team up with a large system. In fact, all CAHs are required to have a larger support hospital. So we tested the effect of system membership and found that it did have a small positive effect, but it was not large enough to significantly alter the volume outcomes relationship we show on this slide.

Larger hospitals tend to do better than smaller hospitals, even when the small hospital is part of a hospital system.

Another hope was maybe there are just certain hospital systems that are really good at coordinating care, so we also looked specifically at a couple of the systems with the strongest reputations, the kind of systems that get mentioned in Washington. Again, we did not see any significant effect of being in a system. The smaller

hospitals in these well-known systems continue to have higher risk-adjusted mortality than the average large hospital.

So what could be done to improve the care beneficiaries receive in rural areas, especially given the challenging effect of low volumes on outcomes? First, we could try to increase participation in quality reporting. Currently, some Critical Access Hospitals can opt out of tracking their quality metrics and reporting those metrics.

Second, we could try to come up with measures that are most relevant for rural patients. We should note that some rural patients may have different concerns than the urban patient. The urban patient may be concerned about arriving at the ER and having it being overcrowded. The rural patient may be concerned about arriving at the ER and the on-call physician may not be present in the hospital.

Therefore, a reasonable measure for a small hospital may be the time it takes from when the patient arrives at the ER to when the physician arrives at the ER and sees the patient.

A second concern is that many of the smallest hospitals do not always have a pharmacist on staff reviewing

the medications. A process measure could be the percentage of time medications are reviewed by a pharmacist before the first dose is administered to the patient, at least in non-emergency situations.

Another important function of the smallest hospital is transfer instructions. The rural hospital could be evaluated on whether they provide the receiving hospital with a certain amount of information in a timely fashion. As an aside, there can also be issues with the information flowing the other way, from the referral hospital to the CAH.

It may be appropriate not only to adjudge the small hospital on its flow of information to the tertiary care hospital, but also judge the tertiary care hospital on its flow of information back to this rural community hospital when the patient is discharged to receive post-acute care at the CAH or the SNF. The end objective here is to make sure that even the smallest hospitals are in the game of collecting quality data and continually trying to implement evidence-based medicine.

Now we'll try to pull together what we said into a couple of guiding principles on expectations for the quality

of care. First, Medicare beneficiaries who live in rural areas should get the best care possible that can be delivered given circumstances of the community. For non-emergency care where there is a choice of whether to treat the patient locally or to transport them to a larger urban facility, the rural facility should be held to the same standards as the larger facility. In other words, the small rural facility should be as good as the alternative site of care.

However, emergency care is different. There is no alternative. In these emergency situations, our expectations for outcomes at smaller rural hospitals may not be the same as for larger facilities. For example, rural providers may lack certain services such as a Cardiac Cath Lab. They may be forced to use thrombolytics to treat heart attack patients because there is no other option available. Because the small rural hospitals don't have the same options, we should not expect the same outcomes.

Second, most hospitals are currently evaluated on the care they provide to Medicare beneficiaries in their performance as public report on Hospital Compare. However, as I said, some Critical Access Hospitals have been exempted

from these reporting requirements.

To allow equal access to information for rural and urban beneficiaries, all rural and urban hospitals could be subject to public disclosure of their performance scores. This may improve tracking of care in the smallest hospitals and hopefully end up improving the quality of care.

Now we have some potential discussion topics. The first is the mandatory collection and reporting of quality data that I just discussed. A second is developing rural-specific quality metrics such as the review of medications by pharmacists. This is discussed further in your mailing materials. Collection of this data may lead to a better understanding of how to improve outcomes in the smallest hospitals.

And third, there is the volume outcome relationship amongst rural hospitals. Is there anything we should do to address this issue such as maintaining an incentive for neighboring hospitals that are both suffering from low patient volumes and low occupancy to merge into a single facility? Now I'll open it up for discussion.

MR. HACKBARTH: To the list of discussion topics, I'd also invite Commissioners to comment on the principles

that were on the preceding slide. In fact, in particular I'd like people to react to those principles. Let's see. We're on this side. Clarifying questions, Karen and Ron.

DR. CASTELLANOS: Jeff, good job. This is really a ½ level question. My understanding is PPS hospitals are required to report Hospital Compare data.

DR. STENSLAND: Yes.

DR. CASTELLANOS: But the Critical Access Hospitals are not required to do that. Can you put up Slide 10? That's the same as we have in the book. You know, in the data -- this is just outpatient process data and it's the same as we have in the material. One of the concerning points, and this is, I guess my question is, why is that -- why do they have the option not to do it? Because as you put in your material that you sent out, with this data, only about 12 or 13 percent of the hospitals reported it.

So it tells me there's 87 or 88 percent that haven't reported it. And it doesn't seem very accurate. So, you know, data is what's important. Mandatory reporting is, I think, a good point. But I guess the question really is, why aren't they required to do it?

DR. STENSLAND: I think there's two different

types of cases. There are some cases where they won't report specific things and that might be the 12 percent you're talking about. These really small hospitals just don't do it, so if they don't have the cases, they're not going to report.

Then there's the other situation where they can choose not to report anything, and this is, don't report my pneumonia results or they wouldn't report their heart failure results. And in this case, most of them choose to voluntarily report. About 80 percent choose to report those types of things. And about 20 percent, though, say they're just not going to participate, or maybe they have the data computed, but they don't release it to the public.

DR. AKAMIGBO: So, Ron, I think you're talking about the outpatient measures on the screen.

DR. CASTELLANOS: Right.

DR. AKAMIGBO: The number there was about 12 percent reported, on average, across those measures.

DR. CASTELLANOS: Right.

DR. AKAMIGBO: The outpatient set is the newest set of measures on Hospital Compare to be publicly reported, and so the reporting rates actually vary. So fewer CAHs

report the AMI measures and even fewer report the outpatient measures. That number might go up, but for now, it's very few of them are participating. So they could be doing better and we just don't know, but without data, it's hard to know.

DR. CASTELLANOS: I guess that speaks to my point about mandatory reporting.

MR. GRADISON: Mine is a very closely related question. Who exempts them from reporting? Is it the Congress or is it CMS or is it CMS under pressure from the Congress? Why aren't they reporting?

DR. STENSLAND: I'm not sure. We can see if it's CMS regulation or if it's Congress. I'm guessing it's in the law, but I'd have to check.

MR. GRADISON: Thank you.

MR. GEORGE MILLER: Yes. Very good report, very informative, and it's very helpful for me. One of the questions I would like to pose are the quality measures, and I think, Jeff, you mentioned a little bit -- and this is anecdotal information from when I was a rural hospital CEO. The challenge was not transferring the patient in a timely manner. The challenge was getting the accepting physician

at the urban facility to accept that patient and the time it took us to get that done.

So if you measure how long it took the rural hospital to transfer that patient, part of that time is just getting them to accept or getting them to find an accepting physician for that particular specialty. If it was a heart attack, then finding a cardiologist, if it was a broken leg, getting an accepting orthopedics, or it was a head injury, a neurosurgeon. And that what's took a lot of the time.

So I'd be cautious in how we measure it. Yes, we should have a measurement, but equally important, the problem sometimes is on the other end, of getting not only the accepting hospital, the accepting physician who may be on call or who may require the hospital to pay him to be on call to get him to accept that patient. So I just wanted to point that out as well.

DR. STUART: If you could turn to Slide 12, please? And this question applies to other things and I don't want to be misunderstood in terms of trying to push you in one direction that I don't think you want to go in. But it rises here.

I look at these numbers and they look awfully

close to me, and so I'm wondering whether these differences, you know, meet standard levels of statistical significance -- in other words, how big is the variance around those medians that you're presenting?

Now, I do want to say this. I don't want to get into the position where everything is presented with standard deviations. That's not where I'm going here. I'm just wondering about these particular things.

DR. STENSLAND: Yeah, we can present that. It's all statistically significant all across all of these differences.

DR. NAYLOR: So on the principles slide, I'm wondering if, number one, the data that you have uncovered in this great report led you to frame it this way. Meaning, is there a threshold of expectations in rural hospitals that we should expect in emergency situations, and is that a different -- I'm just wondering what led you to frame it that under these circumstances, the best care that providers can deliver versus there should be a threshold of expectations in emergency situations. I'm just wondering where your thinking was on it.

DR. STENSLAND: I think there could be an

expectation in emergency situations, also. It just might not be the same as in urban areas. I also think sometimes when we start talking about rural quality, people will say, Well, don't look at that AMI measure because that's an emergency thing. We don't do it very often. And then we end up getting kind of side-tracked onto this thing of, Don't look at quality at all.

So I think it's trying to make sure we focus on some topics that everybody can agree are important in rural areas, and everybody can agree that we think that the quality expectation should be equal, rather than let the emergency care differences in capabilities, differences in technology end up being a distraction that leads us away from talking about the differences in quality, the other thing.

DR. NAYLOR: I totally agree with that. That's why I was wondering whether or not re-framing it saying there should be a threshold of quality expectations, even given the circumstances, so thank you.

MR. HACKBARTH: So the next step in that conversation, I think, becomes, Well, what is that threshold and how do you accommodate the huge variety in

circumstances? And it becomes a very complicated discussion pretty quickly. And if I hear Jeff correctly, he's trying to avoid that thicket and focus on an issue where it may be it's a bit easier to focus, namely, when there's an opportunity to go elsewhere on those services, are we performing at the needed level.

MR. GEORGE MILLER: Glenn, I apologize.

MR. HACKBARTH: Sure.

MR. GEORGE MILLER: Just to follow-up, I can't let Jeff get away with that, that statement. I don't think that any rural provider ever has tried to lead the discussion away from talking about inequality. I think that's what you just said. We certainly would agree to that, and I know for the last ten years I've been involved in NRHA and even when Tom was, we always talked about quality and the quality measures. It's the appropriate quality measures for what we do, is the issue.

So I just can't let that statement that we want to guide the discussion away from any quality measures. We do. It's just got to be appropriate for what we do in our communities.

DR. MARK MILLER: And I just want to add, I think

what Jeff was trying to capture and you were saying what led you to frame it that way, is that there was a previous discussion among the Commissioners where a lot of this came out of, and some of them are organized the same way. I don't know how that happened.

It came out of some things that Kate said, Tom said some things along these lines at the time. He was sitting over there, but there was actually -- we were trying to track and build this out of a conversation that the Commissioners were having of where they were saying, Well, wait a second, maybe we should expect some differences in certain circumstances.

So I think Jeff was just trying to track to all of that. I hear you and maybe he didn't state it quite right. Mary, that's where it came from. He may have not caught it quite there, but I think that's what he was trying to capture.

MR. HACKBARTH: Bill.

MR. HALL: Staying on this principles slide, I think statement number one is kind of "wuzzy." Wasn't it in Alice in Wonderland the queen said, I use a word to mean what I want except when I don't?

[Laughter.]

MR. HALL: That's a rough paraphrase.

[Laughter.]

MR. HALL: What we really say is that in non-emergent situations, people who live in rural communities should have the same expectations of quality as someone in an urban area, right? I think that's what we're trying to say. I think this could be misinterpreted as what are they talking about, because I don't think we're really saying that it's -- well, you know, if there's a dance at the town hall and the nurse can't get there in time, then that's understandable because everybody in our town goes to that dance. And maybe others don't see it that way, but I worry about that being taken out of context.

DR. NAYLOR: Poor nurses.

DR. STUART: Well, they're on that bus.

[Laughter.]

MR. KUHN: I have several questions. If I could go to Slide 9 for a moment. There is a conversation that goes on in the health care community that maybe some of the variance we see here is a reflection of coding and the ability to code more accurately. At urban hospitals, they

just have more staff more heavily focused on coding. You don't see that so much in a rural area. Is there anything in the literature that would explain away some of those variances that we see there? Is it just as a result of a function of coding, not necessarily in terms of the quality of care that's being delivered, but it's just not documented as well?

DR. AKAMIGBO: Yes. We looked at some differential coding practices a few months ago and smaller providers, FQHCs, rural RHCs, don't have the same built-in incentive to code as completely, if you will, as some larger facilities. That might explain some of the differences, but it's -- you know, given -- when you look at claims or when you look at claims data that would feed into Hospital Compare, what we try to do is present things that you would have -- that should have been done and would have absolutely been documented regardless of the type of provider or the location of the provider. So while there is literature suggesting that there are definitely differences in coding practices and we see that in the data -- I think there's a 55/45 percent split between urban and rural -- I'm not sure to what extent that is explaining some of the variation we

see here.

MR. KUHN: Okay. It might be helpful in the future if we could look at that a little bit more. It might explain some of the gap, as you suggest, maybe not all of it, but there might be something there to look at.

DR. AKAMIGBO: Yes.

MR. KUHN: If I could go to Slide 13 -- oh, go ahead.

DR. MARK MILLER: [Off microphone] Before you ask, one quick thing. Your point may stand, but for these measures, these are process measures, right --

DR. AKAMIGBO: Yes.

DR. MARK MILLER: -- and are these risk adjusted?

DR. AKAMIGBO: Umm --

DR. MARK MILLER: No.

DR. AKAMIGBO: No.

DR. MARK MILLER: I don't think they are, so --

DR. AKAMIGBO: No.

DR. MARK MILLER: But I still think your point stands.

DR. AKAMIGBO: Absolutely, yes.

DR. MARK MILLER: I think it stands as it relates

to outcome measures --

DR. AKAMIGBO: Yes.

DR. MARK MILLER: -- and then I think your --

MR. KUHN: Maybe it comes into play there.

DR. MARK MILLER: Right. But I think, then, what I think you're asking us is do we have any better feel for the differentiation in coding and how it might influence those numbers.

MR. KUHN: Correct.

DR. MARK MILLER: Okay.

MR. KUHN: Thank you.

DR. MARK MILLER: We can follow up on that.

MR. KUHN: And then on 13, and maybe this is something where Tom and even George could help me a little bit, think this one through, I guess earlier you said that there's no difference -- I think it's on page 11, the slide, where you said there's no real difference in terms of readmissions. But yet we know, at least in my experience of what I've seen in some rural areas, is that some of the care patterns do vary differently because of family circumstances, how well the family knows the people at the hospital, and a lot of individuals might be in a hospital as

part of a care pattern that in maybe some urban areas they might not be admitted as an inpatient. They might have been somewhere else.

So, I guess, is there any correlation, as you get down to these smaller hospitals with discharges, they might have a higher mortality rate, but their readmission rates are lower? That is, basically, it's an inpatient and a hospice stay together. I mean, that's just kind of where they're going to die, is at the hospital. So I'm just wondering if there's any correlation there that might explain some of those differences, as well. Does that make sense, what I'm asking?

DR. STENSLAND: Yes. First, the readmission rates for the smallest hospitals are on a risk-adjusted basis actually slightly higher, not big enough to really say that they're different, but slightly higher. So that doesn't really hold.

Then there's the question of why do they seem to be doing not as well on mortality but roughly equal on readmissions, and there is some research going on in that area. I think the Upper Midwest rural, we have a research center that has a project going where they see if that's

related to your source of discharge at all. And there is a situation where if you're a rural patient, especially in a real small hospital, you're more likely to be discharged to a swing bed status, and that means you might be getting your post-acute care in the same bed that you were in when you were an acute care patient, and so there might be less of a concern of, oh, let's race this person back to the hospital if you opt to a SNF because you're already in the hospital. You're in the same bed you were when you were an acute care patient. So that might affect some of the differences that we see between the mortality rates and the readmission rates, and we'll get some research on that.

MR. KUHN: Okay. That would be helpful to see.

And, I guess, just two other quick things. One is on the Critical Access Hospital reporting, and I know there were questions about that earlier. You're going to look into the information. But in the reading, I saw that it was about 15 percent of the Critical Access report on outpatient. Is that about the same on the inpatient side in terms of the data that they report?

DR. AKAMIGBO: No. So for pneumonia and heart failure, Critical Access is reporting, or participation

rates is in the 80s --

MR. KUHN: Oh, it's in the 80s?

DR. AKAMIGBO: -- across the board, yes. It's much lower for AMI. For outpatients, about 12 percent. AMI, as I eyeball it, average of maybe 30 percent of Critical Access Hospitals.

MR. KUHN: And because of the reporting here, CMS, I think, puts a threshold of 25 cases either per reporting period or per year --

DR. AKAMIGBO: Right.

MR. KUHN: -- so a lot of Critical Access Hospitals might be reporting, but the information just doesn't appear on Compare because there's not a significant number, is that correct?

DR. AKAMIGBO: Yes. That's -- yes.

MR. KUHN: Okay. Thanks.

DR. BERENSON: Yes. I want to ask a couple of statistical-type questions, if you could go to 9. It's sort of a Dartmouth-style question, which is intra-category variations. I could hypothesize that there might be a large number of rural hospitals performing sort of at the national average, but that there might be some low performers

bringing down the overall score. Have you looked at that to see if there's, I guess, greater variation, sort of a more of a bimodal distribution in rural than in urban?

DR. AKAMIGBO: Yes. So when you look at the full range of process measures as reported on Hospital Compare, the first thing that strikes you is that even among the rural counties, there's great variation in their performance. So rural adjacent and non-adjacent and frontier tend to drag down performance scores for all rural, and I don't think -- I think I might have that in the mailing materials, but not on the slide here. So -- but rural micropolitan counties tend to look very similar. The differences there are much smaller. So your point is well taken and we do see that frontier, for the most part, tend to underperform compared to the remainder of the rural counties. So there's definitely --

DR. BERENSON: But there's not -- but within the frontier category, is there more of a bimodal distribution where a bunch are really pretty comparable, but then there are some very low performers?

DR. AKAMIGBO: I didn't break out frontier.

DR. BERENSON: I mean, I think it would be useful

to know if there is some sort of real low performers that may be targeted improvement or something else could be.

Let me ask a similar kind of question -- yes.

MR. HACKBARTH: Bob, on that same one, are these medians or are these means?

DR. AKAMIGBO: These are means.

MR. HACKBARTH: Yes. That's what I thought.

DR. BERENSON: Well, that's where I was going with my next question.

DR. AKAMIGBO: One of the issues we might have, though, on the frontier, there's only 201 hospitals and that's total, so we might start having an "n" problem as we look at --

DR. BERENSON: But you could present medians, also.

DR. AKAMIGBO: Right.

DR. BERENSON: And that's where I was going with my next one, which is on Number 10, picking up on what George was talking about with sort of logistical issues, unusual things that might happen, is it possible that there's a tail of patients who never get referred or it takes three weeks to get them referred that is bringing up

the mean, but that the median might show a very different set of findings on these, especially on these time measures? So could you look at that?

DR. AKAMIGBO: Absolutely, yes.

DR. BERENSON: Great.

DR. STUART: Yes. This is going back to 9, and I like the idea of having the significance noted in the footnotes for all of these. The statement here, though, indicates that the metropolitan is different from all of the rural indications, all of the rural classifications, including that top one, 95 percent metropolitan, 95 percent rural micropolitan.

DR. AKAMIGBO: So the test -- I didn't report to -- I just reported metro versus all rural.

DR. STUART: But, I mean, is --

DR. AKAMIGBO: Yes.

DR. STUART: -- is that rural micropolitan some fraction of a percent less than the metropolitan at both 95?

DR. BERENSON: [Off microphone] All right.

DR. AKAMIGBO: Yes.

DR. STUART: Oh, I see. All rural.

DR. AKAMIGBO: Yes.

MR. HACKBARTH: [Off microphone] Round one clarifying questions.

DR. DEAN: If I could just comment on the question that Bob just raised, as I recall, the folks in Washington, Gary Hart and that group did a study looking at MIs a few years ago and they found just exactly what you said, that there was really a wide range of variation and that there were certainly some of these facilities that performed very well or as well as anybody could expect and then there were a number at the other end. And so on an average, there was a problem, but they said that it -- and I think that testifies to the whole issue when you're dealing with very small facilities. One or two people make a huge difference, and if you've got progressive leaders, they tend to do reasonably well, and if you don't, then things lag. Of course, that is a challenge, but --

DR. BERENSON: But it has implications for where to target policy, it seems to me --

DR. DEAN: Yes.

DR. BERENSON: -- that phenomena.

MS. UCCELLO: I think you talked about this in the chapter and I think you touched upon it today, but can you

remind me why it isn't necessarily the case that redefining -- revising the definition of Critical Access Hospital wouldn't necessarily mean -- would not necessarily mean a synergy with improving the quality as well as kind of lowering the payments? I think you talked about that. Because when I first read it, I thought, oh, there's this synergy here. If we redefine Critical Access Hospital, it looks like we'll also get an improvement in quality, as well as lower payments. But then it seemed like later on you said, oh, but it might not necessarily --

DR. MARK MILLER: Let me ask you this. Are you asking a question about if the payments and the definition of Critical Access were more targeted, it would bring --

MS. UCCELLO: Yes.

DR. MARK MILLER: She's going to the consolidation thing. I think that's what she's asking.

MS. UCCELLO: Yes. Yes.

DR. STENSLAND: Yes. Generally, if there was something hypothetically saying if you have to be ten or 15 miles apart to get to Critical Access Hospitals -- maybe I'll just tell a story. How about this.

So once upon a time, I was talking to a hospital

administrator, all right, and the hospital administrator had a neighbor who was another hospital administrator and they got along well, and they were both about 15 miles apart, and he said they both agreed that they could serve their patients better if they would merge, okay. And they thought about, well, if we merge, one of us is going to have to lose our hospital, but that's best for the patients and we should do it, so they thought they should do this.

And then they went to go talk to their boards and the boards basically said, it's fine as long as it's in our town, and they both had the same position and so nothing ever happens. But these are both Critical Access Hospitals, so what he said they ended up doing is they both ended up just remodeling both their hospitals. So you kind of had this dysfunctional situation which is perpetuated by the cost-based reimbursement. You can both remodel these things 15 miles away.

And if you said there was some criteria where they couldn't be a Critical Access Hospital, that they could only have one Critical Access Hospital in those joint communities, then you would remove the benefit of the Critical Access Hospital program unless they merged. So you

would create an incentive to merge. You would create incentive for higher volume. And to the extent that volume improves outcomes, either through more colleagues or more practice, you could end up in a situation where you would have less spending and better outcomes.

MS. UCCELLO: So the issue is whether the incentives for merging actually work versus if they merge, it does appear that the increased volume would result in better quality.

DR. STENSLAND: And I think I should also say, everybody agrees that there are certain places that are isolated that are so far away, you don't want them merging. You know, when you have this hospital that's out there 60 miles away from someplace, I've never heard anyone say that we shouldn't be having some extra special care to make sure that place stays around, the close ones.

MS. UCCELLO: And happily ever after, is that --

[Laughter.]

MR. HACKBARTH: So, Jeff, are you saying or implying that one of the implications of your story, which has the ring of plausibility to me, is that it might be a policy worth considering to give a financial inducement for

institutions to merge in that situation, so that the two boards when they look at it would say, well, rather than building separately, oh, we can get a significant increase in our resources if we come together to have one larger-scale facility.

DR. STENSLAND: [Nodding head.]

MR. GEORGE MILLER: [Off microphone] You currently have SCH status, currently. That's an incentive. So I would ask, conversely --

MR. HACKBARTH: Yes --

MR. GEORGE MILLER: -- based on his hypothesis, would you do that in an urban area, too, two hospitals right next to each other?

DR. STENSLAND: I think I would say if you have two hospitals right next to each other in an urban area, they shouldn't both be getting cost-based reimbursement.

MR. GEORGE MILLER: Oh, well, you're talking about only cost-based reimbursement.

DR. STENSLAND: Yes.

MR. GEORGE MILLER: Okay. All right.

MR. HACKBARTH: And so just to pick up on that, the question would be, if the two hospitals merging would

qualify for Sole Community Hospital status and that would be preferential financial treatment to what they have as Critical Access Hospitals, then SCH might be attractive. But I don't think that it does end up being on that more attractive SCH status.

MR. GEORGE MILLER: But not cost-based reimbursement.

MR. HACKBARTH: Right.

DR. MARK MILLER: But I think the other way you could think about this is -- I won't get the mileage right or anything, but, you know, if there's two hospitals that -- let's just say for the purposes of discussion are ten miles apart and they're both qualifying for Critical Access Hospital payments, I think one of the implications of Jeff's story is there's not a lot of reason for them to try and come together, whereas if Critical Access said, tomorrow, actually, you have to be 20 miles apart, then suddenly that conversation becomes different between the two hospitals, because to keep the Critical Access status, they would have to come together. And I probably got all the math wrong, but you understand what I'm trying to say, I think.

MR. GRADISON: [Off microphone] -- one of them

has to move to the other end of the county --

DR. MARK MILLER: Or, yes --

MR. GRADISON: Then you have both of them.

DR. MARK MILLER: Well, there's -- yes, okay.

MR. HACKBARTH: Experience suggests to us that taking Critical Access Hospital status or any other preferred status away from an institution that already has it is a politically challenging task, which is why -- I'm not proposing this, but I would think that it might be more effective to provide a positive inducement for people to merge and create a larger institution, although that costs money.

DR. DEAN: On that point, you can -- these decisions basically end up getting made by communities, and you can have medical staffs who agree, you can have administrators who agree, you can even have boards that agree, and you will get huge push-back from the community and the political powers within the community. So they end up being a fairly complex decision even when the professionals understand the advantages.

MR. HACKBARTH: Peter.

MR. BUTLER: Well, one quick comment. I the

preferred payment to merge does not -- it still keeps them -- if they don't feel like doing it, they're still both supported by cost-based reimbursement, so they're still there. You'd be better to kind of withdraw the preferential treatment as an inducement, but that's not what I -- this is more of a round one comment that I was going to say.

Where does the magic -- is there any science around 15 miles? I mean, is that -- it's a weird kind of number. If you're applying the guiding principles that you suggest for elective and so forth, is there --

DR. STENSLAND: There is no strong evidence to the 15 miles. I think it's -- maybe there's something about having to drive an extra 15 miles in the ambulance, an extra ten minutes in the ambulance or 12 minutes in the ambulance, but I'm not aware of any science. I do know when I talk to people, a lot of times when you get above 15 miles, they'll intuitively feel like that's quite a distance. Like, at 25 miles, they might intuitively feel that's quite a distance to go. That's too far for our people to travel. When we get less than 15 miles, it's rare that somebody says, you know, we're seven miles away from them. That's just too far for people to travel.

MR. BUTLER: I won't get Mitra going on the 15 miles.

[Laughter.]

MR. BUTLER: The minute I said it, I said, oh oh. I shouldn't have said that.

[Laughter.]

MR. BUTLER: But 15 miles in Frontierville is nothing, in some cases. I mean, that's just a short distance. All right.

MR. HACKBARTH: We went over this last time, and if we were starting with a clean piece of paper, travel time might be a more sensible metric than a fixed mileage standard, but -- Scott.

MR. ARMSTRONG: Just briefly, to remind me for context, of the total spend annually for Medicare, how much is on rural health?

DR. STENSLAND: Rural people? I think they're about 20 percent of the population and it would be maybe slightly less than 20 percent of the dollars --

MR. ARMSTRONG: So actually we're talking here --

DR. STENSLAND: -- for rural --

MR. ARMSTRONG: -- just about hospital care, which

is a subset of that, then, right?

DR. STENSLAND: So, yes. If you talked hospital care -- Critical Access Hospitals by themselves are about $8 billion out of $140 billion, and the bigger rural hospitals, I don't know, maybe another ten percent.

MR. ARMSTRONG: So about 20 percent of it is what you're saying?

DR. STENSLAND: Probably less, less than 20 percent is going to rural hospitals.

MR. ARMSTRONG: Okay.

DR. STENSLAND: But more than ten.

MR. HACKBARTH: And 20 percent of Medicare's expenditures on hospitals --

DR. STENSLAND: On hospitals.

MR. HACKBARTH: -- are going to rural hospitals.

MR. ARMSTRONG: But 20 percent of Medicare beneficiaries live in what we define as a rural area, is what you're saying? Okay. Actually, that --

DR. STENSLAND: And the reason is that they get some of their care in the urban areas. For their tertiary stuff, they go to urban areas.

MR. ARMSTRONG: Great.

MR. HACKBARTH: Jeff, in your presentation, you mentioned that you had looked at performance within some well-known systems, and thanks for doing that. I mentioned that at the last meeting. And I'm struck by what you report, that even within some of these well-known systems, there's still this persistent difference in performance and that intrigues me. It seems to me that there might be an opportunity here to get some insight.

Last time, I mentioned Intermountain Healthcare solely because I used to work for Intermountain Healthcare -- - full disclosure. But just to use them as an example, here's an organization that has a very systematic approach to quality improvement. It is almost a religion. I would love to hear, if they're one of the systems that you looked at, why they think that there is still a persistent difference in quality, what they've done to try to reduce it, and give a much more qualitative feel for the issues that are here that you can't get from looking at the statistics.

You know, another -- as I recall, Billings Clinic also is affiliated with some CAHs. Now, I don't -- it's not an ownership relationship so far as I can remember, but Nick

Wolter is somebody that all of us, or many of us know and respect. To get some people who are really good and who have really zeroed in on this and tried to remediate it, that might be a very informative discussion.

MR. GEORGE MILLER: Glenn, just to follow up on that, and Jeff, were you able to dissect that, especially in the heart failure and pneumonia, was the lack of presence of a hospitalist, an ICU, CCU, or intensivist a measure of the difference for those rural hospitals where they would be in the urban hospitals?

DR. AKAMIGBO: We didn't look at that specifically --

MR. GEORGE MILLER: Oh, I'm sorry.

DR. AKAMIGBO: -- but it's knowable from -- if we merge a couple of data sets.

MR. GEORGE MILLER: Yes. I wonder if that's the quality reason under those issues. You mentioned Nick Wolter, because I think they do own some Critical Access Hospitals or have relationships there --

MR. HACKBARTH: [Off microphone]

MR. GEORGE MILLER: Right. Right. And our Christians Hospitals have the same thing. But we put an

EICU for some of our rural hospitals and it helped improve the quality because we had a visual. There wasn't an intensivist in the rural hospitals, but we did have the EICU.

MR. HACKBARTH: [Off microphone] -- at the statistics leads you to speculating about why this, why that, and having somebody who's actually wrestled with the issues in the real world might bring some more -- enrich the conversation about what the issues are.

Round two, Karen.

DR. BORMAN: I'm comfortable with the principles and I think they're nicely articulated. Relative to how we go about defining what kinds of unique measures or subset measures there might be here, I would make -- one of the things I've not heard measured and I would make a plea for from prior experience is to include in some of the conversation perhaps some people that are at the receiving hospitals of a large number of these kinds of transfers. Having personally worked for some period of time in that setting in a prior life, I think there are lessons that -- or observations that those individuals may be able to provide that are additive. I think it's hugely important to

hear from the rural providers themselves where the challenges are.

But I think having observed a volume of transfers also allows one to make some conclusions or observations about where issues may be or how things could be changed or improved and it might also lead to some metrics about communication that have some practicality and benefit both sides of the communication relationship, which is hugely important in these kind of transfers to optimize care. So I would just say that's another source of input, and I would like maybe as we develop text or whatever to include them as a group that should be involved in defining those things.

MR. GEORGE MILLER: Just an observation and piggyback on what Karen was saying. I think she was being very polite on our side, transferring patients, appropriately packaging the patients, sending the right information has certainly been a concern. I've heard that back from the urban side.

But I do want to emphasize that we should have quality standards and make that very, very clear, and they should be measurable and applicable to the rural areas, but everybody needs to be in the quality game without question.

And then I also want to emphasize that -- and I think it was mentioned earlier -- that part of the quality piece is having a pharmaceutical oversight, and that may be part of the challenge. How we wrestle with that issue is something we need to address, but making sure that pharmacy piece is there and measured and have a quality standard for that, as well, is important.

MR. HACKBARTH: Ron and Bill, before we get too far away from you, are you comfortable with the principles? Do you have any comment on principles?

DR. CHERNEW: [Off microphone] I think the next slide, on 16, the mandatory reporting, I think that's important.

MR. HACKBARTH: And so as we go around, if you would pay particular attention to commenting on the principles, I'd appreciate that. Bruce.

DR. STUART: I agree with where this is going. I also agree with Bill that that first sentence should be rephrased, but --

DR. NAYLOR: Ditto.

MR. HALL: I thought this was very informative. I learned a great deal from this, so except for the slight

semantic argument, I'm really quite happy with this.

MR. KUHN: I, too, think the guiding principles work for me. I think Bill's refinements make a lot of sense. I think the discussion topics are pretty key here. But my kind of take-away, and maybe I'm oversimplifying this a little bit, but to me, the real policy issue is volume and does volume really relate to improved process measures as we go forward.

And so one additional area, Jeff, as we continue to think about this issue on a go forward basis might be to look at some ED issues, low volume versus high volume rural EDs and whether the physician is on site versus on call and is that impacting some of the differences that we're seeing out there, as well, might be helpful to add to the discussion as we go forward.

And one other thing on that is just -- and the other part that's kind of perplexing to me as I look at this, particularly when I think about surgical measures, you know, there should be little variability in surgical measures because there's uniform adoption of standard practices there. And so the fact that we're perhaps seeing some discrepancy in some of the surgical areas, and some of

the physicians around the table could maybe talk more about this, but that does bother me when I see that variance in that area. So that would be interesting to have more information on that, too.

DR. BERENSON: Yes. My comment will be that even though our recommendations last year on the QIO program went in a different direction, there is a tenth Scope of Work at this point and I think it would be useful to see if there's anything in there that has particular relevance to rural quality and whether there's particular strategies in that that we should be informed about.

MS. BEHROOZI: I won't say all that other stuff about being from an urban area, except the second bullet under number one, where it says quality of emergency care may differ between rural and urban areas due to limitations of small rural hospitals. I hope that we're going to be thinking about the delivery of emergency care without the necessity of there being a hospital as the institution to provide it, and that probably goes back to the incentives in the payment system.

But in the urban context where we've lost a hospital and thereby increased travel times, hospital

systems have said, let us put an emergency treatment facility there and we will take care of the community's emergency needs without a hospital. So if that can work on the Lower West Side of Manhattan, maybe that can work in rural areas, as well, and then you don't have to support all the infrastructure of beds, whether it's above or below 25, and be able to put more resources into the technology, like tele-emergency room and tele-pharmacy and all of those things that can really give you the best bang for the buck in terms of the quality of the emergency care prior to transfer to a hospital.

DR. CHERNEW: So in general, I support the principles, and I certainly like the report and support the spirit of what's going on, but I am going to say something mildly contrarian.

MR. HACKBARTH: [Off microphone] We would be disappointed --

DR. CHERNEW: Yes, exactly. I think it's worth some caution in moving from descriptive analyses to causal interpretation and then policy recommendations. So while I can accept that the analysis descriptively shows that, say, two hospitals that are smaller don't do as well and it might

seem to make -- well, let's merge and then they'll be bigger, it doesn't really follow that if you take two small ones and merge them together, they're inherently going to be bigger -- they may be bigger, but they may not be better for whatever reason. And so looking at examples where hospitals merge, where they didn't, is important, and all of them, as I think Tom pointed out, there are sort of unique cases. Some of them are outstanding, some of them not.

So my second related comment is, in all these cases, there's sort of a deeper policy analysis one would do. So if one wanted to give an incentive, for example, for hospitals to merge by changing the radius of Critical Access Hospitals, which certainly is sensible and I can envision going around the table and coming to convince ourselves, yes, that seems to make sense, but, of course, we have no idea how many of the hospitals that would be in that case are the hospitals that we think are bad. What are issues related to travel times or not for various things? So there's a whole set of policy analysis related to that that I'm not sure we've fully done.

And if you read, on the quality reporting, and I know Arnie's not here anymore, which I -- besides missing

Arnie, the information was always better and we always wanted to measure and you needed to measure, and I believe that, generally speaking. But in this case in particular, in the documents when you talk about the measurement, it says some hospitals have been exempted because of administrative burden and other reasons. I'm not completely sure in my general desire to have things measured that I completely understand the full ramifications of the burden on these places to measure. Is it worth measuring if a sample size is so small we're not going to in the end know something about that specific hospital because they just don't do enough when we measure that.

So there's a series of sort of deeper questions, that while I'm very much supportive of the spirit of measuring quality so we can monitor it, trying to prevent inefficient hospitals from existing where they do, and I believe the analysis -- I do believe they do for the sort you said -- I do think sometimes there's a rush to go from sort of general descriptive notion of what we think is going on to some policy implementation that may or may not work quite as well as we think it would. So --

MR. HACKBARTH: So that sounds smart to me.

DR. CHERNEW: [Off microphone] Contrarian.

[Laughter.]

MR. HACKBARTH: So what I wonder about is where you go with that. So it's, as I say, it sounds like a reasonable point. Let me focus on your first example. If we, in fact, were able to get the two hospitals to merge, there is no guarantee that we would have better quality, and so does that mean that you don't do it, or where do you go with this?

DR. CHERNEW: I wish I knew, but the guy to my left knows what -- I listen to people who know a lot more about rural areas, George, Tom, other people. I guess my general instinct in this whole area is sort of a "do no harm." So I see these differences. They don't seem enormous to me, and when they are enormous, there's nothing we can do about them.

So I'm not in any rush to come into recommendations to solve a problem unless I'm convinced the significance is so great that we really need to act. So I tend to -- I like the principles. Again, I really do support what -- and I think the report's very good -- but I don't think when we see the differences of some of the

magnitudes that we saw here -- some of them seem relatively big, but overall, you have evidence is mixed. Some of them don't seem so big. The process ones look a little closer in many areas. We don't know if a hospital that's good in one is good in all of them, for example.

So I tend to want to look at literature that maybe might be a little more causally oriented, and until we know a little more, my inclination is just to step back, say something about it, think about it more, and not jump in to change things.

MR. HACKBARTH: I thought that's probably where you would go with it, and this is sort of reminiscent to me of the conversation that we had at our retreat about this, and this is not going to do the whole conversation justice, but around the table, there was some sentiment -- do we have a problem here that warrants recommendations that would cause significant changes and turmoil, or is this more a success story? We stabilized a lot of small hospitals and prevented some potential significant access problems. Should the test be, oh, do no harm no as opposed to just continue to tinker, tinker, tinker?

We won't try to answer that right now, but I think

that's -- when you step back and look at it in the big policy context, like the Congress must, that's a critical question. Should we be applying the first "do no harm" rule, and exactly how would you apply it in this case?

Tom.

DR. DEAN: Just to follow up, I would agree completely. I mean, I think you -- it just reminded me -- this is some old data back 20-some years ago, but the folks, again, out in Seattle looked at obstetrical care in areas where hospitals had closed as opposed to where they were still available locally, and presumably if, for the reasons that Mike was just talking about, if you consolidated care, things should improve. In fact, it went the other direction. Costs went up and outcomes got worse. And so you do need to be careful about those things.

So I guess it would lead me to say, I think while, in general, increasing volumes probably do lead to better care, it makes sense to provide some carrots but not the sticks, you know. If communities can see ways to pull that together and there can be agreement and they can work together, then probably it's the right way to go. But to force consolidations in situations where there isn't the

initial inclination to do so, I think you can end up doing a lot of harm. So just on that point.

A number of comments. The volume issue really is an important issue, because what happens is as the volume goes down, the breadth of responsibility of the providers gets bigger. And so, like, for instance, in the JAMA article that we all looked at, in one of the areas where the hospitals performed least well was in caring for MIs. But when you dug down into their data, the average number of MIs that those folks had cared for was six over a 23-month period, which meant that they dealt with one MI about every four months. And in a condition where time is very important and where familiarity with protocols is really important, and when you're dealing with things like fibrinolytic drugs which kill people if they're not used properly, naturally, you know, when I get in that situation, I get nervous, and we probably don't move as fast as if I was in a CCU and I was doing it on a regular basis.

You know, is that -- am I just being defensive? Yes, probably, to some degree. But it kind of speaks to some extent to the whole -- again, to the principles. The circumstances do change and it's really tough to determine -

- to answer Mary's question, what should the threshold be, because it does change with each setting. You know, I don't know what that -- I find myself looking at some of these numbers kind of tied up in knots because I can explain some of them. Does that mean I defend them? No, I don't really defend them, but I think I know why they happen. And we need to figure out ways to improve.

Actually, I think the technological responses hold huge promise in this area, for instance, the whole pharmacy area. Every one of the orders that I write, even though we're in a very remote area, is reviewed by a pharmacist 125 miles away and then comes back to us. Sometimes it drives me nuts because they're not as fast as I think they should be, but in terms of -- and that's relatively easy technology. It's not -- and we just had a discussion just this past week about other ways to improve patient monitoring from sort of an EICU set-up even in a remote setting like I'm in.

So there really are some potentials, I think, to expand that and to hopefully overcome some of the isolation that I think leads to some of us to maybe be a little slower in responding to some of these things than we would like to

be.

The issue of the transfer time is bothersome, although some of it is exactly what George said. We have to jump through a whole bunch of hoops to get somebody to say, will they accept the patient. And secondly, just the pure logistics. If we're going to transfer somebody with MI, it takes a helicopter more than an hour to get from its base just to get to our place. And so, again, it's a complicated issue.

The issue of the mortality rates is also something that -- and I don't know if this was figured into the risk adjustments, but these small facilities oftentimes serve at least in part -- part of their role is essentially a hospice function. When I left home earlier this week, we had four patients in the hospital. Two of them were recovering from fractured hips, but the other two, one of them had widespread metastatic cancer and the other one had end-stage heart failure. Those folks had both been cared for in tertiary care institutions for a good part of their care. I have every belief that their final days will be in our hospital, as it should be. I mean, that's perfectly appropriate. But I think it will alter the statistics.

So I don't know whether that is -- whether that comes out in some of the risk adjustment or not, but again, it makes some of these things -- I think it needs to be taken into consideration. I guess that's what I'd say.

So, in general, I think the principles, I wholeheartedly support, although I also understand they're a little mushy in terms of it would be nice to have, you know, precise thresholds. But I'm not sure that -- the circumstances vary so much that I'm not sure that it's really practical to do that and be fair about it, so --

MR. GRADISON: There's another angle of this that we haven't talked much about, if at all, and that is how all the things we're discussing will look from the viewpoint of the potential patients. In some areas, at least, it's possible, especially with the improvement of highways these days, to get into a big hospital in the big city with reasonable speed. I'm not talking about emergencies, but to the extent that -- I'm not saying we're doing this, but to the extent that minor, statistically minor -- statistically significant but small differences made public undermine confidence in the capability of that hospital, people can vote with their feet, or more specifically go with their

automobiles.

I represented an area with a large teaching hospital and all the things that went with that, but also some more rural hospitals, and it was just interesting to see the movement of obstetrics towards the big city, not in emergencies, but where people, as is increasingly the case, I think, kind of plan when that baby is going to come. I don't pretend that the quality was better, but the rural hospital, so to speak, lost that business and that volume and also that experience.

So another instance in which rural hospital or a county hospital -- county-supported hospital lots its Medicare accreditation -- as it should have, I mean, there was never any question about that -- but came very, very close to closing before they were able to get back on their feet because they were limited to the financial reserves that had been built up before, and if they hadn't had that, they would have closed. The county did not have the resources to come in and, quote, "save them."

So just think a little bit about the patients who have choice. Now, that wouldn't be the case -- I understand that wouldn't be the case in your situation. It would be in

the ones that I observed, which I'm talking about maybe 50 miles.

DR. BAICKER: So Mike's point about not necessarily knowing what the right answer is from the associations, can we really draw causal inferences, is well taken, but I think that the framework that we're outlining here is well positioned to move us in the right direction in that the principles tell us what we think we're aiming for, which is rural hospitals are not going to look the same as urban hospitals. That's not the goal. We want them to produce an acceptable quality of care, and that differs between the critical emergency functions and functions that could be moved to another hospital and patients voting with their feet is actually things working, patients saying, this other hospital, I have time to get there and it's doing a better job. Maybe I should do that. When I don't have time, I need those critical services to be there.

So then we have an idea what the goal is. We need the metrics to be able to evaluate that and the metrics for these rural hospitals might be different, so developing a different supplemental set of metrics to capture that really diverse set of needs would be really helpful in us

evaluating and in patients evaluating.

And then removing the disincentives to provide high-quality critical care is my version of first doing no harm. It doesn't necessarily mean not doing anything right now. It means, first, stop doing the harmful things. Then maybe start doing helpful things once you figure out what they are. But if we think that having this particular payment system discourages hospitals from merging that would be better off doing so because they lose a payment that they would otherwise get, then we're doing harm now. So we need to think about reforming the incentives to be in line with achieving those goals.

And then once you're sort of neutral in that way, I would think that institutions would be able to take more positive steps to achieve higher quality. Even if we don't know from the evidence right now ourselves what those steps are, maybe they do and we can set up payments that help them move in that direction or at least don't hinder them doing that.

And all the things we're talking about so far, to me, seem to line up with that. Figure out what the goal is. Measure your progress towards the goal. Remove barriers to

people getting to that goal. And then do refinements from there as more evidence comes in.

DR. CHERNEW: The only issue is some of the things that are barriers that we might be doing harm now were put in for a reason, that might also be doing a benefit. So it's sort of the netting that out and understanding what the net is that matters.

MS. UCCELLO: Yes. I'm very comfortable with these principles, and not just these principles, but it seems like every report that you've given us along the way have really used principles for that particular kind of metric, whether it's access or whatever, and I think it's really helped frame for me the issues as I'm reading through it. So I think this is very helpful.

And as Kate said -- I just want to highlight something she said in terms of the second bullet on this one is kind of the bottom line here for emergency care, is finding the relevant measures may differ by urban versus rural.

MR. BUTLER: So I'm torn, Glenn, between the two ways you said we could characterize this. I do have some concern that 1,200 Critical Access Hospitals on cost-based

reimbursement kind of can freeze them in time while the rest of the world moves ahead and just to not say anything about that, I think, is a problem.

Now, on these principles, we're all saying we can support them. I'm trying to put my hat -- the staffer's hat on now. What do I do with this? Because if you go from the equal quality for non-emergency services, and go one more time to Slide 13 -- so you say equal quality for -- these are non-emergency services and you reach the conclusion -- it looks pretty systematically in size. It's, like, a 30 percent greater chance of dying if you're in the small versus the large.

And so they say, okay, you've got this principle. What are you going to do about it, you know. You've left -- and so your approach, Glenn, well, maybe we ought to have kind of a qualitative focus group to find out what's going on, and there's limited time. We've got a June report. So, again, I'm trying to put my staffer's hat on. What are you going to do --

[Comments off microphone]

MR. BUTLER: Then I say, are there some statistical things that could explain away this pretty

quickly, like maybe you do -- it's the place you die, and you can get at a couple of the quick variables in short order. But I think we need to think -- I have a feeling it's going to be we need some more analysis, but this is one area where we clearly have a difference and we ought to kind of -- now I'm stuck, a little bit. But I'm just raising that as a key consequence, because of all the things we've looked at, we keep saying access is about the same, satisfaction is about the same, there's a lot of things that are about the same, and this one just stands out.

MR. HACKBARTH: [Off microphone] I like the way you're thinking about it, Peter, and I sort of scribbled down some thoughts about how we might proceed from here. But before I go, let me ask Scott for his comments.

MR. ARMSTRONG: Well, my comment was going to be kind of in the same neighborhood. It was helpful just to be reminded that this is just the quality section of the rural health report, and sometimes it feels a little like the way we're structuring this is constraining our ability to ask more broadly, you know, how is the overall health for people, the 20 percent of our beneficiaries that are cared for and live in the rural communities? How is it working

out for them and what could we learn there that might be relevant and applicable to urban areas and/or vice-versa? Maybe that's a little bit of what you're saying.

But as far as the principles and the way in which you're talking about going forward with this section of this report, I support that. I have no problem on that.

We talk a lot about, you know, how do we coordinate care, get the benefit of understanding how siloed payment structures break up health systems and all that kind of stuff, and then we get to rural health and we stop talking about all those things. And so I just wonder if there's a way that we could learn more about that.

So having said that, then, I also would just say you look at the agenda between now and next summer and it's huge, and I really wouldn't prioritize that over a lot of the other things that we're doing.

MR. HACKBARTH: So, I've been trying to sort of map out in my own mind what our collective thought process is here, sort of what are the logical steps that we are going through, not necessarily in a one, two, three, four way, but more meandering right now. So I'm going to try to pick up on things that different Commissioners said.

Kate said we could think of the principles as a target, and based on what I heard, there's sort of broad agreement, okay, this is a good description of the target that we ought to be shooting for when we look at rural delivery. So that's good.

Then we've got data that Adaeze and Jeff have reported to us assessing how close we are to that target, and we see some differences.

The next question raised by Mike is, how compelling are those differences? Yes, they are statistically significant, but are they significant enough to warrant action, and Mike suggested the "first, do no harm" principle.

DR. CHERNEW: [Off microphone]

MR. HACKBARTH: Yes. Well, in fact, that's going to be my next step. Let's stipulate that we've got some differences. There are different types of tools, potentially, at our disposal to redress differences where they exist. Some of them have more costs and risks attendant to them than others. So one type of tool is simply better, more accurate reporting so all of the participants in the system know where they stand and maybe

also so patients know what the options are that are available to them.

A second step is to -- and I forget, I think it was Kate said, remove barriers. Are there things that we're doing that we can simply take out of the way that might be impediments to improvements?

A third, and I'm sort of ratcheting up the scale -- is positive inducements to change. You know, take the example of the merging hospitals. Does it make sense to give them a positive inducement to come together? And then sort of the high end of the scale is penalties if they don't. And the notion I'm toying with, and I'm making this up as I go along, is that, you know, thinking about the quality of the evidence. You would only want to go to the harsh end of the scale when you really believe, this is a material difference. This is a real problem. You might work at the other end of the scale, reporting and removing barriers, where there's a difference that we think is real, it's statistically significant, but it's not of the same compelling nature.

And so I think it may be useful to go through those steps. What's the target? What do the data say? How

compelling are the differences? And then graduating a policy response to a judgment about how big and compelling the differences are. So just a thought.

Thank you, Adaeze and Jeff. Good work.

And let's see. Our last session for today is on the Inpatient Psychiatric Benefit.

MS. KELLEY: In our June 2010 report to Congress, the Commission reported on its first analyses of Medicare's prospective payment system for inpatient psychiatric facilities. We provided an overview of the payment system, the providers who furnish the IPF services and the beneficiaries who use them. We also discussed some potential issues with the payment system and the need for quality measures.

Staff has continued to monitor trends in the supply of inpatient psychiatric providers and the use of these services, and for the first time we've begun to explore providers' payments and costs under the IPF PPS and to consider what differences in provider profitability might tell us about the accuracy of payments.

We've also begun to analyze the use of other health care services by Medicare beneficiaries who have

stays in inpatient psychiatric facilities since, as we've discussed before, providing quality care to beneficiaries with serious mental illnesses requires looking beyond the IPF stay.

So today, I'm going to present our most recent findings on inpatient psychiatric capacity and supply, and the use of these services by beneficiaries. And then, I'll turn to provider payments and costs under the IPF PPS and the implications of our findings for payment accuracy. And then, we'll take a brief look at seriously mentally ill beneficiaries' use of some other health services. And as you'll see, I think, we have some more work to do before we can take up the question of payment updates for this sector.

So our goal today is to get your reactions to our findings thus far and your suggestions for any future work.

So let's start with a quick review of the IPF PPS. Phase-in began in January 2005 with full implementation by July 2008. Payments are made on a per diem basis with adjustments made for diagnosis and other patient characteristics such as age, certain medical comorbidities and length of stay. Payments are also adjusted for facility characteristics such as area wages, teaching status, rural

location and the presence of an emergency department. There's an add-on for each electroconvulsive therapy treatment and an outlier pool equal to 2 percent of total payments.

The IPF PPS applies only to cases in freestanding inpatient psychiatric hospitals and in distinct-part units in acute care hospitals. But of course, inpatient psychiatric care can also be furnished in regular acute care beds in a hospital. When these beds are occupied by a beneficiary with a psychiatric MS-DRG, they are referred to as scatter beds.

So to give a complete picture of inpatient psychiatric use, we've shown both IPF cases and scatter beds in this slide. IPF cases in 2009 are shown in that first column. The second column shows scatter bed cases.

We wanted to show you both to illustrate a point. Controlling for the number of fee-for-service beneficiaries, the number of IPF cases has declined almost 2 percent per year since the PPS was implemented. But when we look at IPF cases and scatter bed cases combined, we can see that the drop in cases is smaller, again controlling for fee-for-service beneficiaries on the second line. Less than 1

percent is shown in the last column.

What this tells us is that some cases that might have been furnished in IPFs before are likely being provided in scatter beds now. Some of the decline in inpatient psychiatric cases, regardless of setting, may also reflect better availability of psychotropic medication under Medicare Part D.

You can also see in the bottom two lines of this chart the difference in payment in the two settings. The average payment per day is more than $200 more for patients in scatter beds, but because their average length of stay is about two-thirds as long, the average total payment for a scatter bed case is lower.

This slide shows the number of IPF facilities and beds for IPFs that submitted valid Medicare cost reports in 2009. There are a number of psychiatric facilities that treat very few, or even no, Medicare beneficiaries, and those IPFs are not included here. Scatter beds are also excluded from this slide since those aren't designated beds that we can count.

The total number of IPFs has been declining for many years, even before the IPF PPS was put into place. But

you can see here in the last column that the supply of IPF beds under the PPS has been pretty stable. Beds are shifting out of distinct-part units and to freestanding facilities. We'll talk a bit more about that trend in a minute.

We can also see that under the PPS there's been a marked shift in the ownership of beds, with more beds located in for-profit facilities. The number of beds in for-profit facilities has been growing almost 4 percent per year since 2004.

So, a quick look at the beneficiaries who use IPFs. Scatter bed users, again, are not included in this group. AS a group, IPF users are much younger than the typical beneficiary. A majority qualify for Medicare because of a disability. Many are poor, and almost one-third have more than one IPF stay in a year. These beneficiaries tend to be heavy users of other Medicare-covered services as well.

Beneficiaries admitted to IPFs generally are assigned to 1 of 17 psychiatric MS-DRGs, with the 5 MS-DRGs listed here accounting for almost 94 percent of total IPF cases. The vast majority, almost three-quarters, are

diagnosed with psychosis. Psychosis is a blanket term that includes patients with schizophrenia, major depression and bipolar disorder.

So now I'm going to turn to our analysis of payments and costs. As always, when we take a look at a type of care that's furnished in both hospital-based and freestanding providers, it's important for us to understand why costs might be different in hospital-based units. Typically, we have found in analyses of other hospital-based providers, such as SNFs, that units have higher costs than their freestanding counterparts, and the challenge has always been to explain why.

So in looking specifically at distinct-part psychiatric units in acute care hospitals, we note a number of characteristics that might affect their costs.

First, IPF units may service a somewhat different mix of patients than freestanding IPFs. Psychiatric patients with comorbid medical conditions might be referred to hospital-based IPFs rather than freestanding facilities so that they can receive additional treatments or monitoring. Our research has found that units care for more patients with dementia and that they discharge more patients

to post-acute care. So this suggests a patient population that may be more resource-intensive.

There are also some facility characteristics that have nothing to do with patient mix. Units typically are quite a bit smaller than freestanding IPFs, so they have fewer economies of scale. And IPF units may, of course, have higher costs because of the standard practice of hospitals allocating overhead costs across all units in its facility. The effect of this practice may be that IPF units report higher overhead and total costs than they would if they only reported the costs of providing services to their IPF patients.

There are some other characteristics of IPF units that aren't quite so easy to categorize. Research has found that units typically have higher staffing levels than freestanding IPFs and that their patients use more nursing and staff time. What we don't know is if this is because units serve a more complex mix of patients or whether it's because there's a general standard of care in an acute care hospital that results in greater availability of nursing and other staff. And we also don't know if the additional use of nursing and staff time has a measurable effect on

quality.

And finally, acute care hospitals may have underlying reasons for operating psychiatric units that generally aren't factors in freestanding IPFs. For example, maintaining an IPF unit may improve a hospital's performance under Medicare's inpatient PPS. Our analysis of 2008 Medicare cost reports found that acute care hospitals with distinct-part units do have higher Medicare general inpatient margins than hospitals without such units.

As you know, it's not easy to tease out the relative effects of these variables. IPF units do report higher costs than freestanding facilities, but with the relatively limited information we have about psychiatric patients, it's difficult to say if those costs are because they care for sicker patients or if they have different quality of care or outcomes.

So by isolating freestanding IPFs, which we've done here, we can partially control for differences in staffing and patient mixes across facilities, and we can set aside concerns about the allocation of overhead.

So this is what you'll see here. We've looked just at freestanding IPFs. This is the cumulative change in

per diem payment and costs of freestanding IPFs from 1999 to 2009. Units are excluded, as I said, and also all government-owned facilities which have a very different cost profile. They are excluded as well.

As you can see, payments per day to freestanding facilities grew rapidly during the transition to PPS, climbing an average of 6.8 percent per year between 2005 and 2007, while cost growth generally was held below the level of the market basket, rising just 2.8 percent over the same period.

Between 2008 and 2009, growth in payments per day slowed to 3 percent, slightly less than the market basket of 3.2, but cost per day increased just 1.3 percent.

Here, we have margins for that same period, for those same freestanding IPFs. After the IPF PPS was implemented in 2005, Medicare margins rose rapidly for freestanding IPFs, climbing from 0.9 percent in 2004 to 19 percent in 2009.

CMS anticipated some increase in freestanding IPFs' payments and margins. That's because the PPS payment rates were calculated using cost data from both freestanding IPFs and hospital-based units, which, as I said, have higher

reported costs. So the new base payment under the PPS would thus be higher, generally speaking, than the cost-based payments freestanding IPFs were receiving before, and total payments would increase as the transition to the full PPS progressed.

We looked at the characteristics of freestanding IPFs with the highest and lowest margins. These are IPFs in the top and bottom 25th percentiles. As you can see in the second row, lower per day costs were the primary driver of differences between freestanding IPFs with the lowest and highest margins. Low margin freestanding IPFs had an average standardized cost per day of $735, almost twice that of high margin IPFs.

Moving to the third row, you can see that despite their much higher costs low margin IPFs average per diem payment of $708 was just 6 percent higher than that of high margin freestanding IPFs.

That average payment includes outlier payments, but I have broken out the outlier portion on the next line. You can see that payments for high cost outlier patients are much higher in low margin IPFs, but it’s not clear if this differential is due to differences in efficiency or in the

severity of the patients that they care for.

The average number of beds in low margin IPFs is 55 compared with 97 for high margin IPFs. So economies of scale may play a role in financial performance.

And the last thing to note --

MR. HACKBARTH: Dana, could you say how you define high and low?

MS. KELLEY: Yes. I'm sorry. Those are the top quartile of margins and the bottom quartile of margins, and then that margin that's shown there is the average for the group.

The last thing to note here is that the high margin group comprises almost entirely for-profit facilities. Since our analysis of margins also showed significant positive margins for for-profit IPFs in general, we decided to look more closely at their payment and cost growth under the PPS.

Here again, we have the cumulative change in freestanding payments and costs, but this chart breaks out the facilities by ownership. And you can see some interesting patterns here.

Nonprofit IPFs appear to be responsive to changes

in payments, adjusting their costs per day when payments per day change. By comparison, cost growth for proprietary IPFs has been very flat, even negative, in the last few years. Meanwhile payments per day have climbed dramatically. While growth in payments has slowed since 2007, negative cost growth has produced improved margins for the for-profit facilities.

As you know, there is no assessment tool in this setting, and so we sort of have to dance around the issue of severity of illness in these facilities. One thing we tried to look at here is if they have a different mix of cases and if that explains differences we're seeing in costs. We've collapsed the psychiatric MS-DRGs into the broad categories you see here. The 5 case categories represent about 98 percent of all cases in freestanding IPFs.

And we do see some differences. Nonprofit IPFs care for twice as many dementia patients and also more cases of depressive neurosis, organic disturbances and mental retardation and substance abuse. But for both types of facilities the vast majority of cases are still psychosis cases.

There's only one MS-DRG for psychosis. So the

payment for the majority of those cases is the same.

We also looked at source of admission as somewhat a proxy for patient severity. We posited that cases transferred to an IPF from acute care hospitals, SNFs or from the legal system were more likely to need additional nursing and staff time compared with patients who checked themselves into an IPF under the advice of a physician or a clinic.

From this angle, we can see more differences between nonprofits and for-profits. Patients in for-profit facilities are more likely to have been referred by a physician or a clinic. Patients in nonprofits are about twice as likely to have been transferred from an acute care hospital and are almost six times as likely to have been referred by the legal system.

These differences in costs lead us to wonder if we have a problem with payment accuracy. We, and other researchers --

[Laughter.]

MS. KELLEY: We, and other researchers, suspect -- we suspect that Medicare's payments are not well calibrated to patient costs and that there are systematic differences

across facilities that are allowing some patient selection to go on, which would mean that providers have an incentive to avoid admitting patients who are perceived to have greater resource needs.

Part of the problem, as I said, is that the information reported on the Medicare claim is the only patient information IPFs submit to CMS. So the payment system can't make any adjustment for patient characteristics that we know from previous research significantly affect nursing and staff time. These include deficits in activities of daily living and predisposition for dangerous behavior. Collecting this information would necessitate the submission of additional information or some sort of an assessment tool.

Another problem with the IPF PPS is similar to one we've seen in other payment systems such as the SNF PPS. When CMS developed the IPF case-mix groups and the weights, the agency based its estimates of routine costs on average facility costs because the data on patient-specific routine costs was not available. But by doing that, CMS established case weights that assume that the routine nursing and staff time is the same across all patients, whether that patient

is an older patient with dementia who requires significant one-on-one observation time and assistance with several activities of daily living, or younger depressed patient, for example, who has no ADL deficits and spends a significant portion of their day in group meetings and activities.

Since routine costs represent an estimated 85 percent of IPF costs, Medicare's payments for patients requiring high levels of nursing and staff time are almost certainly too low, and payments for patients requiring relatively little nursing and staff time are likely to be too high.

Reforming the payment system to more accurately calibrate payments with costs would reduce incentives for providers to avoid more costly patients. This would appropriately change the distribution of payments, and it might possibly reduce margins that we're seeing as well. I'm sorry, reduce the variation in margins that we're seeing.

Finally, we've been working on another aspect of IPF patients, and this is when you showed some interest in the past. I want to thank Kate Bloniarz and Carol Frost for

their assistance with this.

We wanted to show you some preliminary results from our analyses of health care by IPF users. As you noted in the past, adequate and appropriate ambulatory care can reduce the severity of mental illness, improve patient productivity and quality of life, and limit the need for inpatient care. So it's certainly an important part of the care that beneficiaries with mental illnesses receive.

We matched IPF users in 2009 to their claims for physician services furnished in physician offices and ambulatory clinics and health centers during the year. We included users of freestanding IPFs and those of distinct-part units in this analysis. We found that overall beneficiaries who had an IPF stay during the year averaged 14 physician visits during the year compared with about 10 visits for all beneficiaries.

We also looked at the use of physician services within the 30 days prior to an IPF admission. This is a time period during which a mentally ill beneficiary might be spiraling down to the point where inpatient care is needed. We found that only 46 percent of IPF users had a physician visit within 30 days of admission to an IPF and only 16

percent had seen a psychiatrist during those 30 days.

We also looked at the post-acute care services IPF users received and compared their PAC spending levels across different types of IPFs. We note two things.

First, as a group, IPF users had more than three times as many SNF days as the average fee-for-service beneficiary.

We also saw substantial differences in SNF and home health spending, depending on where beneficiaries received their IPF care, and that is shown here in the last two bullets there.

Users of freestanding IPFs had an average $2,000 in SNF spending in 2009. SNF spending for users of IPF units was almost twice as much, and spending for users of scatter beds was even higher, averaging about $4,500. We saw a similar pattern with home health spending.

So this also sort of lends credence to our theory that there are differences in the types of patients that are treated in these different IPFs.

So to sum up, we're continuing to gather evidence that payments under the IPF PPS are not well calibrated to patient costs and that this provides an opportunity for

patient selection that may place some providers of inpatient psychiatric care at a disadvantage.

Again, this is not unlike the problems we've seen in the SNF and home health PPSes, but in those payment systems we had data from assessment tools to provide much more patient information. Because of the relative scarcity of information on IPF patients, we're forced to go at this problem rather indirectly. In proving the accuracy of payments, like I said, will likely require more information from facilities about their patients.

We've got some ideas for next steps with a goal of helping CMS identify promising pathways for payment reform. We hope you'll weigh in on these and make any additional suggestions you might have.

First, we plan to explore whether there are ways to improve the payment system using available data. CMS, in the past, contracted with both RTI and the Urban Institute to develop and test the IPF PPS, and their work does suggest some tweaks that could be made, such as decompressing the case-mix adjusters to effectively increase payments for high weighted MS-DRGs and decrease payments for lower weighted MS-DRGs, and refining the length of stay, the day of stay

adjusters.

Currently the length of stay adjusters are applied to the day of stay, but that's actually not the way the regression analyses were developed -- the upshot being that patients that have shorter lengths of stays probably don't have payments that are high enough and patients with longer lengths of stays are probably paid too little.

We'll also consider whether there are other data sources already available that could be tapped to provide information about patient differences that affect costliness, for example, HCC scores and other things like that.

And in addition, we can consider whether changes to the outlier payments could provide greater relief for facilities that care for the costliest patients.

Looking at longer-range improvements, we'll consider whether an assessment tool would be a useful addition to the payment system, whether the burden of doing so would be worth the added information and accuracy. As part of that, we'll determine whether there are tools that are already out there being used by providers or the private sector, private insurers, that could be adapted for use by

Medicare.

So I'll end there, and I'm happy to take any questions.

MR. HACKBARTH: Thank you, Dana. Good job.

I think we're on this side for -- the other side. Scott, clarifying questions.

Peter.

MR. BUTLER: So I'll make a statement and turn it into a question so it qualifies for round one.

The statement is that there is a suggestion that hospitals that have hospital-based units have higher profit margins, and therefore, that must be a good thing. I suspect that those same hospitals are probably doing pretty well anyway, and they're just not as willing. They don't get rid of it as quickly as some other institutions that are financially stressed, and that's why they have it. It's not that it props up. They can just afford to continue to have it where some can't.

So now I'll turn it into a question. When you look at the hospital-based units over -- you know, they've decreased in numbers. Can you -- do you have any data that says how many have opened distinct units in the last two or

three years? Probably not many, but I'd like to know the number.

MS. KELLEY: It's not easy to determine with the data that we have, but I think your assumption that it's very few is probably accurate.

DR. MARK MILLER: Some of that also -- I mean a hospital can either do that or put the patient in a scatter bed.

MS. KELLEY: Yes, they can.

DR. MARK MILLER: That's why it gets a little bit complicated. So I may not have, or you, or whoever may not have a unit but may be handling those patients more throughout the beds in the general units.

MS. KELLEY: And one of the things that I didn't put up in the slide but we've been talking about internally is making an effort to talk more with some hospitals that have closed IPF units or have kept them open, to get a better sense for the types of factors that go into those decisions.

MR. BUTLER: I'll just comment quickly just to close the loop. I've been at three different places now where every time this is a big loser, but there's often

still a little bit of a contribution margin of keeping it open. And so, the payments exceed the direct costs, and if you don't have something else to put in that unit, you're better off having it than not even though fully allocated costs is a bigger loser.

So that's typically what goes through thinking.

MR. HACKBARTH: Clarifying questions?

DR. BAICKER: Just one question about how much you can learn from the data that you have available. My -- if I've understood correctly, there's limited granularity at the patient level because of the current system.

MS. KELLEY: Right.

DR. BAICKER: Do you have a sense of given the covariates that are available beforehand, the usual risk adjusters, how good a job those do at predicting the hospital-level costs, or some proxy for the patient costs, to get a sense of how good a job risk adjusters might do?

Is there something fundamentally different about this class of patients such that we're not going to get very far with the usual risk adjusters, or is it just impossible to tell from the data? Or, could we get pretty far if we could just do the risk adjustment we wanted?

MS. KELLEY: The analyses that were done to establish the PPS did find that there were -- did find good predictability with some variables such as limitations on ADLs, whether or not the patient was a danger to him or herself or others, kind of the things that basically directly affect the staff and nursing time that a patient needs, whether it's observation time or direct hands-on care. Those were significant predictors of costs.

So there are some things that were uncovered in those analyses, but that, because of the lack of information on claims data, could not be initially adapted into the PPS.

DR. MARK MILLER: I think one of the things that we're trying to say, like for example, where it says HCC, is could you go out and find one of these proxies, which I think is what you're reaching for, and would that help boot-strap you into this discussion. And I think that's part of the agenda, to see if we can do that, but we're not up to doing that ourselves.

And just to clarify the statement you made there, that was a collection of data on some patients that were done for the purposes of putting together -

MS. KELLEY: Yes.

DR. MARK MILLER: -- the payment system, which is not collected.

MS. KELLEY: Exactly. That was actually a time and motion study that was done by RTI on 40 or 50 IPFs, looking at all patients, not just Medicare patients, and getting a sense of how patients spent their day, how those days differed across different patient characteristics. So there's lots of information on that group, not so much on the larger Medicare population.

DR. BAICKER: And what I was getting at, which you were getting at correctly, is based on data we would actually have on hand --

MS. KELLEY: Exactly.

DR. BAICKER: -- how good a job are we going to be able to do, or does it turn out that the predictors are stuff that's just not available universally so that we're going to have a really hard time constructing risk adjusters that work for this population.

MS. KELLEY: Without additional collection of data, you mean. Yes. Right.

DR. BAICKER: And stuff that would be available for literally every beneficiary, not correlations that are

available --

MS. KELLEY: Right.

DR. BAICKER: -- from survey that we know are predictive but that we're not going to have when you get your next patient.

MS. KELLEY: Right.

MR. HACKBARTH: Tom.

DR. DEAN: Well, just a follow-up. Do you have access to the actual diagnosis for these patients? I mean the one DRG obviously encompasses a huge range of different patients. Do you have access to the ICD-9 codes?

MS. KELLEY: We do. We have all the underlying ICD-9 codes. So we're able to look at whether or not there are differences in the actual diagnosis of say psychosis patients across different kinds of facilities.

What we still don't have is the severity of those conditions. Research has -- it's been well established in research for many years that the DRGs are not a good predictor of costs in these patients. They simply don't capture the severity of illness between depressed patients or between patients with bipolar disorder. And they're not particularly useful clinically for mental health

professionals either, who use -- generally really on the DSM to describe their patients.

So even with the underlying ICD-9 codes, we're lacking the real information that's needed to describe the costs of patient care.

DR. CHERNEW: I have two loose clinical questions.

The first one is there's basically three types of settings that are discussed here. There's hospital-based IPFs, there's freestanding IPFs, and there's scatter beds.

MS. KELLEY: Yes.

DR. CHERNEW: Is that pretty much the universe of places where these people would be cared for in --

MS. KELLEY: For inpatient care?

DR. CHERNEW: -- an inpatient setting?

MS. KELLEY: Yes.

DR. CHERNEW: And my second question is how discretionary or not -- I don't know if that even makes sense -- is the inpatient treatment?

So I assume there's a lot of people with the conditions that we're discussing here, that at any given time aren't in a hospital. They're being cared for in the community or in some other way.

MS. KELLEY: Sure. Yes.

DR. CHERNEW: And so, how discretionary is the actual hospitalization?

MS. KELLEY: I'm not sure. Did they choose to admit themselves, do you mean? I don't understand what you mean.

DR. CHERNEW: Well, no, I'm not saying it's necessarily on their part. I'm saying in the system, you know, you see someone admitted. I'll give you maybe an example.

MS. KELLEY: Okay.

DR. CHERNEW: If someone has a heart attack, you can pretty much assume that if people have a heart attack they're going to be admitted, with some exceptions. I'm not sure that's true in this case.

MS. KELLEY: No, I'm not sure it's true either.

There are partial hospitalization programs that can be used for some patients. There is this issue of what they call boarding in the emergency room, where some patients hang out in the ER for a long time.

DR. CHERNEW: And how are they paid?

MS. KELLEY: Under the outpatient PPS.

There are less sort of -- I think it's fair to say that there are less clinical guidelines that draw bright-lines between patients in terms of the proper site of care.

I don't know if I'm answering your question.

MR. HACKBARTH: So you could imagine this might be one of the Dartmouth supply-sensitive services.

MS. KELLEY: Well, we do see big differences in use across geographic areas in our data as well. But without the whole, the full universe of information about the other care that patients receive, it's hard to say sort of what they're getting instead.

And of course, we don't have easy access to Medicaid information. Since so many of these patients receive care under the Medicaid system, it's also a hole in the information we have about the entirety of their care.

DR. MARK MILLER: We don't want to give the impression that these admissions are uniformly optional.

MS. KELLEY: Oh. Oh, no, no.

DR. MARK MILLER: All right.

DR. CHERNEW: I wasn't implying that. I was just trying to get some sense of how wide that segment is.

MR. KUHN: Some are court-ordered. I mean on the

boarding issue every hospital you'll talk to is, over the weekends, they can't find people to take care of these folks. Over the weekends, law enforcement has a difficult situation with someone in jail, and they just take them down to the hospital emergency department.

I mean you name it; it happens.

MS. BEHROOZI: Yes. I just wonder if there's a use to overlaying demographic characteristics like race and socioeconomic status, at least by Medicaid eligibility, over the profitability, or somehow to get a little more at some patient characteristics that might have a relationship to cost.

MS. KELLEY: Okay. That's definitely something we can look at.

Can I just go back to Mike's question for just one second?

I think the other important factor that is important in the care for patients with serious mental illness is just the level of social support they have. So you can imagine a patient who is in a crisis but is living with their family and has support at home. They might have different options for treatment than someone who's homeless

or without that kind of social support.

DR. CHERNEW: But you wouldn't expect a change in payment to change the availability.

MS. KELLEY: I do think that those support factors can affect the cost of caring for patients. You know, finding an appropriate place to discharge a homeless person is going to take the staff at an inpatient setting a lot longer than if you're going to send someone home with their spouse.

MS. BEHROOZI: Yes, and also, you did have some statistics on the rate at which people had seen a psychiatrist prior to their admission, and for African Americans it was much lower.

MS. KELLEY: Right.

MS. BEHROOZI: So that would also be something that to a lay person would kind of indicate that they might be in worse shape --

MS. KELLEY: Right.

MS. BEHROOZI: -- than those people who had had ongoing psychiatric care.

So to the extent that those characteristics are proxies for exactly what you're talking about, it might be

useful to overlay them.

MS. KELLEY: Okay. Thank you.

DR. BERENSON: Yes, and one issue -- I'm back at the starting line. I missed something very basic, which is if a patient is admitted to a distinct-part psychiatric unit or a scatter bed of an acute care hospital they are paid under IPPS? They're paid under what?

MS. KELLEY: Patients in distinct-part psychiatric units are paid under the IPF PPS --

DR. BERENSON: Okay.

MS. KELLEY: -- just like freestanding IPFs. Patients in scatter beds are paid under the inpatient PPS --

DR. BERENSON: Okay.

MS. KELLEY: -- on a discharge basis.

DR. BERENSON: Okay. So that helps.

So then my next question is if a patient is admitted to a general medical floor, coming through the ER with erratic behavior. You're ruling out medical problems. You then make a diagnosis, transfer the patient. Is it the transfer policy that then pertains? How does that work?

MS. KELLEY: There's no -- what am I trying to say?

We have a very -- it is a new payment if they switch from one facility to another.

DR. BERENSON: It's a distinct-part unit in a hospital. They've been three days on the medical floor. They're now transferred to psych, which is what I used to do. I used to transfer lots of patients to psych. Are there two payments being made?

MS. KELLEY: I need to double-check on that.

MR. HACKBARTH: Are you saying within the same hospital?

DR. BERENSON: Within the same hospital.

MS. KELLEY: I think Craig actually has the answer for us.

MR. LISK: Yes. The transfer policy would be applied so that we get two payments. So you would have if the transfer policy applies to that DRG they would get a reduced inpatient DRG payment and then the other.

DR. BERENSON: So then on slide 4, where we're comparing performance or spending and payment per day between IPFs and scatter beds, we're comparing one facility that is being paid on per diems and another one that's being paid on DRGs.

MS. KELLEY: Yes, that's right.

DR. BERENSON: So that would go into my thinking about explaining some of these differences although I do think there's a case-mix difference as well.

But, thank you.

MR. KUHN: Dana, thanks again for this. It's good follow-up from the previous discussion we had a year or so ago on this issue. So, two or three quick questions here.

One is on the CMS work on the assessment instrument, are they currently contracting with any vendor to develop that assessment instrument, or has that work completely stopped and not going anywhere right now?

MS. KELLEY: I don't know of any official work that's going on at this time.

MR. KUHN: Okay.

MS. KELLEY: Right now, CMS is working on developing quality measures that they're required to put into place under PPACA, beginning in 2014. So there's been work, a fair bit of work, that's been going into that effort.

What is coming out of that effort is that virtually all of the measures that clinicians are

recommending for use in IPFs require more than just administrative data. So I'm not quite sure where exactly --

MR. KUHN: Okay.

MS. KELLEY: -- you know, what exactly is going to be recommended.

MR. KUHN: And kind of on that same boat of CMS, you know this is a maturing PPS system. I think it was finalized in 2005. So usually about this time CMS goes in and looks at the PPS systems and make refinements.

MS. KELLEY: Yes.

MR. KUHN: Where are they in their schedule of refinements to this system and will they be making their own set of recommendations?

MS. KELLEY: I don't know when they'll make their own set of recommendations. They said in the last -- in the last I've spoken to them, they are finally feeling now that they have enough data to be able to start thinking about refinements, but I don't know what their plans are for the upcoming rate year.

MR. KUHN: Okay. And then finally, the outlier pool, how big is the outlier pool in terms of percentage and how accurate is CMS predicting? Is it all spent?

Are they overshooting, undershooting?

Where are they on that, generally?

MS. KELLEY: It's 2 percent of total payments, and they -- I'd have to go back and look at the overshoot/undershoot question.

MR. KUHN: Thank you.

And one final thing, on slide 5 you talked about the array of IPF facilities. Government facilities were 16 percent. You didn't talk about their financial performance. What do we know about them?

MS. KELLEY: I haven't looked at the government facilities' financial performance. Their cost structure is so completely different from that of the other IPFs.

They really are a different animal in many ways. Their lengths of stay average more than twice as long. Many of the patients there are long-term patients. Many are forensic patients. They really are very different from the other IPFs which generally serve a short stay population to try and get them back into the community.

They also have other sources of funding typically.

So I haven't looked at that.

DR. HALL: On slide 7, you list the top IPF

discharges by MS-DRG. So here it makes no difference. Three-fourths of the diagnoses fall into one DRG. This is so unusual, and as you already mentioned, it just screams out for refinement because in that DRG 885 is such a -- I can tell you just an incredible array of patients.

MS. KELLEY: Yes.

DR. HALL: It might mean someone who is -- well, now we're talking about people who are Medicare-eligible.

But a depressed person whose spouse has died and they threaten to commit suicide, they have virtually no nursing care needs -- they just need to be taken care of -- versus a violent criminal brought in off the street who has just tried to assassinate somebody. So it just cries out for that.

So if you took just that DRG would the differential between cost and margin be widened or shortened, do you think? I'm guessing it's going to be widened.

MS. KELLEY: Yes, I would guess it would be wider, but I haven't looked at it and I don't know.

DR. HALL: All right. So I mean I think that's a place to do a lot of data mining and just pull it out.

And I have just one other question. We didn't look at anything about Medicare D in this whole thing? That's not included in any of these expenses, or is it?

MS. KELLEY: About Part D?

DR. HALL: Yes.

MS. KELLEY: I don't have that here. That is something we looked at in our June 2010 report. Off the top of my head, I don't --

DR. HALL: But it wouldn't -- it's not reflected in these numbers or these?

MS. KELLEY: No.

DR. HALL: Okay. That's all I wanted to say because there's so much variability in --

MS. KELLEY: yes, and that is something we can look at further.

DR. HALL: -- brand name and generic drugs.

Thank you.

MR. HACKBARTH: Given the heterogeneity of that DRG, you would think that the financial performance would be highly variable because of the dramatic difference in the patients. And so, at the institutional level, a key question would be do these patients get sorted

systematically to different types of institutions, and if they are, you might see extraordinarily high margins for the institutions that get the better end of the cost distributions and extraordinarily bad margins for the ones who have your criminal patient.

Bruce.

DR. STUART: Yes, if you can move back to slide 6, please. This is again trying to figure out a little bit more about who these people are, and I'm struck with the high rate of under 65 and most of those being duals. And I'm wondering whether the small, relatively smaller number, 41 percent who are over age 65 -- do you know the percentage of those who were former SSDI?

MS. KELLEY: I don't, but that is an interesting question.

DR. STUART: Because part of this, I think, gets to the question of whether we're dealing with the same people over and over and over and over again, or whether this is more spread broadly. So that would be easy to check.

And then also, do we know the sex differences, the proportion that are males and females? You have a chart in

the table. I mean you have a table in the chapter, but it doesn't show the sex breakdown.

MS. KELLEY: As a group, the sex differences are not that stark, but by diagnosis and by eligibility, they are. The psychosis patients are more likely to be male.

DR. STUART: Yes.

MS. KELLEY: The dementia patients are more likely to be female. And the age breaks out that way as well.

DR. STUART: I guess I'm not surprised by that, and that leads to my final point, and that is it possible to identify veteran status to these individuals.

MS. KELLEY: I don't know. That's something we can look into.

Can you speak a little bit more about --

DR. STUART: Well, when I look at that age distribution I'm wondering whether we're looking at some -- well, it's not Vietnam anymore, but now it would be early Iraq and Afghanistan.

MS. KELLEY: Okay. Thanks.

MR. GEORGE MILLER: Yes, slide 14. It would also be helpful. Do you have a map of where all of these are located? Just wondering if they're mostly concentrated in

urban areas, particularly those that are nonprofit and not making as much money as the for-profit.

MS. KELLEY: I don't have that. It's very easy to do.

MR. GEORGE MILLER: Okay.

MS. KELLEY: So I can break that out for you.

MR. GEORGE MILLER: Yes. And I'm wondering if the -- what the reason is for the difference in cost because it's a pretty pronounced difference in cost per day and wonder if there are any conclusions we can draw from that.

But the reason I want this chart -- do we have this demographically also, where they come from, the social demographics, very similar to Mitra's question about where? Could you overlay that here?

MS. KELLEY: Yes, I can do that.

MR. GEORGE MILLER: Yes, that would be helpful.

Thank you.

MS. KELLEY: Okay.

MR. GRADISON: I just have a couple questions. If there are any publically owned for-profits, it would be interesting just to see what their financials look like.

MS. KELLEY: That's a very interesting point.

For this year that I'm looking at, 2009, there were two major publically traded freestanding IPF companies. Since that time, in 2010, one has bought out the other. So now there is one company that owns a very large share of the freestanding for-profit IPFs, and they are consistently rated very highly by the financial industry, so in general, are considered to be doing quite well.

MR. GRADISON: Well, in addition just to the very important question of how they're doing financially, which is actually I guess what I was asking about, it may be that some of their public reports would give a little more insight into the breakdown, their breakdown of their patient load or other things that might be relevant.

MS. KELLEY: Yes. The details typically are limited to the distribution of payers and less about the actual patient information. But they do have to make those reports, and that is something that I do try and pay attention to.

MR. GRADISON: And finally -- and I'm not sure where this question would go, and what I'm referring to may be out of date, but my sense is that there, at least at one time, was a great deal of pressure within these institutions

to de-skill, to substitute lower skill levels, which I took to be a reflection of cost pressures. Now maybe it was just trying to make more money. I don't know.

But are there data available that would give you any insights into ratios of psychiatrist to the patient load of a facility, or clinical social workers or any of the major categories of the skilled personnel?

MS. KELLEY: We can look at some details of skill mix from cost report data. I don't know how detailed it would be in terms of like physicians. That's something I would have to look at more closely.

MR. GRADISON: Thank you.

DR. CASTELLANOS: This is round one, correct?

MR. HACKBARTH: That's correct.

DR. CASTELLANOS: Okay. One of the things that I see in our community is bed capacity. I can't find a psychiatric bed. Have you looked at that and found out what the bed capacity?

I'm sure there may be a geographic variation, but I think that would be very interesting for me.

MS. KELLEY: Okay.

DR. CASTELLANOS: Another one, and it really is

access to care. Now I know on slide -- was it 16? It said that 16 percent of these patients who are admitted had a psychiatric visit within 30 days. Is that because of an access problem?

MS. KELLEY: I don't think we know.

DR. CASTELLANOS: Let me comment on that in round two if that would be okay.

MS. KELLEY: Okay. Sure.

DR. CASTELLANOS: And of course, that goes along with the workforce problem. We have a significant problem with workforce -- the number of psychiatrists that participate in Medicare, et cetera.

I know we're talking about finances, but we're also talking about care.

MS. KELLEY: Sure.

DR. CASTELLANOS: Have you looked at the workforce problem, the professionals, similar to what Bill just mentioned? I think that would be interesting too.

MS. KELLEY: Okay.

DR. CASTELLANOS: Okay. Thank you.

MR. HACKBARTH: Ron, if you want to go ahead and complete your point, you don't need to hold it for round two

if there's something else that you want.

DR. CASTELLANOS: Okay. Well, I'm just going to make some real-world observations. You know, a lot of you don't live in the real world. You live in the Beltway.

A lot of -- you know, I can tell you that we're dealing, in the Medicare group and in the non-Medicare group, with a very vulnerable, vulnerable population, and this is a real serious problem. I'm sure the hospital administrators here can talk on that.

You talked about Baker Acts and putting the people in the emergency room on a bed there for days because we can't find access to care.

We can't find, in our community, psychiatrists. We finally have one that will come to the hospital but refuses to come to the emergency room.

I have a personal issue with a family situation, not myself or my wife, but one of my children had a very serious problem in a different city where I live in. You know, in my community, I don't know if I have some influence, but I have a little bit of influence. In a larger city, there's no influence.

And I couldn't get her access to care, and she had

good insurance. There wasn't a problem with that. I just could not get access to care, either as an inpatient facility or for a psychiatrist and finally had to go through an emergency room to get her into a hospital where it was a serious, serious problem.

I notice the hospitals where I work at, boy, they are building outpatient facilities. They're building ORs. They're building orthopedic units, and they're building neurosurgery units. I don't see any psychiatry units being built.

And it was very, very interesting. I went out and visited out in Billings, Montana, and he showed me around his hospital. Nick showed me around his hospital, and he showed me this building being built and this building. And I said, Nick, where are your psychiatry beds? He didn't have an answer.

So what I'm trying to say to you -- and I know this is a combobulation of a lot of things, but this is a real serious problem in the real world. And as Tom will tell you and I'll tell you and I'm sure Bill will say that we have a very serious problem dealing with this most vulnerable population.

DR. BORMAN: As you explore potentially workforce items, and I'm not sure exactly how you would get at it, but there are certainly a subset of folks who self-designate as geriatric psychiatry, and I think that maybe knowing a little bit about those numbers might be particularly helpful and/or units that portray themselves as geriatric psychiatry --

MS. KELLEY: Okay.

DR. BORMAN: -- units because I think that there may be great -- with the increasing number of patients that enter this degenerative neurologic disease, which I believe is where Alzheimer's, dementia and so forth live under, under that characterization on here, you know, that certainly interdigitates in a big way with the Medicare program.

And so, my impression is that the geriatric psychiatry units are pretty few and far between, and knowing something about that --

MS. KELLEY: Okay.

DR. BORMAN: -- and access to them and to those practitioners may help us inform this conversation about things we might want to try and reach out to support or

incentivize, or whatever, as we consider what things may be less productive.

MR. HACKBARTH: Okay, round two comments.

Scott.

MR. ARMSTRONG: Yes, just briefly, and I want to acknowledge that Ron and I really agree on this, and there are a lot of things we don't agree on. So I thought it was worth acknowledging.

[Laughter.]

MR. ARMSTRONG: And I am from the real world, and even though I'm not a doctor, but --

[Laughter.]

MR. ARMSTRONG: I think the direction that this evaluation is headed in sounds very good to me. I really don't have any adjustments to the description of next steps except, as Ron was saying, we spend a lot of time working on how we do a much better job of early on, well before the need for acute care services, that we're serving populations of patients who can be very well served, and primarily are well served, before they need acute care services. And I just think we ought to think about how access to those kinds of services might influence some of the findings and

assessment that we're doing here in the acute care side.

MR. BUTLER: So we have a child psych unit. We have two adult units. We have a geriatric unit. We have a day intensive outpatient program. So we have a big commitment to this.

But I have to say, and I'd like to think, that we could be, or I could even be, a big contributor to identifying the distinction between the kinds of patients that are treated in our organization versus in a freestanding. I can't.

So I'm struck with the call it your literature review or your references, how little has been done and how little has been done lately, to you know, to look at the issue and help provide some scholarly assistance.

And I don't think we even hear very often from the psychiatric leadership about some suggestions. So if you're in the audience, we'd love to hear from you.

But I ask that as question. Other places -- you know, when we look at case-mix and other things in almost any other services we look at, it seems like there are far more people looking at the issue than in this area. Is that true?

MS. KELLEY: I don't know how I would compare the two. The write-up you have is not a complete review of the literature, so I'm sure there are -- I know there are -- studies out three, recent studies that are not included in this. I'm not sure how I would compare the two.

You know, I think in general this is a very, as we've said, vulnerable population and a relatively small population among Medicare patients. And so, perhaps it doesn't get the same kind of attention.

MR. BUTLER: So I'm struck, Glenn, by your comment in our last session about the rural and the data doesn't say it all. This is kind of a little bit like this too. You know, trying to understand people that are in the middle of this might help provide a little bit more guidance and insight about how patients are ending up where they are.

MS. UCCELLO: Yes, Scott kind of made my point with respect to trying to understand this more broadly in terms of looking at community-based care that may help stave off the need for this acute care.

But it sounds like -- I mean one way to look at this might be to say okay, look at people with similar diagnoses and see how they differ in terms of whether or not

they end up needing that acute care versus not. But it sounds like those data aren't available.

MS. KELLEY: The problem is really controlling for severity of illness, and we struggled with this in trying to define episodes of care and the best way to go about that. And it's something we're still working on.

So you know, we're still trying to get at it better and trying to see if there are differences, and we'll just keep plugging away.

DR. DEAN: I guess I don't have a question. This is just a comment that this is really an area where coordination between the different elements of the system is so important and very often is poorly, poorly handled.

Even in my area we have reasonable access to an inpatient facility. It's a long ways away, but we usually can get the beds. But the coordination and the follow-up and making sure that once the inpatient treatment is completed that there's some kind of coordination afterwards is just a constant headache.

You know, I don't have anything to offer, but somehow if whether it's -- I don't know. Whether it's some place where bundling has a role or something, but the

coordination, which has huge implications in terms of how effective the long-term treatment is, is really a challenge.

DR. CHERNEW: Yes, those comments illustrate sort of my longstanding belief that measuring things by provider or type of provider we obscure the underlying clinical things that we care about, and this is a perfect example of why we do that.

Even apart from bundling for payment, just in measurement, just in seeing here's what's going on in costs for people with psychoses, apart from the subset of them that happened to be admitted in IPF but not a scatter bed, or freestanding versus not, to get a whole. When you look at TEFRA versus the prospective payment system, we're only looking at a subset of patients, and we want to see how it affected a whole patient population.

The problem, which is what I was really going to say, is our data seem so bad I'm not even sure we can capture all of the people in various ways that have these conditions. It seems remarkably hard to case-mix one way or another.

And the challenges in the written materials, you see these paradoxes like a decline in the number of

hospital-based facilities. And then, there is some discussion -- well, maybe they're not so profitable. And you begin to think well, we're not paying enough.

And then, you see this increase in for-profit facilities. And so, you know, generally speaking, when you see for-profit beds increasing, someone is finding out to make some money somehow.

So there are two possibilities. One is they're more efficient, and there's some discussion in the text -- well, there's more staff in this place and not that place. So maybe we really should feel good that there are some efficient things going on.

And then, you worry though that we don't have good quality measures. And so, there's another hypothesis that you're having these bad quality facilities coming in and driving out the good quality facilities and making big margins, and we see that in some of the other long-term care. We have this exact same discussion when we do long-term care stuff.

So I'm left with uncertainty about what to do except to start with trying to figure out what the best data we could get is and try and bring some data into this

process. And that's data -- you know, it's sort of at a patient level because, otherwise, I think we're going to be stuck in this morass that we're often -- you know.

Some of Tom's margins, we want to lower the margins, but others aren't, and we can't tell what the quality is. I think that's where the challenge is going to be throughout all of this whole -- [Off microphone]

DR. BERENSON: Yes, just very briefly, I guess I would concur first with Mike that we really need to get data here to really understand stuff. But the data that I think -- I mean this; there's a sort of -- what's the word? Code creep isn't it. Issue creep.

I mean I'm with Ron a little bit, to try to understand why it is so sort of undesirable to maintain psych units within general hospitals and why freestanding ones, as far as I can tell -- and there may be some for-profit entering for some reasons, but I know a lot are shutting down. I believe that's right. And I think that may be related to cutbacks in Medicaid spending.

But I'd like to understand the dynamics a lot more on the sort of case, the payer mix, what will happen under health reform, potentially, with payer mix, what kind of

benefits do people have, if any, in private insurance -- sort of get a bigger picture of the situation for the facilities themselves and then try to figure out how the Medicare piece fits into that.

And for nursing homes, I think we now have a pretty good understanding of the interaction between Medicaid payments for sort of residential and Medicare's payments for skilled nursing and nursing homes, and the small role of private insurance.

I don't have that same sense here, and so I'd be interested. And then, we might have a little better clue as to why Ron's phenomenon is occurring.

And yet, I am a little worried that we're going afield. That's not directly related to sort of refining the payment system for psych hospitals, which has to happen.

So I don't know how quickly you could do what I would want to do, but to me, that would be the ultimate goal is to understand that.

MR. KUHN: Also, picking up on that same theme that Bob had -- and Ron kind of started talking about the infrastructure -- this work is critical in another dimension here. And that is as many states continue to grapple with

their budgets and have walked away from behavioral, supporting behavioral health and closing facilities, their reliance more on private hospitals, independent psychiatric facilities, et cetera, is growing more all the time. And so a chance for us to look at this payment system, to help kind of stabilize that side, I think would do a good service in terms of kind of what's going on in the states and the dynamic that's out there.

I know in Missouri over the last decade we've closed 1,000 inpatient psych beds across the state, and that's probably not uncommon in terms of that level that you're seeing in other states that are out there. Obviously, some of that is being driven by better drug use. The Part D program has allowed people to be treated outside the hospital setting, which is a good thing. But nevertheless, there's always going to be a need for those inpatient psychiatric beds that are out there.

So anything we can do to help continue to stabilize that system by a refinement of this PPS system is good.

In that regard, Dana, on page 19 of your next steps, I think all those are good areas for us to spend

additional time and look forward to those further conversations.

DR. HALL: Well, you know, I think we have to keep in mind sort of the historical aspects of this. The reason there aren't so many beds anymore, it was a concerted effort by behavioralists a generation ago to say we don't need inpatient beds anymore. We have very powerful anti-psychotic drugs, and we can keep people out. So everywhere, New York State has closed virtually all their hospitals.

So now we have a population that I would bet is aging in place, and as they get older, they're going to be much more vulnerable and they're going to end up in the hospital more.

So now we say well, gee, there are no beds. How could this situation have developed?

I think this is worth looking at because there are a lot of hidden costs to Medicare involved in this population that aren't entirely reflected just in who gets admitted to an IPF.

Let me just tell you the typical scenario is somebody who's very agitated, maybe dangerous to others or themselves, arrives in an urban emergency room on a Friday

night, usually about 10:00. There's no family. There is -- well, now there is a record with EMR.

And the game that is played is one of it's called clearance. The psych resident will see the patient and say well, we need medical clearance because there's a slight fever, or maybe the glucose or some other metabolic parameter is a little bit off, or maybe the blood pressure is either high or low. So this patient better go to a general floor.

But the medical team is also involved in the clearance game, and they say well, this patient is too dangerous to be on our service. We don't have the facilities.

And they're both right, and they're both wrong, but the point is that the end result is that the chaos that involves is largely more related to strength of personality than it is to patient need, I would say, in many places.

So a lot of the expense here isn't even reflected because it's all taking place on medical services.

And then at the tail end of that, when it's time to discharge patients, you don't just transfer from the psych back to the regular hospital. You discharge, and all

of the redundancy and paperwork that gets involved in that.

So I think looking at particularly the big league diagnoses of psychoses will -- I think what you're going to find is that there are a lot of frequent flyers in here. It's the same population that is just rotated around over and over again.

And maybe we can get out of that some kind of statement that says this is a problem that not only sort of cries out for kind of rectitude from a clinical standpoint, but has extraordinary expenses to the Medicare system and that maybe there needs to be some -- a better way of certainly working with case-mix.

I'm convinced that that's where our issue is here. We're not able to really look at these patients in a way that's going to allow us to make informed decisions about payment and placement. So I think this is well worthwhile looking at.

It's going to get much worse, by the way.

DR. NAYLOR: So I agree with everything that's been said. I think two things that struck me in this report were I think the notion that 15 percent or fewer had any documented comorbidity in the end. So it's seems to cry

back to this notion that we totally need some continuing assessment that spans settings and so on.

MS. KELLEY: I just wanted to clarify that it's about 15 percent have a comorbidity that tweaks the payment.

DR. NAYLOR: It tweaks the payment.

MS. KELLEY: So there may be other comorbidities, but it doesn't affect payment.

DR. NAYLOR: It doesn't affect payment.

So I think we need -- I mean I think that's -- we've actually had this in multiple conversations. But for this population, to really understand -- we know the effects of psychiatric comorbidity on physical comorbidity and vice versa.

So I think it's if there's one opportunity here to think about promoting wherever it is, some kind of continued clinical assessment that would follow the person so you would begin to really understand what are the right case-mix adjusters, what are the clusters of health problems and issues that get to, and result in, the care delivery that's going on right now, and therefore, what are the opportunities to change that. I think that this really is a chance to reinforce this.

So I support all of your recommendations and think it starts with getting the right kind of assessment for everyone, regardless of setting, where they are.

DR. STUART: I'd like to follow up very briefly on my point about the veterans and related to the age of this population.

My guess is -- and it also responds to a point that Mike raised about availability of data. My guess is that you're going to find it difficult to obtain VA status and particularly disability status from CMS, but if you had access to the VA system you could find out easily who was qualified for Medicare.

Now you guys aren't going to be able to go into that system, but there is a literature talking about Medicare eligibility among the veteran population. Whether it addresses this issue or not, I just don't know. But to the extent that they're both government programs, at least there's certainly a possibility for coordination and clearly a need for better coordination, but it's something that I think deserves to be followed up with.

Thanks.

MR. GEORGE MILLER: Yes, very briefly, I'm just

wondering if there's a correlation between Medicaid payments in states that there's better access to care versus those states that don't have that.

I can think of two anecdotal stories when I was a CEO. Well, I better not call the state, but speaking of boarding. And I think as Tom said, before we could transfer a patient to a psychiatric bed or inpatient bed, we had to clear that patient medically. We had to have medical clearance, and they would not accept that patient until we had.

There could be nothing, almost nothing, wrong. We had to do a full assessment, virtually certify and send medical records there's nothing wrong with them medically before we could transfer that patient. And that meant that patient -- we had to -- in some cases, we had to do CT or MRI to get that patient cleared.

And if they were brought over by the police department or law enforcement, then we had to bear that cost because the police department said well, they're not under arrest, so you can't bill us. So we had several games we had to deal with -- a real-world situation.

And then, I moved to another state where we had an

inpatient psych unit on the grounds of our hospital. It was very easy to transfer them. We just called them. They would come over, do the assessment, clear them medically, and we would discharge them and send them to the inpatient facility. And that state had a better Medicaid system, so they were able to flourish. Now, with things changing with states, I don't know how much that will be, but that's something we may want to take a look at.

And then finally, it does make sense to get data so that we can make a full assessment of that situation.

MR. GRADISON: I want to think more about this whole issue in relationship to the sorry record this country has had in discrimination with people who have psychiatric problems. The lack of mental health parity, including in the Medicare program, I think it's fair to say, right from the very beginning in terms of payment responsibilities of the patient.

And I don't know what the significance of that may be. I certainly think it helps to, may help to, explain why you can't find a psychiatrist, even within the Beltway. I hate to mention this, but if you pick up the big, thick book the Blue Cross-Blue Shield puts out with their PPO and you

look under psychiatrists, I'll tell you it's a very short list, and no assurance that even if you call them that they've got time to work in new patients.

So what I'm saying may, or what I say in addition may or may not have a relationship to what we're talking about, but my sense is we're probably in a very slow transition from the way it was to the way it ought to be.

And whatever we discover -- and your report, excellent -- may reflect that Medicare is affected by these larger trends within the society.

DR. BORMAN: Just briefly, and maybe I'm over-reading it, but the part where you mentioned about 75 percent of the people have the diagnosis of psychosis. It seems to me one of the confounding factors we have here in teasing this apart is that that's fairly broad and nonspecific.

Perhaps, one of the things that we may need to point toward is making recommendations, or having text, that relate to how do we get better data. I mean we may, in the end, have to conclude that for lack of good data there's a limit to how far we can go down this road, but then that perhaps does leave us with an obligation to say what are

some of the data that would help us make a better decision going forward as we take a longer-term view about this.

And then the other thing, I did want to commend you on sort of looking at the pre-piece of did they have a visit before this acute admission and wonder whether or not there might be some value to be extracting, looking at the readmission group. Unfortunately, again, this psychosis sort of broad thing may preclude that. But finding out if we can ascertain in some fashion what, if any, are common features in the readmissions, there might be lessons for us there.

And that sort of speaks to the end point of the bundle as opposed to the pre-point. And as we've talked about so often, we'd like to know things about that pre/post, and I would hope that we go that direction a little more.

MS. KELLEY: When you say readmission, do you mean sort of our strict definition of readmission or do you mean the people who have repeated admissions over some length of time?

DR. BORMAN: I think that it would just be -- because we know so little about this, I think it might be

helpful to know do they have any kind of hospital readmission since we don't know whether it's to one of these scatter beds or what it may be within some relatively short time frame. If a whole boatload of these people are being readmitted within 30 days, it suggests we have some huge failure of our intervention. You know.

And maybe set two or three things we can look at. The universe of your time and the data we can get are constricted, but I think there might be a couple of things that might just be bellwethers, that we could say at least we're concerned about this and then in the future have to go forward.

In terms of being able to make concrete things now with available data, which is sort of what's on the table, I think we will experience some limits. But the things you proposed, in terms of going down those roads up there, seem very reasonable.

MR. HACKBARTH: Okay, so this has been an interesting and important discussion, and it evolved as we went through it. And we started with a focus on data that seemed to pretty clearly indicate a problem with the inpatient payment system, but as the longer we talked about

it the more the issues became not just an inpatient payment system issue but a much broader care delivery issue for a very vulnerable population, which you know raises the question, which we won't to try to answer now, of:

Does it make sense to try to address the inpatient payment system issue independent of discussion of the broader issues that exist in care delivery, or is this an issue that calls out for a more holistic approach, that we would look at not just inpatient payment system but issues that Ron and Bob and others have raised about payment for outpatient psychiatric services, issues about the benefit? There are a lot of different elements, potentially, in this conversation.

So that's food for thought. Do we try to break this into small bits, or does it really require a more comprehensive take? I'm too tired right now myself to think about trying to answer that.

[Laughter.]

DR. MARK MILLER: Well, one of the things that I was thinking that we could do because I think constructing the episode view, and this is not the first time we've heard this -- you've said some of this last time -- is given the

difficulty of the data, that will be hard too. And I think you were sort of saying can you really even find the person until they've hit the -- you know had the event and all that.

But there is one thing. When you think about workforce, you think about where. There were questions along the lines of: Where do these patients come from? Do all the admissions have to occur? Why do people keep this units open, or close them, or what happened in the community? The deinstitutionalization, drugs, but you know, by the way, we're investing all kinds. We have a big commitment to this.

One thing that maybe we should organize is the notion of talking more broadly to the caretakers, the systems that have them, the systems that don't have them. Look at some areas where you have a lot of capacity, you don't have capacity, maybe to see about the Medicaid. And walk around and talk a little bit to people, and try and come back to you with at least what we can pick up off of the ground from three or four different actors.

Meanwhile, we can do our usual stuff of looking at data that may end up being a cul-de-sac, but we can mess

around with that. But maybe we can at least try and come back with a richer picture to understand, touch some of these questions and see if there's a direction to go from there.

MR. KUHN: Glenn, I think Mark is right. A kind of a richer picture would be nice.

But the other thing that's probably going to influence our thinking, or might influence some of our thinking here, is where is CMS in terms of its refinement process because if they're going to issue a rule soon, you know our work will be more kind of reacting to a proposed rule out there and it will be just a comment letter versus something that's more front end to help kind of influence the discussion and some of the policy conversation. So that too, I think, needs to factor into our thinking.

MR. HACKBARTH: Thank you, Dana. Good work.

We'll now have our public comment period.

Seeing no one approach the microphone, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:22 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, October 7, 2011.]

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 7, 2011
8:32 a.m.

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

AGENDA PAGE

P R O C E E D I N G S [8:32 a.m.]

MR. HACKBARTH: Okay. Good morning. Our first session this morning is on reforming Medicare's benefit design, and, Joan, are you first?

DR. SOKOLOVSKY: Yes, I'll start. Good morning, everyone.

In our June 2011 report, we discussed the fee-for-service Medicare benefit design. At that time you said that the benefit with its high Part A deductible, comparatively low Part B deductible, and no limit to out-of-pocket liability was problematic. It leads to a small group of people owing most of the cost sharing. Cost sharing is uneven and varies by site of care. Most people, about 90 percent, get supplemental insurance, but if you have to buy it yourself, it's very expensive and not always available.

The most popular of the individual cost sharing actually fills in all cost sharing -- I'm sorry, I can't read this -- and leads to higher use of services -- both necessary and unnecessary services. Taking this into account, we begin today presenting some alternative benefit designs that begin to address some of these issues. Our goal today is to assess your interest in developing these

options for us to continue working on them for next month.

First this morning we will present our findings from focus groups we did with beneficiaries and near beneficiaries to get their perspective on what they look for in health insurance choices. Next Julie will present three options that start to address some of the issues that we identified last year. One of the options actually has more beneficiary liability than the current benefit design. The second option, the liability is pretty much the same. And the third option has less beneficiary liability than the current package. All of these options include an out-of-pocket limit on spending. Based on your discussion, we will further develop these in November.

With facilitators from NORC and Georgetown University, we conducted 13 focus groups with beneficiaries and near beneficiaries in Bethesda, Dallas, and Boston. Seven groups were composed of Medicare beneficiaries, and the other six were composed of individuals between the ages of 55 and 64. The participants had a range of health insurance arrangements and health outcomes and incomes. We screened the individuals so that their incomes were too high for Medicaid but not so high that they would be indifferent

to the relative costs of packages.

Future beneficiaries included those with generous employer coverage, several who were uninsured, and some who purchased individual insurance. All of the Medicare beneficiaries either had supplemental insurance or were in Medicare Advantage plans. Those in the latter group, the ones that purchased their own insurance, tended to have very high deductibles, some as high as $10,000. We asked them to discuss what they looked for when they made health insurance choices and to discuss possible tradeoffs that they would make in thinking about their Medicare choices.

Participants tended to evaluate benefit designs in terms of both their current insurance and their health status. They thought about benefit changes in terms of how much it would cost or save them compared to what they currently had. For Medicare beneficiaries who, remember, all had supplemental insurance, and some had very generous retiree benefits, they tended to see possible changes as a loss. Near beneficiaries were more interested in considering tradeoffs.

There was a lot of discussion of having higher deductibles to lower premiums in the context of an out-of-

pocket limit on spending. Several of those compared choosing a higher deductible with the way in which they chose automobile insurance, so people might choose a higher deductible and then get lower premiums, or they might want a lower deductible and are willing to pay higher premiums.

Several seemed comfortable with much higher deductibles, in the thousands of dollars, if they thought they could save that money in advance. They were not able to articulate specific amounts that they would pay for an out-of-pocket cap though either higher deductibles, higher cost sharing, or premiums. They also realized that their health risks and costs would increase as years went on, and most of them wanted the ability to reconsider their choices in an open season in future years.

DR. MARK MILLER: Joan, Glenn and I were just asking each other, the tradeoff point that you just made, is that for the near or is that for both?

DR. SOKOLOVSKY: That was for the near. I'm sorry. The Medicare beneficiaries were much less interested in talking about tradeoffs. They saw most tradeoffs as a loss.

Participants placed the greatest value on

certainty in making health insurance decisions, but all were very enthusiastic -- and this includes the Medicare beneficiaries -- about the idea of an out-of-pocket cap. Some said that fear of costs that would exceed their ability to pay was a primary reason for purchasing supplemental insurance. Some near beneficiaries thought that if there was such a cap they might be inclined not to purchase supplemental coverage.

All participants, both Medicare beneficiaries and near beneficiaries, did not like coinsurance. Many of them, including the near beneficiaries, were aware of the 80/20 split on Part B, and they knew that they could be liable for 20 percent of charges, but they also knew that they wouldn't know what those charges were in advance, and so they saw coinsurance as an open-ended liability that they could not, again, budget for. Because co-payments are known in advance, participants were much more accepting of them. They thought they were more predictable and, therefore, more acceptable.

Both current and near beneficiaries were familiar with the idea of limited provider networks. Participants tended to place a high value on keeping their own doctor,

and this included participants in Medicare Advantage plans who were very satisfied with their physicians. Some individuals said they would be willing to pay more to have an unrestricted network of providers, but others said they would be more willing to limit their network if they could be sure that they could trust the network that was being offered to them.

Now, Julie is going to talk to you about the distribution of cost-sharing liability within the current fee-for-service system.

MS. LEE: First we begin with a very quick review of the current cost-sharing requirements in the fee-for-service benefit. You have a complete list of these requirements in your mailing materials.

The basic structure of the cost sharing in fee-for-service Medicare is the following: a separate deductible for Part A and Part B; per day co-payments on hospital and skilled nursing after a specified number of days; and 20 percent coinsurance for most Part B services. But there's currently no cost sharing on some services, such as home health, hospice, and clinical lab, and there's no limit on the maximum cost-sharing liability a beneficiary

can incur.

As a result, in any given year, a small group of beneficiaries can have very high cost sharing. For example, this slide shows the distribution of cost-sharing liability for fee-for-service beneficiaries enrolled in Parts A and B for the full year in 2009. At the one end of the distribution, over 40 percent of beneficiaries had cost sharing under $500, but at the other end of the distribution, 6 percent had cost sharing over $5000.

Please keep in mind that these amounts are cost-sharing liabilities, not what beneficiaries actually paid out-of-pocket. Supplemental insurance, if you have it, would pick up a part or even all of these amounts.

One additional thing to keep in mind: This is a distribution in a given year. If we were to look at a longer time period, a much larger share of beneficiaries would have some high-cost years, especially as they get older.

As Joan mentioned in the beginning, the Commission has focused on looking at short-term changes to reforming Medicare's fee-for-service benefit design to address the following features: no limit on out-of-pocket spending;

fairly high Part A deductible and relatively low Part B deductible; and uneven cost sharing by type of service. In developing alternative benefit designs for you to consider today, we chose an initial set of three benefit packages to address these issues. All of them have an annual out-of-pocket cap of $5000.

The first alternative -- named the coinsurance package on the slide -- has a combined A and B deductible of $500 and 20 percent coinsurance on all Medicare services, including hospital. Its overall cost sharing is higher compared to current law. We included this option because it (or some variant of it) has been proposed and discussed by various policymakers. So it provides a useful reference point.

The second and third alternatives take the co-payment approach common under Medicare Advantage plans. At this point the only difference between the two packages is the size of the combined deductible, $750 versus $500. Both packages have a $600 co-payment per stay on hospital; a $20 co-payment on physician and $100 on outpatient visits; and $100 co-payment per day on skilled nursing. They also have a 20 percent coinsurance on DME and 5 percent coinsurance on

home health. The MA-neutral package -- that's the second column -- has an overall cost sharing that is roughly equal to current law, and the MA-plus package has cost sharing that is lower than current law.

We modeled these three options using 2009 data, and we'll be presenting the results in two steps. In the first step presented today, we apply the new cost-sharing requirements assuming current utilization patterns. And in the second step, in November, we'll model how people's utilization could change in response to the new cost-sharing requirements. Now Scott will present our preliminary results from the first step.

DR. HARRISON: For this project we are using a new database that we have constructed from many sources within CMS. For all Medicare beneficiaries, we know their enrollment in Parts A, B, D, and MA. We also know if a former employer is receiving a retiree drug subsidy for providing them with Part D coverage.

We also know if they are enrolled in Medicaid and if they are receiving the low-income subsidy for Part D. And we know if they have supplemental coverage that coordinates benefits with Medicare fee-for-service. This

means we know if employer-sponsored coverage, Medigap, or other insurance is filling in Medicare cost sharing for beneficiaries. Additional demographic information includes the beneficiary's county of residence, age, sex, race, and HCC risk score.

We have matched all this data to the beneficiary claims history data which includes Medicare spending and cost-sharing liability divided into the seven groups of services that Julie laid out on the last slide. We also have four measures of utilization: the number of hospital stays, outpatient visits, physician visits, and skilled nursing facility covered days. We do not have a home health measure, which is why our MA-style packages use home health coinsurance rather than co-payments.

So using the data I just described, we simulated cost-sharing liability in 2009 under the current system and under the three alternative benefit packages. We simulated the cost-sharing liability of more than 20 million Medicare beneficiaries who were enrolled all 12 months in both Part A and Part B and were not enrolled in Medicare private plans or Medicaid.

If you look at the last two rows, you'll see that

in 2009 beneficiary cost sharing liability in the simulation population averaged about $1,350, and the median was about $600. The coinsurance package increased average cost sharing to $1,550 and the median to about $900. The MA-neutral package yielded cost sharing just under the current package and a median above current law. The MA-plus package with its lower deductible lowers the average liability and moves the median significantly towards current law.

The introduction of higher deductibles and out-of-pocket maximums shifted in all three alternative packages the distribution of cost-sharing liability towards the middle of the liability distribution. Due to the higher deductible, there are fewer beneficiaries with less than $500 in liability under the alternative packages and no beneficiaries with liability above the out-of-pocket maximum of $5,000.

Now, I need to note that on the slide all the beneficiaries in the $5,000 to $10,000 range are actually at exactly $5,000.

Now, if you combine the first three rows, you'll see that under the MA-style packages, 82 percent and 85 percent of beneficiaries would have had cost-sharing

liability of less than $2,000.

We also examined the simulated changes in cost-sharing liability for 2009 if the alternative packages had been in effect. If you look at the light boxes at the bottom, you'll see that primarily due to the introduction of the out-of-pocket maximum cap, some beneficiaries would have liabilities more than $1,000 lower than under the current system.

At the other end of the distribution, the red blocks show that some beneficiaries would have liabilities more than $1,000 higher than under the current fee-for-service cost sharing due to the relatively higher deductible and other cost-sharing differences. And while you can't see this from the chart, most beneficiaries would have seen their liabilities change by less than $500.

Now, as Julie said earlier, it is likely that as beneficiaries age, they will have some years of low cost-sharing liability and some years of higher liability. So one thing I would like to stress is that the simulations are for one year, and while some options may show that more beneficiaries would have higher cost sharing in a single year, in the long run beneficiaries are more likely to have

some years where they would have lower liability under the MA-style packages.

Next month we will enhance our simulations with the effects of supplemental coverage, questions such as: How does liability transfer to -- I'm sorry. How does liability and cost-sharing changes translate to out-of-pocket spending changes? And how would the benchmarks -- how would the -- I'm sorry.

We will also break down the effects for subgroups of Medicare beneficiaries by type of supplemental coverage, for instance. Later, we hope to refine our analysis of alternative benefit packages by adjusting the packages based on your feedback and more detailed claims data. For example, we currently have a single co-payment for all outpatient visits even though we know some visits are simple office visits and others may be outpatient surgeries. We suspect that some differentiation may be appropriate there.

And finally are there other benefit designs to consider, other than the deductible, the co-payments, and out-of-pocket caps that we have presented today? We look forward to your discussion.

MR. HACKBARTH: Okay. Thank you. Round one

clarifying questions.

MR. ARMSTRONG: I think you just covered my question in the very last slide. These three packages that you've modeled don't include any consideration of the out-of-pocket costs for a Medigap-type plan, and you intend to model the impact on overall out-of-pocket costs for our next meeting. Is that correct?

DR. HARRISON: Correct.

MR. ARMSTRONG: Great. Thanks.

DR. CHERNEW: I have two questions. You mentioned some things like low-income subsidy and stuff, but you don't have any Part D in this. This is all A-B?

DR. HARRISON: That's correct.

DR. CHERNEW: And my second question is: When you do your simulations -- I think it was on Slide 11 or one of the slides where you did your simulations -- did you make any behavioral assumptions about people changing their behavior in response to the cost sharing? Or did you just take the utilization you saw and figured out if they used the exact same stuff what would they pay?

DR. HARRISON: Yes, and we intend to put the behavior in next month.

DR. MARK MILLER: One way to think about what we're doing is we are -- you know, the Commission has said many things over the last several times we've talked about this. What about a unified deductible? What about a catastrophic cap? What about some co-payments instead of coinsurance? And so we're trying to get you to zero in on this about what you're thinking. You obviously have to be very conscious of the middle one's budget neutral or can be made to be budget neutral. The first one costs less -- or costs the program less, the beneficiary more. The last one costs the program more, the beneficiary less. And so, you know, we probably have to think a little bit about that issue, but we're trying to get you to kind of zero in on is this the nature of the package that you're interested in. Then we use that as the framework to start working through the remainder of the issues.

Is that all correct?

[Dr. Harrison nods head yes.]

DR. BERENSON: On Slide 9, where you have your alternative benefit packages, you don't have all services there, like clinical lab or rehab or something. Are they too small to affect the analysis, or did you make some

assumptions about them as well?

DR. HARRISON: I think the spending numbers are actually included in physician. It's sort of other carrier.

DR. BERENSON: All right. So basically somewhere every service is represented in this, is I guess my question.

DR. HARRISON: Right.

DR. BERENSON: Okay.

DR. MARK MILLER: And the attempt is, as we go forward, to see if we can detail more of the services.

DR. HARRISON: Correct.

DR. MARK MILLER: So hopefully we're going to get to some more refined categories than this, although it's not going to be as granular as -- it won't be perfectly granular.

MR. KUHN: Joan, just a quick question about the focus group work and the markets of Bethesda, Dallas, and Boston. In light of our conversation yesterday about rural health care, I noticed there's an absence of discussing with rural Medicare beneficiaries. Would that have yielded any different results or any additional information? Or were some of them captured in these three markets? I'm just

curious about that --

DR. SOKOLOVSKY: I suspect that -- well, remember last year we did all rural focus groups, so that's -- but the subjects were different. But based on what they told us about their supplemental coverage at the time, we could probably expect that there would be more people with Medigap and fewer people with very generous retiree benefits. So to the extent that that might have affected what people would say, you might hear it then, but I suspect the Medicare beneficiaries would still be saying the same thing. The near beneficiaries -- and the near beneficiaries would probably be more willing to consider tradeoffs as well.

DR. HALL: Could we go to Slide 12, the nice colored slide? In that red group, under certain plans you could see slight differences, people who would pay $1,000 plus, and $1,000 plus could go up to almost -- a much larger number, I would assume.

DR. HARRISON: Well, because there's an out-of-pocket cap in each of these, it's not going to get a lot higher than that.

DR. HALL: It's not going to get a lot higher? I'm wondering about whether you could segment that part of a

hypothetical population who are assuming to have the highest medical costs and always reach their out-of-pocket cap. I'd like to know whether that's 2 percent of the population or 50 percent of the population. Maybe I'm just not honing in on the slide properly.

DR. HARRISON: Okay. So if you look at this slide, everybody who hits the cap is going to be in the $5,000 to $10,000 --

DR. HALL: Right, okay.

DR. HARRISON: The first package is really not generous. It is more cost sharing than under current law, and 10 percent hit the cap there.

DR. HALL: Right. So, philosophically, personal liability, however you want to attach that to insurance, is supposed to make the consumer aware that there's a cost to health care and choices -- except for that subgroup of individuals who really don't have that choice and could possibly be really harmed. It's very hard under current -- looking at MA plans and lots of other things, to really kind of help people make that decision when there are many plans available.

DR. HARRISON: Right. And under current -- you

know, under a cap also the people above the cap may not be as sensitive once they've hit the cap.

DR. HALL: It's all gone, anyway. Right.

DR. MARK MILLER: On that you can think of constructs like in Part D where you do continue some sharing even above the catastrophic cap but reduce it significantly. There's a range when it's like that you can think of.

DR. STUART: Can we go back to Slide 8 please? My question is, first, why you excluded decedents. And then, secondly, how would this look if you included decedents? My thinking is that if nobody dies in Medicare, obviously that's going to increase our costs over time, but there also is a very high cost associated with, you know, the time before dying, and this has to be covered by Medicare.

MS. LEE: For this slide we just looked at the full year enrollees just because for consistency, because that was the data set we used in the modeling. Now, we did look at the fee-for-service population, so the people who are aging in, so those are the partial-year enrollees, and then at the other end of it, you have the people who are dying, so they will also be partial year.

So if you actually included those two groups, the

distribution is better at the lower end, but it's pretty similar because you have the people who are young aging in or becoming eligible who are going to have a very low cost, and you have the people who are dying who are going to have a higher cost.

DR. STUART: I can't believe it evens out. I mean, I understand you have a higher proportion of people coming in that are going to be relatively lower cost. But the ones that are going out, at least if we believe these end-of-life articles, are extraordinarily high cost.

MS. LEE: Okay. But you also have -- the distribution of people's death is distributed over the year, so people who are dying in January are going to have a lower cost relative to people who are dying in December. So you are looking at annual cost.

DR. STUART: Okay.

MR. HACKBARTH: So, Julie, on that issue, when you say you think the distributions would look more or less the same, you've done the analysis with decedents?

MS. LEE: Yes, we have done that, and so recall that these are annual costs. So, you know, the number of months you are on the program. One data point, if it would

be helpful, we did look at just the people who have died in a year and their cost-sharing liability, and for them it's about 20 percent would have more than $5,000 or higher in their cost-sharing liability. I don't know if that's helpful.

DR. MARK MILLER: And this is --

DR. STUART: The question is: If it doesn't matter, then why not just include the decedents in the new enrollees so that the question never arises?

DR. HARRISON: The database is actually going to be constructed as a snapshot, so you had to have been in -- and I happen to have August 2009. There's some information that's only available at August 2009.

DR. MARK MILLER: But this has been the subject of internal conversation back and forth, and I think a couple of things we were trying to do here was to get a sense of if somebody's on full year, what does their liability look like, and as we explore -- we don't have to close this issue and say there's only one way to do it. We are open to considering this and looking more carefully at it. And what Glenn was saying up here is that as we go forward, the details of the distribution may look a little bit different

as more young beneficiaries come into the program.

So this has been intense internal discussion. It's not closed. We can keep thinking about it. This is how we thought it made sense to present it for this session.

MR. HACKBARTH: Clarifying questions?

MR. GEORGE MILLER: Yes, thank you. I'd like to go back to Slide 12, and I think I'm going to try to follow up on what Bill first raised. I guess my concern -- or my question and then maybe a concern is at the top end of that income distribution -- I'm sorry, the red area. I'm interested in knowing what the income distribution of that red area. My thesis is that it could be lower-income folks that could have that higher 1 percent, particularly if you go back to the previous slide, Slide 11, in the coinsurance package, that 10 percent that would -- pretty significant difference between the $5,000 to $9,000 from the current law, 4 percent and then it goes up to 10 percent. Do we know the income distribution of those folks? Or is this just a model and we wouldn't know?

DR. HARRISON: We don't know yet, and we're going to be challenged on income because what we have is we know who is a dual and we know if you're getting the low-income

subsidy. But beyond that, at this point we don't have any income information, and that's something that we want to look for.

MR. HACKBARTH: And, George, the reason that you think there might be a disproportionate number of low-income people is simply because of a higher burden of illness in the low-income population.

MR. GEORGE MILLER: Absolutely, yes. So they would pay more than they're currently paying, according to this, if my thesis is correct.

MR. GRADISON: I think you answered this for Scott, but I just want to make really sure. My understanding is that these numbers with regard to out-of-pocket do not take into account the premiums that are being paid for the insurance.

DR. HARRISON: That's correct.

MR. GRADISON: Shouldn't they?

DR. HARRISON: Yes, I think they should, and that's something that we would add.

MR. GRADISON: I just wanted to make sure.

DR. HARRISON: You're talking about supplemental premiums not the Part B premium, right.

MR. GRADISON: Yeah.

DR. HARRISON: Okay.

DR. BORMAN: When you compare the beneficiary and the near beneficiary focus groups, other than age are they similar in demographics? I guess my leading question would be: Were they gender similar in that with the increasing age you get a more female-dominated beneficiary group? And so were they similar in demographic? Because those women perhaps would be motivated to make some slightly different choices.

DR. SOKOLOVSKY: I'd need to put together for the chapter a matrix that would really answer that, and now I'm giving you a perception, but my perception was that, in fact, they were very similar. And there were a very large number of men in the beneficiary group, which is somewhat affected by the fact that they were not the oldest old in those groups.

DR. BORMAN: Yeah, I guess that does raise the other thing. I realize it's very difficult, probably, to engage that top end group in an effort like this. But I think failing to capture perhaps where they might be in this is not necessarily from their attitudes because you may not

be able to get that in conversation with them, but where they play out along this spectrum of sharing and cost obviously is something I'm sure you're thinking about how to capture and put into the models.

MR. HACKBARTH: Could you put up Slide 8, please? If I'm reading this correctly, it says that 6 percent of beneficiaries have cost-sharing liability of $5,000 or greater in 2009 under the current benefit structure. So I want to go to the point that I think Julie mentioned in the presentation, that this is a one-year analysis. This is the percentage of beneficiaries who exceed $5,000 in one year. However, if you look at a multi-year analysis, particularly as a beneficiary ages, the probability that at some point in that period of time that they're going to get over any given threshold increases. And I think that's an important point because I think sometimes, as I think Joan said, in the focus groups people tend to evaluate these things in terms of their current health status, and if you're relatively healthy, the tradeoff of higher front-end cost sharing for catastrophic may not look that great. But if you think of it in terms of a longer cycle, then it becomes potentially a more attractive deal because the probability that you're

going to take advantage of the catastrophic coverage increases.

So it's sort of like I sometimes feel about the insurance on my house. You know, I've been paying premiums for 30 years. I haven't collected a dime yet, and sometimes that seems like money down a rat hole. But, in fact, in this population, given the age and the increased risk of serious illness, if you look at this over even a few years, it looks like a very different sort of bargain.

And so I think that's an important insight, Julie, and I think it might be useful in our deliberations if we could see more of that multi-year analysis. Is that possible?

DR. HARRISON: Not yet, no.

DR. MARK MILLER: But we had this conversation.

DR. HARRISON: Yes.

DR. MARK MILLER: And at the time I recall we were going to do some of that.

DR. HARRISON: Well, I did look at younger and older slices, and the distributions changed, they didn't change markedly. And I think particularly --

DR. MARK MILLER: Just to be clear here, in the

internal conversation one of the thoughts -- just because I think this is what you're saying -- was even with one year of data maybe you could parse it and see how the distribution -- the percentage of people who were exceeding the cap. That was one quick look. You don't think that works?

DR. BAICKER: Well, no, it's just that that can't capture this parameter that looking at multi-years would, which is the persistence of high health status.

DR. MARK MILLER: Agreed. And, you know, I think that's a look, too. But we were going to take a quick look.

DR. HARRISON: Right. Now, one thing to think about is in both of the MA-style packages, if you have a hospital stay, you're pretty much guaranteed to be a winner. But about maybe 25 percent of beneficiaries in a year have a hospital stay, somewhere around there. I'm sure someone knows better. So on average, you're not going to have a hospital stay, but you probably are going to have one over a few years.

DR. MARK MILLER: So are we going to be able to do more than one year of data to try and --

DR. HARRISON: Right now we only have one year of

data.

DR. MARK MILLER: All right.

MR. HACKBARTH: Okay, let's move to round two.

MR. ARMSTRONG: First, I would just start by saying I think this is important work for MedPAC to be doing. I think an out-of-pocket cap is really an important feature of the kind of Medicare program that our beneficiaries should be getting in our country.

I like the way you're beginning to organize this analysis, and in particular, when you refer to some of the work that's planned for going forward, I am really a little bit struck by a point Mike actually referred to, that there's not much consideration for influencing utilization in the way that we've both analyzed these models, but I think that it feels a little to me like we're modeling different alternatives to just sort of move around the cost sharing without necessarily consideration for how we try to create more value or really influence behavior in a way that makes the best service the lower out-of-pocket cost service for our beneficiary and vice versa, for the lower-value services.

I think there are a lot of employers today who are

modeling benefits for their employees that are based on sound evidence that really do advance, you know, better utilization and that, in fact, overall using the design of the benefits to complement so many of our other policies toward the goal of lowering the medical expense trends.

So within a cap, I think there are a lot of opportunities, and I think here we have talked about some of these, around how generic statins have no co-pay, as an example, or other high-value procedures have differential out-of-pocket costs. And so my hope would be, without getting into too many specific examples, that as we continue to do this work we can look at different ways of modeling benefit designs that do more than just cap out-of-pocket costs and rejigger those out-of-pocket costs within a cap, but actually invest in, you know, higher-value services and try to change utilization patterns over time.

The last point I would make would be that you make a reference to there is a set of expectations for current beneficiaries and different expectations for beneficiaries that are going to be becoming Medicare eligible on down the road. I think that we understate how expectations are changing and how as the boomers age into this product, that

there are a lot of people who are living with and are very comfortable with and actually benefit tremendously from benefit designs that are much more value driven. And so I really like the initial evaluation that you did, you know, what people are saying through those focus groups, but I would really look at what are some of the contemporary designs that employers are offering or others are offering that a lot of the boomer generation is going to be much more familiar with.

DR. MARK MILLER: Yeah, and we can decidedly do things like -- and we've even done some of this, where we've brought people in from the insurance markets and sort of talked about what they're doing in terms of innovating their designs, and we've reported some of it out.

What I do want to set a little bit of expectations for is our ability to break categories of service in detail, and then within a category of service say let's say that, you know, a visit -- let's just take a different example since this is A-B, a visit for chronic, you know, maintenance of your -- that kind of detail we're not, unless I'm missing something, going to be able to get down to. We can get some more detail here, but it's still going to be

kind of blocky categories of services.

Then I think for that type of thought -- and then I think Mitra has made arguments about more managed benefits types of arguments -- we might be able to -- we can certainly talk about overlays, but modeling it in detail I think could be difficult. Or you could make some assumptions about behavior within a category, but it's going to be very blunt, I think is the word.

MR. HACKBARTH: Mike, this is an area of interest and expertise for you. So what I hear Scott asking is about modeling the impact of value-based insurance design on total costs. I suspect that's something that you -

DR. CHERNEW: Well, first let me say Scott did such a good job of describing value-based insurance design, I'm almost on the verge of tears.

[Laughter]

DR. CHERNEW: And if someone could put that up on YouTube, I'd be greatly appreciative. I could not agree more. I guess what I was going to say when it got around to me -- I'll just say this now before my other comments -- is I wouldn't let the limitations on modeling limit the options that we put up on the table and make sure that we're clear

in the discussion about the nuances and the opportunity that Scott says. And if you can't model them, you can't model them. But I think it's very different if you said someone spends $1,000 and it was on something that was totally unvaluable, you know, I don't feel badly about that if someone chose to do that. Whereas, if some spent $1,000 on something that they absolutely should have had, I feel horrible about that. So I don't think you're going to change your analysis. I agree with you completely. But the discussion surrounding it and the options on the table I think have to be explicit on that.

DR. MARK MILLER: And I think we're saying the same thing. We can talk about that. We can talk about it, but I don't know that we can grind it down into the --

DR. CHERNEW: [off microphone] I agree.

DR. MARK MILLER: We're saying the same thing.

MR. BUTLER: I'm struggling with what the boundaries of our recommendations might be in the end, and we spend so much time on pricing of services to make sure we have the right access and quality, and now we're pricing it through the eyes of the beneficiary.

One of my lenses -- and this is more of a

question, but I'm looking at it three different ways. One is through the eyes of the bene -- what do they want? And you've captured some of that in focus groups, and so you could say, okay, in a budget-neutral way should we kind of jigger it a little bit different to give them the security and so forth from their standpoint.

The second might be influencing the use of the rights services at the right time and the right place in a way that is different from it is now in kind of, again, a budget-neutral way.

And then the third lens is, oh, my God, there's so much demand that is created by the dual eligibles or the supplemental insurance, this is a huge budgetary opportunity if we address it.

And so that gets me into our offset list of yesterday. If you were to put this on the table, this is a huge number potentially, and that's not something we've typically dealt with here in terms of kind of a scoring approach to this. So I'm having a little bit of -- yet the introduction to our chapter kind of has the flavor of there's no governor on demand, and the downstream utilization is excessive, and we better do something about

it.

So I'm just struggling where we're trying to come at this from and how we kind of get our arms around the range of options we might present.

MR. HACKBARTH: So this is a really important question, and I will stumble in trying to answer it. This isn't even an answer. This is just sort of my thinking about it.

When we talk about three packages -- one which has a lower actuarial value than the current Medicare benefit package, one about the same, and one richer -- here is what that triggers in my mind. The first one, the one that's less rich than current, I sort of cringe at. You know, I don't think that the current Medicare benefit package is all that rich. I'm not wild about the way it's structured, but just in terms of the amount of cost borne by the patient, I think it's on the lean side rather than the expansive side. So saying, oh, MedPAC thinks we ought to have an even less rich Medicare benefit package is something that I'd have to think long and hard about.

Going to the other end, oh, there needs to be a richer Medicare benefit package in a time when, you know, as

our discussion yesterday exemplified, money is in very short supply, that seems a little bit optimistic, shall we say.

Now, you know, a key vector in this conversation is the supplemental coverage and how that interacts with the benefits. And so if we were able to have -- that's a potential source of savings that could offset some of the cost of an expansion of the basic benefit package if we can limit the extent to which people supplement it and eliminate the front-end cost-sharing.

However, yesterday one of the options in Tier II is an excise tax on supplemental coverage, the purpose of which is to reshape supplemental coverage so that it has, you know, less front-end -- fills in less of the front-end cost sharing. So we're already spending that money for another purpose, to offset SGR. It's not also available to offset an expansion of the Medicare benefit package.

So, you know, trying to think through this is complicated, and it's an important point. I don't know where I personally come down and how to sort through this.

Am I sort of talking about the same thing that's on your mind, Peter

[Mr. Butler nods head.]

DR. MARK MILLER: The way I also think about it -- and, again, trying to draw from the conversations, I think there was some sense that first-dollar coverage could be restructured in a way that was better for the program and ideally better for the beneficiary. Some of the points --

MR. HACKBARTH: [off microphone] Co-payments.

DR. MARK MILLER: Yeah, co-payments versus coinsurance, but also things like Peter and Mike were just saying, particularly when Mike was tearing up.

But the other thing that came through from the Commissioners was, well, if we're going to discuss things like that, we want to do it in the context of a fairer overall benefit, and so I think that's where you start getting into the catastrophic cap discussion. And so the way I think about it, Peter, is, is there some more large structural changes in the design and then within that we'll have this discussion of first-dollar coverage, is sort of the way I think about it. And then you have to sort of face the realities that Glenn was going through, whether it's on net budget neutral or on net savings, and there is some assumption already that that option is a place holder that there are some savings coming out of first-dollar coverage.

So that's kind of the way I'm thinking about it, and this is kind of like the big box that the Commission constructs and then says, okay, within this what do we want to do with first-dollar coverage.

Does that help or make it worse?

MS. UCCELLO: Well, I think that made a lot of sense.

DR. MARK MILLER: Now I'm tearing up [off microphone].

MS. UCCELLO: I agree with all the comments that have been made so far. I really like the direction that this is going. We're moving away from focusing solely on just changing the deductible but keeping the coinsurance and adding some co-payment designs as well as the focus you found from focus groups. I've spoken with some plan actuaries who are also saying that plans really focus more on co-payment structures currently.

A question I have is on -- this is more of a round one question, but can you distinguish in the data what type of Medigap plan people have?

DR. HARRISON: No, we just know they have Medigap, but since this is 2009, most of it is going to be first

dollar, but not all of it. So we'll have to come up with some sort of factor.

MS. UCCELLO: And I think what you're doing for next month when you're bringing in the behavioral assumptions, I think there's going to be a lot of attention paid to the explicit assumptions you're making. And so I would just advise you to be as transparent as possible on those assumptions.

With respect to this multi-year analysis, I think it's really important that we not just say that, oh, by the way, if you think about in a few years you're going to be more likely to fall in this high-cost category, you know, we need to find a way to show that. And if we can't do that with the data that we have, is there any way we can use some other kind of longitudinal data just to show the persistency of high-cost people or something like that? You know, you wouldn't have to go into the detail that you would need to do this kind of analysis, but that would provide some kind of --

DR. HARRISON: Yeah, we could find something, right.

DR. CHERNEW: [off microphone] HRS, some other

type of survey thing, won't give you the whole actuarial thing, but they'll answer the questions that Cori's asking about.

DR. HARRISON: Right. I think we can find something.

DR. BAICKER: I'm really glad that we're talking about the insurance value of insurance, and your homeowner's example comes to mind a lot when talking about insurance, not just Medicare but Medicaid or any kind of insurance reform, that people often have the mind-set that the value of it is how much care you got protected this year, and we're taking a big step in the direction of highlighting it has value for protecting you against variance, not just averages. But it's hard to convey that, and you can look at the mean versus the median, you can look at distributions, but when even talking about this group of people paid $500 more and this group paid $250 less, even the group of people who paid more might still be better off because they didn't know ahead of time where they were going to fall. They might fall into the really high spending category.

And so I would love to inject that language even more throughout, that just because you spent more under one

regime did not mean you were worse off. In fact, in expectation you might have been better off because you still had that protection. Even though it didn't happen to be realized this year, it might be realized next year, or it might have been realized this year.

So I know you have to layer on a lot of assumptions to monetize that, but there are ways to try to put an order of magnitude on it by saying if you were, you know, this risk averse has this kind of insurance value and show that even packages that might raise spending on average for a particular group of people have that kind of insurance value.

MR. HACKBARTH: Right, and I see a link between that point, which I agree with, and the multi-year analysis. The multi-year helps people understand that, oh, while you may not use it this year, if you look at this over time, your probability of using it goes up.

DR. BAICKER: And I think that would definitely help to have some measure of persistence, that some people fall into high cost one year and other -- but I would still be careful that even if you end up not having fallen into high cost over a five-year period, you've still got

insurance value. So I don't want to take that too far, but I think that helps illustrate to people, even though that's not the -- the core point is that it doesn't really matter if you happen to get the bad luck of bad health that year, it's a nice way to illustrate. The challenge there that I know you're addressing more in the next round is in truth, while almost everybody's buying Medigap so they are not being -- so the insurance value that this would produce is being provided by another good right now. And the question is, you know, how much better off would everyone be if we moved that insurance protection into Medicare itself, into the main benefit, as opposed to having the supplemental plans. And part of that we know is -- in our discussion of the excise tax or other restrictions on that is that those plans are priced in a way that doesn't take into account the spillover effects of the main Medicare program of the change in utilization they induce, and that's one of the advantages, plus we think that having a unified package of benefits would really facilitate value-based insurance design in a way that this hodgepodge wouldn't. But that does make it a challenge if you look at the missing insurance value that the main benefit lacks because of not

having these caps on catastrophic plans. We can't quite call that the benefit of fixing it because people are already in-filling that. The benefit of fixing it is filling it in in a more rational, holistic way that doesn't have the spillover effects. So that's going to require a lot of nuanced discussion.

MR. HACKBARTH: And not only more rational, you avoid the high administrative load that's associated especially with individual Medigap policies.

DR. DEAN: I guess I would just agree with much of what has been said. I think this would be a great opportunity to really look seriously at value-based design and try to build that in here.

I wonder, is there a plan to then look at supplemental policies and what influence we might have on those? Because obviously, as Kate just said, anything that we do to restructure this part of the design can be neutralized or will be affected by whatever the design is of the supplemental policies. And, you know, if, like you said, you could build it all into one, that probably would be even better. But whether that's an option, I'm not sure. But it would seem to me we should look at those designs and

see if we can figure out a way to make sure that what the supplemental insurance does doesn't work in conflict with what we're trying to do here to come up with a more rational structure.

DR. CHERNEW: So obviously I think this is a crucially important question. I actually think it's much bigger than some of this discussion.

First let me say, for example, I think Part D is really relevant. Thinking of a cap but not thinking of a cap at all in Part D seems odd in a certain set of ways. So I do think that the structure of Medicare makes it really difficult for your work to address Part D. So I understand that some of this is driven by the data you have and the work you can do, and so that's fine. But I would encourage us not to limit what we think of just because of the data that we have or the structure. And I think in general Part D is an area where thinking about the added protection or not is important. It's going to come up in issues of duals and low-income subsidies. We've had discussions of least costly alternative in the other chapter they wrote, which is terrific, and I think thinking about that is relevant.

Frankly, as you heard a little bit yesterday

morning, there's this discussion of private contracting now which relates to what people are going to have to pay. And so the overall big-picture question of how much beneficiaries should be responsible, what the program should pay for, it's just going to be crucially important as different people try and figure out how much they want the government to pay, how much they want beneficiaries to pay.

I think our goal, Glenn, to get to a comment you made, has to be, at least to start with, that we need a benefit design that's smarter, not more generous or less generous, just smarter. And the good news on that is the current benefit design is so poor on that score that we could -- it's like shooting fish in a barrel.

[Laughter.]

DR. CHERNEW: I would start, very much in the spirit of what Kate said, with some description of the theory of insurance and why we're charging beneficiaries. This is not simply a shift. As Scott eloquently said, the behavioral things are crucial. There's the financial protection stuff, and explaining to people the notion of what cost sharing is doing and why and how is actually fundamental in changing, I think, the paradigm for how

people think about that. And I think Medicare has some unique features, like we don't worry as much about price shopping -- because the prices are set -- than we might in other cases.

The stuff that came up in the focus groups I think is really important. Again, both it's interesting to see what people's preferences are, but also related to the theory, say co-pays versus coinsurance. So you could ask people what they like, but there are some very important nuances. If you don't have the ability to have very specific value-based designs -- and I'm a big fan of it, but there's a lot of limitations to it, I would be the first to say. There are some advantages of coinsurance because it charges you if you choose the really expensive treatment that doesn't add you any extra value. If you put in a flat co-pay rate, you pay this much per surgery, that's for the high-value one or the low-value one. Unless you're willing to distinguish, there's some advantage of coinsurance.

I agree. People hate coinsurance because they don't know what they're going to have to pay up front, and they aren't thinking about it as this is a way to incent me to do X, Y, or Z. In fact, people don't like being incented

to do X, Y, or whatever letter in health care.

So I think this is a wonderful project because I think going forward, given the fiscal constraints, the notion that we're going to shift more onto individuals is important. And by doing things like bringing Part D in, it moves us away from an A-B kind of thinking to a whole beneficiary perspective disease thing, and I think that's valuable. And I hope that this is going to end up being more than sort of one chapter, oh, here's what we think, by the way, about benefit design. But this is going to come up, I think, repeatedly through all of the activities that we end up doing.

DR. MARK MILLER: A couple of quick follow-ons. The Commission does not support shooting fish in a barrel.

[Laughter.]

DR. MARK MILLER: But Mike and Kate have also made comments in the past of as we think through what we do on fee-for-service, make sure to be mindful of leaving some flexibility on the MA side to design benefit packages, things that you've said before. Kate and Mike and Mitra and others have also made the point of, once again -- and I think he made quick reference to it, but I just want to make

sure that I draw this out, this notion of there are also overlays that sit on this in terms of program management and sort of, you know, reference pricing, purchasing types of policies that can also complement this.

This will be more mechanical about the benefit package, but we can continue to have these other discussions that go along with it, and you've made these points before, so I just want to make sure they don't get [off microphone].

DR. SOKOLOVSKY: Could I add a little bit on the focus groups? Because we did ask them about some of these issues, and I didn't have a chance to write about it. And maybe I didn't write about it because it was a little depressing.

People thought it would be great to give them incentives to do things that were good for them if they were already doing them. People did not want penalties.

Also, there was as lot of very positive talk about prevention among both beneficiaries and near beneficiaries. But there seemed to be a general sense, we could not get people to say, well, maybe -- there were very few people who were going to say, well, maybe if this was more expensive, I might think twice, you know, if my problem was serious

enough, say, to go to a physician. We felt like there was a lot of not very nuanced thinking about this amongst the people that we talked to. It seemed like there was a lot of education that might be necessary.

DR. CHERNEW: I apologize for saying this part. So I'm very supportive of the focus groups, but there is a sense in which I think you have to take them with a grain of salt. And I think I will just [off microphone] leave it at that.

DR. BAICKER: Can I just say one quick thing? There's a key distinction between people not liking incentives because it charges them more to do stuff they might not want to be charged more to do, and people not liking the uncertainty of not knowing 20 percent of what. And, of course, insurance design theory, as Mike pointed out, the incentives don't work if you don't know 20 percent of what. Nobody's better off when they don't know 20 percent of what.

So there's a legitimate question about should it be $20 or 20 percent, but it's clear that if there's coinsurance people need to know ahead of time 20 percent of what so they can at least have the option of making a

rational decision, and that cuts -- that supports both views.

MS. BEHROOZI: Just on that last point, I agree with Mike on almost everything, but I think that there is really value in the focus groups because we've used them to really understand how important the messaging is. And, you know, "incentives" people start to recognize as a euphemism for cuts, or whatever, you know, higher payments elsewhere. So you really do have to be careful, and that kind of goes back to my comment at the last meeting and echoes what Scott said today, that zero charge is a great marketing tool for the highest-value stuff. It doesn't always have to be zero, but that's one of the reasons that we stay with zero for so many things, because of the things that you raised about how people are so resistant to penalties and cuts.

I had a question that I probably should have raised in round one. On Slide 8, if you don't mind going back to it -- and I know this is just one year's snapshot, but do you know whether that 6 percent in the highest two bands has higher than the average 90-percent rate of Medigap coverage or not?

DR. HARRISON: We may know that next month. We

don't know it yet.

MS. BEHROOZI: That would be a little interesting to know. You know, I think what Scott said is very important about how really covering that highest cost or any of those costs along the way may be more about shifting, or shifting how it gets paid for and what people said, you know, bringing it into the program rather than having it be paid through inefficient private insurance. But also then it kind of drives more to the second rationale for doing it, which is theoretically to give Medicare the point-of-service costs as a management tool, and there's been a lot of discussion about how that doesn't work so well as an across-the-board, very blunt tool, you know, so I'm not going to go too deeply into that. I am going to note that you did mention in the paper the fact that, you know, when there are uniform -- or when point-of-service costs are always available because they're not covered by Medigap or whatever, then they can be reduced or eliminated, and that all goes to how to construct a package that really recognizes value. And I would also like to note or appreciate that you noted that the adjustments also could include cost-sharing protections for low-income

beneficiaries because I think that the analogy of homeowner's insurance is limited, because your choice of house, 4,000 square feet versus 1,000 square feet, is going to be linked to your income. And so your income -- the availability of income to pay the higher cost of the insurance associated at a 4,000-square-foot house is related to the thing that you're insuring. You don't have a choice of body, you know, and so the idea that there's a uniform cost to insure that body across all types of bodies and across all types of incomes and income and body, or health status, don't match up I think means that when you talk about insurance theory, it doesn't fit like homeowner's insurance. It is different, and I think that income is a missing variable because we tend to look at low income as Medicaid eligible or LIS eligible or whatever.

So I think it would be cool, if we could, if you could go to Slide 11, I think George raised -- or somebody was talking about these figures don't -- oh, no, I'm sorry. George didn't raise this. But he raised the issue of income stratification, and I think if we could add the premiums for Part A and Part B, and maybe actually even as Mike said, the average and median Part D spending, and then show average

and median Medicare beneficiary incomes, I think that would be a really good way to fix in our minds everybody paying a minimum of $750 every year when the average -- or the median income, I guess, of Medicare beneficiaries is 200 percent of the poverty level. You know, it's a different load then to -- it will just help us see relatively what it is that we'll be asking people to pay and the importance of giving people ways to choose lower-cost options that will enable them to choose high-value care. When Mike said he'd be horrified, or whatever, very upset about somebody paying $1,000 for high-value care, I'd be very upset that somebody wouldn't get that high-value care because they wouldn't be able to pay the $1,000. You know, their income is going to be the thing that makes the difference there.

Just in terms of, Mark, what you said about how you can't do too many breakdowns when you're modeling the cost, but maybe consistent with our SGR recommendations about, you know, primary care versus specialists, and what I had raised as a caution that if it's going to still be a coinsurance model, you're going to end up paying relatively more than you do now for primary care, maybe you could model primary care at $10 and specialists at $20 by the same

criteria that we used in the SGR discussion.

DR. HARRISON: Yeah, we need to find moire data on that, but we definitely -- most MA plans, for instance, have a primary care and a specialty care co-pay, different tiers.

DR. BERENSON: Mitra's comments were a perfect lead-in to what I was going to talk about. What I'm troubled about in these analyses -- and I was going to suggest you will be asked to do the following analysis, just the one that Mitra said, which was to assess the impact in relationship to people's incomes.

What I'm troubled by is how useful incomes are for the Medicare population, how misleading it might or might not be in comparison to a younger population. The whole core of the Affordable Care Act is affordability in relationship to people's out-of-pocket spending to their income. My mother was a wealthy woman, had not much income the way she had structured her assets, and so I guess my question is: To what extent -- I understand, I guess, there's major operational barriers to getting people's assets to be able to determine who has an ability to pay. But for analytic purposes, how meaningful or distorted are incomes for seniors -- and I'm distinguishing them from

disabled younger populations, where I think it may well be a good measure. Is there anything -- does anybody know to what extent we are somewhat making errors of judgment about people's affordability to pay just basing it on annual incomes? I guess that's my question, and I don't need an answer today, but that's what troubles me.

DR. MARK MILLER: It's good that you don't need an answer today because I can tell that we need to think about this a little bit. And I also want to just reinforce a point here. How much we're going to be able to grind the income into the model is somewhat limited. We're going to be able to distinguish blocs of people based on certain characteristics -- poor, Medicaid, LIS, those types of things. We may be able to take the income question and handle it in some ways the way people were saying about distributions, multiple years, that type of thing, looking at other data sources and trying to say and keep in mind that this is what the distribution looks like, even if we can't model it down to the specific benefit design. And then meanwhile we'll look into this assets question, but I don't know that any of us feel ready to jump on that in this meeting. Joan, correct? Okay. You looked like you were

about to say something. All right. But we understand the question.

DR. HALL: I think we're all kind of struggling with what does this mean to the consumer and how does this help to inform the consumer to make valid choices that are based on value and cost effectiveness. And I wonder if there isn't some way we can use these data to start to move in that direction.

If you look at the signals that a 64-1/2-year-old gets when they're going into Medicare and looking at various forms of coinsurance or Med-Sup or MA plans, there are two messages that come over very strongly. One is the Affordable Care Act says when this gets in place, don't worry, no matter what's wrong with you they have to accept you and they can't cut you off -- "they" being this adversarial relationship.

On the other hand, if you look at the advertising for any MA plan -- I don't care which one it is -- you would think that people who buy that plan spend their summers skydiving in the Rockies and sunning themselves in Cabo in the wintertime. It's a totally -- the message is like the old cigarette ads, that if you're really cool you'll buy my

product and don't worry about the consequences.

So it's tough, I think, and I know some places that maybe some of you from Massachusetts who do work with an exchange, I understand that people say it's simple. I don't know. I've not tried it. I wonder if it's possible as we look at this to try to put it in the context of what it's going to mean to the decisionmaking of a consumer and in what way the design of the plan and its construct and how it is advertised, if that's the right word, or detailed to the individual could actually be an important behavioral change motivation.

You mentioned that people don't like this idea that I have to do something for my health, but I think at age 64-1/2 a lot of people might really want to take this very seriously, that if I'm overweight -- so now we're talking almost 50 percent of this population in a couple years, the way things are going. If I'm overweight and my doctor says I've got a little bit of diabetes, should I buy a high-priced plan? Well, one other alternative is that maybe I should buy a plan that's going to really emphasize a lot of health preventative aspects of this. And then one could almost say, And depending on that choice, this is

likely what my risk is going to be for expenses.

Now, that may be trying to really milk much more out of the data, but I think the more we can use concrete examples -- and they don't have to be stratified. You know, it's like all people in inpatient psychiatric facilities fit in one DRG. I think three or four different examples would really do that because I think that would help us down the way to kind of operationalize this in the way that's really going to get to some of the goals we're talking about in terms of having people make value-based decisions.

MR. HACKBARTH: Bill, do you know Arnie Milstein?

DR. HALL: I know his literature. I don't know him.

MR. HACKBARTH: Arnie used to be a MedPAC Commissioner, and he often would say, on different topics but this one included, that you need to think about this in two pieces. One is, you know, trying to rationalize the insurance design, et cetera, but then the second really critical, almost always neglected piece is how it's communicated and how you help people make decisions about what are really complicated choices. He would often appeal for a big investment in computer-based tools or some

mechanism that would allow people to analyze much more efficiently what their choices are so that they could go through the scenarios, they could say, "I'm the diabetic," and, you know, have some modeling done for them.

I don't know of anybody who has created that tool as yet, but there really is a two-step process here. There's rationalizing the options but then also helping people grapple and understand the options, people who aren't used to making these sorts of decisions.

DR. MARK MILLER: And I heard two things. I heard that, you know, like how can we think about how the beneficiary would consume this information and interpret it. But the other thing I might have heard -- and this is why I'm asking. So after, let's say, there's a process here and we design something, you could almost take certain demographic profiles and say this is what it means to this kind of a person. So an 80-year-old female, diabetes, this is the risk or the expenditure structure, and this is how it would appear under this new structure versus the old structure, that type of thing where you drive --

DR. HALL: I think so. It's a hackneyed expression almost now that the current generation isn't

going to live as long as the prior generation or is not going to be as economically well off. But in point of fact, there's a lot of truth to that, that people are merging onto age 65 with a lot of time bombs for the most part, largely related to behavioral things that they've chosen to do in their life. And one could argue, depending whether you're an optimist or pessimist, that 64-1/2 is not too late to start.

DR. NAYLOR: I generally really like the direction of this conversation kind of getting us back to what was so helpful yesterday to that set of principles that we then will go back to and say, Did we get there? So is at the end of the day the set of recommendations leading us to a smarter design? Is it leading us to the kind of behavioral changes and performance in terms of value that we're seeking?

I think the notion of inclusiveness of -- I don't know about including Part D, but I think that's a really important element if we can do that. And do we have recommendations in terms of the right messaging? So I don't really have anything to add, but I just like the notion that a framework has emerged from the conversations over the last

couple of days that I think may be -- and also what is the impact of these particular redesign recommendations on the other set of recommendations that have just occurred so that we understand the cumulative impact on the beneficiaries?

DR. STUART: Wow. I guess I'm struck by the difference that I see between the theoretic ideas about making smart choices and designing decisions ahead of the time when you need to make a decision about seeking medical care or not and the way beneficiaries behave. And part of it comes from the focus group, but part of it also comes from our knowledge about these decisions.

I mean, we all know that it makes no sense to buy a Medigap policy. Right? Because the premium is far more expensive than the actuarial value of the Congress. And so if we had smart consumers, they wouldn't buy, you know, assuming risk stratification and whatnot or, you know, not having stratified risk, I guess. So people buy these policies on the basis of a notion that they are getting more value than, in fact, they are.

Deductibles. Deductibles make all kinds of sense, and people hate deductibles. And if you look at Part D, plans that require a deductible are the least commonly

purchased plans. And if you look at MA, which is excluded from this, MA plans generally don't have deductibles.

So another way of thinking about this is that people are making decisions with respect to their scarce dollars that kind of fly in the face of what we think are rational decisions by avoiding front-end costs. So that's one point, I think, that's really important, that people vote with their feet and their pocketbooks in a way that, you know, we're not going to change overnight just with knowledge.

The second thing that I think is important is that if you're got nothing to protect, then, you know, you don't buy insurance. And nothing about insurance makes any sense if you don't have anything to protect. And the point that Mitra was taking, that the average income of Medicare beneficiaries is around 200 percent of the poverty line, in the analysis that we're looking at here, you exclude all of the dual eligibles. So the average income of these people is obviously going to be higher than the mean because you've cut out all of the bottom, and these people may behave differently than do the average Medicare beneficiary.

But I think it's really important to think about

what the implications are for people who are above and just above the dual-eligible thresholds because that's a big bolus of our population. You know, you can look at MCBS or CPS or something to get a really good idea about what the fraction of the overall population that falls in that band is. And my guess is that those people are going to behave -- may behave rationally by avoiding front-dollar costs because they're looking at a certain out-of-pocket cost in terms of the combination of a premium and front-end deductibles that could be a substantial fraction of their income even if we were to argue that over time the insurance value of this is substantial. The insurance value may be substantial, but if the initial cost has real consequences in terms of -- you know, and it's overstated, you know, buying medicines or eating food. But, you know, it's still there. It's a really important issue.

The other point that I want to raise -- and it's building on something that Bob said about assets -- you can get information on assets from MCBS. There's something called the Insurance and Asset Supplement that is asked every spring, and it's actually really useful. Nobody uses it. It's not part of the public release of MCBS, but you

can obviously get. I strongly recommend you take a look at that. But I also think that there is -- we have to be really careful in terms of going forward in thinking about the value of assets as the structure of pensions changes.

So if you look at somebody who retired with a defined benefit pension, the value of that, the current value of that pension is not part of their assets. I mean, that's out there. The income comes in. That's the income. But there's no asset value that shows up for one of those pensions. Whereas, as the population who are aging into Medicare increasingly have 401(k)-type plans, they're going to look like they have much more in the form of liquid assets than do people who have retired in the past. And yet if you pull those assets down, what happens is that you are reducing your future income stream. You know, this is really hugely important.

And then finally -- and these are nuances, and we knew we were going to get in nuance land here, but there are some protections that people have currently, and it would be interesting to know, you know, how used these protections are. Many states do have Medicaid programs for the medically needy, and so if you had high out-of-pocket

medical costs, you can spend down and then you get into dual eligibility. So you've got some people in your model here that are going to end up in 2010 and 2011 in dual eligibility because they spent down. And you're going to have some other people who have some protection, my guess is, through the Medicare savings programs -- again, through some of the same mechanisms.

These kinds of protections, the MA, the Medicaid spend-down and the Medicare savings plans, are going to be particularly important, I think, for this bolus of the population that is not poor enough to be currently eligible for Medicaid but is potentially eligible for Medicaid.

So all I would say is I know how difficult that would be to simulate, but at least to note it in our deliberations and to not lose sight of that.

MR. GEORGE MILLER: Thank you. This has been a very rich discussion, and I've enjoyed it and certainly enjoyed listening to and hearing the commissioners' viewpoints, such that maybe we should invite CSPAN to come in and listen.

Oh, we've done that before. Okay.

But the point that I want to make and just

highlight a couple of things that Scott mentioned at the beginning, in the beginning, and I think this is an opportunity for us to take the opportunity to look at value design and try to drive behaviors.

As Bill just mentioned, the way to really drive behavior is information, if we could design programs to deal with that, deal with those issues.

In my mind, I came up with looking at the top five chronic diseases and try to design value that would move people to make the right decisions based on these processes, in ways that would bring value to them and then probably in the long term save money to the program if we're able to do that.

Just mention about the insurance value I think Mitra brought up and Bruce just mentioned. But there are people in this country who make life decisions every day about whether to pay for insurance, or whether to eat or pay utilities, and that's just a real consideration. And what has happened the last couple of years with high unemployment, that number has just grown.

So if we could target, or we look at targeting, folks between 55 and 64 who are yet to come onto Medicare

and educate them, give them the information that they make certain choices, we may be able to derive value for them.

And again, I'll go back to what I said earlier about the five chronic, leading chronic diseases. And whatever number, whatever design, what Scott was talking about, benefit design -- I think we have a unique opportunity to do that at this point, going forward.

MR. GRADISON: One of the joys of a long life is that you look back and try to figure out what experiences you are a survivor of, and in my case one of them is that I am a survivor of the last national discussion of catastrophic health insurance, which occurred a little over 25 years ago. I look back with some pride on my behavior at that time since I went down with the ship and did not vote for the repeal, but I lost.

And I don't think it hurts to look back on that experience, as I've tried within my own mind over the years, and see what lessons can be learned, and there are a few. So these are probably pretty obvious.

One is that people were pretty keen and positive about the benefits but not paying for them. I think that has a direct relationship to what we're talking about

because any of these options will create some losers as well as some winners.

Nowadays, the losers and the winners kind of make that choice pretty much on their own, not for the benefit design but particularly in their choice among the 10 options and so forth. And I think that's worth keeping in mind.

Kathryn referred to the hodgepodge effect, I believe. It was a very good phrase. There's nothing necessarily wrong with a hodgepodge effect except that it assumes a degree of rationality which may not be appropriate to this issue.

Bruce mentioned rationality twice at least. I tried to count it because I was going to use it anyway.

And so, I approach this with a recognition that there are not only going to be some losers, but there are going to be some people out there who are going to want to organize the losers. For example, adding a co-insurance for home health is not just going to be of interest to people who think they may need home health services, but maybe even to people who provide home health services as we well know.

I. personally, see a lot of charm in coming up with a revenue-neutral plan which has a catastrophic

element, a unified deductible.

And I'm looking forward very much to the discussion, carrying this discussion further next month. But my message is we really have to -- not that we wouldn't do this without my saying it, but I think we really have to keep an eye on who the losers are, and that isn't just an income factor.

Looking back on catastrophic, the people who really sunk that were the higher income people. I think that's a very important matter of history. They really deep-sixed it.

And so, you may think from what I've said that one of my causes in life is to identify and understand the limits of rationality, and I guess it really is because of what I used to do for a living. But I think in approaching this issue, as we try to identify the losers as well as the potential losers, potential winners, I think we have to keep asking ourselves how does it compare with just simply continuing the hodgepodge effect.

Stark and I, among others, came up with this idea of structuring the Medigap market in the A through J at that time, and it was a consumer-oriented approach, I think of

some value, and tried to strike at some of the abuses with people buying two policies or more in some instances and that sort of nonsense. But it exists, and it is well used, and people are accustomed to it.

I think whatever we do we ought to weigh against okay, why don't we just stay with where we are.

DR. BORMAN: From the perspective of having gotten to hear everybody, it's been a very broad and very diverse discussion, and that's to the good of the Commission and to the beneficiaries. I think, conversely, we also have to say how do we bring this to something that we can -- some piece that we can put our arms around, something that we can legitimately ask staff or task staff to bring to us, and what we can accomplish.

And so, in the past, we've often said we have a very broad discussion, but in parallel we have to work on what is in the here and now that we can make better. We sort of have a dual mission in terms of perhaps long-range, longer-range strategies versus the here and now.

And so, I think that some of what we've seen today helps us look at what can we look at in the here and now because the shorter-term time horizon things that we can do

are more predictable, more readily modeled, and whatever. And I think this has been a wonderful start down this road, some of the things we've seen.

I think that for me, personally, it would be helpful to have some projection, and recognizing all the flaws inherent in projection, about what will the beneficiary pool look like at a 10 or 20-year time horizon because all the cultural and social and economic trends that we've mentioned in terms of shift from defined benefit to defined contribution, to the number of people that have been unemployed during what would normally be very productive income years.

What can we say compared to today's beneficiary pool whose behaviors we sort of understand and, at least in aggregate, have statistics about?

What is that pool going to look like 10 and 20 years from now because we've got this huge effect of the Baby Boomers aging in and then progressing in age in it, and at least right now can we make some guesses about at least that first wave, what they will bring in, in terms of their retirement income and asset activities?

What will they look like?

What kind of costs can they bear -- because I have to say I really feel somewhat at sea in understanding particularly for that 20-year group, and that would influence what I think might be reasonable to design for them if I knew a little more about that 10 and 20-year group.

The other thing, that perhaps another way to come at thinking about this, is it kind of builds a little bit off Bill Hall's comment. If we could sort of create a couple of template beneficiaries profiles, if you will. That maybe is somebody that's more near the entry point into Medicare, somebody that's kind of in that mid-range and then maybe a sample at the high end, vulnerable, higher spender, and for every package show for that typical beneficiary what would this look -- how would this play out for them.

That would help me sort of bring it to a more personalized level, looking at the packages in aggregate, and then combined with knowing how much of the population is going to match, be sort of in the group represented by that template. Perhaps that would help me make a better informed choice and at least maybe allows us to leverage data that we have, or at least maybe have more confidence in, to bring to

bear into this.

And I was also struck by something, Scott, that you said. The clear winners are somebody that had a hospitalization. And so, maybe a fertile way to look at this would be to pick out the group who were hospitalized versus the group that weren't in terms of impact.

I mean as Bill Gradison said, there are clearly winners and losers in everything we talk about and do, and that's -- once you said that, it was perfectly obvious to me, but I hadn't thought of it in that way. And that, to me, says there's value in maybe saying how these things impact, by looking at that obvious winner versus loser group.

It doesn't begin to speak to the value and all those things that are incredibly important as we look at the system as a whole, but I think at least it starts to take us down the road in the Medicare world, which is what is our first obligation to advise about.

So those would just be some summative thoughts based on the conversation.

MR. HACKBARTH: I confess that I don't have a handle on this one yet, a clear sense of where to go.

Bill Gradison's comments are somewhat chastening in that so much of our discussion is about what's rationale and consistent with insurance principles, but when it hits the political process there's a different dynamic.

I was actually in the department at the time of the catastrophic episode. We were thinking rationally, but when it intersected with the political process it's a completely different dynamic as it were.

So those are really important reminders, Bill.

I want to draw on a couple other things that were said, and again, this isn't sort of definitive thinking but just where my mind is at this point.

We are constrained by a budget. There are limited resources, and so my instinct is if we're talking about a restructured benefit package, we're talking about something that restructures currently available dollars as opposed to expanding the benefit package.

As Mike said, there is ample opportunity even within that constraint to rationalize the structure, and I think that's what drew us all into this conversation.

It does inevitably though -- because it redistributes, it creates winners and losers, as Bill

Gradison reminds us.

Because we're constrained by a budget and the amount that we exist -- the existing expenditure on Medicare, and the existing Medicare package is not all that rich in terms of actuarial value. I think it's very likely, if not inevitable, that there will still be an impulse to supplement whatever new benefit package we were to come up with. And so, dealing with that supplemental market will be an important part of what we do, or any effort to move towards value-based insurance design will be undone through the supplemental market.

When I think about the supplemental market, I see at least three challenges.

One, as Kate points out, the way the product is priced does not reflect the spillover costs on traditional Medicare, and that was the thinking behind the notion of an excise tax.

The second is that the supplemental market potentially interferes with any effort we make to rationalize and introduce value-based principles, et cetera.

The third is the high cost of the supplemental policies, especially the individual polices, relative to the

insurance value -- the point that Bruce was making. I think it's true, and Scott, maybe you can correct me if I'm wrong, but I think that the administrative load on individual supplemental policies is often in the 20, 25, 30 percent range.

DR. HARRISON: Twenty percent is about right for Medigap.

MR. HACKBARTH: Yes, and that's a high price to be paying for the insurance value, which leads me to at least consider the possibility that maybe, if there's going to be a demand for supplemental coverage, can it be met more efficiently and priced in a way that reflects the spillover costs through a government-offered supplemental policy.

So here's the basic benefit. We're constrained by costs. If you want to buy more coverage, we can offer it at a lower administrative cost, more efficiently. It's going to be priced for spillovers, spillover effects.

Now, a note. Some people say well, oh, boy, that's the government taking over the private insurance market, and that's not in tune with the times.

That may well be correct, but I would draw a distinction between what happens in Medicare Advantage and

what happens in the supplemental insurance market.

I'm a staunch believer in Medicare Advantage because I believe that those plans can do things that traditional Medicare finds very difficult to do, in terms of identifying high value providers and managing the care in ways that are difficult, if not impossible, to do in fee-for-service. So the private plans and Medicare Advantage, I think have the potential to add huge value to the program for beneficiaries.

Supplemental insurers, by their nature, do not add that value. They are simply filling in deductibles and co-insurance. They're piggybacking on the fee-for-service system. And so, we're paying, the beneficiaries are paying, a very high price for a product that adds very little value, that could easily be provided by the government at a much lower price.

So I'm not anti-private insurance by any means, but this market has never made any sense to me in terms of trying to do the best we can by Medicare beneficiaries.

So that's just the state of my current thinking about this.

We need to think about restructuring,

rationalizing, but we also need to deal with the realities, the political realities, that Bill has identified for us and also the realities of the urge to supplement whatever benefit package that we come up with. That's a mouthful. That's a lot of work to do.

So, thank you all. Good work.

We will now move on to our final presentation on potentially preventable hospital admissions and emergency department visits.

[Pause.]

MS. MUTTI: Okay. Sorry about that. So this presentation will begin to explore the value of using measures of preventable admissions and preventable emergency department visits to assess population level quality of care.

Focusing on these measures may address some concerns about the limitations of quality measures used by Medicare to date. In particular, the advantage of these two measures is that they tell us about how well the system is meeting beneficiaries' needs before they get to the hospital. 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. In addition, these measures are outcomes measures rather than process measures and the Commission has expressed interest in pursuing outcomes measures when possible.

In this presentation, we consider preventable admissions and ED visits sequentially, but we pair them together for a few reasons. First, both avoidable hospitalizations and ED visits expose patients to the risk of adverse events, like hospital-acquired infections and medication errors, and they disrupt the continuity of care for the patient.

Second, using scarce resources to provide care to those patients whose needs could have been better met elsewhere compromises the ability of hospitals to efficiently meet the needs of patients whose acute care needs can't be met elsewhere.

Third, use of these services unnecessarily adds costs to the health care system.

So I will first talk about admissions and then Nancy will discuss ED use. And here, I would also like to acknowledge Kate Bloniarz and Kelly Miller's contribution to this work.

So in looking for a specific measure of potentially avoidable admissions, we start with the Prevention Quality Indicators, known as PQIs. The PQIs developed by AHRQ are a set of measures that identify conditions for which admission to the hospital can often be avoided with appropriate primary care. The PQIs consist of 14 conditions and they are measured as rates of admission to the hospital. The 14 include chronic conditions, such as diabetes, COPD, CHF, as well as acute conditions, such as dehydration, bacterial pneumonia, and urinary tract infections.

Because PQIs are considered potentially preventable rather than absolutely preventable, it is important to emphasize that the right rate of PQIs is not zero. This means that some of the admissions that we are calling potentially preventable are avoidable or preventable, but some are not. So it is the relative rates that are important to focus on.

PQIs are NQF endorsed as population level measures. According to NQF and AHRQ, they are not suitable for public reporting and accountability at the provider level, but they are useful to providers as they evaluate the

care that their collective health care systems are providing to the community and help them identify unmet needs.

As a first step, we looked at claims data to see what the national rate of PQIs is and what degree of variation is evident across communities. In this analysis, we defined communities by Hospital Referral Regions, or HRRs. HRRs represent regional health markets for tertiary care and the nation is divided into 306 of them.

We chose to use HRRs here for two reasons. First, data by HRR was easily accessible, and HRRs are large enough markets to be used with a sample set of claims. And second, they are a reasonable approximation of a referral network. But we consider this initial analysis and are considering other definitions to use in the future.

Also, because PQIs don't have a robust risk adjustment built in, we adjust PQI rates using HCCs, and we recognize that HCCs are imperfect, and we have had several discussions about this already, but we thought that it was better to try and risk adjust for health status than not at this stage.

So we found that, nationally, nearly 17 percent of Medicare-covered hospital stays were potentially preventable

as measured by PQIs. Bear in mind that in this analysis, we did not distinguish between admissions and readmissions. A CMS analysis, however, found that about 18 percent of Medicare PQI stays were 30-day readmissions, so that suggests that more than 80 percent of these PQI stays are what we might call initial admissions.

Looking at PQI admission rates across HRRs, we find considerable variation. The mean of the top quartile was 21.8 percent, about nine percentage points higher than the mean of the bottom quartile, which was just 12.9 percent.

It's important to note, though, that there is a significant disadvantage of examining PQIs as a percent of all Medicare admissions, and that is that a community's propensity to admit for non-PQI conditions can cloud our view of the relative rate of PQIs. For example, having a higher number of hospitalizations for non-PQI conditions can make a community appear to have a low rate of PQIs when really their number of PQIs, when adjusted for population size, is quite comparable to the national average.

So for this reason, we also present variation in the incidence of PQI admissions as a rate per 100,000

beneficiaries. This takes the variability in overall admission rates out of the question. The national rate of PQIs here is 6,311 per 100,000 beneficiaries based on 2008 Medicare claims for the fee-for-service over-65 population. We present quartile rates on this slide, both unadjusted to the left and adjusted by HCCs on the right. So as you can see, the mean rate of the top quartile when risk adjusted is 7,991 admissions per 100,000 beneficiaries and that's nearly twice as high as the lowest quartile. We also see more than a four-fold difference between the lowest and highest HRRs or communities.

It is important to note that PQI admission rates are higher for most minorities and for people with low income. An analysis by AHRQ finds that African Americans across all ages have more than twice the rate of admissions for PQIs than whites. Hispanics were higher than whites, also, but the gap was much smaller.

AHRQ also looked at the income and found that the lowest income quartile had rates about twice as high as those in the highest income quartile.

In our analysis of the HRR data, we found that the quartile with the highest PQI admission rates had the

highest proportion of African American beneficiaries, at ten percent. In the quartile of HRRs with the lowest admission rate, only two percent of beneficiaries were African American.

Other research finds that variations in hospital rates for conditions like PQIs across HRRs are substantially greater than the disparities by race within a given HRR. This means that where patients live has a greater influence on the care they receive than the color of their skin, and we found this when we were looking at readmission rates, also.

So by reducing geographic variation in PQI admission rates, strides can be made in improving the care of minority populations, most particularly for African Americans. In fact, a National Quality Forum panel has identified PQIs as a key measure of disparities and concluded that PQIs represent a step toward integrating the reduction of health care disparities into the quality measurement agenda.

So now I'll switch gears to discuss next steps and considerations that can shape our future research on admission rate measures.

First, we might want to think about a more refined definition of community. In particular, Hospital Service Areas may be a good alternative to our HRRs because they reflect smaller market areas, ones that are defined by who provides primary care rather than tertiary care.

In addition, we plan to explore the measure of avoidable admissions developed by 3M, a firm that develops health care coding, classification, and payment systems. 3M has focused on identifying admissions for ambulatory care-sensitive conditions like PQIs. It adds some conditions to the base line of PQIs, such as seizures and migraines, and excludes other types of PQI conditions. For example, it excludes surgery for vascular complications of diabetes because these are not preventable unless appropriate care is given several years before the admission.

In addition, the 3M approach differs from the PQIs in that it includes a comprehensive risk adjustment methodology when it compares admission rates. It uses Clinical Risk Groups, 3M's own product that measures the relative illness burden for each individual patient. This product has the potential also to factor in functional status, like beneficiaries' ability to walk and bathe

themselves, using data from MDS and OASIS. It also specifically adjusts expected spending for those with substance abuse and mental health problems.

I'll also note here that another line of our next steps is the separate MedPAC research underway to improve the HCCs, and obviously that work will have bearing on this topic, as well.

Another possible next step is to consider a category of avoidable admissions that is not fully captured by PQIs and these are admissions for beneficiaries living in nursing homes and other institutional settings. The definition of potentially avoidable hospitalization tends to be broader for beneficiaries in long-term care than those in the community because it includes hospitalizations that result from inadequate assistance with activities of daily living, deficient monitoring and treatment of chronic conditions, and inadequate responses to acute conditions that at least under optimal circumstances could be addressed within the facility. The particular list used by researchers varies, but they often include things like skin ulcers, malnutrition, falls, sepsis, as well as many of the PQIs.

One study found that 39 percent of all hospitalizations for the dual population in SNFs, nursing homes, and home and community-based waivers in 2005 were potentially avoidable. Other studies, using a structured review by expert clinicians, looked at the broader population. One study in Georgia of Georgia nursing facility residents found that 67 percent were potentially avoidable and another study in New York that focused on long-stay residents found that 23 percent of admissions were avoidable.

MedPAC has identified five conditions that are potentially preventable from SNFs and uses these as a quality metric in the update analysis. For those five conditions alone, MedPAC finds that the average rate of rehospitalization is about 17 percent.

So that would be it for the admissions part of the presentation, and now Nancy will talk about emergency department use.

MS. RAY: Thank you, Anne.

Along with potentially avoidable admissions, we are also exploring the value of potentially avoidable emergency department visits, ED visits, as a population

based quality measure. Both measures are similar in that for many beneficiaries, treatment in both sites could have been delivered in a less acute setting.

There is general agreement that the hospital ED is not the best place to treat conditions that could have been addressed in other ambulatory settings. First, medical practitioners in the ED typically do not have a relationship with the patient. They are not familiar with the patient's baseline condition. They often lack medical records and history. And there is typically no follow-up. The lack of continuity of care might reduce efficacy of treatment. In some instances, potentially avoidable ED visits lead to potentially avoidable hospital admissions. For example, a patient with diabetes arrives in the ED for treatment of a complication and is subsequently admitted to the hospital. This is where the two measures overlap.

Second, potentially avoidable ED visits detract from the primary mission of EDs: To provide emergency and life-saving care. When emergency departments treat conditions that could be addressed in other settings, fewer resources are available to respond to emergency and trauma cases.

Lastly, it costs Medicare and patients more for ED treatment than treatment in other ambulatory settings. For example, a Level 3 visit -- and this would include both physician and facility fees -- is about double in the ED compared to the physician office.

So potentially avoidable ED visits are often categorized into three groups. The first group would be for conditions that are non-urgent, that is, emergent treatment was not needed.

The second group is an urgent condition, but the condition could have been treated in another ambulatory primary care setting. These conditions are often referred to as primary care treatable.

And the third group is an urgent condition was presented at the ED, but appropriate primary care might have prevented the ED visit, and this group of conditions are often called ambulatory care sensitive conditions.

So the process for identifying potentially avoidable ED visits is not as far along as the process for identifying potentially avoidable hospitalizations. AHRQ is currently developing a definition for potentially avoidable ED visits and we have been talking to them about their work.

To begin our analysis in the area, one of the things that we have done is we have used an easily available data source, the 2009 National Hospital Ambulatory Discharge Survey. This is a national survey of hospital ED visits conducted by the National Center for Health Statistics, which is a part of the CDC. The survey provides estimates of the total number of hospital ED visits and also includes several variables that might suggest that the ED visit was potentially avoidable. And these ED -- these variables include whether the ED triage staff considered the visit to be non-urgent, whether the ED visit was preceded by either another ED visit or a hospital discharge, and the timing of the ED visit, the day and the hour that the visit occurred.

So here are some of our findings. The first row is the estimated number of ED visits. This is in thousands, and you see it across different payer groups. This is for 2009. For example, in 2009, there were about 23 million ED visits from Medicare beneficiaries. And the rows underneath are our first look at ED visits that may be potentially avoidable. For example, in the first row, five percent of visits for Medicare patients and other -- well -- I'm sorry. Five percent of visits from Medicare patients were

considered non-urgent by the ED medical triage staff.

Moving to the next row, for about four to five percent of ED visits across the different payer groups, the ED visit was preceded by another ED visit in that same emergency department in the previous 72 hours. And the thought here is that better coordination and communication might have avoided the subsequent visits. About five percent of the ED visits were preceded by a hospital discharge in the last 30 days, and here the notion is that better follow-up care might have helped here to reduce the number of subsequent ED visits.

Finally, 28 to 34 percent of all ED visits across the different payer groups occur during physician office hours, which we defined as being Monday through Friday, 9:00 a.m. to 4:00 p.m. Of these visits that occurred during office hours, five percent of the visits for Medicare beneficiaries were considered non-urgent. And again, I want to point out the denominator difference here. The last row, the non-urgent visits as a percentage of ED visits that occur during office hours, the denominator here are ED visits that occur during office hours. For the rows above that, the denominator is all ED visits.

Like the plans for the analysis of potentially avoidable hospitalizations, we are planning on exploring 3M's measure of potentially avoidable ED visits. Their list includes conditions that are primary care treatable as well as ambulatory care sensitive conditions. We intend to look at variability across different beneficiary groups and regions.

So this concludes our presentation. We are hoping to get Commissioner feedback on the use of these two measures as population based quality measures.

MR. HACKBARTH: [Off microphone] Okay. Karen, clarifying questions.

DR. BORMAN: Yes, I have a couple. First, could you tell me how the analysis handled what I'm going to call observation admissions? That is, there's kind of a space between you come to an ED and you get discharged. You come to the ED, you get admitted or you're a direct admit for whatever reason. And then there's people who are admitted to observation status. Are they lumped into the admit part, hospital admission part, or are they just a group that we don't have a way to capture, Because a bunch of those people presumably will have these treatable or sensitive conditions

because they could be turned around by some interventions within a relatively short period of time. So I just want to try to make sure that we're capturing that group in some way.

MS. RAY: Right, and in the subsequent work, we're planning on doing with 3M, the ED option of that will be limited to ED visits that are treat and release.

DR. BORMAN: Okay. So that the rest, then, presumably, the remainder, then, represents the observation folks, or represents just hospital admission folks?

MS. RAY: Umm --

DR. BORMAN: Well, I guess I --

MS. RAY: That's a good question. I think --

DR. BORMAN: I mean, I don't know that --

MS. RAY: I don't think they're captured --

DR. BORMAN: I think there is a category that sounds to me like maybe isn't being captured anywhere --

MS. RAY: Mm-hmm.

DR. BORMAN: -- yet I think could be very fertile in terms of identifying a group that is sensitive to interventions --

MS. RAY: Mm-hmm. Mm-hmm.

DR. BORMAN: -- that presumably we're going to try and move towards, so just a --

MR. HACKBARTH: So, Nancy, could I just ask you for a clarification of your response to make sure I got it straight. Are they not counted at all if they go into observation status, even though they entered through the ED? They would be totally absent from this count, or -- your response sounded like if they weren't -- didn't go through the ED and then released immediately, that they would not be in this count. That's what I thought I heard you say. Is that right?

MS. RAY: Right, and that was not the impression I wanted to give.

MR. HACKBARTH: Okay.

MS. RAY: For our 3M analysis, what we are thinking of right now is that folks arriving in the ED and who are not admitted to the hospital, those would be the people -- those would be the visits that the potentially avoidable ED analysis would focus on.

MR. HACKBARTH: So the observation people would be in that group.

MS. RAY: Yes. Yes. As long as they were not

admitted to the hospital -- subsequently admitted to the hospital.

DR. BORMAN: And we're pretty confident that whatever site of service indicator or way that we're selecting them does, in fact, include observation, because at least on the hospital side, and the hospital guys can correct me if I'm wrong, it's a pretty distinct entity subset and I -- I think it's great if we're capturing them under one of these groups --

MR. HACKBARTH: Right.

DR. BORMAN: -- but I just want to be sure that we are capturing them somewhere.

MS. RAY: Right. Right. Right. And we can identify the observation stage using the APC groups.

DR. BORMAN: And then when you say that they're treated during office hours, is that based on the arrival to the ED time or the discharge from the ED time? And I know that seems like a picky question, but if you came at 2:00 in the morning and went home at 2:00 in the afternoon, you're going to appear like somebody who could have been handled during office hours--

MS. RAY: It's arrival.

DR. BORMAN: -- when presumably, if it was important enough to wake you up at 2:00 in the morning and get somebody to bring you, then it was a more --

MS. RAY: That was arrival.

DR. BORMAN: That was arrival time.

MS. RAY: Arrival to the ED.

DR. BORMAN: Okay, great. And then the other, on Slide 13, you have the group that's preceded by an ED visit and I thought that was a great question to ask. Do you have any way, and I suspect the answer may be no, but do you have any way to know what of those were perhaps planned, because there is a circumstance, for example, where the ED provides a service? It's not clear that the patient will have a good follow-up mechanism and they purposefully say, return to the ED for this check-up. And some of that is buried in there and that doesn't really denigrate the importance of finding out that there were multiple ED visits. It's a different kind of failure of care, but some of these may, in fact, be planned. And the thing that most commonly I would think of but doesn't exactly fall into non-urgent would be somebody who had a laceration repaired is told to come back and get their sutures out in the ED because that's who put them in.

But I'm sure there are certainly other times where something has been manipulated or given or a short course of drug treatment and it's, come back and let us look at you, and do we have any way to parse that out of that number? It may be too big a leap to take, but just a question.

MS. RAY: Right. Keep in mind, this is a national survey of ED visits.

DR. BORMAN: Right.

MS. RAY: So the unit of analysis is the visit, not the person.

DR. BORMAN: Okay.

MS. RAY: That being said, let me double-check on the variables in the survey, and if there is something that can parse that out, I will get back to you.

DR. BORMAN: Because you want to subtract them.

MS. RAY: Mm-hmm. Yes.

DR. BORMAN: Otherwise, great work.

MR. GRADISON: Thank you. I was kind of struck by how high the proportion was pretty much across the board here of visits that occurred during office hours, but having said that, are there any data available that would correlate this information with the availability or lack of

availability of urgent care centers within the described districts?

MS. RAY: You know, we can come back to you next time with more information on that. There have been studies that have shown that the -- for specific population groups, particularly Medicaid, uninsured, that the availability of other ambulatory care settings, like FQHCs, for example, has decreased use of the ED. But I would want to come back to you with a little bit more information on that.

MR. GRADISON: Thank you.

MR. GEORGE MILLER: Yes. On Slide 7, I want to make sure I'm understanding this correctly. You are saying African Americans had twice the rate of admissions, but, however, you believe that that's based on where they live versus the skin color. I'll accept the statement, but it still seems to me that if they're getting more PQIs than the white population in that community, there's still a problem, and --

MS. MUTTI: Absolutely. It wasn't suggesting that it wasn't --

MR. GEORGE MILLER: Oh, okay.

MS. MUTTI: It's just that --

MR. GEORGE MILLER: It's just --

MS. MUTTI: -- it's a nuance onto the problem.

MR. GEORGE MILLER: A small nuance in my view, but I think I understand the nuance, then. So it's their location. It's where they're located. So apparently, then, these are large urban areas, my assumption is, or do you know the stratification where they're located?

MS. MUTTI: I don't have that off the top of my head, but I would -- I think we're both a little hesitant to immediately buy into the larger --

MS. BLONIARZ: Yes. I think the rates are higher in the South --

MR. GEORGE MILLER: So it wouldn't, quite frankly, it wouldn't matter. It's just twice as high. Yes. Okay. Do we know why? Does your research tell why this is the case, that they have twice as much PQIs? PQIs, by definition, are not good.

MS. MUTTI: Right. I mean, I think that people believe that PQIs comment on the effectiveness of the primary care system to meet beneficiaries' needs, so it suggests that there is a breakdown in the system, in the community access to care, quality of care in providing those

primary care needs so that they can avoid hospitalization.

MR. GEORGE MILLER: But this leads to our discussion about disparities, which really concerns me. This is a startling statistic that I had not seen before, but it probably parallels the issue about disparities. At some point, we need to address this issue, at least in my view, in a very profound way. This is disturbing, at least to me.

MR. HACKBARTH: [Off microphone] It wasn't twice as high --

MR. GEORGE MILLER: It's off the chart.

MR. HACKBARTH: Yes, and I agree, George. One of the challenges here, if I understand these measures correctly, the question is who is the accountable party. These are measures that reflect a breakdown, but there's nobody -- part of the problem -- part of the reason there may be a breakdown is there's nobody accountable for assuring appropriate access to care. And so unlike our hospital measures of performance about inpatient care, you know who you go to with the number and say, what's going on here? Here, it's an amorphous community of ambulatory providers that is the issue.

MR. GEORGE MILLER: Yes, I agree. However, we have a significant population that's not getting appropriate care.

DR. MARK MILLER: Remember some of the other work that we've run across this phenomenon, and Anne was involved in this, too. There is some sense in the literature, and I don't want to state this too strongly, that certain minority groups will tend to cluster in the hospital literature in hospitals that have poor quality, and one wonders --

MR. GEORGE MILLER: A couple months ago, yes, I remember --

DR. MARK MILLER: -- and while we can't necessarily attribute to individual people in the community, whether some of that is going on in the ambulatory setting, as well.

MR. GEORGE MILLER: If I remember correctly the discussion, some folks were selectively choosing not to go to certain hospitals and bypass them, if I remember, and I think it was in New York, if I remember correctly. Okay.

DR. STUART: Just two questions, one you probably can't answer, and that is I think we all agree that the appropriate portion of PQI admissions is not zero, but then

what is kind of the target that you're aiming for here, or is there any research that would help that?

And then the second is, maybe this is next-next steps, but it would seem to me that this would be one of those obvious cases where you'd want to link A, B, and D data and see whether there's a relationship between utilization of -- appropriate utilization of medications and lower rates of PQI admissions.

[Pause.]

DR. NAYLOR: So thank you very much. A couple questions. In Slide 6 on exploring 3M's work going forward, will that methodology be able to help us understand clustering of conditions and relationships to ED visits? I mean, clearly, we do know that people with multiple chronic conditions, not one or this one or that one, tend to have the highest use of emergency rooms and hospitals and re-hospitalizations. So will you be able to cluster?

MS. MUTTI: Absolutely.

DR. NAYLOR: Okay.

MS. MUTTI: Yeah.

DR. NAYLOR: I think that would a huge contribution to understand which combinations of problems.

I mean, it's a crude measure --

MS. MUTTI: Right.

DR. NAYLOR: -- condition for these individuals who, say, really manifest problems with symptoms, which cluster or tend to contribute. On the second, related to that, is you mentioned 3M's capacity to add, and I think the issues around function and cognition are -- and depression -- because these are all -- so how much capacity would they have? I don't know their disease or severity burden measure, but does it capture these other issues that really impact ED use and re-hospitalizations, hospitalizations?

MS. MUTTI: Okay. On function, we feel that they can make a contribution here. I don't know that they've had a lot of experience with it, but that their model is intended to allow us to use OASIS and MEDICARE'S data so to give it functional data so that they can assess what -- you know, break it down as to what would be the expected admission rate and how those vary.

DR. NAYLOR: Okay. So then it's from extracting from existing data that they -- okay.

MS. MUTTI: We're going to see how it works because, you know, it's something that they're developing

and we're going to try.

DR. NAYLOR: Great. And last comment has to do with in Slide 9, are you also going to be looking at -- I mean, the whole framework of avoidable admissions from SNFs, nursing facilities and home health?

MS. MUTTI: We could. I guess the idea here is that there may be additional conditions on top of the 14 PQIs that maybe we should be taking a look at to see -- especially those that are for this population that are institutionalized or maybe even in home health, if we're missing some that are not in the PQI list, and add those on and do an analysis of that, how common those admissions are, also.

DR. NAYLOR: Thank you.

DR. HALL: Just to build on Mary's point, I think it would be important as you go through that to see if you can dissect out what might be called geriatric-specific conditions she was referring to. The scenario is that many older people, particularly from nursing homes, present to the emergency room with things that are not necessarily codeable such as confusion, fear of falling, and a number of others.

They inevitably end up being coded as urinary tract infection or mild congestive heart failure or something that is more reimbursable. So I don't know that there's a way of doing that, but you did cite some literature that was done last year by Walsh and also a number by Auslander that have tried to take a careful look at that. And I'm not really an expert on how you dissect that out, but I think we need to be very careful as we collect data that we're looking at diagnoses that were made more for billing purposes than what really reflected what the patient's real problem was.

MR. KUHN: In both the advance read or anything in this presentation EMTALA never came up and I'm just curious. Is EMTALA triggered by any of this conversation or discussion we'll have on these issues?

MS. RAY: Yeah, that's an ED question, right.

MR. KUHN: Yeah, correct.

DR. MARK MILLER: My client would like to take the 5th. Unless you have something, maybe we'll come back.

MS. RAY: Well, the only response I have to that is, I guess, more of a process issue for the hospital ED in that a person presents and they are obligated to have --

examination is not the right word --

MR. KUHN: Assessment.

MS. RAY: Thank you. I knew it was something like that. An assessment. And so that would affect -- I've done some little reading that that can affect the utilization of a non-urgent clinic. That being said, at least according to the National Hospital Ambulatory Medical Care Survey that I looked at here, roughly about half of the EDs reported having a non-urgent clinic along with their ED. So I guess that process they've been able to build that in. But to be honest with you, I need to do more -- a little bit more work on that.

MR. KUHN: Yeah, what I'm thinking about is diversion opportunities as we continue to go forward on this, you know, avoiding the overload on the ED, you know, more in the clinic-type setting. So it might be something to think about as we move forward here.

Can we go to Slide 13 for a moment? And a couple quick questions there. On the non-urgent line, I hadn't seen this data before so I was kind of interested in the Medicaid and the uninsured numbers. And I was curious, does that -- are those numbers pretty consistent across the

country or do they vary by state or region of the country depending on how levels of uninsured in given states or the robust nature of the Medicaid programs, who they cover, payment rates particularly for primary care physicians, things like that?

MS. RAY: I will have to get back to you on that. This allows -- the survey allows us to look at regions, not states.

MR. KUHN: Okay. Some regional mapping might be interesting to look at that. The second question on the office hour numbers, and that was interesting. Can that further be broken out by weekends? And the reason I'm curious about that is that, at least anecdotally, I hear, particularly for a lot of nursing facilities, trip to the ED occur on the weekends.

Physicians are busy people. They can't work 24/7. If the nursing facility calls on the weekend says we've got an issue with a resident, and the response is, send them to the emergency department. And can we break it out by weekends as well?

MS. RAY: Yes.

MR. KUHN: Okay. That would be interesting to

see. And then finally, as the work has continued to go forward and people think about measures and activities out there, is there any way to measure in terms of the wait times that people call, you know, for a physician or a clinic office visit and the wait times that they might have for urgent appointments so we have some correlation?

If they're told, Well, if you want to come by the office or clinic, it's going to take you X hours. The person says, Well, I'm just going to go to the ED instead.

MS. RAY: We will look in the literature to see if anything has been written on that. I mean, from the national survey, and I think even from the -- at least one of the years of NCBS I recall you can get an ED wait time. But in terms of trying to, you know, do an analysis of the wait time in getting an office or clinic appointment versus the utilization in the ED, that's something bigger.

MR. KUHN: Okay.

MS. RAY: But we will take a look for that.

MR. KUHN: Thank you.

MR. HACKBARTH: I think there are sort of natural experiments in terms of how the availability of alternatives affects ED use. Scott, I imagine that Group Health has

urgent care as an option for members after hours as an alternative to ED. Certainly we did at Harvard Vanguard. When we put that in, we were able to dramatically reduce our non-office hour ED visits and dramatically reduce costs.

You know, it might be hard to do that on a community level, and using the datasets that you are using, assess what the impact of having urgent care is, but there are some organizations that have that built into the structure.

MR. KUHN: And the importance of that, I think, Glenn, is if you look at that number, the 10 percent of Medicaid right now, I mean, think what's going to happen in 2014 where we're going to have another 16 million people enrolled in the Medicaid programs. You know, the number of people seeking care are going to grow and those numbers could grow accordingly as well.

DR. NAYLOR: I just want to add, there's state-level efforts to dramatically change the use of the emergency department services that have been in play for a couple of years. So we might be able to look, given national data, what impact they have had.

MS. RAY: There have been. That's a very good

point. The DRA permitted state Medicaid programs to consider implementing cost-sharing for non-urgent ED visits for Medicaid beneficiaries if the hospital could set up an appointment at another ambulatory care setting, and we could come back to you next time with more information about that.

DR. BERENSON: My question, and maybe Mark should get in on this also, is sort of the purpose for doing this work. You've said it's for discussion use of potentially avoidable hospital admissions and ED visit, population-based quality measures. But I see a number of potential policy implications for what we're going to be learning here around how we're defining Medical Homes and the expectations of Medical Homes, the payment model for Accountable Care Organizations, which I could get into if anybody is interested, how we do our readmissions policy, which is bonuses for lower -- or lack of penalties for low readmissions, but nothing about index admissions.

I could conceive of using some data like this that would come out of a measure to affect policy. So I guess my question is, are we simply interested in developing some measures, or do we really want to use this as a take-off to get into some potential policy, which I think would have a

much bigger impact?

DR. MARK MILLER: Our thinking here is that there was a fair amount of development work that still needed to be done here, and even on the admission side and even more so on the emergency room side. We didn't want to get too far ahead of the curve here. But there's no reason that as this develops and stabilizes and we think that these are valid measures, that we can't take the conversation in that direction.

DR. BERENSON: I guess the point I'd make is that I think there's some potential policy levers that don't actually require sophisticated measures, but are related to simply -- I mean, specifically the one around the Medical Home definition. We did, at Urban, an assessment of ten Medical Home assessment instruments, and nine out of the ten give very little attention to access and availability to services.

I mean, it's there, but pretty low on the totem pole in terms of what the expectations are for a Medical Home. Only the State of Oklahoma's Medicaid Medical Home actually has a lot of attention to that area. I'm a big believer not only -- that primary care is not only doing the

good things in the office to teach patients self-management skills and doing care coordination with other docs, but being available at three in the morning to talk to the ED or talk to the patient, being willing to be involved with sick patients.

There seems to be a growing trend of just not being available after hours, and so I think after hours coverage and how that is done, as well as the ability to encourage patients with urgent problems to come into the office rather than discouraging them because the schedule is full.

I think that should be an absolutely core part of the Medical Home and it gets very little attention. So I think we could, if we wanted to, sort of take off on the kinds of data and variations of practice that you're finding even without sophisticated measures.

I actually think it's useful and I'm not saying we shouldn't do it, re-urge this, but I think we could broaden this if we have the resources and the time, et cetera, to really look at the broader implications for what we're finding for policy.

DR. MARK MILLER: Yeah, and I don't think there's

any resistance to any of that, and just to remind you and other Commissioners, you probably remember, but we also, when we did the criteria, what we thought the criteria should be for the Medical Home, and Cristina might reinforce this, make sure it's right.

We did have some criteria about availability as what we thought. If you're going to qualify as a Medical Home, if you're going to get a PMPM type of payment, then you need to do these types of things. So we had some of that criteria. And I think the connection you're making is, could this be a measure that tells you whether a Medical Home or an ACO is doing a good job on that front. Is that the connection you're making here?

DR. BERENSON: Yeah, if we have a measure it's better, but just simply as an expectation. I mean, most of these assessment instruments sort of allocate points to, do you have the following systems in place, do you have the following processes in place.

So even if we didn't have the measure, there's an opportunity to suggest that -- I mean, I'm aware of some folks over at Health System Change, Ann O'Malley being the lead, who are doing a study on -- I think they're looking at

multiple models of after-hour coverage, and that kind of thing could, if understood, I think inform definitions of Medical Home.

CMMI now has a new demo they just announced on primary care, and I think one of the five major components of that is around access and availability after hours, and so I think could contribute to that beyond what we would learn just from an outcome measure, which again I think would be terrific, but I don't think we have to just focus around the measure piece.

DR. MARK MILLER: I think I'm hearing you now. I think what you're saying is, let's say it doesn't end up being a fine and beautiful and perfect measure, but it does show you enough variation that it drives you back to these other models to have these requirements to try and overcome the faults.

DR. BERENSON: And even helping sort of develop those models might be a direction to take at some point.

MS. BEHROOZI: Yeah, I had a question about the regional variation that you found in the hospital admissions. So as you mentioned in the presentation, you also found that the lowest quartile had rates about twice as

high, but you didn't indicate in the paper whether that variation followed the pattern for the variation for African-Americans, you know, whether it was greater across regions than within regions. I don't know if you looked at that.

MS. BLONIARZ: We don't know the answer, but that is a knowable question.

MS. BEHROOZI: Okay. And then one more question on the regional variation. Did you or could you do an overlay with either the Dartmouth Atlas, you know, regional variation in spending, or the MEDPAC regional variation in intensity? I don't know which way it goes then causality-wise, but it just might be interesting to see how much that lines up, if the high-spending places are spending a lot on inappropriate admissions or inappropriate ED use, when you get there, or if it's intensive of use or whatever.

MS. BLONIARZ: We can definitely do that.

DR. DEAN: This may be actually the same question that Mitra just asked, but I was interested, too, on Slide 7 where you said that the African-Americans had twice the admissions. Is the issue where they live? In other words, is it a community phenomenon or is it an ethic group

phenomenon? In other words, it might be useful, presumably, to look at those communities and see what the other groups, what is the rate for the white population in that area.

My sense is that it may be a community phenomenon because of the availability of other care and stuff. But I don't know. But I think it would be useful to know that.

MS. MUTTI: I think that --

DR. DEAN: And that's probably what Mitra was asking.

MS. MUTTI: -- your sense is consistent -- and she's asking on the income side, not just on the race side.

DR. DEAN: Yeah.

MS. MUTTI: But I think your understanding is consistent with mine, but let me go back and flesh this out a little bit more and explain all the different ways they've looked at it in the literature and make it a clearer picture for you.

DR. DEAN: And on Slide 13, the rates for Medicare of potentially inappropriate ED use, when we add those together, it's just a portion -- I was trying to figure out -- what is the overall rate for the Medicare population?

MS. RAY: The overall rate of ED visits?

DR. DEAN: No, of -- I guess maybe I'm -- the ones that occurred during office hours, are they also in the group that's listed above, in other words, like non-urgent? If it occurred during office hours, is it also listed under the -- would it also be --

MS. RAY: Right.

MS. BEHROOZI: Are they mutually exclusive?

DR. DEAN: Yeah, are they mutually exclusive?

DR. MARK MILLER: We talked about this, Nancy. I don't think that as of -- let me try and get it corrected. I don't think they're mutually exclusive.

DR. DEAN: Okay.

DR. MARK MILLER: So if you look at like preceded by an ED visit.

MS. RAY: Right. They are not mutually exclusive.

DR. MARK MILLER: Right. But that's what kind of drove her little break-out. We just want to make sure that you understand how many of that 34 percent are non-urgent.

DR. DEAN: Okay.

DR. MARK MILLER: That's what the little 5 percent is at the bottom of the slide.

DR. CHERNEW: People have emergencies during

office hours.

DR. DEAN: Absolutely, yeah.

DR. MARK MILLER: And that's the point, is that we're saying most of those appear to be.

MS. RAY: Right. That's why I wanted to do that additional break-out.

DR. DEAN: Okay. I guess probably what I was asking is the overall group, how many were considered possibly avoidable, and I don't know, maybe it says here. Maybe I'm just not getting it.

MS. RAY: Well, we did not calculate the rate of potentially avoidable ED visits from this data, and one of the reasons why is this was just our initial pass at this. This is -- I would say this is a pretty conservative approach because we did not look at the conditions of the patients. You know, we didn't see if they were primary care treatable or ambulatory care sensitive. We just used these variables. But in our future work, we will be getting back to you with that.

DR. DEAN: Thank you.

MR. HACKBARTH: Clarifying questions?

MR. BUTLER: So on this slide, I actually think

that your Table 4 in what you sent us is even more interesting than this, but it relates to some of these figures. I've frequently said that emergency departments are the most wildly popular service that we provide. Even though we don't do it very well, people keep coming.

MR. HACKBARTH: At very high prices, too.

MR. BUTLER: Yeah. So you say there's a 51 percent increase in visits between 1996 and 2009, overall, right? And that it looks like it's across all payers. The only change, interestingly, in that time frame in terms of payer mix has been mostly the Medicaid population, which is now like 29 percent versus 22 percent. You're going to correct me?

MS. RAY: No. You've got it.

MR. BUTLER: But most of that is not the rate per thousand. It's just because there are more Medicaid enrollees. So what is the most interesting, though, to me that the rate per thousand increase, by far, the biggest increase is in private insurers, 50 percent increase, and you would think that that's the one where we've increasingly, over that period of time, gone from a zero kind of deductible to 150 to 200 bucks to make that visit

occur.

So I know I'm in a little bit of a Round 2 and I won't speak in Round 2, but that would be an interesting thing. The people that are choosing to come and pay a lot more out-of-pocket, the rate of increase is faster in private insurance than any other component.

MS. RAY: Yes. I mean, I think the thing about the rates, of course, is that on the enumerator, the number of ED visits is increasing for PRIORITIES. The denominator, the number is increasing, but not as fast and not as big as for the Medicaid or the uninsured or even the Medicare groups. And so, that's why you're seeing that their rates between '96 and '09 have grown the most.

MR. GEORGE MILLER: On Peter's question, though, it would be interesting to know if they're paying it. It's one thing to be billed in the private insurance for the out-of-pocket expense. The question would be the bad debt on the ED, if they're paying it, because ours just exploded all over the board. Everybody, whether they had the ability to pay or if they had insurance, our bad debt in the ED just went through the roof.

DR. MARK MILLER: We will take this offline and

talk about it a little bit more, because Jeff has also raised some points about how in private insurance the pricing negotiations go. So you may have a negotiated price for an office visit, but if the person goes to an ED visit, then you're paying a different price. And so, we kind of noticed this phenomenon, too. We'll do a little more thinking and see if we can't figure this out a little bit more.

MR. ARMSTRONG: So I will be brief because I think this gets close to Round 2, but all I would say is that in contrast to the points that have been made, there are systems -- I happen to work for one of them -- but there are others who have implemented a series of changes in care delivery that I've seen 20 to 40 percent drops in unnecessary ED room visits and hospital days.

Some of it has been documented in Health Affairs and other places, and we really ought to bring some of that experience into this discussion, too.

MS. MUTTI: I think that was one of our next steps and we've been collecting it ourselves, the documenting all the different strategies that different people are using out there, and come back to you with that.

MR. HACKBARTH: Okay, Round 2.

DR. BORMAN: I'd just like to echo or support what Bob Berenson said about the importance of making sure, as we think about how to use this work, that access to care is part of any coordinated care benefit or entity or payment or whatever that we make, because to make it solely a Monday through Friday, nine to four activity, certainly speaks against presumably all the principles and the reasons behind having a continuous care benefit.

And then my one other question was, within that Medicare group on Slide 13, MA is in there? I'm sorry, I missed if you said MA was excluded, or does that include MA people in there? Because you'd like to think that the MA people have different behaviors. Maybe if MA is doing what we would like it to do, you would like to --

MS. RAY: I think it's in there.

DR. BORMAN: Is in there? Okay.

MS. RAY: But let me just double-check.

DR. BORMAN: Because it would just be interesting to see, does it have a different trend of data that we would like to at least impute is behavioral because of the presumed advantages of MA.

MS. RAY: I just want to just say, I don't think we can break out, because this is a national survey, the MA, fee-for-service versus -- Medicare fee-for-service versus MA.

MR. HACKBARTH: Would this kind of a survey have the same issue that we face in our patient access survey, where sometimes beneficiaries don't distinguish -- if they're enrolled in MA, they don't think of themselves as Medicare any longer.

MS. RAY: But this information was extracted not from the patient, but from the hospital ED.

MR. HACKBARTH: Oh, okay.

MS. RAY: So as long as that, presumably, that is --

MR. HACKBARTH: Well, then that wouldn't -- since the private plans, the payer, why would they be identified as Medicare?

MS. RAY: Let me double-check on that.

MR. HACKBARTH: If it's coming from hospital discharge, we'd think it would have the payer on it, but I don't know anything about these surveys.

DR. BAICKER: No, those data do -- the discharge

data usually distinguish Medicare Advantage from a private insurance that isn't Medicare Advantage.

MR. HACKBARTH: Okay.

MS. RAY: All right, thank you.

MR. HACKBARTH: Bill, George?

MR. GEORGE MILLER: Just briefly, the slide on for-discussion, since we've discussed this issue concerning PDIs for race, I'm not sure how to frame this, but I'd certainly like to see that as part of the discussion at some point. You make a good point, Glenn, but who do you hold accountable, which is one of the issues.

The second quick point, I wonder how much of the analysis has been impacted by my perception that in some states, physicians are dropping Medicaid because of the payment and medical malpractice. I remember in Illinois we could not find, at least in the city I was in, OB-GYNs to take Medicaid business because of the payment issue. And has that driven more patients to the ED and has that had an impact across the nation on your numbers? Or do you know? Did you study that?

MS. RAY: We will have to get assistance on that one.

MR. GEORGE MILLER: Love doing that.

DR. NAYLOR: Briefly, so first, terrific work. I really like the framework of thinking about this path and all of these what we used to call transitions, vulnerable transitions, what gets you to the ED, what can prevent you from having to be admitted, all of this. So I really like the framework.

I really also appreciate the challenges that you'll experience with the very significant limitations, ambulatory care-sensitive conditions, so the opportunities now that you have with the methodologies to really enrich our understanding about the complexity of factors that contribute to use of the ED visits, some of which are grounded in people's medical conditions, but many of which have nothing to do with that, have to do with incentives operating in other parts of the system and other complexities.

I do think we really do need to pay attention to people at or near end of life in this process and what opportunities there might be. And finally, in addition to why we would do it, in addition to everything else that's been said, I think it creates a tremendous baseline for us

in understanding impacts of states' efforts to create alternative paths for the emergency rooms, of the NCQA's efforts to have new criteria implemented, which really promote access and continuity with the primary care, and of these demos that are unfolding.

So I think that there are multiple purposes, but really applaud the effort.

DR. HALL: Well, even if you didn't do any more massaging of the data, I think you've established a point that we would all agree with, that there are avoidable admissions of the hospital and avoidable visits to the ED.

I think Scott's suggestion that we look for best practices is really a very key one, because there are places that have tried to tackle this problem, and I think those strategies will probably be that there's some alternative care delivery models that have been set up. It isn't that they just avoid seeing the patient, and so there's more and more 24/7 services that don't involve EDs, I think, that would help inform all of us.

MR. KUHN: I agree completely, that I think the need to measure in this area, both on preventable ED visits, preventable admissions is a great opportunity, and I'd

thought a little bit about how this could drive some other kind of policies, but I think Bob's comments earlier were very instructive and very helpful to really begin to think more about the inter-dependencies of all thee programs and what's playing out here.

You know, for example, if you take a hospital that's looking at maybe the issue of readmissions, or ACO, or whatever the case may be, and is looking at post-acute care providers, I think they'd like to really know the performance of those post-acute providers.

So if there were a set of measurements that, say, nursing facilities that looked at their admission rates for falls, UTIs, different things like that, I think it would be very informing in terms of the marketplace picking the right kind of partners and helping drive people to high-performing systems or care providers that are out there.

So I think Bob's on to something there about the inter-dependencies that this could create, and it's more than just measurement. I think there are some other policies where we can get kind of a -- there's a lot of portability of what we could do here that could impact other kind of policy activities, so you can get kind of a two-fer

out of it hopefully.

MR. HACKBARTH: The beauty of a system like Scott's is that you have an accountable party. They're responsible for all the full range of services for a defined population. And because they have full financial responsibility as well as full clinical responsibility, they have both the incentive and the resources to establish alternative that are efficient and effective.

If you have any partial system where there isn't full responsibility, take Medical Home, then you potentially have an additional cost, but they're not reaping all of the benefits of the investment in the expanded capacity and you've got a bit of a disconnect that you've got to try to manage around. Bob?

DR. BERENSON: Let me give you a concrete example of unintended consequences around this issue. I have a very good friend, professional colleague, whose practice of about 18 internists is combining with four other practices to become an IPA. They're interested in becoming an ACO. Initially they're talking to private insurers, not yet Medicare. They're not ready for that. In fact, some of these practices don't see new Medicare patients, so that's

an issue.

But their data -- what they've done is robust availability. So the practice, the one I know very well, they have an hour of phone call hours a day, in the morning from eight to nine, non-reimbursed. They schedule their urgent patients then. They're talking to the hospitalists and they're doing all that stuff. Most practices don't do that.

They're taking calls. They now have access to an electronic health record to help them. And the upshot of all of this is that when the insurer looked at their performance, their hospital days are 150 days per thousand, which is pretty good. Right, Scott?

In a fee-for-service world with no incentives to be at 150 days per thousand, and the shared savings model, whether it was one-sided or two-sided, gives them no rewards because they're already -- the insurance company says, Why would we pay you any more because you are two standard deviations lower than the average? You're already giving us that benefit.

And so, they're going to have trouble making a deal. The insurer doesn't want to put more money on the

table, understandably, and the practice says, Well, what's in it for me to do better than what I've already been doing on my own dime?

And so, I mean, the basic point I want to make here is, those kinds of processes, even in traditional fee-for-service practices where some docs do it and other docs don't do it, is sort of unrecognized. And I sort of like the idea, with Scott and Bill, about developing some models not only in large groups, group practices, but what have been the successful models that maybe haven't been supported that some practices are doing regardless, and then how do we think about how do you support it so that more practices will do it? I think that might be a very good idea.

MS. BEHROOZI: I think the paper raises some interesting issues about nursing facilities, skilled nursing facilities, and my earlier question about the influence, or whatever, the fact that you see so much higher rates among low-income people, to what extent is that dual eligibles in nursing homes who are being cycled through the three-day hospital stays to trigger the higher payment, which might show up as a negative quality indicator for a nursing home?

But then again, if it's like sort of the culture

in that region or if it's driven by state Medicaid bed-hold policies, to some extent, you know, apart from trying to do the good things about finding good models of care and things like that, trying to root out what are the distortions in the -- I mean, that we know about, but really, you know, to pull the data together around the distortions in the payment system that drive bad things.

Not to say they're bad people, you know, for doing that. I understand they need to maintain their revenue, but to figure out better, more productive, efficient ways to do that rather than by cycling frail, elderly people through the hospital unnecessarily.

DR. CHERNEW: I think that the delivery system bears a lot of responsibility for much of the things we're discussing, I just want to say, because it hasn't been said much before. There's a lot of self-management issues related to a lot of these things, and so that brings in some of the benefit design and a whole series of other issues that we haven't discussed.

DR. DEAN: Just sort of to, I mean, in a sense, restate some have already said. I mean, so much of this really does depend on the incentives that are developed.

And as you said, Glenn, it has struck me as we've looked at systems that are really performing, it's primarily those that, one way or another, are working with a fixed budget.

It's the safety net systems. I mean, we heard from the folks in Denver and Dallas, and I know my son, you know, is at a safety net hospital in Minneapolis and they're doing some of these things just because everything they can do to reduce admissions actually they gain. Whereas, most community hospitals, it's just the other way around.

So it really is an overall -- it's an issue of the overall structure of the system because it's from that flow the incentives to do these other things that we know can prevent some of these things.

In response to Herb's comment about EMTALA, for us that was a big issue because I work, as you know, in a little tiny system where we're in the same building as the emergency room, but if somebody wandered into the emergency room in the middle of the day with -- sometimes they didn't know that the clinic was available, maybe it was somebody from out of town, or for whatever reason, the emergency room would, where they felt obligated to keep them there and to treat them in the emergency room, which is a terrible burden

for us because we're the -- the ER docs are the same as -- we are the ER docs, and so we would have to leave a busy office practice to go across, down the hall, spend time in the emergency room, and leave it.

So it really is a problem. I think we're beginning to work through it. There are options within the EMTALA legislation to allow people, once they've had their, quote-unquote, assessment to send them to the clinic. But it really did produce some issues. So it's something to look into.

Just a very picky point. If there's a citation t Auslander in the written material that I tried to find, it's not in the references. Maybe you could find that. Thanks.

DR. BAICKER: So I stand firmly with everyone against avoidable hospitalizations. And the investment in the measures of really honing in on what those are seems like a great investment for just understanding how well systems are performing, and also then, potentially in the future, moving into policy levers.

I agree that right now, the measures may be too crude to be able to move into policy levers, so that investment seems well worthwhile, because it seems

particularly problematic given that we want the policy levers to operate at the provider level, and we know that the measures that we currently have really perform best at the community level, and that when you break them down into the provider level or, you know, more difficult still, subgroups within the provider level, you're not capturing in as refined a way as you would like to, the real unavoidable, unavoidable hospital admissions. So the refinement would let you have policy levers you wouldn't have right now.

MR. BUTLER: Quick comment on unintended consequences. Herb, you brought up the impact of expanded Medicaid in 2014. I think unintended is likely to be the -- you'll have increased demand, but I think you're going to have a shift from the large public safety net hospitals. Those people are going to be taking their cards to other hospitals.

And so, while you're trying to prop up those institutions, the reverse may occur because those that now have Medicaid are going to go elsewhere. It happened in OBVIOUSLY over the years. The number of deliveries at public -- you know, now that Medicaid -- they took their cards and they went elsewhere for care. So just something

to be aware of.

MR. ARMSTRONG: I won't repeat many of the points that were made that I think are really strong points. I just want to say I agree that this is an important topic and I'm excited that we're pushing this. Bob said it in Round 1. We really want to think about how this is more than just how do we flesh out an indicator of quality, but how does it give us insight into other issues that are really important to the Medicare program.

I would say, even if we can't replicate features of integrated systems that I'm familiar with, to me this topic highlights the real value that comes from our discussion around payment policy to providers being aligned with incentives and benefits that affect individuals. And that it's really bringing those two together in areas like preventable admissions and ER visits. You can get some real traction.

It also strikes me that a similar kind of payment policy has recently been considered and implemented around readmission rates to hospitals and that we ought to look and see, what are we learning from that experience? Why are we paying for potentially avoidable admissions to hospitals, as

a question.

And are private insurers no longer paying for some of those? And what's that experience been? I think those would be interesting questions for us to pursue. And I'll leave it at that. Thanks.

MR. HACKBARTH: Okay. Thank you very much. Look forward to hearing more about that.

We'll now have our public comment period. Seeing no one at the microphone, we will adjourn and see you all, let's see, November, right?

[Whereupon, at 11:32 a.m., the meeting was adjourned.]