

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:
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MICHAEL CHERNEW, PhD
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WILLIAM J. HALL, MD
HERB B. KUHN
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BRUCE STUART, PhD
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1 debt ceiling legislation, the alternative is a 2 percent
2 sequester in payment rates in Medicare to take effect in
3 February 2013. In formal legal terms, that sequester has
4 not yet been formally triggered. That would happen at a
5 later point, but the common assumption is that the sequester
6 seems likely.

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

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

1 When we make update recommendations, they are
2 recommendations for a percentage change in that base rate.
3 And so just for the sake of illustration, if you think of
4 the base rate for a provider category as \$100 and we
5 recommend a 1 percent update, what we're saying is we think
6 the base rate for that category of providers should go to
7 \$101 for the fiscal year in question, and we are making
8 recommendations now for fiscal year 2013.

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

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

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

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

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

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

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

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

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

11 As we discussed last month, margins improved from
12 2008 to 2010, and this was due to two factors:

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

16 Second, with the downturn in the economy at the
17 end of 2008, hospitals responded by tightening expense
18 control. The result was slower cost growth in 2009 and
19 2010.

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

1 We estimate that overall Medicare margins will go
2 from negative 4.5 percent in 2010 to negative 7 percent in
3 2012, which is about where margins were in 2008 prior to the
4 full effect of the documentation and coding on revenues.

5 The drop is primarily due to reductions in
6 inpatient updates that occurred in fiscal years 2011 and
7 2012 to partially offset changes in hospitals' documentation
8 and coding. These documentation and coding adjustments to
9 the update resulted in inpatient payments increasing by only
10 1 percent from 2010 to 2012.

11 We also expect cost growth to increase from
12 roughly 2 percent to 3 percent per year. We expect input
13 prices and hospital costs to increase due to an improving
14 economy and a reduction in hospitals' pressure to constrain
15 costs after achieving high all-payer margins in 2010. We
16 expect the net result will be slower payment growth and
17 faster cost growth, causing approximately a 2 or 3 percent
18 decline in margins over the two-year period from 2010 to
19 2012.

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

1 kept their 2010 costs down below Medicare payment rates.

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

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

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

22 The second difference is in the distribution of

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

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

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

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

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

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

22 Part of the rapid growth in outpatient services is

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

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

9 For example, for E&M office visits provided in
10 OPDs or in free-standing physician practices, the percentage
11 that is provided in OPDs has increased at an annual rate of
12 3.5 percent per year over 2004 through 2008, but by 9.9
13 percent in 2009 and by 12.9 percent in 2010. Moreover,
14 incentives are present for this acceleration to continue.

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

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

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

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

14 Do OPDs have more complex patients?

15 Do OPDs maintain standby capacity for that
16 service?

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

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

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

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

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

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

22 However, the effect on hospital revenue differs by

1 hospital group. We estimate that Medicare revenue would
2 decline by 1.1 percent among major teaching hospitals but by
3 0.4 percent among other teaching hospitals and non-teaching
4 hospitals.

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

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

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

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

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

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

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

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

1 the relatively high payments for their DSH and teaching
2 status.

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

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

18 [Laughter.]

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

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

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

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

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

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

1 patients in the community.

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

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

9 MR. HACKBARTH: Thank you.

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

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

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

1 DR. BAICKER: I support the recommendation.

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

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

20 DR. HALL: I support this.

21 DR. BERENSON: I am supportive.

22 DR. NAYLOR: I support the recommendation, but I

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

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

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

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

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

7 DR. STUART: I support the recommendation.

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

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

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

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

20 DR. ZABINSKI: Yeah.

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

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

10 DR. CASTELLANOS: Thank you.

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

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

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

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

18 DR. BORMAN: I support the recommendation.

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

1 Opposed to recommendation 1?

2 Abstentions?

3 Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 that regard.

2 The first is to have what we've referred to as a
3 "stop loss" for institutions that experience a greater-than-
4 2 percent loss in their total Medicare revenues and, in
5 addition to that, have at the median or a higher ratio of
6 disproportionate share patients, namely, low-income Medicare
7 or Medicaid patients, and that stop loss protection would be
8 in effect for the first three years.

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

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

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

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

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

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

11 DR. ZABINSKI: Two-thirds the second year.

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

14 DR. ZABINSKI: Right.

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

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

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

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

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

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

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

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

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

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

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

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

22 There is one thing that I am somewhat bothered by,

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

15 So, again, I strongly support these
16 recommendations.

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

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

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

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

12 DR. ZABINSKI: Potentially, yeah, sure.

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

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

1 overall. So if you were to apply a 10 percent reduction to
2 outpatient, that would, all other things being equal, be a
3 20 percent loss for those institutions in that last 5th
4 percentile.

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

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

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

16 MR. HACKBARTH: Okay. Yes.

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

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

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

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

22 And then the third is not just teaching hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 So I'm in favor of the policy.

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

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

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

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

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

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

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

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

1 recommendation 3.

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

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

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

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

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

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

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

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

1 DR. ZABINSKI: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. STUART: I support both recommendations, and I

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

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

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

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

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

3 I do have one technical question regarding Slide
4 13, and it gets to the eloquent point that Peter was raising
5 about the impact on specific facilities, and that is, do
6 these numbers, both by transition year and when fully phased
7 in, take account of the stop loss?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 MR. HACKBARTH: And Mary.

5 DR. NAYLOR: It's totally okay.

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

9 All opposed?

10 Abstentions?

11 Okay. On recommendation number 3, all in favor?

12 Opposed?

13 Abstentions?

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

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

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

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

10 Cristina, are you --

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

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

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

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

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

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

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

22 At the December meeting, we discussed measures of

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

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

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

1 also require ambulatory surgical centers to submit cost
2 data.

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

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

1 cost data.

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

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

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

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

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

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

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

15 So the second draft recommendation reads, the
16 Congress should direct the Secretary to implement a value-
17 based purchasing program for ASC services no later than
18 2016. Given the need to develop additional measures and
19 gain experience with reporting them, we think that 2016 is a
20 reasonable time frame for starting this program.

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

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

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

11 And now I will hand things over to Cristina.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MR. GRADISON: I support the recommendation.

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

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

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

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

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

18 Within the medical community, there's a strong
19 ongoing feeling that we hope maybe Congress will enact the
20 27.4 percent cut. What that will do, if it is put in, it'll
21 make the Medicare beneficiary and the physician community
22 and the hospital community really seriously thinking about

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

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

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

1 we'd get an answer.

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

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

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

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

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

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

16 DR. ZABINSKI: Yes, that's correct.

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

20 DR. ZABINSKI: That is right.

21 MR. GEORGE MILLER: Okay. Thank you.

22 MS. BEHROOZI: I support the recommendations, and

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

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

18 MR. KUHN: I support both recommendations.

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

1 the ASC. Could you give me a little more about that?

2 What's that based on? And is the sort of the measure of the
3 complexity -- I mean, the burden of that complexity manifest
4 in longer OR times? Do we have anything else to be able to
5 demonstrate that, in fact, that there are increased costs
6 that support such a differential?

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

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

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

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

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

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

18 DR. BERENSON: Okay.

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

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

22 DR. DEAN: I support the recommendations. I would

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

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

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

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

22 MS. UCCELLO: I support the recommendations and

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

6 MR. GEORGE MILLER: Cherry picking.

7 [Laughter.]

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

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

22 DR. BAICKER: I support the recommendations.

1 MR. ARMSTRONG: Yes, same.

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

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

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

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

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

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

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

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

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

10 Thank you. Good work.

11 We will now move on to outpatient dialysis.

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

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

16 [Laughter.]

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

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

20 MR. HACKBARTH: I led Cristina astray, too.

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

1 Opposed?

2 Abstentions?

3 Okay. And number two, all in favor?

4 Opposed?

5 Abstentions?

6 Now I think we're done. Thank you.

7 [Pause.]

8 Nancy, you can start whenever you are ready.

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

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

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

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

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

16 There was also a question about changes in the use
17 of other dialysis drugs. Between 2009 and 2010, the total
18 volume of iron agents increased by one percent. And between
19 2009 and 2010, the total volume of Vitamin D analogs
20 decreased by two percent.

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

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

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

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

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

1 transfusions, and we will baseline blood transfusion use in
2 2009 and 2010, and once 2011 data become available, we will
3 make the comparison.

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

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

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

22 Access to capital appears to be good. Merger and

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

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

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

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

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

17 We are concerned about the direction of margins
18 for rural facilities. Tomorrow morning, Jeff and Adaeze
19 will address the dialysis low volume adjustor that began in
20 2011 under the new payment method and that this low volume
21 adjustor is anticipated to disproportionately benefit rural
22 facilities. Recall that 2010, the year that the margin is

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

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

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

1 And I look forward to your questions.

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

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

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

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

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

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

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

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

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

20 MR. BUTLER: I support.

21 DR. CHERNEW: I support.

22 DR. DEAN: I made a mess.

1 [Laughter.]

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

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

13 DR. BERENSON: As am I.

14 MR. KUHN: I support the recommendation.

15 DR. NAYLOR: As do I.

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

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

1 DR. STUART: I support the recommendation.

2 DR. CASTELLANOS: I support the recommendation.

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

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

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

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

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

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

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

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

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

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

12 Opposed.

13 Abstentions.

14 Okay. Thank you, Nancy.

15 Our next session is on hospice.

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

22 This slide provides a snapshot of Medicare hospice

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

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

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

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

1 part on how the formulas are implemented operationally.

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

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

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

1 So now to review our payment adequacy indicators.
2 First, our indicators of access to care are positive. The
3 supply of hospices continues to grow, increasing more than
4 50 percent since 2000 and almost 3 percent in the most
5 recent year. For-profits account for most of that growth.

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

10 In terms of quality, we do not have any data on
11 which to evaluate trends in hospice quality. However, in
12 2013 per PPACA, hospices will begin reporting quality data.
13 Those that do not report that data will face a 2 percent
14 reduction in the update beginning in 2014.

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

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

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

5 Now, in terms of margins, the aggregate margin is
6 7.1 percent in 2009, up from 5.1 percent in 2008. You'll
7 recall this estimate does not count cap overpayments as
8 revenues and excludes nonreimbursable bereavement and
9 volunteer costs.

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

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

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

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

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

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

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

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

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

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

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

19 MR. HACKBARTH: Okay. Thank you, Kim.

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

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

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

5 I support the recommendation.

6 DR. BERENSON: I support the recommendation.

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

8 DR. DEAN: I support the recommendation.

9 DR. CHERNEW: As do I.

10 MR. HACKBARTH: People are speechless.

11 MR. BUTLER: Not so easy.

12 [Laughter.]

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

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

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

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

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

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

1 MS. NEUMAN: Yeah, that's true.

2 MR. BUTLER: Okay.

3 MS. UCCELLO: I support the recommendation.

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

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

15 DR. BORMAN: I support the recommendation.

16 MR. GRADISON: As do I.

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

1 familiar with that?

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

4 DR. CASTELLANOS: I think so, yeah.

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. HACKBARTH: Okay.

22 DR. STUART: I support the recommendations, Kim.

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

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

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

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

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

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

4 Opposed to the recommendation?

5 Abstentions?

6 Okay. Thank you, Kim.

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

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

20 Sharon.

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

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

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

12 MS. McILRATH: Well, honestly --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to have those services available that we can improve care.

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

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

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

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

8 So, Carol, thank you.

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

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

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

1 2010. There is quite a bit of variation, as you can see on
2 this slide, and in part this reflects cost differences
3 across facilities. For example, nonprofit facilities have
4 costs per day that are 7 percent higher than other
5 facilities, after adjusting for differences in wages and
6 case mix. The variation also reflects the biases in the PPS
7 that raise payments for high therapy care above these
8 patients' costs.

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

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

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

1 to rebase payments:

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

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

6 Some SNFs have both low costs and high quality;

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

9 Three key concerns have been raised about rebasing
10 Medicare payments. First, Medicare's payments were already
11 reduced by 11 percent in 2012. But remember that this
12 reduction was made to correct unintended overpayments in
13 2011 that we estimate resulted in margins in the 24 percent
14 range. Even after the reductions, we estimate margins will
15 be over 14 percent in 2012.

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

1 program should be established to do this.

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

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

1 that payments are redistributed before reductions occur.
2 Rebasing would not occur until the following year, in 2014.
3 It also acknowledges that a transition is important. The
4 reductions would be taken in steps, with the reduction in
5 2014 seen as the first step in aligning payments and costs.
6 And we will be monitoring industry performance each year as
7 rebasing is implemented.

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

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

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

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

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

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

1 ample opportunity for some SNFs to lower their
2 rehospitalization rates.

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

10 Mary, you asked about the alignment of the
11 hospital and SNF incentives if a SNF rehospitalization
12 policy was implemented. This chart shows which providers
13 are at risk under a rehospitalization policy that would
14 include a 30-day window after discharge from the SNF. The
15 hospital stay is shown in the first bar and the SNF stay is
16 in the second bar. If a rehospitalization occurred within
17 30 days of discharge from the hospital, both the hospital
18 and the SNF would be at risk, helping to ensure good
19 transitions between these providers. That's the overlapping
20 red bars.

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

1 risk may make sense since at some point the hospital is less
2 accountable for care provided considerably after a
3 beneficiary is discharged from it. Looking at the risks
4 after the beneficiary is discharged from the SNF, the SNF
5 would be at risk for rehospitalizations that occurred within
6 30 days, helping to ensure adequate transitions after the
7 SNF stay.

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

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

1 that providers have an incentive to lower their
2 rehospitalizations.

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

10 As required by PPACA, we include information on
11 Medicaid trends in spending, utilization, and financial
12 performance for nursing homes. The details are in the
13 chapter, but here are the highlights. Service use increased
14 between 2009 and 2010, and while spending decreased
15 slightly, since 2002 spending has increased 16 percent.
16 Average daily payments vary twofold across states. Both
17 non-Medicare and total margins improved between 2009 and
18 2010. In 2010, non-Medicare margins were slightly negative
19 while total margins were positive.

20 And with that, I look forward to your discussion.

21 MR. HACKBARTH: Okay. Thank you, Carol.

22 Since these recommendations sort of fit together

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

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

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

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

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

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

14 DR. HALL: Right.

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

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

22 DR. DEAN: I support the recommendations. I guess

1 I don't have any other questions.

2 DR. CHERNEW: Me, too.

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

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

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

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

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

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

16 MR. HACKBARTH: Well, yeah.

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

1 MR. HACKBARTH: Okay.

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

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

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

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

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

3 Was this recommendation in the packet of our SGR
4 proposals?

5 MR. HACKBARTH: The rebasing?

6 MR. ARMSTRONG: Yeah.

7 MR. HACKBARTH: Yes.

8 MR. ARMSTRONG: Was it? Okay.

9 DR. MARK MILLER: And the rehospitalization.

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

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

1 DR. MARK MILLER: 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 So a good question. More thought on that.

6 DR. BORMAN: I support the recommendations.

7 MR. GRADISON: I do as well.

8 DR. CASTELLANOS: So do I.

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

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

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

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

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

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

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

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

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

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

20 MR. GEORGE MILLER: I support the recommendations.

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

1 "caution," Carol, with which it proceeds. It's not just
2 about protecting those that are providing services that we
3 want them to keep providing them for the patients that do,
4 but, in fact, rewarding them, you know, shifting the balance
5 to make it easier for them to do that and not lose money.
6 And so it's an improvement of access policy, recommendation
7 1, so I think that's great.

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

10 [Laughter.]

11 DR. NAYLOR: But I do want to highlight how
12 building on Peter's comment, you know, the industry, a lot
13 of attention has been paid in the last decade to
14 rehospitalizations focused on hospitals and technical
15 assistance, starting with the QIOs and building through CMS
16 efforts, including CMMI's Partnership for Patients,
17 community-based care transitions, a lot of attention on
18 getting better data, data flow, getting better competencies
19 in the workforce to be able to really manage people in those
20 24 hours after hospital discharge. So I think if we could
21 stress whatever opportunities might exist to help in this
22 plan to build the technical assistance and support that's

1 needed.

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

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

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

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

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

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

20 DR. BERENSON: I support the recommendations. I
21 would reiterate that I am a big supporter of recommendation
22 2 to try to figure out how to provide incentives for SNFs to

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

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

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

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

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

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

3 Okay. All opposed to recommendation 1?

4 Abstentions?

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

7 Opposed?

8 Abstentions?

9 Okay. Number 3.

10 [Comment off microphone.]

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

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

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

15 [Laughter.]

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

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

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

22 MS. AGUIAR: Thank you. Our analysis was

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

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

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

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

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

22 As a quick reminder, we use the same framework for

1 payment adequacy as the other sectors.

2 We will begin with access to care measures and
3 supply. In 2010, there were close to 1,180 IRFs with at
4 least one IRF located in every State. Changes in supply in
5 2010 vary by IRF category, but the overall picture suggests
6 that supply is adequate.

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

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

1 2010, an increase in outlier payments, and an increase in
2 patient severity.

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

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

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

1 2010. There is also a relationship between volume and
2 margins, with margins increasing as bed size increases.
3 Margins vary substantially between freestanding and
4 hospital-based IRFs. Freestanding IRFs, which account for
5 almost 42 percent of total IRF spending, had over 21 percent
6 margins in 2010. In comparison, hospital-based IRFs, which
7 account for 58 percent of total IRF spending, had lower
8 margins of negative 0.2 percent.

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

1 contribute to their parent hospital.

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

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

17 The draft recommendation for your review is, the
18 Congress should eliminate the update to the Medicare payment
19 rates for inpatient rehabilitation facilities in fiscal year
20 2013. On the basis of our analysis, we believe that IRFs
21 could absorb cost increases and continue to provide care
22 with no update to the payment in 2013. We estimate that

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

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

11 MR. HACKBARTH: Thanks, Christine.

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

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

15 MR. HACKBARTH: Microphone.

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

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

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

8 MR. GEORGE MILLER: Yes.

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

10 MR. GEORGE MILLER: Yes.

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

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

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

1 for both hospital-based and freestanding IRFs.

2 MR. GEORGE MILLER: Right.

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

5 MR. GEORGE MILLER: Right.

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

9 MR. GEORGE MILLER: Yes.

10 MS. AGUIAR: -- with hospital-based having about
11 22 percent of their patients with stroke and freestanding
12 it's about 16 percent.

13 MR. GEORGE MILLER: Yes.

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

16 MR. GEORGE MILLER: Thank you.

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

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

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

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

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

1 little smaller than units, but that really seems high.

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

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

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

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

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

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

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

21 DR. BORMAN: I support the recommendation.

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

1 answered.

2 DR. BAICKER: I support the recommendation.

3 MS. UCCELLO: Me, too.

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

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

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

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

2 DR. HALL: I support the recommendation.

3 DR. BERENSON: And I support the recommendation.

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

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

9 MR. HACKBARTH: Oh, right.

10 [Laughter.]

11 [Discussion off microphone.]

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

14 [Laughter.]

15 MR. HACKBARTH: Herb.

16 MR. KUHN: I support the recommendation.

17 MR. HACKBARTH: Mary.

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

1 P4R to P4P?

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

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

7 DR. NAYLOR: For this sector.

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

12 MS. AGUIAR: Exactly.

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

16 MS. AGUIAR: Yes, exactly.

17 DR. NAYLOR: Thank you. I support it.

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

20 MR. HACKBARTH: Okay.

21 [Laughter.]

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

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

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

16 Opposed?

17 Abstentions? Are you stretching, Bill, or are you
18 --

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

21 MR. HACKBARTH: Aggressively voting yes? Okay.

22 And abstentions? No hands? Okay.

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

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

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

12 You'll recall, of course, that LTCHs furnish care
13 to patients with clinically complex problems who need
14 hospital-level care for extended periods. In 2010, about
15 118,000 Medicare beneficiaries had almost 135,000 LTCH
16 stays. Medicare spent \$5.2 billion on this care. About 412
17 LTCHs filed Medicare cost reports in 2010, and Medicare's
18 payments to LTCHs are made on a per discharge basis based on
19 the MS-LTC-DRGs, which are the same groups that are used in
20 the acute care hospital PPS but with weights that are
21 specific to LTCHs.

22 Before I go on with the update summary, I wanted

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

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

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

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

15 And finally, Tom, you asked about the distribution
16 of length of stay in LTCHs, and you can see here that there
17 is a long tail of the distribution showing that some cases
18 really are quite lengthy. The mean length of stay over --
19 this is for all MS-LTC-DRGs combined, as you can see up top
20 there. The mean length of stay is 27 days and the median is
21 24.

22 So turning now to our update framework, our first

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

11 To gauge access to services, we first looked at
12 available capacity. This slide shows the number of LTCHs
13 nationwide. A moratorium on new LTCHs has slowed the growth
14 in facilities. There was a net increase of one LTCH between
15 2009 and 2010. The line representing the number of LTCH
16 beds looks very similar to this one, so we're seeing the
17 same pattern there. Between 2009 and 2010, the number of
18 beds remained steady, as well.

19 And looking at growth in the number of cases per
20 10,000 fee-for-service beneficiaries, we see an increase of
21 3.5 percent between 2009 and 2010. So taken together, these
22 trends suggest to us that access to care has been maintained

1 during the period.

2 Turning now to quality, as you know, LTCHs don't
3 submit quality data to CMS, so we rely on claims data to
4 examine trends and in-facility mortality, mortality within
5 30 days of discharge, and readmission to acute care, and we
6 use these to assess more high-level changes in quality of
7 care in LTCHs. In 2010, these rates were stable or
8 declining for most of the top ten diagnoses, or most of the
9 top diagnoses, rather.

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

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

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

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

14 For purposes of projecting 2012 margins, we
15 modeled a number of policy changes. We included updates in
16 2011 and 2012 and also, of course, the PPACA mandated
17 reductions. This resulted in an update of minus-half-a-
18 percent in 2011 and an increase of 1.8 percent in 2012.

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

1 up at projected market basket levels.

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

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

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

22 MR. HACKBARTH: So when the Secretary has

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

3 DR. MARK MILLER: Market basket.

4 MS. KELLEY: Market basket.

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

7 MS. UCCELLO: I support the recommendation.

8 MR. HACKBARTH: Kate.

9 DR. BAICKER: As do I.

10 DR. BORMAN: I'm fine.

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

12 DR. CASTELLANOS: Same here.

13 [Members around table shaking heads.]

14 MR. HACKBARTH: Herb.

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

22 DR. BERENSON: I support the recommendation.

1 DR. HALL: I support the recommendation.

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

8 MR. HACKBARTH: Mike. Peter.

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

11 MR. HACKBARTH: Yes.

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

15 MR. HACKBARTH: Yes.

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

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

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

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

9 Opposed to the recommendation?

10 Abstentions?

11 Okay. Thank you, Dana.

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

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

1 issue was included with your mailing material.

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

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

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

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

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

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

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

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

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

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

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

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

22 There's been some concerns raised about this

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

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

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

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

22 Finally, the same out-of-pocket limit will

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

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

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

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

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

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

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

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

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

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

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

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

11 MR. HACKBARTH: Thank you, Shinobu.

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

1 categories for brand drugs.

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

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

20 DR. STUART: That would be my recommendation.

21 MR. HACKBARTH: Okay.

22 MR. GEORGE MILLER: I support the recommendation.

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

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

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

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

18 MR. HACKBARTH: Yeah.

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

21 [Laughter.]

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

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

3 DR. NAYLOR: I support the recommendation.

4 MR. KUHN: I support the recommendation.

5 DR. BERENSON: I support the recommendation.

6 DR. HALL: Support.

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

12 MS. SUZUKI: Yes.

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

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

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

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

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

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

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

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

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

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

8 DR. CHERNEW: [off microphone] Right.

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

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

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

1 for low-income subsidies, right?

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

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

5 DR. MARK MILLER: [off microphone] Illustrative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MR. HACKBARTH: So Peter gave an example that he

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

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

9 DR. MARK MILLER: Right.

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

19 MR. HACKBARTH: Bruce, do you have --

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

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

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

14 MS. SUZUKI: Mm-hmm.

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

17 MS. SUZUKI: That and --

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

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

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

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

10 DR. MARK MILLER: And I think --

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

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

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

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

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

1 DR. MARK MILLER: [off microphone].

2 DR. CHERNEW: [off microphone].

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

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

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

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

3 MR. HACKBARTH: So --

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

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

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

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

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

22 So I'm just wondering what kind of information is

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

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

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

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

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

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

1 changes.

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

7 DR. BORMAN: I support the recommendation.

8 MR. GRADISON: I do, too. I have a quick
9 question. My recollection is that in the new health act,
10 133 percent is the cut-off point for mandatory Medicaid
11 coverage. This is 135. Is that statutory?

12 MS. SUZUKI: Yes

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

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

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

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

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

19 Opposed?

20 Abstentions?

21 Okay. Thank you.

22 And our final session is on Medicare Advantage.

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

4 DR. HARRISON: Good afternoon. We are here to
5 report the current status of the Medicare Advantage, or MA,
6 program in terms of enrollment in the program, the
7 availability of plans for 2012, projected Medicare payments,
8 and quality indicators for those plans.

9 Our March chapter is a view of the landscape of
10 the program and contains no formal recommendations. There
11 is more detail in the chapter than we are presenting here
12 today just to keep things short, but we invite your
13 questions and comments on all the material in the draft
14 chapter.

15 Let me begin by describing the MA program and
16 payment system. The Medicare Advantage program allows
17 Medicare beneficiaries to receive their Medicare Parts A and
18 B benefits through a private plan rather than through the
19 traditional fee-for-service Medicare program. A beneficiary
20 who enrolls in a plan continues to pay the Part B premium
21 and any additional premium that the MA plan charges. The
22 Medicare program pays the MA plan a monthly capitated

1 amount that is adjusted for the health risk of the
2 individual beneficiary. The plan then provides coverage for
3 the Medicare A and B benefits and usually provides coverage
4 for additional benefits. In 2011, about 25 percent of
5 Medicare beneficiaries were enrolled in MA plans.

6 In some of the analyses, I will differentiate by
7 plan types and other plan characteristics and I just want to
8 define some of them for you here. Coordinated Care Plans,
9 or CCPs, are either HMOs or PPOs. CCPs have provider
10 networks and various tools to coordinate or manage care.
11 Under the MA program, there are local PPOs and regional
12 PPOs. The difference is that the local PPOs can serve
13 individual counties while regional PPOs are required to
14 serve entire regions, which are made up of one or more
15 complete States.

16 The MA program also includes private fee-for-
17 service plans which historically had no provider networks
18 and paid providers' Medicare fee-for-service rates. Recent
19 legislation changed the plan requirements, and as of last
20 year, these plans must either have networks or can only be
21 offered in areas where there are fewer than two network
22 plans.

1 We sometimes make other distinctions. Special
2 Needs Plans, or SNPs, limit their enrollment to either
3 Medicare-Medicaid dual eligibles or to those beneficiaries
4 who have either certain chronic or disabling conditions or
5 who require institutionalization. And there are plans not
6 available to individual beneficiaries but only to employer
7 or union groups. Our availability numbers that you will see
8 do not include these so-called employer group plans or SNPs
9 because these plans are not available to all beneficiaries.
10 But our enrollment and payment numbers generally include
11 them.

12 Plans submit bids each year for the amount they
13 think it will cost them to provide Parts A and B benefits.
14 There is a separate bid for Part D drugs, but the MA plans
15 just get paid for Part D as if they were stand-alone Part D
16 plans.

17 CMS actuaries review the bids to make sure they
18 are reasonable. Each plan's bid is compared to a benchmark,
19 which is a dollar amount set for each county. Benchmarks
20 are administratively set based on historical payment rates
21 for each county. A plan's benchmark is based on the
22 benchmarks of the counties it serves, and beginning in 2012,

1 on the plan's quality rating. Carlos will discuss the plan
2 quality ratings shortly.

3 If a plan bids above the benchmark, Medicare pays
4 the benchmark and beneficiaries make up the difference with
5 a premium. If a plan bids below the benchmark, Medicare
6 pays the bid plus a rebate calculated as a percentage of the
7 difference between the bid and the benchmark. The rebate
8 must be used by the plan to provide extra benefits to the
9 beneficiaries. These extra benefits can take the form of
10 reduced cost sharing for A-B services, additional non-
11 Medicare benefits, such as dental, vision, hearing, or gym
12 memberships. They could also take the form of improved Part
13 D benefits, including lower Part D premiums.

14 There has been growth in Medicare Advantage
15 enrollment each year since 2003. From November 2010 to
16 November 2011, enrollment grew by about six percent, or
17 700,000 enrollees, up to 12.1 million beneficiaries.

18 Among plan types, HMOs, at eight million,
19 continued to enroll the most beneficiaries, and as a result,
20 16 percent of all Medicare beneficiaries were in HMOs in
21 2011. Private fee-for-service enrollment shrank from about
22 1.7 million to about 600,000, with enrollment shifting to

1 network plans. PPOs exhibited rapid enrollment growth, with
2 local PPO increasing about 65 percent and regional PPO
3 enrollment increasing about 34 percent.

4 Going forward, plan bids project overall
5 enrollment growth in the seven to eight percent range for
6 2012, but almost all of the projected growth is in HMOs.

7 Enrollment patterns differ in urban and rural
8 areas. About 26 percent of urban Medicare beneficiaries are
9 enrolled in Medicare Advantage, compared with about 14
10 percent of beneficiaries residing in rural counties. What's
11 not shown here is that urban MA enrollees are much more
12 likely to be in HMOs and rural enrollees are much more
13 likely to be in non-HMO plans.

14 So let's look at plan availability. Medicare
15 beneficiaries have a large number of plans from which to
16 choose. MA plans are available to almost all beneficiaries.
17 Zero-point-three percent of beneficiaries do not have a plan
18 available.

19 Looking at the top line here, in 2012, 93 percent
20 of Medicare beneficiaries have an HMO or local PPO plan
21 operating in their county, up from 92 percent in 2011 and 67
22 percent back in 2005. And if you combine the local CCPs

1 with the regional PPOs, you would find that 99 percent of
2 beneficiaries have a Coordinated Care Plan available in
3 2012, but don't look too hard at the chart because that
4 number is not on there. Regional PPOs are available to 76
5 percent of beneficiaries in 2012, down from 86 percent in
6 2011 due to the withdrawal of the only California regional
7 PPO for 2012. Access to private fee-for-service plans
8 decreased from 63 percent to 60 percent of beneficiaries.

9 In most counties, a large number of MA plans are
10 available to beneficiaries, although the number varies by
11 county. At the high end, beneficiaries in Miami and New
12 York City can choose from more than 50 plans in 2012. On
13 average, 12 plans, including eight Coordinated Care Plans,
14 are offered in each county in 2012, and that's the same as
15 was in 2011.

16 And in 2012, 80 percent of beneficiaries have
17 access to at least one MA plan that includes Part D drug
18 coverage and charges no premium beyond the Medicare Part B
19 premium, and that's compared with 90 percent in 2011.

20 So we use the plan bid projections to compare
21 projected MA spending with projected fee-for-service
22 spending on a like set of fee-for-service beneficiaries.

1 Because we are comparing fee-for-service expenditures with
2 plan bids and the resulting MA payments, we are using a
3 growth factor for 2012 similar to what the plans use to
4 develop their bids. Plans generally assume costs will grow
5 modestly and discount the likelihood that physician services
6 would be cut by the SGR. We also used this assumption, as
7 we have done for the previous two years. The numbers here
8 assume no SGR cut during 2012.

9 So looking at the top row, we estimate that, on
10 average, 2012 MA benchmarks, bids, and payments will be 112
11 percent, 98 percent, and 107 percent of fee-for-service
12 spending, respectively. For 2012, the county benchmarks
13 average approximately three percent less than the benchmarks
14 for 2011 before you took into account any of the quality
15 bonuses that are starting this year. However, almost all
16 2012 plan enrollment is projected to be in plans that will
17 receive add-ons to their benchmarks for quality. The
18 quality demonstration in effect offset most of the PPACA
19 benchmark reductions that were scheduled for 2012.

20 The pre-quality benchmark reductions, however, may
21 have encouraged plans to tighten costs and lower their bids
22 for 2012. The average bid is now 98 percent of the

1 projected fee-for-service spending for similar
2 beneficiaries, and the HMO bids average 95 percent of fee-
3 for-service. Now, the bids of the other plan types are
4 generally above fee-for-service, but they are closer to fee-
5 for-service than they were last year.

6 As a result, we project that plan payments in 2012
7 will move closer to fee-for-service spending. And with the
8 exception of employer group plans, the payments for all plan
9 types are projected to be closer to fee-for-service levels
10 in 2012 than they were in 2011.

11 Before we go on to quality, let me make a few
12 summary observations about the direction of some areas of
13 MA. Enrollment continues to grow in the more tightly
14 managed care plans, namely HMOs, which we think have the
15 potential to increase the quality and efficiency of Medicare
16 services. Over each of the past four years, HMO enrollment
17 has grown by seven percent and plans project similar growth
18 for 2012.

19 Led by the HMOs, the plans have responded to the
20 tighter benchmarks by lowering their bids relative to fee-
21 for-service spending. The average bid is now lower than
22 fee-for-service spending.

1 Payments, even after including the quality
2 bonuses, have moved closer to fee-for-service spending
3 levels, and at the same time, the benefit packages offered
4 by MA plans have not eroded in terms of the dollar values of
5 the extra benefits offered.

6 Now, as promised, Carlos will present findings on
7 quality and the quality bonuses.

8 MR. ZARABOZO: I'll give you a quick overview of
9 the most recent quality indicators in the Medicare Advantage
10 program, which are discussed in detail -- in fact, in
11 excruciating detail -- in your mailing material.

12 Looking at the clinical process and intermediate
13 outcome measures that plans report, we find that between
14 last year and this year, there's been improvement in those
15 measures. Among HMOs, for example, 14 of the 45 measures
16 that we track showed improvement between 2010 and 2011 among
17 plans reporting in both years. For local PPOs, nine
18 measures improved. For the other two types of plans,
19 private fee-for-service and regional PPOs, their results are
20 generally not as good for HMOs and local PPOs. We did not
21 see major improvement between this year and last to the
22 extent that we can evaluate results for the small number of

1 these plans that report quality measures.

2 For some measures, we're able to compare the
3 performance of Medicare Advantage plans with the performance
4 of fee-for-service Medicare. For example, a beneficiary
5 survey administered in both sectors tracks vaccination rates
6 for influenza and pneumonia. For the most recent time
7 period, the surveys show that vaccination rates are about
8 the same in each sector and have improved in each sector
9 compared to last year's rates.

10 As we found in the past, newer plans tend to have
11 lower levels of performance on quality measures than more
12 established plans. And this year, we attempted to look at
13 Special Needs Plans in particular, sometimes using a proxy
14 method to identify those plans in the broader data. We
15 find, in general, that the Special Needs Plans are lower
16 performers than other types of plans, albeit with major
17 exceptions.

18 Beginning this current year, 2012, Medicare
19 Advantage plans will receive bonus payments based on their
20 performance on quality indicators. Plans are awarded a star
21 rating, between one and five stars, based on their
22 performance on clinical measures, patient experience

1 measures, and contract performance measures. The 2012
2 bonuses are based on the year 2011 star ratings that were
3 announced at the end of 2010.

4 Although the statute established the manner in
5 which the bonus system was to be implemented, CMS is using a
6 program-wide demonstration project to determine bonus
7 payment amounts. While under the statute only plans with a
8 rating of four stars or higher would have been eligible for
9 bonuses, in the demonstration, bonuses begin at the three-
10 star level, meaning that based on the bids that we saw and
11 the projected enrollment, 93 percent of enrollees are
12 expected to be in plans that will receive quality bonuses in
13 2012 versus 25 percent of enrollees that would have received
14 bonuses under the statute because they're in four- to five-
15 star plans. As a result of this and because CMS has set
16 higher payment amounts to the bonuses themselves, the
17 demonstration is expected to result in an additional cost of
18 \$2.8 billion in 2012.

19 The Commission sent a letter to CMS expressing its
20 concern over the use of demonstration authority for this
21 purpose, that is, to do a program-wide demonstration, and
22 over the cost of the demonstration, the resulting cost.

1 Another concern that we raised regarding the star
2 system is the actual method for determining the stars of
3 plans. The concern that we raised last year was that the
4 stars placed too great an emphasis on contract performance
5 measures, that is, things like how responsive the call
6 centers were and whether or not they had foreign language
7 interpreters versus clinical measures such as outcome
8 measures, intermediate outcome measures, and patient
9 experience measures that are from the CAHPS regarding
10 patients' perceptions of their care.

11 CMS did address this concern and they are now, for
12 the bonuses that will be effective in 2013, they are using a
13 weighting system to assign different weights to different
14 types of measures, resulting in a system where contract
15 performance measures are not as heavily weighted. Higher
16 weights are now attached to outcome measures and patient
17 experience measures with less weight given to process
18 measures and contract performance measures. And again, the
19 new system will be the basis of bonus payments in 2013.

20 This concludes our presentation. We look forward
21 to any comments you may have on the draft chapter, any
22 additional information you would like to see included in the

1 chapter, and any questions you may have on the draft chapter
2 or on the material that we've just presented. Thank you.

3 MR. HACKBARTH: Okay. Thank you.

4 Scott, could you put up the slide that has the
5 comparison of the bids and payments, Slide 7. Could you
6 give just a brief reminder of what the recent trend has been
7 on the bids to fee-for-service ratio? My recollection is
8 that over the last several years, that has been trending
9 down.

10 DR. HARRISON: The payments -- yes, it seems to me
11 they were a high of about 114, maybe, a few years ago.

12 MR. HACKBARTH: Yes.

13 DR. HARRISON: Last year, the payments were 110.

14 MR. HACKBARTH: Yes, and I'm focused in particular
15 on the bids to fee-for-service ratio.

16 DR. HARRISON: The bids last year were 100 percent
17 --

18 MR. HACKBARTH: Yes.

19 DR. HARRISON: -- with the HMOs being 97 and
20 everybody else above. And before that, they had been --
21 they'd sort of hovered there a little bit, but they may have
22 been a little bit over fee-for-service for a few years.

1 MR. HACKBARTH: Yes. Yes. That's my
2 recollection, also. So one hypothesis is that this downward
3 trend, especially this year, is consistent with what we've
4 seen in other sectors, so when there's pressure on rates,
5 the providers, in this case plans, respond to that by
6 reducing costs. And here, they want to reduce costs so that
7 they can have money to provide added benefits, which is
8 their mechanism of attracting customers. Now, so this
9 strikes me as good news and consistent with past MedPAC
10 thinking about the Medicare Advantage program.

11 What I wanted to ask about, though, is there any
12 way that this could be confounded by the quality bonus
13 program? Are they somehow bidding less because, oh, we've
14 got this source of money that, as I understand it, is
15 outside this table?

16 DR. HARRISON: No, it's inside the table.

17 MR. HACKBARTH: Oh, it is inside.

18 DR. HARRISON: Right, so the --

19 MR. HACKBARTH: Okay. I misunderstood --

20 DR. HARRISON: The benchmarks have been puffed up
21 for the quality bonus.

22 MR. HACKBARTH: Okay. I misunderstood that point.

1 DR. HARRISON: Yes.

2 MR. HACKBARTH: Okay. Scott, why don't you lead
3 this.

4 DR. MARK MILLER: Can I say one other thing about
5 that? So that also means, because the bonuses are in there,
6 that the 107 on payment is probably closer to fee-for-
7 service than 107.

8 DR. HARRISON: Yes, I would bet maybe like 104 or
9 105, probably.

10 DR. MARK MILLER: So that's the other thing. Just
11 to your point, because it is, in fact, ground into this
12 table, it also means the payments over fee-for-service are
13 closer if you had those bonus payments out.

14 DR. HARRISON: Mm-hmm.

15 DR. MARK MILLER: If you see what I'm saying. So
16 -- everybody with me? Okay. I got one nod, so I'm done.

17 MR. HACKBARTH: Why don't we still just plan on
18 doing one round with clarifying questions and comments in
19 one round. Scott?

20 MR. ARMSTRONG: First, I probably should know
21 this, but the discretionary bonuses that take the three
22 stars, is there a time limit on that? I mean, how will that

1 play out over the next couple of years?

2 MR. ZARABOZO: [Off microphone.] Twenty-fourteen
3 is the demonstration.

4 MR. ARMSTRONG: And at that point, the payments
5 are limited --

6 MR. ZARABOZO: And it goes back to the statutory
7 four-star and above.

8 MR. ARMSTRONG: You said 2014?

9 MR. ZARABOZO: Yes -- 2015.

10 MR. ARMSTRONG: Twenty-fifteen?

11 MR. ZARABOZO: [Off microphone.] The
12 demonstration is 2012, 2013, and 2014.

13 MR. ARMSTRONG: Thank you. Thanks. No, I don't
14 think I have any comments. Glenn, I just was -- I had
15 reacted to this information in a way that's similar to
16 yours, and that is that it seems that there is good news in
17 some of this data in that I don't know what MedPAC's role is
18 in drawing conclusions like that, but the relative cost to
19 the Medicare program of MA plans compared with fee-for-
20 service is getting closer to where we want it to be.

21 Second, you see a real distinction in the
22 progress, and I suppose this has been historical between the

1 different plan types, and I know we describe the
2 differences, but I don't know that we've ever weighed in on
3 those things that we may do through our role in encouraging
4 faster growth of those plan types that are giving us the
5 better results and the better return on our investments, and
6 it just might be something to think about.

7 And then, finally, given that we are going to be
8 teeing up a conversation on down the road around premium
9 support, it really does seem to me that the closer these MA
10 plans get to fee-for-service 100 percent benchmarks, the --
11 I mean, that starts becoming really an interesting part of
12 the conversation that we would have there.

13 But in terms of the chapter itself, I don't really
14 have anything more to say about it.

15 DR. BAICKER: I think it's a really useful point
16 to make. Even though on some level we're all aware of it, I
17 feel like it hasn't quite percolated through into the public
18 discussion that a big reason we pay MA plans more is not
19 because of their bids, but because of the benchmark. So I
20 thought this laid that out really clearly. And what I
21 wasn't as clear on in thinking about the star system is our
22 goal is to pay plans -- reward plans for providing high-

1 quality care in an efficient way, and I wonder how the star
2 system does or is intended to evolve over time in two ways.

3 One, if fee-for-service gets higher quality,
4 should the stars get ratcheted up? Should we expect MA to
5 be meeting or exceeding fee-for-service performance or an
6 absolute performance metric is one dimension.

7 And the second dimension I wondered about is it
8 seemed from the chapter that people, if I'm remembering
9 correctly, disproportionately enroll in higher star
10 programs, plans, which you would hope. People should be
11 moving towards higher quality if we're giving them enough
12 information about it. Eventually, do the stars track actual
13 enrollment patterns in the sense that will every plan that a
14 person is actually enrolled in be a five-star plan
15 eventually, or will that move up as people move into higher-
16 performing plans? And then I know all of it is up in the
17 air in a pilot, but how is it supposed to function?

18 MR. ZARABOZO: Well, one thing about the five-star
19 plans is that they can enroll year-round, so that's an
20 advantage to being a five-star plan, in addition to the
21 higher bonus payments, especially in the absence of the
22 demo, you are going to get those bonus payments. Part of

1 the -- you know, there was a table that showed distribution
2 by type of plan. There are no five-star plans -- for
3 example, regional PPOs are all three-star, pretty much. So
4 that distribution happens to be the current situation, but
5 it does reflect that HMOs tend to have better quality than
6 the other plans, at least in the current measure.

7 Now, in terms of the benchmarks and where the
8 standard would be, CMS is working on how to incorporate
9 improvement into the star system. Right now, it's relative
10 within MAs to a certain extent. They do have threshold
11 levels for, like, the four-star performance is at a certain
12 threshold level and that is typically unchanged from one
13 year to another. But otherwise, it is in relation within
14 MA. So the point about we have always said you need to be
15 compared to fee-for-service, and hopefully at some point
16 there will be a comparison to fee-for-service.

17 MR. HACKBARTH: Kate, we did a report, was it two
18 years ago now, Carlos?

19 MR. ZARABOZO: March 2010, it was released.

20 MR. HACKBARTH: Yes. It was a report that
21 Congress specifically requested on how to go about making
22 comparisons of MA plans to fee-for-service. There are some

1 challenges there, suffice it to say.

2 Cori.

3 MS. UCCELLO: Okay. I have some comments and
4 suggestions on the quality part. There's a lot of
5 information there, a lot of good and important information,
6 but my eyes did start glazing over at all of the detail. So
7 I tried to think about, well, what are the questions I want
8 this information to answer, and I think, actually, in your
9 presentation, you kind of laid things out this way. But one
10 thing is are the metrics themselves meaningful and do they
11 produce meaningful differences between the plans? And what
12 are the overall trends in quality? Is it improving? And
13 are there specific areas that need more attention? And then
14 how does the quality vary by plan type and between MA and
15 fee-for-service, and then also with the dual eligibles and
16 SNPs plans and those things. And then in areas where there
17 are big differences between these plan types, are there
18 lessons that can be learned from MA and transferred to fee-
19 for-service or vice-versa? I mean, those are just kind of
20 the big issues that I'd hope that this kind of quality
21 information can answer.

22 MR. HACKBARTH: Peter.

1 MR. BUTLER: So, Scott, as you were referencing
2 our incrementalism, the flip side of this is that these are
3 a little bit so five years ago, too. These numbers have
4 moved, but not much. And as the enrollment has grown in
5 Medicare -- another way to look at this is as the enrollment
6 has grown in Medicare Advantage, it has been more expensive.
7 So everybody that's enrolled in there is more than the fee-
8 for-service, as much as we as a Commission have valued the
9 incentives associated with them.

10 Now, what I wanted to ask you to clarify in my own
11 mind, we annually report on the status. Is that part of our
12 legislative activity, or is that -- did we just decide to do
13 an annual status report?

14 DR. MARK MILLER: I'm pretty sure -- I would
15 really like to just put my eyes back on the legislative
16 language again. I think it says if we're making payment
17 statements to the Congress on fee-for-service and MA that
18 goes into the March report.

19 MR. BUTLER: But we're not --

20 DR. MARK MILLER: Well, but we have --

21 MR. BUTLER: Right.

22 DR. MARK MILLER: -- so it turns out this time, we

1 haven't, but some of this movement that you see in these
2 numbers that are so five years ago, in your words -- or
3 Scott's -- came from recommendations that we did make. So
4 it turns out this time in the chapter, no, we don't
5 necessarily have recommendations, but we have in the past.

6 MR. HACKBARTH: Peter, was your question
7 specifically about payment recommendations, whether we're
8 required to make payment recommendations, or whether we're
9 required to --

10 MR. BUTLER: I know we don't make payment
11 recommendations unless we have a change in the system.
12 There are no updates to provide.

13 DR. MARK MILLER: Correct. Exactly.

14 MR. BUTLER: I understand that.

15 DR. MARK MILLER: Yes.

16 MR. BUTLER: I understand that, and we choose
17 nevertheless to report in the March chapter how the program
18 is doing --

19 MR. HACKBARTH: Yes, and my recollection --

20 MR. BUTLER: -- and we have had selected studies
21 that we are required to do by Congress, and so I'm just
22 trying to clarify. But beyond that, we don't in our

1 legislative -- I mean, as we were constituted, we do not
2 have to report beyond that level, right?

3 MR. HACKBARTH: Beyond that level. So my
4 recollection, Mark, and help me out, is that there was a
5 period when we didn't have Medicare Advantage in the March
6 report and one of the Congressional committees said, you
7 know, the way we read MedPAC's statutory requirements for
8 the March report, we think you need to report each year on
9 Medicare Advantage, not make payment recommendations since
10 that's the way the MA payment system works, but at least
11 report on the status. And we said, of course, we will do
12 that. The language was ambiguous to us, but we said, if
13 that's what you want, we will do it, and we've done it each
14 of the last, I don't know, three or four years.

15 MR. BUTLER: Yes. So, I mean, I don't need to
16 tell you, Glenn, you repeat it fairly often, the original 95
17 percent of AAPCC is still a long way away from what we are
18 seeing from the plans. So we have 35 pages here. It's just
19 kind of interesting that we have 35 pages out of probably
20 hundreds that we report, and I just kind of wonder as we
21 move more to likely, whether it's ACOs or more Medicare
22 Advantage, whether we should be a little more proactive in

1 thinking about how to shine a little brighter light and a
2 little bit more of our attention on the issue, because this
3 is complicated. And I'm sure the new Commissioners who
4 haven't been involved with Medicare Advantage, this thing
5 takes a long time to go through and understand if you
6 haven't been a part of it and I think it's really important.

7 MR. HACKBARTH: For the benefit of the new
8 Commissioners, when I first joined the Commission, Medicare
9 Advantage payment rates were a very hot issue and we made a
10 number of recommendations on those that went basically
11 unheeded for a number of years. And then in PPACA, Congress
12 moved in the general direction that we have been
13 recommending. The PPACA approach isn't precisely what we
14 had recommended and it has some bells and whistles, like the
15 quality bonuses that we didn't necessarily contemplate, or
16 at least not in the magnitude. But directionally, it moved
17 in a way we have been describing as far back as 2001, 2002,
18 2003. PPACA passed a couple of years ago. Now, I think the
19 next policy debate around the role of private plans in
20 Medicare, as Scott indicated, is in the premium support
21 context, and so we as a group will need to decide how we
22 wish to engage in that debate.

1 Mike.

2 DR. CHERNEW: So I always like these reports, so
3 thank you, and I just have one comment. There's a slide you
4 have about the number of plans, I think, going from 21 on
5 average to 12, or -- on one of the slides. But -- this one.
6 Between 2010 and 2011, the average number of choices -- I
7 assume that means the average number of plans -- dropped
8 from 21 to 12, and I assume a lot of that was consolidation
9 of private fee-for-service plans that needed to have a
10 network and dropped out?

11 DR. HARRISON: That's correct.

12 DR. CHERNEW: Right. And then there were also
13 some efforts to encourage plans to consolidate in general,
14 and you don't see that generally picked up in the
15 enrollment. In fact, the enrollment was rising.

16 So my comment is that the last time we had really
17 big MA payment changes -- well, actually not -- the last
18 time we had really big MA payment reductions, we saw a ton
19 of plans existing, and although you see plans consolidating
20 here, it's not clear you see a lot of exiting, all of which
21 I think is a good thing, although I just want to say, we've
22 been doing some work looking at this in more detail and you

1 do see different patterns, and I can show you the results
2 across the quartile. So now they've set up a system where
3 the generosity, if you will, varies by quartiles, and
4 there's a lot of noise going on for all the reasons you said
5 -- privacy, plans leaving, and plans being asked to
6 consolidate within the same insurer and stuff like that.
7 But there does seem to be some effect within quartiles.

8 The other thing that's going on which I think is
9 really important to understand and why I think you see
10 growth in MA amongst other reasons is there's a bunch of
11 reasons why I think the non-MA system, the traditional
12 system, is going to become less appealing to individuals.
13 Employers are cutting back. A bunch of things are going on.
14 MA remains a place where you can get access to some of the
15 benefits that you might want in a way that, you know, still
16 might be cost effective for individuals. So I think you're
17 seeing the demand for individuals for MA plans really rising
18 and so you see a lot of enrollment, despite the fact that
19 the payment rates are becoming -- are scheduled to become
20 less generous. And we saw our results when they just froze
21 it. Before they even implemented them, we saw some level of
22 consolidation, although we didn't see it in enrollment. So

1 the enrollees are finding ways to go somewhere else.

2 So again, I think that this is really good. It
3 will provide a great baseline. You are going to see a lot,
4 even more as we go forward, as these cuts come in, because
5 there's a big change across certain counties when you move
6 from the benchmark system the way it had been set up to the
7 benchmark system the way it's going to be set up. There's
8 some places that actually -- we had great presentations
9 before about how overly generous some places were because of
10 some of the craziness of the payment system and some of
11 that's getting unraveled by the Affordable Care Act and we
12 can trace what happens, and this is the start.

13 My only point is, as you go forward, thinking
14 about that in the sort of quartile world is important. And
15 I'll share with you the work that we've done.

16 DR. DEAN: These are encouraging numbers. I had
17 some of the same questions that Cori did about the
18 measurement of the quality and also the impact that it has,
19 and it sounds like those things, too, are moving in a way
20 where the measurements are more sophisticated and hopefully
21 more accurate.

22 How much difference is there for the plans to move

1 from, say, three to four stars, or four to five stars? I
2 assume that there's still incentives to keep pushing on
3 those measures, is that correct?

4 MR. ZARABOZO: Right. There are different levels
5 of bonus payments, depending on the star level. And again,
6 after the demonstration, you have to be at four, four-and-a-
7 half or five stars to get a bonus, so --

8 DR. DEAN: For each step up --

9 MR. ZARABOZO: You have --

10 DR. DEAN: -- there will be an additional bonus --

11 MR. ZARABOZO: -- different levels --

12 DR. DEAN: It's enough of a step to really provide
13 an incentive, as far as you know?

14 MR. ZARABOZO: Well, it is more money, so --

15 DR. DEAN: But is it enough to make up for the
16 difference of the investment that they'd likely make to --

17 MR. ZARABOZO: Well, the other thing is, again,
18 the five-stars get to enroll year-round, so that's sort of a
19 little boost there, also.

20 DR. DEAN: Are there any other non-monetary
21 rewards besides the year-round enrollment?

22 MR. ZARABOZO: The marketing. At the Medicare.gov

1 website, the five-stars plans are indicated as being
2 exceptional plans, and the plans that are at the other end,
3 the 2.5-star plans, are labeled as this plan has not been
4 good for a couple of years or something, so --

5 DR. DEAN: And the five-star plans are the only
6 ones that are labeled that way?

7 MR. ZARABOZO: Right. Right.

8 DR. DEAN: Okay.

9 MR. HACKBARTH: So how many five-star plans are
10 there?

11 MR. ZARABOZO: I think we have -- well, this --
12 nine. Thank you. My consultant here says nine.

13 [Laughter.]

14 DR. HALL: Just a couple of comments. One is,
15 this was really a good chapter. This was -- I've seen lots
16 of MA descriptions in a variety of different places and this
17 was really very, very informative and I really thank you for
18 that.

19 In terms of the star system, certainly, that's
20 been a good idea, but it's a little bit like what do we do
21 when everybody's five-star? Do we then stop worrying about
22 things, or is it sort of like Lake Wobegon, that when all

1 the children become above average, you don't really know
2 what to do with them anymore? So one of the things, and I
3 guess I'm -- so I think there's a -- we have to keep a close
4 eye on whether we really have reached nirvana or perfection
5 when we use these star systems.

6 The other thing that I think is correct, and
7 there's sort of some other data that I've looked at
8 recently, is that for any of the major national providers,
9 underwriters for MA services, the rubric or the metric they
10 often use is that in 80 percent of our localities, we are
11 four-star, something like that. But then when you dissect
12 out the regional data, there will be pockets of the country
13 where they're not really very good, even though on a
14 national basis they're really quite good. So the regional
15 variation still exists and this is very, very difficult for
16 consumers to understand. They can go to Medicare.gov and
17 look this stuff up, and I'll tell you, it is a real
18 challenge when you go do that.

19 So not that I have any really good ideas on this,
20 but as we follow this, I think at some point, when everybody
21 gets to be five-star, we have to push the industry to do
22 what it really should be doing and that is to become even

1 more innovative than five stars, and I don't know what that
2 means.

3 MR. ZARABOZO: Well, I'm not sure that's
4 necessarily the case, that everybody will become five-star,
5 again, because of the relatives, that is, within -- I mean,
6 it will be the best plans that are the five-star plans.
7 Other plans will be below that.

8 DR. HALL: But they're trending that way.

9 MR. ZARABOZO: They're --

10 DR. HALL: Yes, I know, that was an overstatement.

11 MR. HACKBARTH: The measures in the system are not
12 fixed, either --

13 DR. HALL: Right.

14 MR. HACKBARTH: -- and so the measures presumably
15 will evolve -- hopefully, they'll evolve to be more
16 effective measures of quality, and so this isn't a static
17 system where people are moving at a fixed target.

18 Bob.

19 DR. BERENSON: Yes. I have two data issues and
20 then one comment. Scott and I talked earlier about two data
21 things which I think it's useful to bring up publicly as a
22 question. One is that Marsha Gold's analysis of Medicare

1 Advantage that she produces at Mathematica for Medicare --
2 I'm sorry, for Kaiser Family Foundation has a different
3 number of Medicare Advantage enrollees and it's -- Scott and
4 I, I think, have figured out that it's because she includes
5 the costs of HMO enrollees. And so, just quickly, could you
6 explain who they are and whether it makes more sense to
7 include them in Medicare Advantage? The difference is two
8 percent. In her data, we're now up to 27 percent of
9 Medicare Advantage, and I just want to understand that.

10 DR. HARRISON: Yes. I think one percent is
11 probably due to the numerator and one percent is due to the
12 denominator. CMS puts out all kinds of different total
13 numbers of beneficiaries, so you could end up picking ones
14 that are slightly different from one another. So I'm
15 thinking that's where part of it is.

16 But the part that I do know for sure is that so
17 there are these HMOs called cost HMOs and what they are is
18 you can sign up for a closed panel -- you as a beneficiary
19 could sign up to get your care from this closed panel, but
20 you don't have to get all of it from the closed panel.
21 You're allowed to go outside of that network and whenever
22 you do, you pay normal Medicare cost sharing. When you're

1 in the network, you're going to pay nothing or something
2 lower. So there are some big pockets of the country --
3 Colorado is covered by a cost plan completely, I believe.
4 Scott and White has lots of parts of rural Texas. And
5 actually even Kaiser in a couple locations is considered a
6 cost plan. And those plans do not submit bids, so they're
7 not really paid the same way. But they may be something
8 worth looking at in the next year or two.

9 MR. HACKBARTH: Scott, is it possible for a plan
10 to get a new cost contract --

11 DR. HARRISON: No.

12 MR. HACKBARTH: -- or these are people
13 grandfathered in under old contracts?

14 DR. HARRISON: Right.

15 DR. BERENSON: So these are clearly not risk -- I
16 mean, they're not Medicare Advantage per se, but they're
17 also not pure fee-for-service, so they're in some middle
18 ground, but okay.

19 DR. HARRISON: Right.

20 DR. BERENSON: The more important issue, if you
21 could go to Slide 7, Peter said that the new Commissioners
22 may have some difficulties. I've written a half-a-dozen

1 articles in Health Affairs and don't think I understood
2 this, because Scott and I were talking. I have long assumed
3 that because MA plans get to decide where they want to go
4 and that they would typically disproportionately settle in
5 places with high benchmarks, high fee-for-service spending,
6 that the fact that the ratio wasn't adjusted for equal
7 distribution -- I mean, I basically assume that if they were
8 equally distributed across the country, that the number
9 might be somewhat different rather than what you're showing
10 here, which I assume showed a bias towards going to high-
11 cost fee-for-service areas. You suggested earlier that
12 you're making an adjustment. Could you explain that, what
13 you're doing?

14 DR. HARRISON: Right. So let's just say we have
15 one plan. So I would take the plan, and I know where their
16 enrollees are and I know the risk scores of their enrollees,
17 and so I assume that those are -- and so I, in a sense,
18 create a different plan with the same enrollment patterns
19 and the same risk patterns and see what those people would
20 cost under fee-for-service, okay. And so we're comparing to
21 a demographically and geographically similar population.

22 DR. MARK MILLER: [Off microphone.] It's MA to

1 fee-for-service --

2 DR. BERENSON: Right. Right.

3 DR. MARK MILLER: -- not across the country, and
4 your comment almost sounded like it was an across the
5 country kind of --

6 DR. BERENSON: Well, now I'm not sure what -- I
7 mean, basically, if my hypothesis is that there's a lot of
8 MA plans in Miami and New York, which you've told me there
9 are, and those are very high fee-for-service spending areas,
10 that if I -- and those are all the plans we had, we would
11 show a pretty low ratio of bid to fee-for-service which
12 might give a misleading picture of how efficient MA plans
13 were if they were actually equally spread across the
14 country. And so I guess the question is, have you made that
15 kind of an adjustment so that your -- do you see what I'm
16 asking?

17 DR. HARRISON: Yes. These numbers are all based
18 on where the plans draw their enrollment.

19 DR. BERENSON: All right. So that adjustment
20 hasn't been made. The one that I'm suggesting needs to be
21 made to be able to say anything about our MA plan is lower
22 cost than fee-for-service, which is a question that policy

1 makers like to ask.

2 DR. HARRISON: Now --

3 DR. BERENSON: We don't really know that answer.

4 DR. HARRISON: Now, the problem is that you may
5 not trust or like the fee-for-service numbers in Miami, but
6 that's what they are, and so --

7 DR. BERENSON: No, I understand that --

8 DR. HARRISON: Yes --

9 DR. BERENSON: -- but if one were wanting to
10 project what a policy might be, one would want to know what
11 the limitations are of the data and one of them might be,
12 well, these plans have gone disproportionately to high cost
13 fee-for-service areas. If they were actually --

14 DR. HARRISON: No --

15 DR. BERENSON: -- if we did away with traditional
16 Medicare and all we had were plans, what might we expect?
17 We don't really know that without doing that kind of
18 geographic adjustment --

19 DR. HARRISON: No --

20 DR. BAICKER: Doesn't Scott's number give us a
21 better sense of what that number would be than what you're
22 proposing in that the counterfactual is what fee-for-service

1 is spending, you know. And so if we're observing
2 beneficiaries in MA disproportionately in areas where fee-
3 for-service spends a lot and they're spending less than fee-
4 for-service there, we want to know that they're located in
5 areas where fee-for-service is spending a lot and not say,
6 oh, wow, the enrollees in Medicare Advantage in Miami are
7 spending a lot more than the fee-for-service enrollees in
8 Minneapolis, that that's not the informative comparison.
9 The more informative comparison is what the MA enrollees in
10 Miami are spending relative to the fee-for-service enrollees
11 in Miami and what the MA enrollees in Minneapolis are
12 spending relative to the fee-for-service enrollees in
13 Minneapolis.

14 DR. BERENSON: That would be better than --
15 comparing Miami to Minnesota wouldn't be helpful, but also I
16 think it would be helpful to do a geographic adjustment to
17 estimate what the spend would be if the plans were sort of
18 naturally distributed or equitably distributed. I don't --

19 DR. BAICKER: But then you'd have to do the same
20 thing to fee-for-service, right, because that looks
21 different in different parts of the country, too.

22 DR. MARK MILLER: [Off microphone.] And the other

1 thing that occurs to me -- the other thing that occurs to me
2 in this, that one of the issues that would get raised in
3 this is you can't necessarily assume that a managed care
4 plan would go to every part of the country, and I get
5 worried that if you make an assumption that says, okay,
6 let's take this and assume it all the way across the
7 country, if you really paid in such a way relative to fee-
8 for-service, there are certain areas of the country where
9 managed care plans wouldn't go.

10 MR. ZARABOZO: We can't do what Bob would like us
11 to do, I don't think, because you would have to say, when
12 this company goes to Iowa, let's say, that had never been
13 there before, we think their bid will be such, and that's X
14 percent of fee-for-service. We can't do -- we don't know
15 what that bid would be of an HMO going to Iowa. All we know
16 is what is out there.

17 MR. HACKBARTH: I think it is reasonable to
18 believe that private plans will be more successful in some
19 parts of the country than others relative to fee-for-service
20 because -- not just because the level of fee-for-service
21 cost varies across the country, but also because the care
22 delivery systems vary.

1 So in a market where you have few providers, a
2 sparsely populated rural area, and those providers have few
3 competitors and therefore substantial market power when
4 dealing with a private insurer, that's a tough market to
5 make a private health plan work and beat Medicare's
6 administered price system, especially if you're talking
7 about the swaths of the country where the utilization rates
8 are also low. So the unit prices are low and the
9 utilization is low.

10 In other parts of the country, you have the
11 reverse situation, where you've got many providers,
12 opportunities for plans to negotiate, steer their
13 beneficiaries towards particular providers, and play one
14 provider off against the other in the negotiating process.
15 And in addition to that, they have high utilization rates.

16 So Bob's observation is exactly the right one.
17 Plans historically have tended to cluster in the areas that
18 have high fee-for-service costs and many providers. That's
19 the rich environment for them and they've avoided the low
20 utilization sparse provider areas of the country until
21 Congress said, well, we want private plans everywhere and
22 adopted the policy of paying way above fee-for-service rates

1 in those sparsely populated areas with few providers in
2 order to attract private plans in.

3 And that's how we got into this situation that
4 somebody alluded to earlier that we had payments way above
5 fee-for-service rates in many parts of the country, ratios
6 like 140 percent, as I recall, Scott, in some parts of the
7 country. MA rates are 140 percent of fee-for-service cost.
8 And what's happening now with PPACA is we're moving away
9 from that and moving closer to having MA payments broadly
10 linked to underlying fee-for-service costs with very
11 important exceptions to that. But I do think it's true that
12 plans cluster in the high-cost areas for understandable
13 reasons.

14 And as I understand these numbers, Scott -- now,
15 to get back to Bob's specific question -- these numbers in
16 this table -- whoops, that table -- the fact that HMOs are
17 95 percent of fee-for-service, that reflects the markets
18 that they choose to be in, the markets that HMOs are
19 actually in.

20 DR. HARRISON: Right. Now, I would like to point
21 out, though, that they are going into more and more markets.

22 MR. HACKBARTH: Yes.

1 DR. HARRISON: The HMOs cover, and I was looking
2 for the number and I don't see it, but I think something
3 like 83, 84 percent of beneficiaries now have access to an
4 HMO, whereas that's way higher than it was before.

5 DR. BERENSON: But the penetration is obviously
6 very different, with some counties being 60, 70 percent and
7 others being -- in any case, I don't think we can continue
8 this now. I would just point to the fact that policy makers
9 and editorial writers like the New York Times a few weeks
10 ago are going to want to argue as to, in a context of
11 premium support discussions, which is more efficient,
12 traditional Medicare or Medicare Advantage, and to the
13 extent that we're able to help ground that debate in facts -
14 -

15 MR. HACKBARTH: Yes --

16 DR. BERENSON: -- I mean, that editorial writer
17 had it wrong --

18 MR. HACKBARTH: Right.

19 DR. BERENSON: -- it would be helpful. And so I
20 actually did, then, understand what you had done and hadn't
21 been wrong for all those Health Affairs articles, so --

22 MR. HACKBARTH: That's good.

1 DR. BERENSON: -- so it's helpful. Let me finish
2 my comments and then I'll move it along.

3 The comment I wanted to make was on the quality
4 side, which I found quite disturbing, the SNP findings. In
5 fact, for regular MA, we do have a choice construct and
6 people can look at the data and deal with their own
7 preferences and decide whether to join an MA plan or not.

8 There's an increasing discussion now about for the
9 dual population about mandatory enrollment in managed care,
10 and so I find the one area that at least some people are
11 contemplating that seems to be the area which was supposed
12 to be sort of the sweet spot of what private plans could do
13 is working on patients with chronic conditions and multiple
14 comorbidities, et cetera, and in that area, at least, for
15 the quality measures we've got, they're actually doing worse
16 than sort of unmanaged fee-for-service. So I'm not sure if
17 there's anything more you can amplify on that, but I find
18 that one is not everybody is getting to five-plus in that
19 area and that's the area that may, in fact, be the most
20 immediate one of policy relevance for us.

21 MR. ZARABOZO: Well, I think the SNP plans would
22 say that some of these measures are not appropriate for

1 them, and the famous one is the colorectal cancer screening
2 measure, which they say -- which is percent up to age 85
3 that have the screening, and they say for many of their
4 people, it is inappropriate to get that screening even
5 though they will suffer in the HEDIS measures by not doing
6 it.

7 DR. BERENSON: No, that -- I mean, clearly, that's
8 a problem across the whole program, where you should stop
9 that at 75, I believe, seems to -- no. Okay. So I'd like
10 to know a little more about what we think about those
11 measures. I mean, the ones -- the flu vaccination --

12 MR. ZARABOZO: Right. That's where -- I mean,
13 it's clear there it's lower and I don't see an explanation
14 why it should be lower --

15 DR. BERENSON: Yes. Okay. I think that one
16 deserves some -- if we're sort of setting out priorities for
17 future work, I think understanding what the SNPs are doing
18 in quality, to me, would be a high priority.

19 MR. ZARABOZO: Yes. And again, it's difficult to
20 identify them because they're often under a larger contract,
21 which is the reporting entity. So we sometimes can't figure
22 out what exactly is happening in the Special Needs Plans.

1 MR. KUHN: A couple quick questions. One, Scott,
2 take me out to, if we could, the 2015, when this current
3 demo ends on the quality that's going on, or maybe Carlos,
4 whoever is working on that one. So we go out to the end of
5 this demo and see the numbers here where the bids are
6 starting to come down. Is there a likely scenario that when
7 the demo's done that we'll see bids start to creep up, maybe
8 be above the benchmark, the extra benefits that people get
9 as coming below the benchmark start to disappear, and we
10 start to see a migration back to fee-for-service and out of
11 MA? Is that a plausible scenario that we could see when
12 this demo ends?

13 DR. HARRISON: It's kind of hard to know what
14 would happen there. I mean, there's going to be a
15 continuing quality program, and as time goes on, that will
16 get a little bit stronger because it's being phased in. It
17 won't be fully phased in until 2017. So there is still
18 going to be quality money. It's just that it's not going to
19 be sort of for the average plans. It's going to be for the
20 four- and five-star plans.

21 MR. KUHN: And those four- and five-star plans --
22 or, I'm sorry, the three-star plans are the ones that are

1 getting this money as the result of a demo. You know, kind
2 of where Bob was talking about, where plans are kind of
3 clustered, are they clustered in parts of the country that
4 are at risk of losing access in the future, or do we know
5 where they are?

6 MR. ZARABOZO: The -- I did look at the geographic
7 distribution to the extent possible because of the way the
8 contracts are set up and the lower-star plans tend to be --
9 well, Puerto Rico is one situation, but in the South. The
10 five-star plans are spread across the country, so you have
11 Massachusetts, Maine, Washington, California.

12 MR. KUHN: Okay.

13 MR. ZARABOZO: I do have a correction. In the
14 four-and-a-half and five-star plans, the increase in the
15 benchmark is the same percentage, so that in 2014, it will
16 be a five percent increase in the benchmark for all those
17 four-and-a-half and five-star plans.

18 MR. KUHN: I guess the reason I'm just curious is
19 that it appears to me that we may be looking at a cliff in
20 2015 and I'm just curious, order of magnitude, what that
21 cliff may or may not be and could it hit certain geographic
22 areas of the country as we go forward.

1 My second quick question has to do with coding
2 intensity. You know, this morning we made recommendations
3 on payment updates for hospitals because of coding and
4 others out there. PPACA had some coding intensity
5 adjustments that are part of the MA plan experience now,
6 started, I think, in 2010 and continues to go forward. Do
7 we -- based on the analysis that you're all doing, do you
8 think the coding intensity that's in place now and moving
9 forward is sufficient to capture the coding that's going on
10 in the MA plan world or do we think there's opportunity for
11 further recommendations or review in the future in this
12 area?

13 DR. HARRISON: There's a variety of opinions about
14 how well the risk system is doing. I think that some
15 actuary types think that there's even more coding that's
16 being corrected for. The coding adjustment factor will go
17 up starting next year. It goes up through, I think, 2017 or
18 maybe even 2019. It keeps going up for a while.

19 But we don't have a really good way to figure out
20 what we think the coding adjustment should be. You know,
21 first of all, CMS changes the model every couple of years
22 and there's also coding changes going on in fee-for-service.

1 So we're really not comfortable saying what we think the
2 true adjustment should be at this point.

3 DR. MARK MILLER: But we do have on our agenda to
4 look at some of the risk adjustment issues here as they
5 relate, how well HCC does, thinking about how it would apply
6 in a dual eligible type of world. And at least on this
7 topic, while what you've said is correct, we don't have an,
8 okay, we know the answer to it type of posture, we are kind
9 of poking around a little bit and looking at this. So it's
10 not just completely stagnant. I think Scott is correct to
11 be cautious as to whether we're going to have something to
12 bring to you, but we are kind of messing around a little bit
13 here.

14 DR. NAYLOR: Just let me echo Bill's comment. I
15 think this was an excellent report. I have no further
16 questions.

17 MS. BEHROOZI: Yes, it's really thorough, and
18 after six years, I'm starting to understand it. And I would
19 just echo the concern that you raise with respect to the
20 star measures applying to broad contracts rather than to
21 units. It kind of goes to Cori's point about, like, we
22 should know what we're measuring, and when somebody sees a

1 star rating, they should know what it's measuring as opposed
2 to some disparate geography, like is McDonald's better than
3 Burger King? What about your local McDonald's on the
4 corner, that kind of thing.

5 MR. GEORGE MILLER: I generally support the
6 recommendation. I guess I would have a question on the
7 total cost as compared to fee-for-service if the MA plans
8 weren't there, if we had the total impact of the entire
9 system for the MA plans and then compared that if there was
10 no MA plans and fee-for-service just to show the magnitude
11 of impact to the system.

12 DR. HARRISON: You mean in billions of dollars or
13 --

14 MR. GEORGE MILLER: In billions of dollars, yes.
15 Soon, we're talking about real money.

16 DR. HARRISON: We have put that number in the
17 report in the past.

18 MR. GEORGE MILLER: Yes.

19 DR. HARRISON: I guess we could do that.

20 MR. GEORGE MILLER: Just curious. It's billions,
21 right?

22 MR. HACKBARTH: -- all part of magnitude in the

1 past.

2 MR. GEORGE MILLER: Twenty billion?

3 DR. HARRISON: Yes. I bet it's lower now, though.
4 I'll bet it's maybe ten.

5 MR. HACKBARTH: Yes. I was thinking ten, 11,
6 something in that neighborhood.

7 MR. GEORGE MILLER: And then the follow-up
8 question, do we get value for that. Certainly, measured by
9 patient satisfaction, it seems that we do, but I'm just --

10 DR. HARRISON: There are extra benefits that the
11 beneficiaries get and now you could argue that there's also
12 you're getting quality.

13 MR. GEORGE MILLER: Okay. Thank you.

14 DR. STUART: I agree with Bill. I think this is a
15 fascinating chapter. I've enjoyed reading it every year.
16 It's a dynamic area and so seeing what's happening within MA
17 is really interesting. And having said that, it strikes me
18 that it would be useful to think about whether we could do
19 this with the Part D MA-PD plans. In other words, in the
20 chapter, the prior chapter, there are some very useful
21 comparisons between MA-PD and PDP. But the question I would
22 raise is are there differences in such things as average

1 premium, premium-free plans, proportion of plans that offer
2 gap coverage among the different MA-PD types.

3 DR. CASTELLANOS: I really appreciate the effort
4 that you put into this. I thought it was great and I look
5 forward to it each year.

6 George, I'm a little concerned that you're
7 supporting a recommendation and Glenn may ask for a vote, so
8 maybe I've been asleep and I don't know.

9 [Laughter.]

10 MR. HACKBARTH: I'm one vote behind, Ron, so --

11 [Laughter.]

12 MR. GRADISON: Thank you for your work. The jury
13 is still out on these programs, but this is very helpful to
14 have an annual review at this level of depth. Thank you.

15 DR. BORMAN: Good job. No questions.

16 MR. HACKBARTH: So, let me just go back to Herb's
17 question about what happens at the end of the demonstration,
18 the quality demonstration, and there's a significant
19 reduction in the total payments going out to plans. This is
20 a critical and interesting policy question.

21 My belief has been that while we could, as a
22 result of that, have somewhat fewer plans and somewhat lower

1 levels of enrollment, on the other hand, there may be some
2 benefits in terms of the type of plan that we get. In order
3 to continue to offer attractive benefits at lower levels of
4 Medicare payments, we may -- my hypothesis would be that we
5 would see plans start to become more organized and more
6 effective and doing what we want private plans to do, which
7 is effectively manage care for Medicare beneficiaries.

8 To put it another way, when we had very high
9 levels of payment relative to fee-for-service Medicare,
10 there was little reason for plans to aggressively manage or
11 try to identify efficient providers and steer beneficiaries
12 towards them. They could, with the excess payments, offer
13 generous benefits to attract new enrollees while not doing
14 much to actually manage the care, and that's sort of the
15 worst case scenario for the program. You get a high
16 enrollment at a high cost and private plans are not engaged
17 in doing the things that we need private plans to do. We
18 have them in the program because they have the potential to
19 do things that traditional Medicare finds difficult.

20 And so I am hopeful that as PPACA unfolds and
21 there's more pressure on the plans, that we will see the
22 private sector innovate and restructure itself, redesign how

1 they work so that they can compete effectively at lower
2 rates. I believe in private plans in the market. I think
3 there's lots of room for them to do very well in Medicare
4 even at lower rates.

5 Scott.

6 MR. ARMSTRONG: Just one more point to build on
7 what you just said. First, just to disclose, so I do work
8 for an organization that has a Medicare Advantage plan that
9 is one of the nine five-star plans in our country. But I
10 will tell you that it's very difficult, and I would just
11 tell you, we do not presume we will be able to maintain our
12 five-star status, even with all the advantages that our
13 organization has. And so in today's bonus payment
14 structure, as we've been talking about it, there are very
15 strong incentives for our organization to figure out how we
16 maintain that. And I think to the degree that -- so, first,
17 I would just say I think it's hard to imagine that the whole
18 industry clustering around five-star, I just don't think
19 that that's going to happen.

20 To the degree there continues to be strong
21 incentives through this bonus structure for advancing
22 exactly the kind of results that we're trying to advance in

1 so many other ways, we ought to be paying very close
2 attention to how this informs us. And I was just thinking,
3 you know, we're about to talk tomorrow morning about benefit
4 design. There are a lot of features of this five-star
5 quality program, but the Medicare Advantage plans
6 themselves, I think, very naturally flow into some of the
7 goals that we'll have in that chapter, too.

8 MR. HACKBARTH: Thank you, Scott and Carlos.

9 We will now have our public comment period.
10 Before you begin, let me just quickly review the rules. No
11 more than two minutes. When the light comes on, that
12 signifies the end of the two minutes, and please begin by
13 identifying yourself and your organization.

14 MR. SPERLING: Thank you. My name is Andrew
15 Sperling. I'm with the National Alliance on Mental Illness.
16 NAMI is the largest organization representing Medicare
17 beneficiaries living with severe and persistent mental
18 illness in this country.

19 This certainly probably goes in the category of
20 futility, but I will make the comment nonetheless. NAMI
21 would again like to express extreme disappointment in the
22 decision made by this Commission relative to cost sharing

1 for low-income subsidy and dual eligible beneficiaries in
2 the Medicare program. This is a profound mistake and could
3 lead to severe disruptions in adherence and treatment for
4 dual eligible beneficiaries, particularly vulnerable
5 beneficiaries, not just with a single condition but with
6 multiple chronic conditions who take many, many medications.

7 We're disappointed that this proposal, quite
8 frankly, appears to be divorced from the real prescribing
9 patterns that go on for these low-income beneficiaries that
10 have multiple chronic conditions, and the idea that,
11 somehow, their brand prescribing is driven by them insisting
12 on brand medications, in fact, they have very little control
13 over the prescribing decisions that are made for them on
14 behalf of their physicians. Many of them have mental
15 impairments and other disabilities that, quite frankly, make
16 adherence difficult, and we're extremely concerned that this
17 proposal is going to disrupt their ongoing treatment and, in
18 fact, cost the Medicare program more in the long run.

19 We recognize this Commission tried to make some
20 concessions by deferring to the Secretary to make the
21 decision about which therapeutic classes will be subject to
22 higher cost sharing. That gives us little confidence, quite

1 frankly, and a decision over time where the Secretary is
2 making more and more decisions that are driven by cost
3 control rather than ensuring strong, good clinical outcomes
4 for vulnerable beneficiaries that, in fact, cost will
5 overcome these decisions. We'll see more and more
6 therapeutic classes subject to higher cost sharing.

7 We're disappointed that in terms of the lowering
8 of the cost sharing to zero, that appears to be only for
9 generics in classes that are designated by the Secretary.
10 So, in fact, many beneficiaries would only get that if their
11 class were designated for the higher cost sharing.

12 I want to be clear. For someone to stay adherent
13 to a brand name medication that's prescribed by their
14 doctor, specifically by their physician, they could be
15 subject under this proposal to cost sharing increases as
16 high as 200 and 300 percent. That would be the cost to that
17 beneficiary to stay adherent to a particular compound
18 prescribed by their prescription, regardless of specialized
19 circumstances in terms of polypharmacy, other drugs,
20 contraindications, the fact that other compounds from that
21 class may have been tried and failed for that individual.

22 So, again, we understand the decision has been

1 made. It will now be transmitted to Congress. We will have
2 to engage our grassroots advocates and all 1,100 affiliates
3 that are in all 50 States and all 435 Congressional
4 districts to educate their members about what the potential
5 of this proposal is for ongoing strong clinical care for
6 dual eligibles and LIS beneficiaries in the program. Thank
7 you.

8 MR. HACKBARTH: Okay. Thank you.

9 We will reconvene at 8:00 a.m. tomorrow morning.

10 [Whereupon, at 4:32 p.m., the proceedings were
11 adjourned, to reconvene at 8:00 a.m. on Friday, January 13,
12 2012.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 13, 2012
8:05 a.m.

COMMISSIONERS PRESENT:

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

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Public comment	173

1 P R O C E E D I N G S [8:03 a.m.]

2 MR. HACKBARTH: Okay. Good morning. We have two
3 sessions today, one on reforming the Medicare benefit
4 package and the other on our mandated report on rural
5 payment adequacy. So who is leading off on the benefit
6 design? Julie? Okay.

7 DR. LEE: Good morning. In today's presentation,
8 we continue our discussion of potential changes in
9 Medicare's benefit design. Recall that we began this
10 discussion last October and November.

11 We have the following goals for today's
12 presentation: We are working toward draft recommendations
13 in spring. To make that happen, we need to define the key
14 characteristics of the new benefit design you wish to
15 include and address policy questions relative to
16 implementing new benefits, such as an excise tax on
17 supplemental insurance.

18 The Commission has been considering ways to reform
19 the traditional benefit package for several years to give
20 beneficiaries better protection against high out-of-pocket
21 spending and to create the incentives for beneficiaries to
22 make informed decisions about their use of care.

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

4 So let's begin with a brief recap of the two
5 previous meetings on the topic. In October's presentation,
6 we discussed the current fee-for-service benefit design and
7 presented three alternative benefit packages for you to
8 consider. All three shared a common benefit structure in
9 that they had an out-of-pocket maximum and a combined
10 deductible for Part A and Part B services.

11 In addition, the first package, presented as a
12 reference point, had 20 percent coinsurance on all services
13 between the deductible and the out-of-pocket maximum. The
14 second and third packages had a set of co-payments instead
15 of co-insurance. The Commission has expressed a preference
16 for co-payments because they are more predictable for
17 beneficiaries.

18 In November's presentation, we focused on the role
19 of supplemental coverage. Specifically, we used one of the
20 co-payment packages from October and combined it with the
21 three alternative policies related to supplemental coverage.
22 They varied in the degree to which Medicare's cost sharing

1 can be filled in by supplemental insurance.

2 The Commission at that time expressed a strong
3 preference for imposing an excise tax on supplemental
4 insurance rather than regulating supplemental benefits.

5 Today's presentation has two main parts.

6 First, we'll go over two benefit packages with a
7 revised set of co-payments. The first package would keep
8 beneficiary cost-sharing liability roughly the same as
9 current law (but program spending would be higher), whereas
10 the second package would keep the Medicare program spending
11 about the same (but beneficiary cost sharing would
12 increase).

13 In the second part of the presentation, we'll
14 overlay an excise tax on supplemental insurance on these two
15 benefit packages. This was the guidance you gave us in
16 November as your preferred policy option toward supplemental
17 coverage.

18 There are a couple of issues discussed in November
19 that are not on this outline. We want to note here that the
20 analysis related to income and the value of insurance are
21 not forgotten and will be presented in the future.

22 If you recall, the fee-for-service benefit package

1 from November had a co-payment structure of the type more
2 common under Medicare Advantage. It was labeled "MA-
3 neutral" because it had approximately the same average cost-
4 sharing liability as the current fee-for-service.

5 Today, we present two illustrative packages that
6 show key tradeoffs between some design elements. We'll
7 first go over what these packages look like. Both have a
8 \$5000 out-of-pocket maximum and a combined deductible for
9 Part A and Part B services. Remember that under the current
10 benefit package, there's no out-of-pocket cap, and
11 beneficiaries face a high deductible of over \$1000 for Part
12 A and a low deductible for Part B. As typical in most
13 private plans, we differentiated co-payments for primary
14 care and specialist visits. In contrast, under current law,
15 all physician services have a 20 percent coinsurance.

16 MA plans also told us that they have a co-payment
17 for advanced imaging services. The \$100 co-payment we
18 included here is similar to what MA plans charge and almost
19 equal to the average cost sharing for those services under
20 current law.

21 Co-payments for skilled nursing facility services
22 are higher compared to current law, which currently has no

1 cost sharing for the first 20 days.

2 Finally, our cost sharing on home health is
3 consistent with the \$150 co-payment per episode the
4 Commission has included in the March report from last year.

5 These two packages are quite similar in their
6 structure, but the levels of co-payments do differ because
7 they were set to meet two quite different budget
8 constraints.

9 Under the first package, average beneficiary cost-
10 sharing liability would be about the same as the current
11 law, but Medicare program spending would be higher. This
12 package is referred to as the "beneficiary-neutral" package
13 on the slide.

14 Under the second package, average beneficiary
15 liability would be higher compared to current law, but
16 Medicare spending would be roughly equal to current law.
17 This package is referred to as the "program-neutral" package
18 on the slide.

19 Comparing the two columns, the second has a higher
20 deductible -- \$750 versus \$500 -- and a higher co-payment on
21 skilled nursing facility days -- at \$100 versus \$80. These
22 differences are highlighted in yellow.

1 Generally, compared to current law, the
2 distribution of cost-sharing liability across type of
3 service is quite different under the two alternative
4 packages. Because of the combined deductible, beneficiaries
5 with very low Medicare spending would pay higher cost
6 sharing overall compared to current law. Those with a
7 hospital admission, on the other hand, would pay lower cost
8 sharing. Those with very high Medicare spending would also
9 see their cost sharing go down substantially because of the
10 out-of-pocket maximum.

11 This is the chart that you've seen before. It
12 shows the results of simulating changes in out-of-pocket
13 spending and premiums for 2009 if the alternative benefit
14 package had been in place. The second and third bars
15 correspond to the two benefit packages we just described.
16 The first one reproduces the distribution from November.

17 So let's start with the one in the middle that is
18 the beneficiary-neutral package. The bottom part of the bar
19 -- that's the blue and green -- shows that 9 percent of
20 beneficiaries would see their out-of-pocket spending go down
21 by \$250 or more under the new benefits. Generally, these
22 are the beneficiaries who reach the out-of-pocket maximum.

1 On the other hand, at the top of the bar -- that's
2 the orange and red -- about a little over 20 percent of
3 beneficiaries would see their out-of-pocket spending go up
4 by \$250 or more. Mainly, these are the beneficiaries who
5 are spending more out-of-pocket due to the deductible.

6 The distribution under the program-neutral package
7 is shown in the third bar. Recall that this package has a
8 higher deductible and overall cost sharing is higher
9 compared to the beneficiary-neutral package. And this
10 difference you can see in the top part of the bar: about 30
11 percent of beneficiaries compared to about 20 in the
12 beneficiary-neutral package would see their out-of-pocket
13 spending increase by \$250 or more.

14 We want to point out here how the picture might
15 look different over a longer period of time. These charts
16 show the distribution in a given year. But as Karen has
17 pointed out in November, people's needs and preferences for
18 insurance change over time as they age.

19 For example, even though a little over 20 percent
20 of fee-for-service beneficiaries have at least one hospital
21 admission in any given year, that number goes up to more
22 than half if we look over five years. That means that many

1 more beneficiaries would see some years in which their out-
2 of-pocket spending would be lower under the new benefit over
3 a longer period.

4 If you recall, in November's presentation, we
5 looked at three policy options that restricted what
6 supplemental insurance can and cannot do. At that time, the
7 Commission expressed a strong preference for the excise tax
8 approach over the regulatory approach. Its main argument
9 was that under the tax approach, risk-averse beneficiaries
10 who wish to buy first-dollar coverage or reduce the
11 uncertainty in their out-of-pocket spending through
12 supplemental insurance should be allowed to do so. Instead
13 of restricting how supplemental coverage can fill in
14 Medicare's cost sharing, the tax would charge the insurer
15 for at least some of the added costs imposed on Medicare of
16 having such comprehensive coverage.

17 As a result, in today's presentation, we show an
18 illustrative example of a simple 20 percent tax on Medigap
19 and employer-sponsored retiree plans. Assuming the average
20 annual premiums, this 20 percent tax translates into \$420
21 per year on Medigap plans and \$200 per year on retiree
22 plans.

1 There are two main effects of a tax on
2 supplemental policies:

3 First, the tax would provide revenues to help
4 recoup some of the additional Medicare spending associated
5 with supplemental coverage.

6 Second, as the insurers pass the tax along by
7 raising premiums, the tax may provide incentives for
8 beneficiaries to switch or drop supplemental insurance.

9 For modeling changes in the take-up of
10 supplemental insurance in response to higher premiums, we
11 consulted the Actuarial Research Corporation.
12 Unfortunately, there is very little data on this question.
13 The conventional assumption seems to be that the response to
14 a premium increase among those who have purchased Medigap
15 policies would be minimal, at least in the short term.

16 The Commission may wish to consider several policy
17 design questions with respect to the tax:

18 What should be the appropriate tax rate?

19 Should the tax be imposed only on plans above a
20 certain threshold of generosity?

21 Should the tax apply only to newly purchased plans
22 rather than all supplemental plans?

1 As mentioned in the previous slide, we made a very
2 simplistic assumption that a 20 percent tax would mean that
3 beneficiaries' expenses would be \$420 higher for those with
4 Medigap and \$200 higher per year for those with retiree
5 benefits, even before we consider the changes in their cost-
6 sharing liability. You can see the effect of this reflected
7 in this chart, where we see a noticeably bigger change
8 compared to the previous slide, which was Slide 8).

9 Focusing on the top part of each bar, we see that
10 the majority of beneficiaries would see their total out-of-
11 pocket spending go up by \$250 or more -- 70 percent under
12 the beneficiary-neutral package and 75 percent under the
13 program-neutral package. For this chart, we assumed that
14 beneficiaries keep their supplemental coverage and pay the
15 tax on their supplemental insurance.

16 This slide summarizes the relative change in
17 annual Medicare program spending under the four policy
18 combinations we presented today -- the two benefit packages
19 with and without a 20 percent tax.

20 For example, if we hold beneficiary cost-sharing
21 liability roughly equal to current law, program spending
22 would increase by about 1 percent. That's because of the

1 catastrophic protection for high-cost beneficiaries. But
2 tax revenues would offset the increase by 1.5 percent --
3 that's the second row -- leaving a net budgetary effect at a
4 half percent in savings.

5 In contrast, under the program-neutral package,
6 Medicare spending would be about the same, but
7 beneficiaries' cost sharing would be higher. With the 1.5
8 percent in revenue offsets, the net budgetary effect under
9 this option would be about 1.5 percent in savings.

10 We want to reiterate several caveats and
11 limitations of our modeling because it represents an
12 imperfect approximation of the policies outlined.

13 First, our results provide a one-year snapshot of
14 relative changes. We want to emphasize that these are not
15 budget scores, which will have to take into account
16 additional factors. But the results do show the relative
17 budgetary effect of alternative policy options, which are
18 useful to keep in mind as you consider and weigh different
19 aspects of the benefit design.

20 Also, the scope of our modeling excludes dually
21 eligible beneficiaries because we assumed that Medicaid
22 would fill in any changes under the alternative benefit

1 package and would keep the cost sharing the same for those
2 beneficiaries.

3 As we discussed in November, our results are
4 sensitive to the behavioral assumptions underlying the
5 model. In addition, our model contains some important
6 simplifying assumptions on supplemental coverage.

7 Finally, we want to point out that throughout our
8 analysis, our numbers do not capture the value of insurance
9 that risk-averse people get when they insure against
10 undesirable outcomes. This value of insurance is real and
11 important for many beneficiaries.

12 To ensure that a new benefit design is flexible
13 enough to respond to changes in medical evidence or delivery
14 system reform, you may want to identify elements of the
15 benefit design that are fixed and those that can vary.

16 For instance, you may want to create incentives to
17 encourage the use of high-value services and discourage the
18 use of low-value services. One way to do this would be to
19 give the Secretary the authority to reduce cost-sharing for
20 services that medical evidence has identified as high value.

21 For your discussion, we present an illustrative
22 example of possible recommendations. IN this example we

1 tried to capture the main threads of the discussions to
2 date.

3 First, direct the Secretary to develop a new fee-
4 for-service benefit design with: out-of-pocket maximum,
5 combined deductible for Part A and Part B services, co-
6 payments that may differentiate by type of service and
7 provider, such as primary care versus specialist visits.

8 Second, authorize the Secretary to reduce cost
9 sharing on high-value services where there's evidence.

10 The next bullet point is more of a direction for
11 implementing the first two. In today's presentation, we
12 combined two constraints in putting the benefit package
13 together, keeping the beneficiary liability neutral versus
14 keeping the program cost neutral. What's the ultimate
15 number you wish to work toward in designing the new benefit?

16 Third, establish an excise tax on supplemental
17 coverage.

18 Finally, that concludes our presentation, and we
19 look forward to your discussion.

20 MR. HACKBARTH: Okay. Thank you, Julie.

21 So today let's do our customary two rounds, round
22 one being clarifying questions. Karen, do you want to lead

1 round one?

2 DR. BORMAN: Julie, if you could go to Slide 6, I
3 just want to make sure I'm correct. The outpatient per
4 visit we're talking about here would be like emergency
5 department or hospital outpatient department? Is that what
6 we're capturing there?

7 DR. LEE: That's correct.

8 DR. BORMAN: I just want to be sure I'm
9 interpreting that correctly. Great. Thank you.

10 MR. GRADISON: Under the current circumstances
11 without a cap, a catastrophic benefit, do we have any idea
12 what actually happens with regard to those rather large
13 sums, that is, whether they're written off or whether
14 they're paid or who they affect in terms of socioeconomic
15 factors?

16 DR. LEE: So with respect to socioeconomic
17 factors, people who have a higher income tend to have
18 supplemental coverage, so they would get catastrophic
19 protection in that way. In terms of who is reaching that
20 very high level of liability, we know that it is pretty
21 stable in that it's about 5 percent of the beneficiaries,
22 but as to exactly who they are, that kind of detail we do

1 not -- or the kind of detail that one would wish, we do not
2 have that. It's very general.

3 There would be some part of that beneficiary
4 responsibility that would not be paid, but actually I do not
5 know at this point to what extent that would be.

6 MR. GRADISON: Thank you.

7 DR. MARK MILLER: Let me just draw a distinction.
8 We have a model built specifically for the purposes of doing
9 some of this estimation. I think your question could be
10 approached differently using a different data set, and we've
11 done some work a few years back where we were looking at
12 distributions of beneficiaries and who was in the extreme
13 tail of the distribution. Again, that's something that we
14 could revisit and bring back to you, but I think Julie is
15 sort of speaking more to, I think, what's in this model
16 where it is not highly detailed to answer the question that
17 you're asking.

18 DR. LEE: Certainly on the socioeconomic
19 variables, we really do not have that much information.

20 DR. MARK MILLER: Right. But we could approach
21 that question through a different data set. So, Bill, we'll
22 try and dig that -- and we've actually done it a few years

1 back, and we can dig some of that back up and bring it back
2 to you.

3 MR. GRADISON: I'd appreciate that. I still have
4 wounds that haven't healed since the Medicare catastrophic
5 dispute of a few days ago.

6 DR. CASTELLANOS: Just on Slide 13, you mentioned
7 creating appropriate incentives. I totally agree. We need
8 to discourage low-value services and encourage high-value
9 services. I see the problem being to be able to at this
10 point in our discussions to clearly identify high- and low-
11 value services. I don't know how you plan to do that.
12 Maybe Mike will help us. Okay. Thank you.

13 MR. HACKBARTH: Ron, why don't we get to that when
14 we get to the round two discussion. Bruce, clarifying
15 questions?

16 DR. STUART: Yeah, I don't have the slides, but it
17 was one of the earlier ones showing the characteristics of
18 the new benefits -- not the effect but the -- yeah, right.

19 I'm curious about outpatient visits at \$100 a pop
20 because that seems to be directly contrary to what we talked
21 about yesterday in terms of equalizing payments across site
22 of service. So I think we open ourselves up to criticism by

1 having such a recommendation. Even if it's only
2 illustrative, it doesn't strike me as being a particularly
3 good illustration here.

4 MR. HACKBARTH: That's a good thing for us to keep
5 our eye on. I would note, though, that our recommendation
6 yesterday was about equalizing payment for E&M services, and
7 outpatient departments are providing a wide range of other
8 services. But good thought.

9 MR. GEORGE MILLER: Yes, thank you. On Slide 11,
10 as I understand the presentation, if we chose to make this
11 effective only on new purchase plans, would that change the
12 budgetary implications of this slide going forward?

13 DR. LEE: Can you repeat the question

14 MR. GEORGE MILLER: Yeah. I believe you said in
15 the presentation we could choose the option of only making
16 this applicable to new purchase plans going forward. So if
17 we chose that option, if I understood that correctly, then
18 would that change the value of the slide?

19 DR. LEE: Yes, that will change the revenue
20 offsets from the tax. That will decrease significantly.

21 MR. GEORGE MILLER: Thank you.

22 MR. HACKBARTH: Mitra, any clarifying questions?

1 MS. BEHROOZI: Yeah, I think a couple related to
2 what Bill was asking, and I think we've asked them before,
3 and I forget.

4 Of those 5 percent of beneficiaries who reach the
5 catastrophic level, is it the same approximately 10 percent
6 who don't have supplemental coverage? Or is it the 5
7 percent of all beneficiaries who are exposed, who are, in
8 fact, exposed to the high out-of-pocket?

9 DR. LEE: So in very broad terms, people who just
10 have Medicare only, they tend to be younger and healthier.
11 So in terms of the probability of getting really sick, it
12 tends to be a little lower. So that's kind of what's
13 reflected.

14 Now, I actually do not remember -- we did look at
15 this cut of the data before, but I actually cannot remember
16 what that was. But it was not actually noticeable in that
17 direction.

18 MS. BEHROOZI: So of the 10 percent who don't have
19 supplemental coverage of some kind, it's probably around the
20 same 10 percent of that group who reaches the -- who has no
21 -- I'm sorry, 5 percent of that group who reaches the out-
22 of-pocket level? I'm trying -- you know what I'm trying to

1 get at? The percentage total of the overall Medicare
2 population who, in fact, is exposed to the catastrophic
3 cost. Not to minimize it. I just want to get an idea.

4 DR. LEE: So I think you are referring to the
5 actually cost-sharing liability, not necessarily their out-
6 of-pocket spending, right? The people with supplemental
7 coverage would have -- they could have a very high
8 liability, but, in fact, be paid very small.

9 MS. BEHROOZI: That's not who I'm talking about.

10 DR. LEE: Okay. So you said the liability --

11 MS. BEHROOZI: I'm talking about the actual expose
12 -- the actual liabilities --

13 DR. LEE: So the liability, that reflects the
14 overall spending. So if you are younger and healthier, it's
15 a relatively smaller portion of that group that will be
16 reaching that liability.

17 MS. BEHROOZI: So it's less than 10 percent of the
18 10 percent?

19 DR. LEE: Yeah.

20 MS. BEHROOZI: Okay. Thank you. Now just leaving
21 that alone then, the 10 percent of people who don't have
22 supplemental coverage, how has that changed over time?

1 That's what I understand to be sort of the present snapshot,
2 but like ten years ago, what was the ratio of people who
3 didn't have supplemental coverage to those who did?

4 DR. LEE: So this is one of the things that --
5 it's from year to year in the chart book. I don't know
6 where -- Dan? Dan would know.

7 DR. ZABINSKI: [off microphone] What's that?

8 MR. HACKBARTH: The question is whether the share
9 of Medicare beneficiaries with some form of supplemental
10 coverage has been relatively constant over time.

11 DR. ZABINSKI: [off microphone] Yes, it has.
12 Around 10.

13 MR. HACKBARTH: Yeah.

14 MS. BEHROOZI: Thank you. And one more question.
15 Sorry. On Slide 10, the changes in out-of-pocket spending
16 in premiums, so this assumes that the premiums will go up
17 because the plans will be covering the excise tax? That's
18 how you get to --

19 DR. LEE: Yes, and we assume that the entire tax
20 will be passed on to the beneficiary.

21 MS. BEHROOZI: Right, and it didn't assume any
22 change in pricing behavior or whatever by the insurance

1 company?

2 DR. LEE: So we did look at it -- so under
3 beneficiary-neutral package, we did not assume any changes
4 in the premiums because the overall cost-sharing liability
5 under the new package was roughly equal to current law.

6 Under program-neutral package where cost-sharing
7 liability is higher compared to current law, we do believe
8 that both the Medigap and retiree plans, there will be
9 change in the premium. For Medigap we did look at how much
10 of -- you know, where the premium increased, that that will
11 shift the distribution of this chart a little bit higher.
12 What is presented here, we did not assume premium changes
13 for this particular chart, but we did look at for Medigap.

14 DR. NAYLOR: Just to make sure I understand, when
15 you define the characteristics of the program on Slide 3,
16 you talk about reducing exposure to unexpected out-of-pocket
17 spending. I don't want you flipping through slides. My
18 understanding is one way in which this has been modeled on
19 Slide 11 is expected increases in Medicare spending for
20 catastrophic under the beneficiary. But the one that I
21 don't understand is how these models are mindful of effects
22 on people in poor health.

1 DR. LEE: To the extent that they are the ones who
2 will incur the higher cost-sharing liability, they would be
3 more likely to benefit from the catastrophic cap.

4 Now, to the extent any special provisions
5 addressing that third point, our current -- what we
6 presented today did not make that distinction.

7 DR. NAYLOR: I guess one way to do it is thinking
8 about if cost sharing gets to lower-value services, and
9 value means higher quality at reduced cost, that might be.
10 But I wasn't clear in how --

11 DR. LEE: So all the discussions today with
12 specific benefit packages, we are mindful of the effects on
13 low-income beneficiaries, but what we have modeled has not
14 distinguished those characteristics.

15 DR. BERENSON: I'm following up on Mitra's
16 questions about the interaction between the benefit changes
17 and then what happens with supplemental insurance, so go to
18 Slide 10. Just looking at this, with 75 percent of people
19 having higher cost-sharing obligations and maybe 6 percent
20 being significantly benefitted, it doesn't look like a good
21 tradeoff from that point of view. But what happens -- I
22 want to understand a little more what the response of the

1 Medigap plans would be. They no longer have to pay for the
2 catastrophic expenses. They don't have to reserve for
3 catastrophic expenses. I assume they reallocate that into
4 covering most cost sharing.

5 So isn't it close to a wash? In fact, if people
6 still were buying Medigap insurance, they wouldn't actually
7 be paying this \$310 on average. They would be paying
8 roughly the same premiums and having the third party picking
9 up their cost sharing. Is that not right?

10 DR. LEE: So that was the rationale we used for
11 beneficiary-neutral package because under that package we
12 rejiggered the cost sharing so that by putting on extra
13 benefit with the out-of-pocket maximum, there were other,
14 you know, increases in cost sharing. So the kind of average
15 value of that package was -- in terms of cost sharing, that
16 was roughly equal to current law.

17 Now, if we look at program-neutral package where
18 overall cost sharing has increased, so even though Medigap
19 supplemental plans might not have to now pay the
20 catastrophic level, there have been enough increases in cost
21 sharing at the lower end of it to increase the overall cost
22 sharing. So we would think then Medigap premium will -- the

1 cost of that will increase.

2 DR. BERENSON: What order of magnitude of an
3 increase?

4 DR. LEE: So the average cost-sharing liability
5 for program-neutral package was about \$130 higher a year
6 compared to current law, using 2009 data, and that was -- so
7 if we assume the average admin load of 25 percent, that
8 translates into about \$160 per year in Medicare -- Medigap
9 premiums. So that was kind of a very simplistic back-of-
10 the-envelope calculation we did.

11 DR. BERENSON: That helps. Thank you.

12 DR. HALL: Julie, that was a very clear
13 presentation you gave. I appreciated it. I have a little
14 bit more to say in round two, but you just mentioned very
15 briefly one sentence, that it's very difficult to predict
16 what sort of behavioral changes would occur in one model
17 versus another, particularly in terms of out-of-pocket
18 expenses. Difficult, but is it impossible? Or is it beyond
19 the scope of this Commission? If the answer is we don't
20 know, I'll wait until round two to come back to that.

21 DR. LEE: We have been asking experts for their
22 opinion. It's a lack of data that I think has been the

1 challenge. So they are happy to express what they think,
2 but they always qualify it with, "Well, this is just my
3 personal opinion."

4 MR. HACKBARTH: So, Bill, are you focused on
5 patient response to cost sharing at the point of service or
6 how beneficiaries might respond to an excise tax?

7 DR. HALL: Yeah, how beneficiaries would respond
8 to what they see as various incentives and disincentives to
9 be insured or not be insured; and, conversely, how willing
10 would recipients be to accept lower costs of one sort or
11 another based on behavioral changes -- the sort of thing
12 that's being done in industry.

13 MR. HACKBARTH: But is it their decision to
14 purchase insurance or their decision to get medical care?

15 DR. HALL: No, no, I think it's to buy insurance
16 like Medigap.

17 MR. HACKBARTH: Okay. I'm just trying to
18 understand what part you're focused on.

19 DR. HALL: Medigap would be a good example.

20 DR. MARK MILLER: And I want you to know that
21 there have been -- I think the sense that one way to put
22 your question is I have now this clearer schedule of co-

1 payment, and as a patient I might then say, "Well, look at
2 the value of the insurance and this increase and the
3 premium, and do I want to continue to purchase it?"

4 And so we've had a number of focused on
5 conversations with people out in the field, and they really
6 -- we have really had a hard time getting a good estimate or
7 sense of when you hit this price point, people will start to
8 change their behavior. And that's what I think Julie is
9 saying, that it's going to be very hard for us to say this
10 is it, now the behavior will change. And I wouldn't
11 anticipate a lot more precision there, although you seem
12 to...

13 DR. LEE: So where people seem to be more
14 comfortable is if you already have Medigap insurance and
15 whether the incremental increase in premium is, you know,
16 \$20 a month or \$40 a month, it's much more difficult for
17 them to drop that Medigap insurance.

18 Now, people did point out that if you are actually
19 coming to that decision whether to buy Medigap or not as you
20 age into Medicare, so you currently do not have it but it's
21 that initial decision, then the higher price might have a
22 bigger effect. So there are various factors that can change

1 that decision, but for the current holder of Medigap
2 policies, there is that inertia.

3 DR. HALL: Thank you.

4 DR. CHERNEW: What I was going to say is most of
5 the time people assume that there's loosely going to be some
6 continuous response, so it's not like no one responds for a
7 nickel and no one responds for a time, and then all of a
8 sudden it's 15 cents and everybody responds. Getting the
9 magnitudes are hard, although it could be investigated in a
10 whole number of ways. One of the challenges regarding this,
11 of course, is you have to decide what employers are doing.
12 So a lot of people are also getting their supplemental stuff
13 subsidized by employers, and there's a bunch of other
14 reasons why there's changes going on in the employer market.

15 My general sense is over time you would also see
16 people shifting to less generous -- they're still buying
17 supplemental coverage, but, remember, in the individual
18 market there's the letters -- you know, C and F are the
19 biggest ones of the supplemental, and so they'll switch to
20 lower premiums in that regard. But I guess what I would say
21 is although people wouldn't want to give you a number, I
22 would be astounded if in the absence of evidence the right

1 assumption is no behavioral change to a price change. And
2 then the question is what level, you know, a conservative or
3 a less conservative assumption or some version of that. But
4 so far there has been incredibly stable participation in
5 supplemental insurance coverage, and I would be surprised if
6 that stayed. In fact, I think a lot of the reason why
7 people have moved to Medicare Advantage is because this gets
8 more -- the other place people run when the premiums go up
9 is they run to Medicare Advantage, which has a whole
10 separate set of benefit design issues.

11 MR. HACKBARTH: It seems to me that this is a
12 really important question because if you were to assume that
13 the excise tax had no effect on purchasing behavior and
14 people just continued to fill in all of the cost sharing,
15 then basically what we've done through the restructuring of
16 the benefit package is nullified largely because people
17 aren't seeing those incentives, and it's just a question of
18 how good is the excise tax as a new revenue source for the
19 Medicare program. And, you know, you compare it to, say,
20 the Part B premium. The Part B premium is a national
21 constant amount, whereas an excise tax would vary according
22 to health care costs in different markets. And some people

1 might think that's a good thing or a bad thing. The Part B
2 premium has some income-related elements. Excise tax, just
3 a straight excise tax would not. And so you'd evaluate the
4 different ways of raising revenue for the Medicare program.

5 If, on the other hand, you think that the excise
6 tax will affect purchasing behavior of supplemental coverage
7 and, therefore, the reformed benefit package has a different
8 effect, then you've got a whole different set of questions.

9 So this is really a central issue in this whole
10 effort, and, unfortunately, there's not a lot of evidence,
11 the experts are telling us, to make an assessment.

12 DR. MARK MILLER: I agree with all of that, and
13 the other way to think about what's happening here, I think,
14 if you guys could track this carefully, is we're sort of
15 assuming at this level of taxation you don't get a lot of
16 movement, which is also a conservative assumption about the
17 effect. I mean, you're basically counting the revenue, but
18 not counting a lot of additional effect beyond that. And I
19 think -- this is correct, right? One nod, that's all I'm
20 looking for. And I think what we feel a little strapped on
21 is, you know, we didn't hear a lot of information from the
22 environment to be more bold in saying, okay, I'm going to

1 assume this utilization effect because, you know, both on a
2 hired basis and just making a phone call basis, we didn't
3 get a lot of people saying you're going to get a big effect
4 here.

5 DR. CHERNEW: There are estimates of the
6 elasticity of demand for insurance from the literature. The
7 question then becomes this is a different population and
8 it's subsidized insurance and you could sort it out. But
9 the assumption of zero as a default assumption for lack of
10 any information strikes me as not -- "we don't really know
11 so we're going to assume no response" doesn't strike me as
12 the right assumption.

13 I would start with an assumption of the literature
14 says in this other population you get this, and now we're
15 going to try and figure out, we're going to shade that a
16 little bit one way or another for this population.

17 DR. MARK MILLER: And I don't think it's no
18 response. I think we have like very small --

19 DR. LEE: That's correct. There was about 3
20 percent dropping at 20 percent tax.

21 MR. ARMSTRONG: Just a question on this point. So
22 the analysis isn't just about the sensitivity to different

1 pricing structure for a Medigap policy. It's also about the
2 relative value of the basic benefit, too, and we're changing
3 both. And so if we're changing the value of the basic
4 benefit to make it more valuable, that too will have an
5 influence over people's choices.

6 So, I mean, I think even more strongly to Mike's
7 point, people are going to move. The question is really,
8 you know, how do you predict how much.

9 MR. HACKBARTH: Let me play back what I thought I
10 heard, Scott. The underlying structure of the Medicare
11 benefit package will logically affect the propensity to buy
12 supplemental coverage, but it is, again, difficult to know
13 exactly how much. But to the extent that the benefit
14 package is simpler and more readily understood by
15 beneficiaries and maybe reduces some reservations they have
16 about co-insurance when they -- you know, it's going to be
17 20 percent of some bill that they have no idea what it might
18 be, and that creates uncertainty. Fixed co-payments may
19 provide some greater confidence and simplicity and
20 understandability in the benefit. The catastrophic may
21 provide reassurance. And so the effect of a tax on the
22 purchasing decision on supplemental coverage is going to be

1 also influenced by what the underlying benefit package is.
2 You've got multiple variables at play here that really
3 complicate the analysis, I think.

4 So let's get back to our round one clarifying
5 questions.

6 DR. DEAN: How much has the premium on
7 supplemental policies varied over, say, the last few years?
8 Has it followed what private insurance does, or has it been
9 more stable?

10 DR. HARRISON: Generally it follows the cost of
11 the Medicare benefit because it's a wrap-around and that's
12 what the insurance companies would be liable for, is the
13 cost sharing on Medicare. So it tends to track Medicare
14 spending.

15 DR. DEAN: So has that gone up in the same way
16 that individual insurance has gone up?

17 DR. HARRISON: It has certainly gone up as
18 Medicare has gone up. Now, the last couple years -- this
19 data is from 2009. I don't think there have been big
20 changes since 2009 because Medicare spending has been
21 growing pretty closely. But it has gone up some.

22 DR. DEAN: And I take it that the rises have not

1 affected the take-up of the insurance; in other words, the
2 proportion of people that are buying the policies has stayed
3 pretty steady.

4 DR. HARRISON: No, I think Medigap has fallen off.

5 DR. DEAN: It has fallen off?

6 DR. CHERNEW: And they moved to MA.

7 DR. HARRISON: That's right.

8 DR. DEAN: Oh, okay.

9 DR. HARRISON: Right.

10 DR. CHERNEW: To some extent, Medicare Advantage
11 payments haven't necessarily risen. For example, the
12 actuaries at CMS have predicted a drop in Medicare Advantage
13 enrollment because the generosity of payment for Medicare
14 Advantage plans has been less, to my understanding. But you
15 see Medicare Advantage plans are rising, and part of the
16 reason is the Medicare Advantage market is connected to this
17 market. So when you're trying to make choices between what
18 you want to do -- the other thing that's going on is the
19 employers are changing what they're doing in ways that we
20 don't know a lot about. But if you don't have employer
21 coverage, you're deciding between getting your gaps filled
22 through a Medicare Advantage plan or through this plan --

1 and people shift between the markets. And I agree, we don't
2 know a lot about those shifting, and so the overall amount
3 with total supplemental coverage has changed. But the mix
4 has definitely changed over the past few years as Medicare
5 Advantage enrollment has changed.

6 DR. DEAN: I see. Thank you.

7 MR. HACKBARTH: Mike, did you have any further
8 clarifying questions?

9 DR. CHERNEW: No. I think I'm halfway through my
10 clarifying and a quarter of the way through [off
11 microphone].

12 MR. BUTLER: My questions were around price
13 sensitivity, too. Another way to look at it is to say, Do
14 we know anything about the profile, the socioeconomic
15 profile of the people in each of the categories now, the 10
16 percent that have no supplemental insurance, those that are
17 employer sponsored, those that are picking the typical
18 supplemental and those that are picking Medicare Advantage?
19 I'm wondering if we knew their profiles that would help us
20 understand their behaviors today. Can we match that?

21 DR. HARRISON: We don't have the data in this data
22 set to do that. We hear things, but Medicare Advantage

1 enrollees tend to be sort of in the middle-income brackets.
2 They're heavier there. The employer-sponsored people tend
3 to be -- the most well-off people tend to have employer-
4 sponsored coverage, and the Medicare-only are probably lower
5 income but not Medicaid.

6 DR. MARK MILLER: And this goes back to some of
7 the exchange there again. This data set has certain
8 characteristics that allow us to do some of these things,
9 most notably bringing together the supplemental coverage for
10 the beneficiary in a place where we can do this kind of
11 modeling. These kinds of questions probably require going
12 out looking at different data and going -- I'm thinking
13 these are the same people, but not precisely within this
14 data set. We don't have the demographics.

15 MR. BUTLER: So I suspect that the healthy 25-
16 year-old that says, "I'm going to just take a catastrophic
17 and pay a low premium" is one thing. There probably aren't
18 a lot of those that are 65 and healthy and saying, "You know
19 what? I've run my numbers, and even though I've got the
20 money to pay for the supplemental, I'm not going to pay for
21 it." I don't know that, but there probably aren't many, is
22 what you're saying, in that category.

1 MS. UCCELLO: Okay. I'm going to ask for a
2 clarification of your clarification to Bob, who clarified
3 Mitra. On Slides 8 and 10, the assumption is that for the
4 program-neutral case, the Medigap premiums are going to go
5 up somewhat. But I'm not sure I heard exactly -- are those
6 premium increases included in these slides?

7 DR. LEE: [off microphone] The premium --

8 MS. UCCELLO: Or do they only reflect the excise
9 tax part?

10 DR. LEE: What's here reflects only the excise
11 part. We did run --

12 MS. UCCELLO: But you're including --

13 DR. LEE: Yeah.

14 MS. UCCELLO: Okay. I just wanted to make sure I
15 knew what I was looking at. Okay. And now I'm going to
16 open up a can of worms. You know, when we think about where
17 to set this excise tax, we're kind of thinking of -- we
18 could think about it in a couple of ways. We could think
19 about it as we're trying to, you know, set it high so that
20 people drop this coverage and in combination with the
21 incentives in the other parts. Or we could set it to more
22 kind of accurately reflect the extra cost that these

1 beneficiaries are incurring. And those extra costs not from
2 selection but given that -- meaning that, you know, people
3 who think they're going to use more get Medigap, but the
4 increase in cost due to the cost sharing -- due to filling
5 in the cost-sharing rates.

6 DR. CHERNEW: Increase in Medicare costs.

7 MS. UCCELLO: Increase in Medicare costs, yes. So
8 I'm trying to get a sense of how does that 20 percent
9 compare to what we think those extra costs are, and then
10 that relates back to what we think the revenue offsets are
11 going to be. And do those revenue offsets depend on people
12 maintaining that coverage? And how does that change if then
13 people drop it? Is that going to come up with the same
14 savings to Medicare?

15 DR. LEE: So even using very conservative
16 estimates of what the induced demand from having that first-
17 dollar coverage from supplemental insurance, that if you
18 translate that difference in spending and then to base that
19 to the Medigap premiums, then it becomes a very high number.
20 So it's definitely over 20 percent.

21 So if you kind of think of it as what's the
22 revenue source versus if somebody drops it and then loses

1 that induced demand from having the first-dollar coverage,
2 so if 20 percent is lower, then the behavior, in fact, will
3 be higher than the revenues.

4 MS. UCCELLO: Okay. So -- all right. That's
5 helpful. Thank you.

6 MR. HACKBARTH: Julie, what I heard you say was
7 that, in fact, if you set the excise tax at the level to try
8 to cover the cost of the induced demand, it would have to be
9 a much higher percentage than 20 percent. How much higher,
10 roughly?

11 DR. LEE: Roughly it was over 50 percent.

12 MR. HACKBARTH: Okay.

13 DR. MARK MILLER: Yeah, I thought even in some of
14 our conversations it was 60 percent.

15 DR. LEE: [off microphone] -- 50.

16 [Laughter.]

17 DR. MARK MILLER: Actually, just to spell this out
18 a little bit more -- I'm sorry, Mike -- what you're doing is
19 you're saying there's this utilization effect, and now I'm
20 going to build it into a premium that is designed to wrap
21 around. And that's why the percentages get eye-popping
22 really quickly.

1 And just to follow up on the second half of your
2 question, but what if they didn't have that, and then what
3 would be the effect on utilization of facing this new cost-
4 sharing structure, now obviously that we could model, but,
5 you know, that's the tradeoff you're trying to set up in
6 this conversation. And the punch line is at this level of
7 an excise tax you are not recovering, you know, the full
8 effect of the utilization -- the utilization effect of the
9 first-dollar coverage. I'm sorry.

10 DR. CHERNEW: The reason why the percentages seem
11 high is because Medicare is such a large share and the
12 Medigap portion is such a small share. And so --

13 MR. HACKBARTH: A lot of leverage

14 DR. CHERNEW: Right, exactly. And the leveraging
15 is what makes it high. But the only other thing I would say
16 in response to that that I think is really important, I
17 don't view this excise tax as a tax because you're really
18 just charging people for something they're getting from the
19 -- you're sort of pricing it correctly. You're not taxing
20 it in some way. I don't know if that makes --

21 DR. BAICKER: You're offsetting a subsidy.

22 DR. CHERNEW: You're right. There's this big

1 subsidy that's going on that these plans are getting that
2 you're kind of making them just pay their full price, which
3 is slightly different than the way you would think of a tax.
4 And the tax language has some -- might have some burden with
5 that word.

6 [Laughter.]

7 DR. CHERNEW: But if anyone cared about the
8 language, I think recognizing that what we're really doing
9 is pricing the plans correctly for the full cost they're
10 impose is a different activity than taxing.

11 DR. MARK MILLER: More correctly.

12 MR. HACKBARTH: Yes, and that's an important
13 point.

14 DR. BAICKER: So I'll want to focus a little more,
15 shockingly, on the insurance value in round two, but in
16 thinking about that, we've talked before about different
17 ways of parameterizing the gain that people are getting,
18 even talking about sort of beneficiary-neutral, it looks
19 like -- it looks like they're paying more and getting
20 nothing if you just look at the numbers, whereas we know
21 they're getting this nebulous insurance value.

22 It sounded like you didn't have enough

1 longitudinal data to be able to say how much is your
2 individual variance reduced under this plan. But is there a
3 way to capture how much the variance is reduced either for a
4 cohort or, you know, for synthetic cohorts to say imagine
5 that the 66-year-old we observe today is actually one year
6 from of the 65-year-old we observe today, which is obviously
7 not quite true, but can you use a model like that to try to
8 capture how much variance is reduced over a span of time for
9 someone and put a number on it to balance against what looks
10 like, well, wait, beneficiaries are just paying more and not
11 getting anything else? What other mechanisms are available
12 to parameterize reduction in variance?

13 DR. LEE: So in terms of just looking at Medicare
14 utilization and spending, we can create a fairly large panel
15 for that. The limiting factor is we do not have the
16 information on their supplemental status, so that's -- and
17 the effect of a new benefit does depend on your out-of-
18 pocket spending, which is a function of the supplemental
19 coverage. So that is kind of the limiting factor for
20 simulating what the effect would be, how much variance is
21 reduced under a new package.

22 In just terms of how your overall spending varies

1 over time, that we can get, but I don't think that is what
2 you are getting at. It's how much of the variance --
3 reduction in variance under an alternative package, right?

4 DR. BAICKER: So you don't have individual level -
5 - for the individuals you observe, you don't observe their
6 supplemental coverage. You have a sense of the supplemental
7 coverage of the cohort so you could make some assumptions
8 about let's just tag people with coverage based on the
9 distribution of coverage for the whole group.

10 DR. LEE: For one year we have individual
11 information, so that's why we've been just looking at a one-
12 year analysis.

13 DR. BAICKER: That also seems like it might be an
14 important input to these other conversations about how
15 Medigap coverage might change under different models
16 because, you know, Glenn was saying, oh, the certainty of a
17 co-pay versus a co-insurance, but I would think that the
18 bigger effect would be you now have an insurance product
19 that's more valuable. If you were paying for Medicare and
20 you had a reduced variance Medicare package, that should
21 come with a different premium, which should then affect the
22 value of the Medigap plans. You're getting a different

1 item, a less valuable item in Medigap because some of the
2 variance has been taken care of by Medicare. So being able
3 to parameterize how much the variance is reduced seems like
4 an input into lots of different calculations to be able to
5 say we've just given you a more valuable Medicare package,
6 you're going to pay less for Medigap because -- you're going
7 to be willing only to pay less for Medigap because it's now
8 worth less because it's not picking up that variance.

9 MR. HACKBARTH: I didn't understand all that,
10 Kate. We need to translate that into lawyer language.

11 DR. BAICKER: But it was so lucid.

12 [Laughter.]

13 MR. HACKBARTH: But one thing that I thought I
14 heard you allude to was looking at this over time and not
15 just a year at a time in terms of evaluating the benefit of
16 the coverage that people get. And so if you look at it over
17 time, especially in a population of seniors, the likelihood
18 that people are going to incur high costs and benefit from
19 the catastrophic presumably grows as you look at the
20 analysis -- not one year at a time but five years at a time.
21 Is that --

22 DR. BAICKER: Actually, having multiple years of

1 data would let you do some additional analysis, but what I
2 was actually hoping to capture doesn't necessarily hinge on
3 having multi-years of data. What I want to know is how much
4 risk are you exposed to this year.

5 MR. HACKBARTH: But only one year.

6 DR. BAICKER: And one good way to figure that out
7 is to look at paths over time and see what might happen to
8 you over a wider window. But another way would be to look
9 across people and say, "I could be the lucky person who
10 stays healthy or I could be the unlucky person who's
11 diagnosed with an expensive disease," and look at a cohort
12 of people who are representative of the many different
13 things that might happen to you. So you don't necessarily
14 have to look over time, although that's a very helpful way
15 to capture that. I was being cognizant of data constraints,
16 trying to think of other ways to say the package is more
17 valuable even if your individual spending goes up by \$10, if
18 your risk of exposure to \$1,000 has gone down, even if that
19 isn't realized today, you still got some insurance value.
20 And I'd love to be able to put some numbers on that to
21 balance against the, well, wait, average spending went up,
22 why isn't that just a bad deal for everyone? We don't have

1 the number that helps put weight on that.

2 DR. MARK MILLER: I guess the last thing I -- can
3 we go to 8, I think? So if we were able to do that -- and
4 notice the real careful choice of words, because I'm also
5 just trying to visualize -- I also now understand how you're
6 saying -- you know, I know it's an over-time phenomenon, but
7 perhaps cross-sectionally you could -- okay, I see that.
8 Not necessarily how to do it, but I see the concept. Then
9 you would actually have -- you think you could derive a
10 dollar value that you would then say put in -- because, I
11 mean, in the end, people on the Hill are going to be saying,
12 "So how does this happen?" Would I really overlay that into
13 a chart like this?

14 DR. BAICKER: That's risky because to put a dollar
15 value on the insurance value, you have to put in a bunch of
16 assumptions about how people feel about risk and how -- you
17 know, it doesn't come out of just summary statistics of the
18 data. But you could create some parallel exhibits that
19 weren't layered on and, you know, looking like apples and
20 apples when they're not. It would say something like, you
21 know, the share of people whose risk was increased versus
22 decreased or -- I mean, everybody's risk should be going

1 down with this, but something to help visually capture and
2 quantitatively capture, even if it's not directly overlaid
3 with this, the fact that people are gaining some protection.

4 MR. HACKBARTH: You can't do this slide just for
5 multiple years of data? So this isn't trying -- actually, I
6 want the one where you're not including the effect of the
7 premiums, sort of the first one where you showed the
8 different benefit packages and how they --

9 DR. MARK MILLER: That's the [off microphone].

10 MR. HACKBARTH: That is this one? Okay. So you
11 can't just do this over time and say that if you look at a
12 five-year span this is how many beneficiaries would
13 experience higher out-of-pocket costs and lower out-of-
14 pocket costs?

15 DR. LEE: We can do that for their cost-sharing
16 liability, but we do not have individual supplemental
17 coverage information.

18 MR. HACKBARTH: That's what I'm saying, just for
19 the liability.

20 DR. LEE: Liability we can.

21 MR. HACKBARTH: Yeah, and how -- I would think
22 that over time, if you look at it over, that it would show

1 that the catastrophic coverage is more valuable. Wouldn't
2 that be an interesting exhibit to have?

3 DR. LEE: So the kind of simple proxy we tried to
4 do was to look at we know that your overall cost sharing is
5 lower compared to current law under the alternative packages
6 if you have at least one hospitalization. And so we looked
7 at, you know, the number of years that you had at least one
8 hospitalization over a five-year period. So the probability
9 in any given year of a hospitalization is about 20 percent,
10 and that goes up to about 50 percent if you look at 50
11 years. So that was kind of a way to see, you know, how over
12 time this one-year snapshot might look different.

13 DR. BAICKER: I think that that would be very
14 helpful for two reasons. One, it would capture that, in
15 fact, this one year may not be a good proxy for how you
16 benefit over time, and just looking at Medicare, not with
17 Medigap, is then capturing the value of this program. It
18 doesn't tell you how individual exposure is changing, but
19 it's telling you how the value of the benefit package is
20 changing. If anything, that's understating the improvement
21 in risk protection that you see because there are some
22 things that are idiosyncratic year to year and there are

1 some things that are persistent. And so the persistent --
2 you also don't know if you're going to be diagnosed with an
3 expensive chronic disease that's going to show up year after
4 year or if you're going to have an idiosyncratic
5 hospitalization that's not going to show up year after year.
6 That will smooth away one kind but not the other, but it's
7 at least getting you partway there.

8 MR. ARMSTRONG: So, Julie, I'm not sure if this is
9 for you or for Kate, but is "parameterize" really a verb?

10 [Laughter.]

11 DR. BAICKER: Oh, yes.

12 MR. ARMSTRONG: I mean, Julie, you just didn't
13 flinch.

14 DR. BAICKER: And then "parameterization" is a
15 noun, and keep going.

16 MR. ARMSTRONG: The Harvard talk.

17 [Laughter.]

18 MR. ARMSTRONG: My question is much simpler.
19 Actually, it goes back to some questions raised earlier.
20 The outpatient per visit out-of-pocket \$100 deductible, I'm
21 familiar with this really being targeted at emergency room
22 visits, and that often it's much higher than that. This

1 seems to be kind of generic hospital outpatient. I'm
2 wondering if you looked at, modeled higher costs for
3 emergency room visits and discarded that, or if that's
4 something still worth considering.

5 DR. LEE: So for physician services, we went back
6 and actually got much more granular data. Now, for
7 outpatient services, we have not done that, so we just have,
8 you know, all different kinds of outpatient visits,
9 including surgeries to emergency room visits, that are just
10 in that number of outpatient visits. We do plan to get more
11 granular information so that we can make such distinctions,
12 but we have not done it yet.

13 DR. BERENSON: I'm going to jump in, Scott,
14 because we were talking a couple of days ago on this very
15 issue, and maybe you can help us, or anybody else. The
16 concern that I have is that we're modeling a traditional
17 Medicare benefit package on a good HMO-type benefit package,
18 and we're going to basically go from 20 percent cost sharing
19 for physicians to a co-payment for a visit. And I'm just
20 wondering if there are models, benefit designs that actually
21 do have more -- that move away from just 20 percent of
22 something you don't understand, but recognize that there are

1 physician services that cost thousands of dollars in many
2 cases.

3 So my question to you is: Is there a way to do
4 this without forgoing 20 percent of revenue and at the same
5 time not creating huge barriers to that care?

6 MR. HACKBARTH: And let me just piggyback on that,
7 Scott, and others who are familiar with current approaches
8 to structuring packages.

9 One particular question that we were asking one
10 another about is what happens today in HMOs when a patient
11 is hospitalized and using physician services, perhaps a
12 surgeon, a radiologist, anesthesiologist, various other
13 consultants. Under this benefit package, as we understand
14 it, there's no cost sharing for the patient for all of those
15 physician services. You're just paying the \$750 co-pay for
16 the hospital visit. Is that the approach currently used by
17 Group Health and other plans or something --

18 MR. ARMSTRONG: Yes, that's correct. When you are
19 hospitalized, it's an all-inclusive bill, if you will. We
20 have a lot of examples where we are really differentiating
21 the out-of-pocket costs for some of these outpatient
22 services that are not associated with an actual admission to

1 the hospital, and we would be happy to describe those. But
2 I think most notable, the advanced imaging and the emergency
3 room services are those that tend to be low value,
4 discretionary, and we place a high out-of-pocket cost on
5 those in particular. But there could be more to that.

6 I think -- and this would be a point I'll make in
7 round two -- part of the issue we're dealing with here is
8 that the HMO plans don't just use out-of-pocket financial
9 incentives. I mean, they have these whole care management
10 infrastructure and all sorts of other things that are really
11 complementary to this, and that is, I think, part of the
12 issue we're dealing with.

13 MR. HACKBARTH: I think that's part of the issue
14 here. We're talking about adopting an HMO-type benefit
15 structure for an open-ended fee-for-service plan that
16 doesn't have those care management factors, and so it's
17 mirroring two different types of ideas.

18 Okay, round two comments, questions?

19 MR. GRADISON: This is going to be a little stream
20 of consciousness but it won't take long. I lived through
21 this, through Medicare catastrophic, and there are a few
22 things I'm proud of from serving in public office. One is I

1 went down with the ship. I never voted to repeal it because
2 I was convinced that, on balance, it would be beneficial to
3 the participants in the program.

4 They didn't see it that way, and I've been trying
5 to understand why it is so hard to bring about change in the
6 Medicare program, and that's a pretty good example of what
7 was happening in that time -- resistance to change.

8 I would summarize my experience that the losers
9 know they're losers, but the winners don't know they're
10 winners. And the winners do have a value. There is a value
11 in insurance. I know that. But you really don't know that
12 you're going to have catastrophic expenses until it's too
13 late to do anything about it and go out and buy the
14 insurance. But our own numbers show that most people -- I'm
15 not talking about dollars, but most beneficiaries are
16 losers. We show that. They actually are going to end up
17 paying more than they pay today under the present system.

18 And so I asked myself, well, why is this? And
19 this is a pretty broad generalization, but I've been trying
20 to figure out why are we basically stuck with a 1965 design.
21 That's the screen at which I look at it. And you say, well,
22 it was a prevailing design at that time; it was based

1 largely on the Federal Employees Health Benefit Plan as it
2 existed at that time. And the world has changed. I mean,
3 today this kind of overall structure doesn't exist in
4 nature, so to speak. I don't mean it doesn't exist at all,
5 but the world has passed it by -- not only with HMO plans
6 but with changes through POS and so forth.

7 So I think that as far as bringing about these
8 changes is concerned, I still am trying to grapple -- I was
9 trying this in my first round -- with learning a little bit
10 more about the potential winners and losers.

11 My hunch is that newer beneficiaries would be much
12 more comfortable with this than existing beneficiaries, and
13 you could say, well, of course, because the older ones are
14 used to this pattern and they would just resist change. But
15 I think it's deeper than that. I think newer beneficiaries
16 have been covered under plans which don't look anything like
17 this. And so we're moving closer, in a small sense at
18 least, towards the experience that they've had.

19 You can justify and say, "What are you driving
20 at?" And I'd have to say it's sort of a stream of
21 consciousness, but I'm really concerned whether we can -- I
22 like what we're doing here, but I'm not sure we can pull it

1 off.

2 MR. HACKBARTH: Bill, let me just pick up on your
3 point about newer beneficiaries might be more comfortable
4 with this than older beneficiaries. Does that imply that a
5 possible approach would be to do this on an age-in basis,
6 that -- and obviously I haven't thought through
7 administrative implications of this, but say that, you know,
8 for people joining the program after some date certain,
9 there's a new benefit package and one that will look
10 familiar to them based on recent experience with private
11 insurance?

12 MR. GRADISON: I think that's well worth thinking
13 about, because up until now we've talked about for everybody
14 -- which I still think makes sense. I hope that's clear.

15 MR. HACKBARTH: Again, the politics of this are
16 difficult. These ideas have been around, you know, for
17 decades, and they don't gain political traction. In one
18 instance they did. There was a strong backlash and it was
19 repealed. And, you know, it's folly just to pretend that
20 that history doesn't exist.

21 DR. STUART: I had the same reaction that Bill did
22 in the sense that in a way we have gone through this before

1 with the Medicare Catastrophic Coverage Act, and there are
2 obviously differences between what you're proposing or --
3 I'm not saying proposing -- what you're examining and what
4 was actually enacted in 1988. But I think that it would be
5 very wise to go back and look at that experience and not
6 just the numbers part of the experience but the reaction by
7 those who knew that they were losing.

8 If you go to Slide 10, the main concern I have
9 with this is a Medicare catastrophic concern. You tell me -
10 - you guys are coming up with a proposal that is going to
11 make 85 percent of Medicare beneficiaries worse off? The
12 face validity of this thing I think is going to be really
13 problematic.

14 Having said that, I agree with Michael that this
15 outcome is highly unlikely, and I say that for a reason.
16 I'm looking at it from the standpoint not so much of those
17 with employer coverage but those who are currently buying
18 one of the Medigap plans, and I add up the extra prices on
19 this, and using a Laffer curve approach by saying, you know,
20 if the price gets to a certain point, then, you know, you
21 get no revenue and the market just completely collapses, and
22 here are the four parts.

1 The first part is Kate's part. If you change the
2 benefit so that you provide catastrophic coverage, you
3 improve the insurance value of the Medicare program, which
4 means that you reduce the insurance value of the Medicare
5 catastrophic coverage. We may not know how much, but we
6 know the direction.

7 Secondly, if you have a 20 percent excise whatever
8 you call it, it's still something that people have to pay,
9 and so the price jumps immeasurably.

10 Third, the Medigap policies already have extremely
11 high loading, and if you look at the demand for Medigap
12 policies, people have said, well, why do people buy this
13 insurance anyway because it's such a lousy value.

14 And then, fourth -- and this is a point that
15 Michael also raised -- is that when you raise the price of
16 this alternative, this 20 percent premium on a good that has
17 less value than it did before, then the alternatives look
18 better and the MA plans look much, much better.

19 And so if I put all four of those things together,
20 my best bet is that the Medigap market would just disappear.
21 You know, I don't know whether that's true, but I'd be
22 willing to put bucks on -- not \$10,000 but a few bucks on a

1 bet --

2 [Laughter.]

3 DR. STUART: -- that said if we were able to try
4 this, my guess is that people just wouldn't buy Medigap
5 policies anymore. They'd just go right to the MA plans, and
6 the MA plan -- and this is the other thing. There's going
7 to be a supply response to this thing. I would really
8 expect that the PPO part of the MA plans would really
9 expand. In fact, the insurers are the same people. They're
10 the ones that are offering the current Medigap plans, that
11 are offering the PPOs, you know, and it's not that difficult
12 to move from one product line to another.

13 So there are two parts to this: the perceptual
14 part, which I think is really problematic, and I would
15 strongly urge you to have something in the language of this
16 that recognizes that we've been through something like this
17 before, and so we don't want to make that mistake; and then
18 you have to pay attention to behavioral responses somehow.

19 And the last point I'll make is that we've
20 concentrated here on kind of the price response to value in
21 the insurance product, but I think we're on much firmer
22 ground in terms of making behavioral assumptions about what

1 will happen when we change the nature of the product. In
2 other words, we have much better research about the
3 elasticity of demand for Medicare services than we do for
4 the responsiveness to the insurance price.

5 MR. HACKBARTH: Bruce, you've made a number of
6 good points. I want to go back and just be the devil's
7 advocate on the very first thing you said. You look at
8 this, and a significant, large majority of Medicare
9 beneficiaries end up paying more, and, you know, isn't that
10 -- I can't remember your exact words, but isn't that sort of
11 a non-starter as an idea, and it may well be.

12 But if you step back and look at this in a bigger
13 policy context, one of the fundamental issues facing the
14 program is if, in fact, we need to lower Medicare costs or
15 slow the rate of growth so they aren't consuming as much of
16 the national resources as they have been, how do we
17 distribute that across the different participants in the
18 system? Increasingly, you know, providers are saying, "You
19 can't take it all out of us because you're going to
20 adversely affect access to care, quality care, and we need
21 to figure out ways to share the responsibility of lowering
22 Medicare costs." So the question is: To what extent, if

1 any, should Medicare beneficiaries share in lowering the
2 costs of the program? And what are the different policy
3 alternatives for increasing the beneficiaries' share?

4 And this whole conversation introduces some
5 potential elements in terms of how you structure the benefit
6 package or whether you right-size the premiums for
7 supplemental coverage by having beneficiaries pay more for
8 supplemental coverage, and then in turn each of those
9 possibilities has pros and cons in terms of the incidence of
10 the burden and which beneficiaries bear a higher cost.

11 I don't think we should, in other words, just stop
12 at your initial observation and say, "Oh, beneficiaries on
13 average are paying more; therefore, it's a political non-
14 starter." If we do that, I'm not sure we're doing a service
15 to the Congress.

16 DR. STUART: Actually, that wasn't my point. My
17 concern here is that if you show that slide, the
18 conversation stops and that whatever else we are trying to
19 do here just doesn't go further because people are not going
20 to -- that was my point.

21 MR. HACKBARTH: I understand your subsequent --

22 DR. STUART: I'm certainly not against analysis.

1 I think the whole point of this is that we think that there
2 are significant problems with the supplementary insurance
3 that Medicare beneficiaries currently have, and what we'd
4 like to do is to move them into something else. We're not
5 trying to get them so that they don't have anything. We'd
6 like to move them into some other kinds of products. I
7 mean, that's in part why I think it's important that we take
8 on the issue of value-based insurance design here. We've
9 got to say something. I mean, that's where the returns are,
10 is getting rid of things that have low value.

11 If we get rid of everything, then, you know,
12 again, I think we're at a point where we're going to hit
13 this wall, and then the policymakers are just not going to
14 listen to us. That's my fear.

15 MR. GEORGE MILLER: First of all, this has been a
16 very helpful discussion in hearing everybody's point of
17 view. This is not one of my strong suits, so this is very
18 educational and beneficial as we try to provide additional
19 service to the Medicare beneficiaries.

20 I'm struck by a couple of things. On Slide 10, it
21 seems to me that it would be very helpful -- I'm sorry, on
22 Slide 7. It seems to me it would be very helpful as we have

1 had the discussion maybe to identify an ED visit separate
2 from an outpatient visit, to push that as a point of trying
3 to move folks from abusing the ED versus just the outpatient
4 line, which I think would be embedded in there, and then try
5 to move folks away from using the ED as a place, especially
6 probably low-income beneficiaries using that as a point of
7 entry to get health care benefits.

8 The other thing that I think as we listened to
9 this, if we think about just applying this to newly
10 purchased plans, that may have some traction, but I
11 certainly would like to see the analysis of what impact that
12 would have on the numbers. I think that had the question
13 answered earlier. I'm not sure who said it, but I'm not too
14 crazy about the term "tax" -- "tax benefit" -- I forgot the
15 name of it.

16 MR. HACKBARTH: "Excise tax."

17 MR. GEORGE MILLER: "Excise tax." If we could
18 come up with a better name for that, a correct -- I think
19 Michael said it, correctly pricing that benefit, it would
20 just eliminate the political negativity about the word "tax"
21 in that design.

22 MS. BEHROOZI: So I think I have two pages here.

1 I'll try not to take two pages' worth of time. I'm trying
2 to distill it into, you know, conceptually how to organize
3 these thoughts.

4 I'm trying to go back to the beginning, which is
5 that I feel like we're doing two different things here. One
6 is providing the catastrophic protection, and the other
7 quite separate thing is trying to build a better benefit
8 design to help control excessive spending in the program.
9 And they're really quite separate things.

10 I think thinking about the 10 percent who don't
11 have supplemental coverage I feel like puts into sort of
12 sharp relief how mashing these two things together might
13 produce some not so great results, because as you said,
14 among that 10 percent probably a smaller share of them will
15 actually get to that true out-of-pocket catastrophic level
16 than among the general population. So you said among the
17 general Medicare population it's 5 percent in a year, so
18 it's less than 5 percent of that 10 percent will actually be
19 protected strictly by the Medicare program being redesigned.
20 And where will the burden fall? On those others who don't
21 have catastrophic coverage who are lower income, as you
22 said, and with a combined deductible in particular, they're

1 not going to be able to access their Medicare benefits.
2 They're not going to be able to afford to get to the point
3 where their Medicare benefits will kick in. I think a
4 combined deductible -- and I said this, you know, when we
5 were talking about this in prior years or last year, or
6 whatever -- I don't think it's a good idea. I think we want
7 people to go to the doctor when they're sick, and the lower
8 Part B deductible is designed, I think, somebody thought,
9 it's better that people get to the doctor sooner rather than
10 waiting until they can somehow come up with, you know, \$500
11 over the course of a year, or thinking that they can't and
12 so they never go.

13 So, you know, there's a reason that different
14 types of services have different thresholds, cost
15 thresholds, before you access them, right?

16 MR. HACKBARTH: Could you tell us a little bit
17 about how your plan is structured in that regard?

18 MS. BEHROOZI: I can't talk about our main plan
19 because we have no point-of-service costs because we use all
20 those other management tools that Scott talked about and we
21 have a very low cost, but it's the all-in cost.

22 We do have a couple of plans that have some point-

1 of-service cost sharing, but we don't have deductibles.
2 It's just co-payments, because I still don't get the point
3 of deductibles. That's just an insurance pricing feature as
4 far as I can tell, and, you know, from conversations with
5 Mike, it's just a way of keeping the premium down or keeping
6 other costs down that you otherwise might shift. But I
7 think it's kind of the worst -- it's the least thoughtful,
8 shall we say, the least targeted way of shifting costs. So
9 if we're worried about the 10 percent who don't have
10 insurance coverage -- or supplemental coverage, I think
11 we're hurting them the most by covering that smaller share
12 of them with Medicare dollars.

13 For everybody else who does have some kind of
14 supplemental coverage, it's just a question of which pocket
15 it comes out of or how it comes out of their pocket. And,
16 clearly, the people who have chosen Medigap plans because
17 they value the insurance protection, the risk aversion,
18 they've chosen to pay a premium not at the point of service
19 -- they don't like, you know, showing up and either not
20 knowing how much they're going to pay or having to shell out
21 dollars at that time. They like being able to write a check
22 once a month or, you know, an automatic deduction from their

1 checking account. And, yeah, those who get it through
2 employers, they may be also contributing toward that during
3 the course of their working time by forgoing raises or
4 whatever.

5 It does seem like more people have a preference,
6 to the extent that they can afford it, to kind of spreading
7 their costs via premiums, via forgone wages, and that
8 instinct I don't think is necessarily reflective of a
9 conscious choice, but it tends to align with what I think we
10 see coming out in the evidence that, you know, the whole
11 issue of whether point-of-service costs deter unneeded or
12 needed care. You know, we keep talking about induced demand
13 as though the demand wouldn't be there but for the coverage.
14 Well, maybe the utilization wouldn't be there but for the
15 coverage and people would forgo needed care and then there
16 would be -- they would suffer consequences. They would
17 suffer poorer health status. Or there would be higher costs
18 later on, and I've cited the research before, but, you know,
19 there's slowly more research coming out demonstrating a cost
20 offset in terms of acute costs later because of forgone
21 care, drug coverage and physician coverage costing more at
22 the front end ends up in some cases -- well, it was the

1 Medicare population, Medicare Advantage population in
2 California I think that was studied that showed a hospital
3 offset, you know, longitudinally, three years later or
4 something like that, the hospital costs presented a higher
5 cost to the plan overall.

6 So whether people know that when they're
7 purchasing that coverage or they just have an aversion to
8 risk or whatever, I think we should pay attention to that
9 signal; and if we are, like I said, worried about that 10
10 percent who don't have coverage -- and I am -- I really
11 don't think this is the right thing to do to them. I think
12 that putting so much cost up front in the deductible is the
13 wrong thing to do.

14 As far as taxing plans, frankly, when we were
15 talking about initially, I didn't think of it only as
16 applying to the new benefit design. I thought of it
17 applying it to the current benefit design. But I would just
18 suggest there because people do have the choice to go to MA,
19 they should also be able to make a choice about their
20 Medigap plans, and they can choose to pay more for more
21 coverage or choose to pay less for lower coverage. That's
22 the way it is now. I think, you know, as Mike says, it's

1 right, load more of the actual cost into those plans. But I
2 think we've got the example in PPACA of the so-called
3 Cadillac plan tax going into effect in 2018. It has to
4 apply to all plans; otherwise, it kind of doesn't make sense
5 because you're trying to, you know, recover the revenue,
6 give people time to choose whether they'll stay with their
7 current plan that's going to be, whatever, 30 percent more
8 or 40 percent more, or go to another plan that might be 10
9 percent more because it offers less generous coverage -- I
10 think it should track the generosity of the plan -- or move
11 to MA. And maybe you'll see insurance behavior changing.
12 Maybe they'll squeeze some more out of their load, as Bruce
13 says, to be able to compete to keep the business and not
14 pass along all of that additional cost, whatever you want to
15 call it -- the excise thingy -- to their beneficiaries.

16 I think that's it. Those are my two pages.

17 MR. HACKBARTH: Let me just nail down one thing,
18 Mitra. What I hear you saying is you're not sold on the
19 combined deductible, even, you know, if we stipulate --

20 MS. BEHROOZI: [off microphone] Not sold.

21 MR. HACKBARTH: If we stipulate that, you know,
22 there's going to be significant cost sharing because there

1 is an existing Medicare benefit package, you are
2 particularly worried about the effect of a combined
3 deductible on access to physician services and would rather
4 see separate deductibles or no deductibles at all, although
5 I suspect that that would imply very, very high co-pays,
6 huge co-pays. And so --

7 DR. MARK MILLER: You would be pushing the
8 catastrophic cap way out, the co-payments up.

9 MS. BEHROOZI: Exactly, and it's not that I want
10 anybody to suffer the higher catastrophic spending, but it
11 is a very small number of people, and, you know, I think the
12 question -- I'm sorry. Somebody on this side asked what
13 happens -- I think Bill asked what happens to those people.
14 I doubt that it's like in the general population where more
15 than 50 percent of personal bankruptcies are driven by
16 medical costs. I don't think that's what happens when you
17 have that high catastrophic costs among that share of people
18 who are lower income or whatever. I bet that ends up in the
19 unreimbursable and gets reimbursed by DHS probably. I mean,
20 you know.

21 MR. ARMSTRONG: Glenn, just one brief comment on
22 this. So we have plans now that have deductibles, but we

1 exclude from the deductible preventative visits or a whole
2 series of visits around 12 chronic illnesses where we want
3 those patients to have no cost out-of-pocket in order to get
4 in to see those providers. And so there is a way, actually,
5 to have both a deductible but to not create the
6 disincentives, Mitra, that you're talking about. So that
7 just may be something for us to look into.

8 MS. BEHROOZI: Yeah, I think that's kind of the
9 problem with a fee-for-service, you know, unmanaged package
10 where -- and then to load more into the deductible without
11 being able to do those things, I mean, you know, unless
12 Medicare wants to administer that. That would be cool.
13 That would be really good.

14 DR. NAYLOR: Nothing new to add to this rich
15 conversation.

16 DR. BERENSON: I don't have much to add. This has
17 been very interesting. I'm still formulating my own views
18 on a lot of this, but I'm encouraged that we're doing the
19 right thing here and that we actually can make a case for
20 the kind of package that we're putting together. I do think
21 in a couple of areas we need more work, like trying to
22 figure out what this sort of hybrid is between a tightly

1 managed HMO and just sort of a traditional indemnity-based
2 20 percent across-the-board, whether we can do something
3 more creative on the physician side. Wherever we can build
4 in some notions of value-based benefits like with
5 identifying services that are excluded from the deductible,
6 I think we should take advantage of.

7 I guess what I want to talk about a little bit is
8 are we going to just get into trouble by proposing something
9 that's smart but is -- I guess you said had no face
10 validity, I think, Bruce, was your -- or was sort of dead on
11 arrival, or whatever. And I don't certainly have a good
12 answer on that. My sense is that -- well, not my sense. I
13 don't think we would be proposing this as a stand-alone,
14 let's redo catastrophic from '88 and just say let's adopt
15 this plan. I'm assuming that Medicare over the next few
16 years is going to be subject to intense review and scrutiny
17 and that there will be proposals and at some point some
18 agreement on some restructuring. Whether that goes all the
19 way towards a premium support model or puts expenditure
20 targets in the program or whatever it might be, in the midst
21 of that kind of a restructuring, this isn't the only -- this
22 could be sort of presented also as part of it. In other

1 words, this is not the stand-alone, we're going to
2 redistribute towards people who have catastrophic illnesses
3 from low-income people who now may have difficulty finding -
4 - I mean, that's not what we want to do.

5 I think what we want to do is have a series of
6 options available, having analyzed them, that it just makes
7 sense if there's a program restructuring that we do take on
8 the benefit structure, which is not a very good one right
9 now. So I'm really thinking aloud here.

10 On a number of these issues, I don't think there's
11 a correct answer. I can argue on the deductible. There's
12 pros and cons of going to the combined deductible and not
13 going to the combined deductible. We've identified
14 beneficiary-neutral versus program-neutral as a policy
15 decision. We've talked about what I guess I'll call a
16 surcharge, not an excise tax -- maybe that's a more neutral
17 term -- versus regulating first-dollar coverage as a design
18 issue.

19 I'd just throw out the possibility that rather
20 than sort of having a defined package that we vote up or
21 down on, that we actually do a very good job of laying out
22 design options, the advantages and disadvantages, and I

1 think present a pretty clear picture of where policy would
2 come out, but don't presume to judge the politics of it.

3 So I just throw that out as a possibility that we
4 might want to talk through, but I guess the major thing I
5 want to say is I don't think we want to be positioning
6 ourselves to endorse a specific package and say we think the
7 Congress should legislate this tomorrow.

8 DR. MARK MILLER: I agree and I want to build on
9 that. So if I could get you just to flip to the last slide,
10 there's a couple of points that you could imagine.

11 I think Bob is absolutely correct that we wouldn't
12 be coming along in a report with a recommendation that says
13 here's the benefit package. We're not doing that. Okay?
14 We're cranking through this for a lot of analytical reasons:
15 to make sure people understand impacts, how levers work, all
16 the rest of that.

17 Notice this slide where you could imagine a set of
18 statements that the Commission says -- and, Mitra, obviously
19 there's at least one in here that you don't agree with, but,
20 you know, we think there should be an out-of-pocket maximum,
21 we think there should be designs and benefit that work like
22 this, co-payments instead of co-insurance. I'm deftly

1 moving past the flashpoint with Mitra.

2 You know, the notion of trying to focus on high-
3 value services and at least giving the flexibility to deal
4 with those as evidence arises, you could imagine statements
5 like that. And then you have illustrations through the
6 chapter, but you're not saying it is \$101 for this service.

7 Bob has even, I think, a point off of that, which
8 says say here are the issues, design issues, pros and cons,
9 and the way you could think about them. And so I want to
10 just take this opportunity to focus you on a final product
11 and make sure that you understand. We wouldn't say, "This
12 is it," you know, because there's detail underneath this
13 that just really needs to be thought out past that.

14 I'm hoping that was building on your point.

15 DR. BERENSON: Absolutely building. Absolutely.

16 DR. HALL: So what I've taken away from the
17 discussion so far is that life is hard, and I already knew
18 that, but that the implications of a lot of these decisions
19 about price point and where you actually interject the price
20 point, we don't know that much about it, and particularly we
21 don't know much about how it influences human behavior,
22 maybe a little bit more about the impact on health.

1 But it seems to me it's so important because this
2 business of price points isn't the same thing as to whether
3 I buy a Kindle or an iPad 2. It has implications in terms
4 of future Medicare expenses if people make wrong choices,
5 and it also has implications in terms of quality of life if
6 we want to throw that into it.

7 So the reason I ask the question of is there
8 anything known about the psychology of choice that we can
9 even interject into this that makes any sense, or at least
10 any proposals we've put forward, say that at least somebody
11 ought to take a look at this, so I have a little challenge
12 here for Mike and for Kate. I'm way out of my league here,
13 but I've been sort of dabbling in some of this business of
14 "Slow and Fast Thinking" by Daniel Kahneman and a few of his
15 experiments in how people view various medical procedures.

16 Isn't there still -- let me give it one more try
17 on this. Isn't there still some way we could interject this
18 kind of thinking into how we judge the relative value of the
19 different options we put forward?

20 MR. GRADISON: Bill, one possible way would be to
21 look at the choices actually made in the Medigap market
22 among the defined plans. The statute has defined what can

1 be offered, and I'm not sure where this would lead us, but
2 there's real information there somewhere about how people
3 deal with the choices that are available.

4 DR. CHERNEW: Two quick things about that. One of
5 them is prior to, of course, standardization, the view was
6 the market was pretty dysfunctional, and you had to
7 standardize it to support the choices. And I would say --
8 and maybe Kate can -- where the more cutting-edge research
9 of people I know would be going would be to try and quantify
10 the mistakes that people made for a whole bunch of reasons.
11 So I think you used to have a paradigm that if you let the
12 market work, people make a bunch of choices. They're
13 telling you something about their preferences, which is
14 really great if you're getting through econ grad school.

15 It turns out that, I think, increasingly people
16 are thinking, looking at a set of choices, realizing how
17 sensitive those choices might be to seemingly minor choice
18 setting modifications and asking, boy, we need to think more
19 strongly about how we set this up, and simple things that
20 would have been the standard answer, we'll just give them
21 information, aren't nearly sufficient to try and modify
22 those, although what I would say in response to Bill's

1 comment is that's exactly right. I don't think -- and,
2 again, Kate can comment. I don't think the science is
3 anywhere near close enough to figuring out exactly how you
4 would do that, because one thing that is true is you have to
5 have a good set of values for what you think other people
6 should do before you start fiddling around with some of
7 these things. And that's a harder lift than one otherwise
8 might have, but it is a challenge, particularly in this
9 population, as challenging as any population, to see that
10 they're making the right choices. And I'm not even sure I
11 know what "right" means, but choices you think are
12 reasonable in the Medigap market. There's a lot of inertia.
13 There's a lot of misinformation. There's a lot of other
14 problems. Kate can...

15 DR. BAICKER: Just super briefly, I don't want to
16 get us off track, but my reading of the evidence on this is
17 that the strongest empirical evidence comes from
18 prescription drug use in part because the setting is
19 amenable to people playing with the choice architecture and
20 the nudges that we think might influence behavior day in and
21 day out as opposed to major procedures where there isn't
22 that same opportunity, and that there are a set of findings

1 that help us understand when people are likely to
2 underutilize or underadhere and when they're likely to
3 overutilize and that price is one factor, but all these
4 other choices -- all these other choice architecture, nudge,
5 contextual factors are really important in those and that
6 there's less information on how those factors affect
7 insurance choice, but where we see the most evidence is from
8 take-up of public programs like Medicaid where it's hard to
9 write down a rational model that explains people not taking
10 up very low cost benefits that are available to them through
11 public insurance programs, and that we can learn some things
12 from there about how people make choices, but it's a
13 different population and we don't have that same kind of
14 data for a Medicare population, in part because in a good
15 outcome most people who are eligible for Medicare are taking
16 it up, and then you're left with these choices that are very
17 constrained in the Medigap market or in the employer wrap-
18 around coverage market that don't give us as strong evidence
19 as we have from some of those other contexts.

20 DR. DEAN: What do we know about the group of
21 people that do not buy supplemental coverage? Do we know --
22 I mean, I assume we know -- is it because -- is it a group

1 that's basically healthy and doesn't think they need it? Or
2 is it a group that feels they can't afford it? Or is it, as
3 I assume, some of both? I wonder how much that helps with
4 some of these questions.

5 DR. LEE: So both of those factors are relevant.
6 If you are young and healthier so you perceive less need for
7 supplemental insurance, then you would not get it. But then
8 even for those who feel they need it, but then affordability
9 can play. So exactly, you know, the relevance of those two
10 factors we don't know.

11 DR. DEAN: I would certainly think that we should
12 do everything we can to move toward these value-based
13 structures, because one of the things that I found
14 frustrating over the years is people -- to oversimplify, "If
15 Medicare pays for it, I'll do it; if Medicare doesn't pay
16 for it, I'm not going to do it." Even for services that
17 I've recommended that I really thought were valuable to an
18 individual and for individuals that I knew full well had the
19 resources to cover it, even so I've had a number of
20 situations, like I said, which I found very frustrating,
21 where people decided they weren't going to do it just
22 because there's this sort of mind-set, like I said, "If

1 Medicare pays for it, I'll do it; if Medicare doesn't pay
2 for it, don't bother."

3 And so the more that we can move to the kind of
4 structures that Scott just mentioned, I think it helps to
5 get past, you know, what I consider to be pretty irrational
6 decisions. But it benefits, I think, both the program and
7 the beneficiary.

8 DR. CHERNEW: I think part of the challenge here
9 is that there are two main goals and they don't always fit
10 well together. The first one I take as our goal is to
11 essentially save money or reduce revenue -- increasing
12 revenue or save money by reducing the distortion associated
13 with supplemental coverage in the supplemental coverage
14 market, sort of this idea of right-pricing, and inherently
15 that's going to shift the burden to consumers one way or
16 another. And I am 100 percent on board with the comment you
17 made, Glenn, that, of course, the alternative is some of the
18 other stuff that we really dislike, and so at least in
19 situations where you think there's a distortion, ignoring
20 the politics, I think we certainly have to think about how
21 to do that. And you could do that without -- so that I
22 think is the first thing, and then the tension in that

1 general array seemed to have been do we prohibit or do we
2 tax. I tend to find taxing more appealing, and I don't like
3 the word "taxing," so I didn't -- by "taxing," I meant
4 something else. But I tend to find "charging" more
5 appealing than "prohibiting" because there are people that
6 might want something. It strikes me as the extreme case
7 scenario is what you said, Bruce, all right, no one is going
8 to buy. So that just gets us to where we would have
9 prohibited it one way or another.

10 DR. STUART: No, actually, I think the point that
11 I wanted to make is that there would be a market response to
12 that and that this would drive the market into MA, and it
13 would be the least managed of the MA because those are the
14 easiest for the insurers to develop. So we might agree that
15 that's a place that we want to go.

16 DR. CHERNEW: But, I mean, there's odd things that
17 one has to think through because, of course, the MAs get
18 paid based on the fee-for-service cost or the extent that
19 people are left in the fee-for-service cost but now they're
20 not covered as much in the fee-for-service -- so there's
21 some complicated dynamics as to how that works, but all of
22 that plays through some notion of we want to get the pricing

1 right to avoid this distortion that I think we all agree
2 exists in the supplemental coverage market, and we want to
3 do that basically for financial reasons because we have pain
4 that has to be shared, we have to fix the SGR, there's a lot
5 of payment that's going on to physicians, for providers that
6 potentially could be problematic over time under current
7 law, and we need to think about that. And so I agree with
8 what you said, Glenn, about that.

9 The second thing that we're trying to do which I
10 view as a reasonably separate thing is improve the value of
11 the package the way it's designed in one way or another to
12 get more value, and that includes a range of goals. One of
13 them, of course, is we want to improve the insurance
14 component of it with the cap. The second part is we want to
15 simplify it in various ways, which I think also matters.
16 And the most important part, I believe, is essentially we
17 want to encourage good behavior change, and by "good," I
18 mean drive people to use the services we want them to get
19 and get them not to use the services we don't want them to
20 get.

21 Ron pointed out that that's a lot easier to say
22 than do, although I think there are a lot of areas where at

1 least at a minimum we could identify what those things are,
2 and I think there will be more if we get half of what we
3 hope to get out of some ongoing research areas. And I do
4 think a little more emphasis on those -- we've had more
5 emphasis in other versions of this type of chapter.
6 Oftentimes these ideas go under the rubric of value-based
7 insurance design, but they're kind of different. One of
8 them of course, is what Scott said, which is the -- or
9 different versions of the same basic philosophy: the
10 carveout within the deductible. So I actually am where
11 Mitra is. I think deductibles aren't useful. For sick
12 people they're just a tax on being sick, and for healthy
13 people they often discourage them from getting the services
14 that you want. But they could be useful if you think
15 there's a lot of waste going on in certain types of
16 services. But if you were going to impose them there, you
17 would want to think about carveouts the way that I think
18 Scott would.

19 We've had, I think, very useful discussions of
20 least costly alternative type programs or other more nuanced
21 benefit designs, and I think there is the potential for
22 doing that.

1 The one thing that I don't understand -- so this
2 is a round one question. I don't know exactly the
3 restrictions that managed care plans are under if they
4 wanted to charge you for a low-value service one way or
5 another. Is the rule that if Medicare has a certain --
6 there's a certain amount that the fee-for-service system
7 would pay for a given service, are you allowed to charge
8 patients more for that, Scott?

9 So say there was one of these proton -- and Ron
10 would probably say this is high value, but at least in my
11 circles, everyone uses this proton beam, whatever these
12 things are. They're big machines.

13 DR. STUART: Expensive machines.

14 DR. CHERNEW: Big, expensive machines, and what I
15 understand from the evidence, they're considered not that
16 great value. Are you allowed to charge people a lot for
17 that even if Medicare covers the cost?

18 MR. ARMSTRONG: So you're asking me as a provider
19 or as a health plan?

20 DR. CHERNEW: As a health plan.

21 MR. ARMSTRONG: So I can just not cover it.

22 DR. CHERNEW: Even if Medicare covers it?

1 DR. BAICKER: Don't you get flowback then?

2 DR. CHERNEW: And are you allowed to cover it but
3 just at a higher copay, or do you actually have to not cover
4 it at all? So if you wanted to --

5 MR. ARMSTRONG: Well --

6 DR. CHERNEW: -- do a least costly alternative
7 version, for example, could you do that?

8 MR. ARMSTRONG: I think so --

9 DR. CHERNEW: Anyway, without going through the --

10 MR. ARMSTRONG: I don't know --

11 DR. CHERNEW: -- the clarifying questions to the
12 non-presenter --

13 [Laughter.]

14 DR. CHERNEW: -- knowing what their limits are,
15 knowing what flexibility the MA plans have to do these
16 better designs and making sure there aren't barriers to them
17 doing them, I think, is important.

18 DR. HARRISON: Yes. Plans cannot do -- cannot
19 make coverage rules that are discriminatory against sick
20 people or things like that. So when they bid, they can
21 propose different fee schedules. They can, for instance,
22 put some copays on home health that are not currently in

1 Medicare, but they have to be careful that, like their total
2 SNF copays are no more than the total SNF copays under fee-
3 for-service. So they could change the structure of them,
4 but the total has to be the same. And then there's some
5 actuarial equivalents rules, but --

6 MR. HACKBARTH: [Off microphone.] So the rules
7 issued within the last several years about the structure of
8 cost sharing on, for example, very expensive oncology drugs,
9 and my recollection is that at a point in time, plans were
10 really charging very high -- some plans were charging very
11 high copays on oncology drugs and Congress moved to restrict
12 that, or maybe it was CMS by rural moved to restrict that.

13 DR. HARRISON: Yes, so Part B drugs, 20 percent in
14 fee-for-service. There were plans that were charging more
15 than 20 percent and that -- I believe CMS said they couldn't
16 do that anymore, but there was also some general legislation
17 that talked about nondiscriminatory --

18 MR. HACKBARTH: So there is flexibility, but it is
19 also constrained --

20 DR. CHERNEW: Flexibility, subject to review.

21 MR. HACKBARTH: Yes.

22 DR. BAICKER: But I do think that's a different

1 question than what Mike asked. I mean, you know, if you
2 impose a copayment on all oncology treatments, you're
3 discriminating against people with cancer. You're
4 discriminating against sick people. Mike asks about least
5 costly alternative. It's not that you won't cover prostate
6 cancer treatment, but you'll pay for it only at the rate of
7 regular old radiation therapy and not proton beam therapy.
8 That, I believe the Medicare Advantage plans can do.

9 DR. CHERNEW: And so my broader comment is think -

10 DR. MARK MILLER: This is what's kind of been
11 bothering me about this conversation, too. So in that
12 example, the managed care plan could have a higher copayment
13 on the proton beam whatever we're talking about here.

14 DR. HARRISON: They would have had to have written
15 it into their original bids, but --

16 DR. MARK MILLER: [Inaudible.]

17 DR. HARRISON: -- service, I'm not quite sure how
18 CMS would have reacted to that --

19 DR. MARK MILLER: Because it's a matter of
20 actuarial equivalency, and then how far out of line it
21 appears in review that you might be discriminating against
22 some set of patients.

1 DR. HARRISON: My guess is that they would handle
2 it through coverage rather than through copay differences.

3 MR. HACKBARTH: Actually, it may even be neither.
4 It may just be handled through clinical decision making.

5 DR. CHERNEW: Right.

6 MR. HACKBARTH: That would be, to me, the most
7 likely outcome. They're not changing copays for different
8 things. They're just saying, our clinicians don't recommend
9 it.

10 DR. CHERNEW: So I think the broader point I would
11 make is separating out the first goal of this supplemental
12 coverage distortion from the second goal of figuring out how
13 to design the benefit package in order to encourage
14 beneficiaries to use those things we want them to use and
15 not use the things that we don't want them to use, I think,
16 is a worthwhile discussion and one that we have done in
17 other chapters. There was the whole -- Joan ran the whole
18 VBID workshop stuff and there was the least costly
19 alternative. There was a whole set of options. And I think
20 in much the spirit of what Bob said, thinking through those
21 and how they might work in the Medicare traditional type
22 program and how they could work outside of that in terms of

1 flexibility, I think, is an important exercise for the
2 chapter to get into.

3 The last thing I would say is all of this, the
4 behavioral assumptions are going to be crucial, so it
5 depends a lot on how much help you could get from various
6 people would depend a lot on what your time line is for
7 doing some of this. But I think you could get reasonable
8 advice on assumptions that at least -- you're still going to
9 get the same -- Julie's same comment of, well, this is our
10 opinion, but I think there can be opinions guided in at
11 least where the literature is, you know, and we can help
12 with that.

13 DR. CASTELLANOS: Can I comment just for a second,
14 because we're all looking at 30,000 feet down to the ground
15 and where Karen is, where I am, and where Tom is and where
16 Bill is, we're on the ground. We're where the tire hits the
17 road. And we all have to work together. If you give the
18 practitioner some ability to have appropriate guidelines and
19 you can protect that person from liability if he or she
20 decides based on good medical evidence, a lot of these
21 issues can be dealt with on the ground level. Now, we're
22 looking at the 30,000-feet level, but I think we need to --

1 in our discussions, as we've done over the last four or five
2 or six years, we really need to kind of put this all
3 together in that respect, too.

4 MR. BUTLER: So I struggle still a little bit with
5 what problem are we trying to solve, and I think in the end
6 it's engaging the beneficiary in part of the reform of the
7 program in a way that we haven't. Glenn made some of the
8 comments I would make, but it does get discouraging when we
9 kind of spend 90 percent of our effort in this Commission on
10 the provider side and often not just looking at ways to
11 influence their behavior and often accusing them of being
12 mischievous or illegal or evil, you know, we almost end up
13 there in some aspects of this when we're trying to kind of
14 do the right thing for an awful lot of committed people that
15 are delivering care.

16 So when I step back and look at this issue, we're
17 also trying to dive right into some of the -- as a
18 Commission, we also like to be as specific as we can in
19 recommendations because just floating concepts doesn't do a
20 lot of good. So I'm struggling here, because we dive right
21 into the copays and the deductibles like, okay, that's our
22 comfort zone. We like to talk about all those things, yet

1 we can't really model them. And so what's the sweet spot in
2 terms of what we pass along here is I think we need to think
3 about.

4 And I wouldn't underestimate the importance of
5 just educating at the front end and kind of resetting the
6 dial and really saying this is about engaging a player in
7 this, the beneficiary in a very positive way. And we need
8 to say we understand that the traditional Medicare has been
9 wildly popular as a government program and that supplemental
10 insurance has provided incredible security for so many
11 people. And we understand that.

12 But we also do need to say very explicitly,
13 there's a price to that, and as Glenn said, one option is
14 just to charge everybody the true costs of that. If you do
15 that, you can keep the same system you have now, the
16 unfettered kind of access and so forth, but there is a price
17 to that and we really need to be clear about that as we
18 introduce the chapter because there's no free lunch in that.

19 And I don't think that even the legislators really
20 understand that very basic, you know, this front end, front
21 dollar coverage, because we wouldn't end up with a health
22 reform package that covers the uninsured now with, guess

1 what, the same first dollar coverage in many of these newly
2 insured under Medicare. And so we're kind of going to
3 repeat some of the same ways of not engaging the consumer.

4 Similarly, it's been two years, I think, since
5 we've looked at shared decision making, for example, in our
6 Commission, and yet it's, you know, it's such an important
7 concept in the way we're going to help reform the package.

8 So I caution us from getting too -- the right
9 balance is tricky. I like Bob's idea of give them some
10 options and some samples, but make sure that we're not so
11 rigid and use this formula, because they'll lift that
12 formula as opposed to missing this opportunity to kind of,
13 hopefully kind of provide education at a little bit higher
14 level, because there should be more pages in our work on
15 this kind of issue than we have taken on in the past.

16 MR. HACKBARTH: So, Peter, I hear some similarity
17 between your comments and Bob's comments. So the track that
18 we were on was framing this issue as a benefit redesign
19 issue and working towards broad principles, not a specific
20 benefit package, as a recommendation. But what I think I
21 hear both Bob and Peter saying is even that may be too tight
22 a focus and the framing maybe should be more engaging of

1 beneficiaries in making the system more efficient and
2 effective and what are the policy options, try to frame some
3 of the policy options for doing that. You know, Bob went so
4 far as to link it even to the discussion about premium
5 support as another type of mechanism for trying to engage
6 beneficiaries. So it's sort of a broad frame as opposed to
7 tight knit on just benefit design. Am I hearing the two of
8 you correctly?

9 DR. BERENSON: I mean, I think Peter's notion
10 needs to be included. I don't know whether I would have
11 that be the frame, which is that this is about consumer or
12 patient engagement, because there are benefit design issues
13 here which -- so, I mean, I think we could figure out how to
14 do both.

15 But in terms of stepping back a little bit and
16 laying out a context for all of this, I think that --
17 exactly what those words would be, I'm not sure, but I think
18 we wouldn't want to lose the context by jumping right into
19 here's the principles. We want to spend some time on what
20 is it that we're trying to achieve here, and I think --

21 MR. BUTLER: I think that's my main point --

22 DR. BERENSON: Yes.

1 MR. BUTLER: -- the context in a way that, whether
2 it's the beneficiary, the legislator, or whatever, it kind
3 of sets a bigger context. We can get into the specific
4 design. Otherwise, we won't be given them much other than
5 concepts. So --

6 DR. DEAN: Just yesterday in the Times there was a
7 story about -- which really relates to what Peter just said
8 -- about the Fairview system in Minneapolis was using an
9 instrument to measure what I think they called patient
10 activation, and they had surveyed something like 25,000 of
11 their patients and then categorized them into those folks
12 that really understood and were involved in decision making
13 and those that weren't, and then were using that to focus
14 some of their advice and counseling and -- I don't know. I
15 didn't get into all of the details. But at least they had
16 invested a substantial amount of money in trying to figure
17 out which of their patients really were using the system
18 properly and had -- they didn't have all the -- they weren't
19 clear through the assessment of this, but their sense was
20 that those that were, quote, "activated," were -- they could
21 sort of make the decisions on their own. And then there was
22 also a fairly large group that didn't meet those criteria

1 that really probably would benefit from some assistance and
2 some help in making the decisions. At least in their view,
3 that was a good investment, so --

4 MS. UCCELLO: I think we've had a lot of really
5 great comments so far, and I really like the way that Bob
6 talked about making sure that we're fairly comprehensive in
7 the chapter on discussing various approaches, even if we
8 come to a consensus of something else. And so to that end,
9 I want to suggest making sure we include a couple of things.

10 In terms of coordinating changes in the fee-for-
11 service design with supplemental coverage, we are strongly
12 supporting this surcharge or whatever we want to call it.
13 But I think we just want to make sure that we discuss in the
14 chapter the regulatory approach and its potential
15 implications. And as part of that section, I think it would
16 be useful to include looking at adding the out-of-pocket cap
17 on a true out-of-pocket approach, that being one of the
18 options that's discussed.

19 Also, with respect to adding the out-of-pocket
20 cap, the way we're looking at this is looking at the
21 neutrality in terms of the beneficiary or the program. But
22 what we're really trying to do, we're adding this out-of-

1 pocket cap and figuring out how to pay for it and we're
2 paying for it really just through the other cost sharing
3 provisions. And there are actually other ways to pay for
4 that out-of-pocket cap, including adding a premium, an extra
5 premium.

6 That may not be something we want to pursue, but I
7 think it's something worth talking about, and it somewhat
8 gets at what Mitra was talking about a little bit. It's
9 kind of somewhat philosophical of do we want to be spreading
10 costs over everyone or do we want to be spreading costs more
11 on those who are actually spenders, the ones who are getting
12 the care, because you're going to get kind of different
13 effects and different people are going to be targeted
14 depending on which approach is chosen.

15 A couple other things that are a little more in
16 the weeds but I think we need to think about, and I'm
17 comfortable with using a combined deductible, but what would
18 that mean for those who are only in Part A? Would they
19 continue under the current cost sharing rules? What kinds
20 of things would happen there?

21 Also, I think we need to think about whether there
22 are any impacts on the trust funds. Are we actually

1 shifting costs from Part B to Part A, or -- is that the way?
2 Yes. Yes, between them. I think we need to kind of think
3 about what -- because that has implications for the funding
4 of the program generally.

5 In terms of when we're looking at levying a
6 surcharge on these supplemental plans, the issue of whether
7 we levy it on only the new people coming in or everyone,
8 it's a slightly different case than the Cadillac tax under
9 ACA, I think. With the Cadillac tax, it's on employer plans
10 that are really looking at -- they're doing their pricing on
11 a year-by-year basis. The Medigap plans have -- they can
12 have a little bit more prefunding. So their premiums could
13 be a little higher in the early years and their premium
14 increases somewhat lower than they would be normally just to
15 reflect the increases in cost over age. So that prefunding
16 -- if we were thinking about doing something on a regulatory
17 approach, I think it would be more difficult, I think, to
18 implement changes on everybody because of that. And it
19 would be more appropriate to make changes just on the new
20 folks.

21 In the surcharge case, it may be less of an issue,
22 but I think we still need to think through whether or not

1 there are implications for some of that prefunding and
2 whether people who then drop out, maybe already paid for
3 something they're not continuing on -- I'm not sure it's as
4 big of a deal, like I said, but I think it's something we
5 need to think about.

6 And I don't know if this is helpful, but I was
7 thinking of, when Bruce was speaking, we're looking at these
8 tables on 8 and 10, looking at what the effects on
9 beneficiaries are going to be given our assumptions of their
10 switching behavior. But the issue is, well, this is what's
11 going to happen to them given most of them are just going to
12 stay, it sounds like. But if they actually have other
13 choices that would save them money -- if they dropped their
14 plan and save more money, then I'm less worried about an
15 increase that they would incur if they're staying with what
16 they have. So I'm wondering if looking at things on a
17 prototypical person basis and laying out their choices and
18 looking at, well, if they stay with what they have or what
19 their other choices are and if we see what their potential
20 gains and losses are as opposed to just looking at their
21 gains and losses assuming they stay or change. Does that --
22 Yes. So I think that's my list.

1 Oh, one more thing. One more.

2 [Laughter.]

3 MS. UCCELLO: Bob mentioned this a little, and I
4 think I may have brought it up before, but maybe one of
5 these -- if we're thinking very comprehensively, we also
6 need to include whether or not there should be a public
7 Medigap type of plan, and that, again, feeds into -- that's
8 on that premium support continuum.

9 DR. BAICKER: So I think there are two separate
10 issues conceptually that interact with each other, so I
11 understand why we may want to bring them together in a
12 chapter like this, but I'd at least like to lay out very
13 separately the issue of good insurance value and value-based
14 insurance design, even though they have a couple of words in
15 common.

16 And by the first, I mean we're inherently offering
17 an inferior insurance product. It doesn't have an out-of-
18 pocket stop loss. The reason people buy Medigap policies in
19 large part is to get the protection that you would think a
20 good insurance policy would provide against catastrophic
21 expenses. And so a consequence of that is that people buy
22 these policies that have these spillover effects back to the

1 main Medicare program that aren't right priced in the
2 Medigap premium and we could fix all of that or improve it
3 by offering a better insurance product with better back-end
4 protection that would then make these alternative policies
5 less attractive, and if they were right priced, that would
6 also make them less attractive, but they would be less
7 important because people would have better protection
8 through the main product.

9 And that seems like just an improvement to the
10 program that could be done in their revenue-neutral kind of
11 way or not, but that would improve the insurance value and,
12 in essence, shift something that's being provided through
13 this inefficient Medigap market into being provided through
14 the main benefit and payments could shift accordingly. So
15 that could be done in a revenue-neutral way.

16 I'd love to make that point more strongly, that
17 the basic benefit is not providing as much insurance value
18 as it could, and we talked in round one in the past about
19 ways to capture that in a more vivid way to juxtapose
20 against what looks like a figure where 80 percent of people
21 are losing out in the transaction, and I would argue
22 strongly that they're not. Even if some of their costs are

1 going up this year, they're still gaining valuable
2 protection. And the fact that they were buying Medigap
3 policies shows that they value that protection.

4 So if there's a way to make that point more
5 strongly, even in the language throughout, that I don't want
6 to call it neutral. I don't want to call it beneficiary-
7 neutral when they have better risk protection. Even though
8 I know what you mean by that, I think that kind of language
9 minimizes the insurance protection that we think that people
10 should be getting from the basic benefit. So that point,
11 I'd really like to make more strongly.

12 And then there's the second point of value-based
13 insurance design where we know that a more innovative
14 insurance product would charge less for services that were
15 really of high value, would encourage high-value use,
16 discourage low-value use, and all of that could be
17 modernized in a way that we're seeing some private insurers
18 experimenting more with and that we have some evidence.
19 That's a bit of a separate issue in that that's not about
20 insurance protection. That's about driving high-value use
21 within a given risk profile, or within a given insurance
22 package.

1 Now, I see that they kind of go together in that
2 if you're going to provide this catastrophic coverage
3 protection and you want to make it revenue neutral, then
4 you're going to increase payments in some ways, and if
5 you're going to start messing with copays, you might as well
6 do it in a value promoting kind of way. So I can see how
7 the end product might be a blend of the two, but I'd almost
8 like to start with the concepts being more separate and then
9 think about what the program's goals are in terms of the
10 insurance product that we're delivering and then how to put
11 those resources to the best possible use.

12 MR. HACKBARTH: So, Kate, just to pick up on that,
13 so the first part about what constitutes a good insurance
14 product, that's a more static idea, whereas the people, to
15 use your point, said it ought to cover catastrophic costs
16 and protect people against that. That's an element of good
17 basic insurance design.

18 The value-based piece of it is a more dynamic
19 process that is changing based on available evidence about
20 different things. So I always think of these things in
21 terms of who the decision maker is in the policy world. You
22 can imagine Congress writing a piece of legislation that

1 redesigns the basic structure of the benefit package. I
2 find it difficult to imagine Congress repeatedly changing
3 that to incorporate value-based principles, and that's
4 something that it seems to me would be more appropriately
5 delegated to the Secretary within boundaries established by
6 the Congress.

7 DR. BAICKER: Yes. At first when you said
8 "dynamic," I thought you were going more towards the effect
9 on future costs and all of that --

10 MR. HACKBARTH: Yes. No. No.

11 DR. BAICKER: -- and abstracting from all of that.
12 Yes. In some ways, the way this recommendation example --

13 MR. HACKBARTH: Right.

14 DR. BAICKER: -- is laid out is consistent with
15 that in that we're sure that insurance protects you against
16 potentially very high expenses. This isn't something we
17 need more evidence on.

18 MR. HACKBARTH: That's right.

19 DR. BAICKER: This isn't something -- we can all
20 agree that better protection against very high expenses is
21 higher insurance value and that we could design a package
22 that improves that.

1 DR. CHERNEW: [Off microphone.] -- expenses --

2 DR. BAICKER: Oh, you.

3 [Laughter.]

4 DR. BAICKER: But the challenge, then, is in
5 something where we're getting all -- improves evidence over
6 time or changing sands and you don't want to try to write
7 down, these services should have this copay, these services
8 should have that copay. And there, you could say we want to
9 promote this through more innovative structures or more
10 flexibility in beneficiary copays over those services and
11 that could be a separate piece of flexibility, not a
12 prescription.

13 MR. HACKBARTH: Yes. Scott.

14 MR. ARMSTRONG: Yes. At this point in this
15 conversation, which I think has been really terrific, most
16 of the points I would want to make have been made. I just
17 would, I think, reiterate a couple of things.

18 First, despite the fact that Bill's wounds are
19 still healing, I'm really glad that we're pushing this and I
20 think it's an important agenda for us. This whole idea
21 that's been articulated, I thought, very well, of balancing
22 our ability to influence the design of payments to providers

1 with the incentives that are in the benefits structure for
2 the beneficiaries themselves, I think, is just an expanse --
3 an area of work for MedPAC that I really look forward to us
4 spending some real time in.

5 I also -- I thought Kate did a great job of
6 articulating a point I would have made a little more simply
7 and with simpler verbs --

8 [Laughter.]

9 MR. ARMSTRONG: I think the Medigap industry is a
10 symptom of a deficient benefit and that I'm really glad that
11 we're diving into some of those issues.

12 One other point I would make is that I do think
13 what we're talking about, in fact, is consistent with and
14 potentially has more alignment with many of the other
15 principles behind other policy proposals that we've been
16 putting forward, you know, the whole idea of bundled
17 payments for post-acute services or ACOs and other things.
18 I look forward to an opportunity for us to think about,
19 well, how could you actually begin to marry benefit
20 structure with provider payment structure and really create
21 even more influence over behaviors by doing some of those
22 kinds of things. I think until we get into this, we just

1 won't even be able to start asking, let alone answering,
2 some of those questions.

3 And I think that's all I'll say.

4 MR. HACKBARTH: Anything that you want to ask
5 about, Mark, to get clarification for next steps?

6 DR. MARK MILLER: No. I think what we're going to
7 have to do is huddle and sort of outline how we would walk
8 across the range of issues that were put on the table here.
9 And then once we have -- and there are some additional
10 analyses that we have got to bring.

11 And then I think I've got to talk to you and Bob
12 about this, you know, how principles versus -- and then how
13 to come back to the Commission on that continuum is sort of
14 that. And I'm not being articulate, obviously.

15 One thing that Cori said on that front in
16 following up is whether the Commission just ends up saying
17 there are six major design principles and here's the pros
18 and cons and here's how you could go, or whether the
19 Commission sort of says, and on this one, we lean this way,
20 or we more than lean, we stand. That might be a way to
21 bring together both your thought and are we going to lean --
22 so that's kind of what I was thinking, even though I can't

1 say it.

2 MR. HACKBARTH: Yes. And I'll be equally
3 inarticulate about it, but that was sort of my sense, as
4 well. This has been a very helpful conversation for me and
5 I have a different sense of this than I did when it started,
6 and part of it is that we need to broaden the frame a little
7 bit and have a run-up that frames the issues. I hope we can
8 also conclude with some statements, directional statements
9 about here's how we might be inclined to resolve some of
10 those issues. But I think the broader framing is important.
11 And highlighting just, you know, there are, as Bob said,
12 pros and cons on many of these different things and trying
13 to educate before we get to, oh, there ought to be a
14 redesigned benefit package that looks like this, I think is
15 important.

16 DR. BORMAN: Just briefly, Glenn, and a piece of
17 this issue that I think maybe we're not -- we haven't talked
18 about yet or I haven't heard yet and that ultimately needs
19 to be brought in. The market as we have it now not only
20 reflects sort of the bad benefit -- or the limitations of
21 the benefit that we provide, but it also is a measure of our
22 inability to communicate to people at a time when they're

1 better able to make rational decisions about their choices
2 and how to think about them.

3 So whatever package or options or whatever we
4 recommend going forward, we may need to give some thought
5 about do we need a more structured educational program, if
6 you will, because right now, as you watch the ads, for
7 example, on TV, you can see how very quickly people get
8 sucked into sort of the fear factor or other ways that they
9 use to make a decision about something that would -- the
10 kind of education about this, for example, needs to start
11 way before you've picked up your Medicare card, and we need
12 to think about how do we better share choosing options. I
13 realize that comes very close to a perilous boundary between
14 what's public and what's private obligation here, but I
15 think that whole education part and communication to help
16 the beneficiary make smart choices is something that we
17 should carry forward wherever we go in terms of the
18 specifics of the issue.

19 MR. HACKBARTH: [Off microphone.] Okay. Thank
20 you, Julie and Scott.

21 So our next session is on the mandated report on
22 rural issues.

1 [Pause.]

2 DR. AKAMIGBO: Good morning. Our aim today is to
3 provide a recap of our findings on the four areas MedPAC was
4 mandated to study, and clarify our guiding principles for
5 each area.

6 Today, Jeff and I will summarize those findings,
7 discuss payment adequacy as it pertains to rural providers,
8 and we look forward to your guidance on the plan as we
9 complete the rural report this spring.

10 So for a quick overview, this report was managed
11 by the Patient Protection and Affordable Care Act and
12 requires us to examine four specific issues. The first is
13 access to health care services, which we discussed last
14 February. Second is quality of care, which we presented in
15 October of 2011. The third is adequacy of rural payments,
16 which was separately discussed in detail in each sector back
17 in December but we'll summarize again today to incorporate
18 access and quality when Jeff talks about the adequacy of
19 Medicare payments later in the presentation. The last issue
20 was payment adjustments to rural payment rates, which we
21 discussed last September.

22 The rural report is due June 2012.

1 We have found, as others have, that there are
2 fewer physicians per capita in rural areas. The difference
3 is in specialists. Non-primary care specialists are even
4 more acute. And recruitment of physicians continues to be a
5 serious challenge for many rural communities.

6 However, despite the differences in the number of
7 physicians, we showed back in February that access to care
8 is relatively equal in both rural and urban areas as
9 measured by volume of hospital services, outpatient visits,
10 and utilization of skilled nursing, home health, dialysis
11 and pharmacy services.

12 Now in some cases, rural beneficiaries may have to
13 drive further distances to access care, but travel times
14 were relatively similar for urban and rural beneficiaries.
15 In addition, our analyses of different surveys confirm that
16 Medicare beneficiary satisfaction with their access in rural
17 and urban areas were relatively equal.

18 With Commissioners' guidance over the past year,
19 we have developed guiding principles to examine rural health
20 care for Medicare beneficiaries. The principle for access
21 to care posits that rural beneficiaries should have
22 equitable access to health care services. Equity and access

1 can be measured by volume of services, number of visits,
2 prescriptions, as well as beneficiaries' reports of their
3 experience once they interact with the health care system.

4 And when we discuss equity and access, we
5 recognize that some rural beneficiaries may drive longer
6 distances, although not necessary travel for longer periods
7 of time, than their urban counterparts.

8 The quality findings we presented in October,
9 which inform these principles, are summarized on the slide.
10 Overall, we found that quality of care in rural and urban
11 areas is similar as measured in each setting, namely skilled
12 nursing facilities, home health agencies, and dialysis
13 facilities.

14 On the other hand, hospital quality across rural
15 and urban areas is mixed. Readmission rates are roughly
16 equal but mortality rates are worse in rural areas and were
17 only partially explained by volume. Clinical quality
18 measures, as reported on Hospital Compare, were also
19 generally worse for rural providers and tended to worsen as
20 providers became more rural.

21 Now on to guiding principles for rural quality of
22 care. First, the quality of non-emergency care delivered in

1 rural areas should be equal to that of urban areas. This
2 reflects the reality that non-emergency care, where there is
3 a choice of whether to treat the patients locally or
4 transport them to a larger urban facility, should be held to
5 the same standards as the urban facility. The small rural
6 facility should be as good as the alternative site of care.

7 However, emergency care is different. There may be
8 no alternative and small rural hospitals are obligated to
9 treat those patients. In these emergency situations, our
10 expectation for outcomes in small rural hospitals may not be
11 as high as they are for larger facilities. Our
12 expectations, therefore, should reflect the inherent
13 limitations that may exist in small rural hospitals compared
14 to large urban hospitals.

15 Finally, most hospitals are currently evaluated on
16 the care they provide to Medicare beneficiaries and their
17 performance is public reported on Hospital Compare.
18 However, some critical access hospitals have been exempted
19 from some quality reporting requirements.

20 As the Commission has stated, providers should be
21 evaluated on all the services they provide. This includes
22 measures common among rural and urban providers, as well as

1 measures that are specific to rural providers, such as
2 timely communication of patient information after a
3 transfer.

4 To allow equal access to information for rural and
5 urban patients, all hospitals should be subject to public
6 disclosure of their performance scores. This may improve
7 accountability and hopefully improve the quality of care
8 delivered in small facilities.

9 Jeff will now pick up with our discussion of
10 payment adequacy and special rural payments.

11 DR. STENSLAND: In your mailing materials, and
12 during our December meeting, the analysts for each sector
13 discussed the adequacy of rural Medicare payments. So in
14 this session, I'm going to try to bring together the
15 different findings on rural payment adequacy from the
16 different chapters and the different presentations you heard
17 in December. We will use the same criteria for rural
18 adequacy as we do for overall payment adequacy, examining
19 variables such as volume of services, payments, and costs.
20 However, we will also examine whether rural payments are
21 adequate relative to urban payments, given our mandate. As
22 we have discussed throughout the process, we will compare

1 different types of rural areas, including the more sparsely
2 populated rural counties.

3 When we discuss rural physician payment adequacy,
4 we have limited financial data so we tend to focus on access
5 to care indicators. In general, those access indicators of
6 payment show that adequacy is good and similar to urban.
7 Our survey indicates that rural and urban beneficiaries
8 report that they have similar ability to obtain physician
9 appointments when they want those appointments, and to
10 obtain new physicians when they're looking for a new
11 physician to accept them into their panel.

12 Consistent with that, when we look at claims, we
13 see that rural beneficiaries have roughly equal volumes of
14 visits as urban beneficiaries.

15 Similarly, rural home health agencies appear to
16 have adequate payments. The number of home health services
17 per capital is similar in rural and urban areas. In
18 addition to that, we tend to see much more regional
19 variation in home health use than we do rural/urban
20 variation. Quality scores are also similar, as are profit
21 margins. Given the rural/urban similarities, we do not see
22 any systematic differences that would require additional

1 assistance to all rural home health agencies.

2 The SNF story is similar to the home health story.
3 There is a similar number of SNF services received by rural
4 and urban beneficiaries per capita. Quality scores are also
5 similar and margins tend to be high in all types of rural
6 areas. Hence, we do not see any rural payment adequacy
7 concerns for the different types of rural counties.

8 For hospice we do see some rural/urban
9 differences. Hospice use is a little bit lower in rural
10 areas but the rate of hospice use is growing. In addition,
11 rural providers tend to have smaller hospices and have
12 slightly lower margins, as Kim discussed last December.
13 However, given the Commission's discussion that there is a
14 need to broadly refine the hospice payment system, the small
15 rural/urban differences we see should be seen as a secondary
16 concern to the larger effort of refining the hospice payment
17 system.

18 In addition, we had a recommendation to adjust
19 hospice payments to pay more for the first days of the stay
20 and more for the last days of the episode. And that would
21 tend to benefit rural hospices. So given the potential
22 changes to the hospital payment system that would benefit

1 rural providers, and given that most rural counties still
2 have healthy profit margins under the current system, there
3 does not appear to be a pressing need for additional payment
4 changes that would target solely rural providers.

5 Now when we turn to IRFs, it's a little bit
6 different because all areas do not have IRFs, and in some of
7 those markets patients will receive care in other settings
8 such as SNFs. So patient volumes in IRFs for different
9 geographic areas is a less useful measure.

10 When we look at profit margins, we have a more
11 complicated story than we've seen in the last few slides.
12 In general, IRFs with more discharges per year tend to have
13 higher profit margins, as you heard yesterday. In the
14 margins for urban IRFs, who see an average of 942 patients
15 per year across all payers was 9 percent while the margin
16 for the handful of IRFs in the rural areas next to urban
17 areas, who saw an average of 104 patients per year was
18 negative 5.6 percent. Certainly, part of that is the
19 economies of scale issue.

20 However, the story is mixed in the most rural
21 IRFs, the ones that are located in counties not adjacent to
22 urban areas and that don't have a city of 10,000 people had

1 a margin of 16.1 percent. This was despite still having
2 relatively few patients per IRF.

3 There's a few things I would like to mention about
4 this. First, notice on the first row, you'll see the
5 numbers we are talking about here are very small. In the
6 adjacent to urban areas, that's only 13 IRFs we are looking
7 at in our sample. In the non-adjacent to urban, it's only
8 17. There's a lot of variation in IRF margins. A negative
9 20 margin is not uncommon, a positive 20 margin is not
10 uncommon. So take it with a grain of salt because there are
11 so few.

12 The second, if you look at the ones that are
13 adjacent to urban areas, they have 104 patients per year.
14 But their census is only about three. So if you're trying
15 to run a business with only three patients in there, you can
16 see where you'd have some real economies of scale problems.

17 The next one, the average census is four. And so
18 maybe from three to four that still sounds small but from a
19 percentage basis it's a pretty big difference and it might
20 explain part of the differential.

21 Finally, probably due to pure chance, there's more
22 free-standing IRFs in the last column than there is in the

1 third column and that can also affect the numbers. So I'm
2 trying to give you some flavor on why you see the difference
3 between those two different categories of urban areas. A
4 lot of it might be the small numbers, some of it economies
5 of sale, and some of whether you're free-standing or non-
6 free-standing.

7 The current policy for IRFs is that they all
8 receive an 18.4 percent add-on if they're in a rural area.
9 There is some concern that this policy is provided to all
10 IRFs and not targeted just to low volume IRFs that are
11 necessary for access.

12 The payment for dialysis appears adequate as
13 capacity has grown by 4 to 5 percent per year in rural
14 areas. While rural Medicare margins have historically been
15 lower than urban margins, a negative 3.7 percent compared to
16 3.4 percent due to lack of economies of scale, starting in
17 2011 small dialysis facilities with fewer than 4,000
18 services per year will receive an 18.9 percent increase to
19 their payments. And it goes to all low volume facilities,
20 no matter what your distance is from another facility.

21 So first of all, this raises some concerns about
22 it not being targeted, if we're giving this addition to two

1 dialysis facilities that are both one mile apart from each
2 other, that might not be an efficient use of Medicare
3 dollars.

4 Also, because the low volume adjustment will have
5 a significant affect on rural profit margins, we have a plan
6 to really look at this again next year and once again look
7 at rural profit margins once they start receiving this low
8 volume adjustment.

9 The other factor we looked at is quality, and for
10 dialysis patients, the process and outcomes measures do
11 appear to be similar in urban and rural locations, and the
12 rates of hospitalization are slightly lower in rural areas
13 but the differences are very small and not statistically
14 significant.

15 The share of hemodialysis patients who receive
16 adequate dialysis virtually the same across rural and urban
17 areas. And for new to dialysis beneficiaries in 2009, those
18 who have a catheter, where we generally think rates are
19 better -- though not always, as Karen has said -- also show
20 that the rates are similar across urban and rural areas.

21 With micropolitan areas, those micropolitans being
22 the rural areas with a city between 10,000 and 50,000

1 people, show the best rates of all the groups.

2 So I would say, in summary, the rural story is
3 kind of lets wait and see until we have this extra rural
4 add-on in the mix.

5 Rural and urban patients also receive similar
6 numbers of hospital services during the year, as we've
7 discussed in our February meeting. We also found that
8 quality of care is mixed when we look at hospitals, with
9 readmissions being equal for rural facilities. But the
10 smallest facilities tend to have higher mortality rates, as
11 Adaeze just mentioned.

12 When we examine profitability, the most rural
13 facilities tend to have the highest margins. This reflects
14 the special payments provided to rural facilities, which
15 we'll discuss later. As we can see on the next slide, this
16 is a relatively new phenomenon, where rural hospitals have
17 higher Medicare margins than urban hospitals.

18 I think the purpose of this slide is to explain
19 why the story might change in our 2012 report compared to
20 what we said in 2001. Somebody might read our 2001 report
21 and then listen to this discussion and say why has MedPAC
22 changed their story? I think the reason is that the

1 underlying story has changed, and that's reflected in how
2 the data has changed.

3 If you look at the slide, you can see back in 2000
4 rural margins were much lower than urban margins. We
5 mentioned that in our report. We made a couple of
6 recommendations to change payments to make them more
7 equitable in rural and urban areas. Those recommendations
8 were largely adopted. Rural margins improved relative to
9 urban margins. And then there was some additional payment
10 adjustments that came into play that further helped rural.
11 And that's how we ended up with the rural margins now better
12 than the urban margins.

13 Now we can examine some of those special payments
14 that we talked about and also discuss the issue of special
15 payments, which is part of our mandate. This slide lists
16 some of the special adjustments that were made to increase
17 rural hospital payments. There's really just two points to
18 this slide. We won't go through each one of these
19 adjustments.

20 First, I want to note that there's many
21 adjustments, and this explains part of the graphic that you
22 just saw on the prior slide. Second, we want to reiterate

1 that some of these adjustments were, in fact, MedPAC
2 recommendations and they did fit some of the principles
3 we've discussed in terms of targeting low volume hospitals
4 that need special assistance. However, some of the other
5 adjustments that were added have not fit our principles that
6 we discussed in our prior meetings.

7 This slide looks at some of the special payments
8 for the other sectors. First, we could say that many of
9 these adjusters are not targeted. They're either going to
10 all the providers in a frontier state, in some cases to all
11 rural providers, or in other cases to all low volume
12 providers. And they generally aren't targeted to low volume
13 isolated providers.

14 Just to go through an example that we can use to
15 show how one of these adjusters might not fit the principles
16 that you discussed in some of our prior meetings on special
17 adjusters this past fall, we look at the hospital low volume
18 adjustment. Starting in 2011, this year, small hospitals
19 will be entitled to an additional low volume adjustment and
20 that will stay in place through 2012. What this will do is
21 it will widen the difference between the rural and urban
22 margins.

1 As I've said before, I think there's generally
2 three problems with this low volume adjustment. First, it's
3 not targeted to isolated hospitals. Second, the adjustment
4 is not empirically based and it uses just Medicare
5 discharges to determine whether you're low volume rather
6 than total discharges across all payers. Third, the sole
7 community hospital and Medicare dependent hospital programs
8 cause some duplication of payments with the low volume
9 adjustment program.

10 If we added the new low volume adjustment to our
11 2010 margins, we would see those simulated margins would
12 rise to a projected 14 percent, which would be far above the
13 margins of other hospitals.

14 So in summary, while a low volume adjuster may be
15 needed for some providers, in this case the adjuster isn't
16 targeted and it isn't empirically justified.

17 So now I'll discuss some of the guiding principles
18 for the special payment adjusters. And we're trying to
19 summarize what we heard from you during the last time that
20 we talked about special payment adjusters in the fall.

21 The first principle is that low volume adjustments
22 should be targeted to isolated providers. The general idea

1 here is it doesn't make sense to provide a low volume
2 adjustment to two competing providers when they're both one
3 mile apart or five miles apart and both suffering from low
4 volume.

5 Second, after we identify who is eligible for
6 additional payments, the question is how much should they
7 get? We want the amount of adjustments to be empirically
8 justified.

9 Third, with respect to low volume adjustments, the
10 adjustment should be tied to the total volume of patients,
11 not just Medicare volume.

12 Fourth, the low volume adjustments should not
13 duplicate other adjustments, as they did in the case of the
14 current hospital low volume adjustment.

15 Finally, it's important to think about the
16 financial incentives associated with the adjustment.
17 Different ways of payment can carry different incentives
18 and, all else equal, prospective payment adjustments tend to
19 have stronger incentives for cost control than cost-based
20 payments.

21 So that's a summary of the four topics that are
22 mandated under our required report. For each of those,

1 we've tried to summarize first, what we found; and second,
2 the principles which were tried to be a summary of what you
3 have discussed at the prior meetings on payment adequacy,
4 quality, access, and special payments.

5 Now we'd like to hear from you any comments or
6 questions you have on the report, any suggestions you have
7 for changes to the principles, or any other guidance you
8 have as we start to draft the report this spring.

9 MR. HACKBARTH: Okay, thank you. Herb, why don't
10 we start with you.

11 MR. KUHN: Are we going to do two rounds or just
12 one? How do you want to do that?

13 MR. HACKBARTH: Let's do two.

14 MR. KUHN: Two quick questions, just on
15 clarification. I think I've asked this in meetings before,
16 and if I have, excuse me for this, I forget the answer. But
17 when we look at the documentation and coding adjustment
18 that's out there, there has been some conversation that it
19 is not as powerful an adjustment in the rural areas because
20 of the types of cases where there's the opportunity to code
21 more accurately is -- they don't see a lot of those cases,
22 perhaps, in some rural hospitals.

1 Is there evidence that there is a differential
2 here, as a result of DCI, that would -- as we make the
3 adjustment, that we might be disadvantaging rural hospitals
4 because we're suppressing their payments further.

5 DR. STENSLAND: There isn't evidence of that, and
6 there's two ways to look at it. At the really granular
7 level, you can look at the different MS-DRGs. And basically
8 what we saw is we saw a movement in all the MS-DRGs, up from
9 where more of them are showing higher rates of complications
10 and major complications. So what we're saying is it's going
11 across the board, your pneumonia admissions, your heart
12 failure admissions, as well as your more complex type things
13 that go to tertiary care hospitals.

14 So because it happens at all the different DRGs,
15 those ones that are treated at small hospitals and those at
16 large hospitals, it's not surprising that when we see the
17 change in case-mix, we see roughly the same change in the
18 small hospitals as we do in the large hospitals.

19 MR. KUHN: Thank you.

20 The second question, when you were talking about
21 quality, the observation from the data that you shared is
22 that it's pretty much the same, for post-acute care

1 hospitals it's a bit mixed. If you were a Medicare patient
2 seeking care in a rural area and you went to one of the
3 compare websites, would you be able to differentiate that
4 from the Compare websites? Or is this a different analysis
5 that goes beyond what's available on Compare?

6 DR. STENSLAND: It's a different analysis, and
7 this was one of the things we talked about. The way the
8 Hospital Compare does its analysis is it uses what it would
9 call a random effects model. The important thing to
10 remember about the model, the key thing that's driving it,
11 is it has this kind of prior assumption that everybody's at
12 the mean. And if you have a really low volume of cases,
13 it's going to assume basically that you're at the mean and
14 it's going to create a weighted value for you on the CMS
15 Compare website that's basically almost completely weighted
16 at the mean and very little weighted on your own data.

17 So if you look at the Hospital Compare website,
18 all the really small hospitals, they're going to look like
19 they're really close to the mean no matter what their actual
20 performance was because what essentially CMS is saying is if
21 it's different from the mean, because the number is so
22 small, we're really not confident on whether that's random

1 luck or really differences in quality. So we're just going
2 to say they're average.

3 Now what we did is we didn't look at the
4 individual observations. So we didn't say oh, this hospital
5 has 15 discharges in CHF. Let's exactly know what that
6 hospital's mortality rate is. That would cause a lot of low
7 volume problems.

8 What we did is we said let's combine the data from
9 a whole bunch of these small hospitals. Like we combined
10 the data from all 1,300 CAHs. So once you combine it from,
11 1,300, you have a much bigger n and you have much more
12 confidence in the n, and you don't have to move to these
13 kind of random effects models like CMS did.

14 So then we can now, looking at this big group, how
15 does the big group compare to this other big group. And
16 then we see that the smaller hospitals tend to have higher
17 mortality than the bigger hospitals, and we also see that
18 rurals tend to have a little worse mortality than urban.
19 And those findings aren't like some news flash. Those are
20 also the same things you will see in the literature for the
21 past 10 years.

22 DR. NAYLOR: Great report.

1 On Time Table 15 can you -- and I know you put the
2 time of each of these MedPAC recommendations and so on --
3 but can you help to clarify the relative impact of say the
4 three MedPAC recommendations on what we seen in terms of
5 changes? I don't know that that's important or not, but to
6 give it a sense of this was instituted and this was the
7 impact? I don't know if that's possible.

8 DR. STENSLAND: Off the top of my head, so this is
9 really rough, first increasing the rural base rate up to the
10 urban base rate was a pretty big move. I'm thinking on the
11 order of a percent difference in your margins. The way it
12 used to be structured is when they originally set up the
13 system, it looked like rural providers had lower costs, for
14 some unknown reason, than urban providers. But over time,
15 we kind of got better at measuring case-mix and other
16 things. And when MedPAC looked at this in 2001, they said
17 there's really no justification for having a lower base rate
18 for a rural provider than an urban provider. Meaning, if
19 their wages are the same and the case-mix is the same, they
20 should get the same.

21 So MedPAC recommended that. And that was a
22 material bump up in the rural profitability when Congress

1 adopted that.

2 The DSH payments was also a material bump up.
3 That was pretty significant. The rural folks used to get a
4 much lower DSH payment even though they had the same share
5 of low income people than urban folks. In 2001, we
6 basically said that wasn't equitable. We made that
7 adjustment. It made a significant change in rural payments.

8 The third was the low volume adjustment. What
9 happened here is when we estimated this, I think we saw a
10 low volume effect closer up to 500 discharges or so. The
11 way it was enacted was CMS, the Secretary, was given
12 discretion on how to enact it. And they looked at it and
13 they said they were only going to give a low volume
14 adjustment to folks with 200 or fewer discharges.

15 And what happened over time was a lot of these
16 really small ones just became CAHs. So this low volume
17 adjustment, as it stood, had almost no effect. Because
18 there just isn't very many with 200 discharges that aren't
19 CAHs.

20 Those are our three policies and how much they
21 affected the margin.

22 DR. NAYLOR: Thank you very much.

1 [Pause.]

2 MR. GEORGE MILLER: Yes, on Slide 5, first of all,
3 I want to state I think that no matter what the quality
4 parameters should be, they should be of high standards and
5 really no difference than any other provider. I'm just
6 curious on the mortality rate. Do you know if that's a
7 function of maybe travel time and distance, why the
8 mortality rate is lower? Do we know the reasons why they
9 would not be at a higher level? I think you said they're
10 mixed, and mortality is one of the reasons they're mixed.
11 Do we know the reason why?

12 DR. STENSLAND: Well, when we looked at this, the
13 two things that we highlighted were pneumonia discharges and
14 CHF discharges. And if you do look at the travel times,
15 there's probably an extra 10 minutes, on average, travel to
16 the hospital. But for a CHF admission or a pneumonia
17 admission, we don't think that's really going to do it. We
18 didn't focus on the AMI admissions in our analysis.

19 MR. GEORGE MILLER: Folks that are AMI, but you're
20 telling me this includes both CHF and pneumonia?

21 DR. STENSLAND: Yes.

22 MR. GEORGE MILLER: All right. Ten minutes

1 wouldn't make the difference on those. I'm just wondering
2 about the AMI. All right. Thank you.

3 DR. STUART: I think you've done a great job.
4 Thank you.

5 DR. CASTELLANOS: Yes, on Slide 17, you describe a
6 15 percent add-on to physician payments billed by the
7 critical access hospital. How about the physician in the
8 community that's seeing the same patient, doing the same
9 service, but not being billed by critical access? Does he
10 or she get the 15 percent?

11 DR. STENSLAND: No. They have to assign their
12 billing to the hospital.

13 DR. CASTELLANOS: Why?

14 DR. STENSLAND: I'm not sure what the rationale
15 there is. I don't know if they were trying to promote
16 integration or what they were doing, but that's the policy.

17 DR. CASTELLANOS: Well, that's similar to a
18 discussion we had yesterday. I don't think it's -- I guess
19 that's an equity issue.

20 MR. HACKBARTH: Is that statutory?

21 MR. GEORGE MILLER: [off microphone] Yeah.

22 MR. HACKBARTH: It's written that way in the

1 statute. This isn't by regulation.

2 MR. GEORGE MILLER: It is statutory, and I think
3 the reason is it was a recruitment issue to areas. It was
4 just a recruitment issue, how to get more physicians in the
5 rural areas, if I remember correctly the rationale for that
6 being --

7 MR. HACKBARTH: I think Ron's point is --

8 MR. GEORGE MILLER: I understand his point.

9 MR. HACKBARTH: Okay.

10 DR. CASTELLANOS: Slide 8, the limited financial
11 data, now that, you know, physicians are employed by
12 hospitals greater than 40 percent, is that data available
13 through the hospital side? Limited financial data on
14 physicians' practices, you know, now that physicians are
15 employed and it's greater than 40 percent, I would think
16 some of that data may be available on the hospital side.

17 DR. STENSLAND: I would have to think about that.
18 I don't think the cost reports are really designed to pick
19 up all of that. We have the clinic part of the cost
20 reports, so we can look at the clinic. And I'm not sure if
21 we wanted to only look at the clinic either when we started
22 to look at what the physicians' expenses are, if we thought

1 there was some difference in relative efficiency between the
2 hospital-based clinics, which are a small share, and the
3 free-standing, which are a big share. I'll have to think
4 about that more to get you a better answer.

5 DR. CASTELLANOS: Okay. Then on Slide 6, just the
6 first one, services provided by the rural hospitals that
7 they choose to deliver. You know, there's some of us -- I
8 go to a rural hospital one day a month. Now, obviously that
9 hospital doesn't have that quality the other 29 days. Maybe
10 I'm making a mountain out of a molehill.

11 DR. AKAMIGBO: I'm not sure I understand the
12 question.

13 DR. CASTELLANOS: Well, you're talking about
14 quality of care should be equal for non-emergency services.
15 In the areas where the provider chooses to deliver that
16 service.

17 DR. MARK MILLER: Ron, where this came from in the
18 discussions -- and this is something that some of the
19 Commissioners were saying -- if a rural hospital decides
20 it's going to do hip replacement or some procedure like
21 that, the thought process is that's a choice and that we
22 should expect quality outcomes to be the same. If somebody

1 arrives at your doorstep after a car accident and it takes
2 30 minutes to get people into the hospital and take care of
3 that patient, you might reasonably anticipate that there's
4 some difference in quality in that circumstance.

5 That's what this is trying to say. It may not be
6 getting at --

7 DR. CASTELLANOS: I guess I'm trying to ask
8 whether it -- I think we best just leave it like it is.

9 MR. GEORGE MILLER: I think, Ron, for the days you
10 provide care at that rural hospital, the standard of care
11 should be the same as any other place while you're there.
12 The days that you don't provide it, then that service is not
13 available and there's no prerequisite for the standard of
14 care when you're not there.

15 DR. CASTELLANOS: Thank you for clarifying that.

16 MR. ARMSTRONG: Do we know, when we look at the
17 overall Medicare program, how much we spend on what we would
18 define as rural care versus everything else? Just order of
19 magnitude?

20 DR. STENSLAND: So the rural people are probably
21 about 20 percent and maybe the rural providers are going to
22 be a little bit less than 20 percent.

1 MR. ARMSTRONG: So we would generally think this
2 chapter is covering something less than 20 percent of the
3 overall spend for the Medicare program?

4 DR. STENSLAND: Correct.

5 MR. ARMSTRONG: Okay, great. I just wanted to
6 get...

7 MR. BUTLER: So this is an older than average
8 population, if my memory serves me right, and I'm still
9 trying to get the profile of the post-acute care services in
10 the average rural community. Go to Slide 11.

11 You've done a nice job kind of slide by slide
12 walking through the post-acute sectors, but just as an
13 example, you know, it looks like about 40 percent of the
14 hospices in the country are in rural areas, yet you say the
15 use is lower. So, obviously, there are a lot of, a
16 disproportionate number of hospices but they're not being
17 used. They could be dinky hospices.

18 So my own visual sense of this is that there's
19 probably more dependency on SNFs than in urban populations,
20 less dependency certainly on IRFs, a little bit of
21 underutilization of hospice, and sporadic availability of
22 home care. But I'm trying to get the -- it might be as you

1 roll this up, you almost look at per capita spending by each
2 of these segments and compare it to the urban areas, and
3 just to get a sense of the dependency on the various post-
4 acute sectors in a rural area versus an urban area, because
5 I think it tells a little bit bigger story than just showing
6 the number of facilities and then one at a time the
7 utilization. It doesn't paint the bigger picture of what
8 the web of services are or are not available in the
9 community.

10 DR. STENSLAND: And I think we can -- that's a
11 good idea, to paint that bigger picture, and the picture
12 here we're painting is the provider picture, so you do see a
13 lot of home health, a lot of SNF use. There's kind of a
14 side picture we can present, which is the patient's picture,
15 and I think the patient's picture is a little different.
16 For some things, like you don't see LTCHs in the rural
17 areas, but rural people in Louisiana use LTCHs because they
18 get transferred out to the LTCH in the urban area. So
19 there's kind of two pictures there that we have to paint:
20 the picture of the rural providers and then the picture of
21 the providers that rural patients get their services from,
22 which are a little bit different.

1 MR. BUTLER: Well, as Tom would remind us, if
2 you've seen a rural area, you've only seen one rural area.
3 They're all a little bit different. But I'd ask him, is
4 that general, am I right that SNF is a bigger participant in
5 general in post-acute care?

6 DR. DEAN: I think that's a fair -- I mean, of
7 course, you know, I'm looking at it from a very sparsely
8 populated area, and it isn't necessarily typical. I'm in an
9 area that probably presents some special problems, but much
10 of what is in this category defined as rural is very, very
11 different from where I live. But where I live, yes, the
12 answer to your question is yes.

13 MR. HACKBARTH: Along, I think, the same lines as
14 Peter's comment about painting a picture, in terms of use of
15 physician services -- and Peter focused on the post-acute
16 care, but can we say something about where rural
17 beneficiaries go for physician services? But my impression
18 has been that they probably get more services from hospital
19 outpatient departments than people in urban areas. My
20 recollection from 2001 is that when you look at the
21 ambulatory visits, the rates are similar between rural and
22 urban, but the mix is somewhat different. Rural

1 beneficiaries are somewhat more likely to see advanced
2 practice nurses as opposed to MDs. So if we can sort of add
3 some more texture to the description, I think that would be
4 helpful.

5 MR. GEORGE MILLER: I, Glenn, to your point, I
6 think if I remember correctly, also the rural population is
7 older, they're sicker, they're poorer, and have other
8 attributes that probably their urban counterparts would not
9 have as well, and to add that context to the chapter might
10 be helpful as well.

11 DR. STENSLAND: We should clarify. You know, we
12 did talk about the demographics, I think in February, of the
13 population, so there are some differences in what we have so
14 far in that mailing that we think will end up in the final
15 report that we should discuss if people have issues with
16 that. First, whether they're sicker is we really found a
17 mixed bag depending on which measure you used. They look
18 healthier on HCC scores. They have more of some co-
19 morbidities, less of some co-morbidities, and we didn't see
20 a big rural/urban difference on the sickness. We saw a big
21 regional difference, like if you look in the south-central
22 states -- Kentucky, Alabama, Mississippi -- there you see

1 people poorer and sicker. And then on the income side,
2 there was some work by the USDA on that where they said if
3 you look at raw income, it's a little bit lower; but if you
4 adjust for the cost of living, it's actually higher. And
5 then if you look at wealth, especially farmers are way
6 wealthier. So it's more complicated than some of the
7 simpler story that we always hear.

8 We will have all that in detail in the report, and
9 you'll have a chance to comment on it, but I just wanted to
10 be clear that it might differ from the standard story.

11 DR. DEAN: Just on that point, after the report, I
12 went back and looked at some of that stuff, and it did
13 appear that there is a difference between the general rural
14 population and the rural Medicare population, and the
15 statistics that I saw at least were actually better for the
16 Medicare population. The thing that George just stated held
17 true for what I looked at if you looked at the rural
18 population in general. But when you looked at just the
19 Medicare population, what Jeff says, it wasn't as dramatic.

20 DR. MARK MILLER: [off microphone] And that's one
21 of the points we've been trying to make, is that sometimes
22 there's that basic description of the rural people that then

1 just kind of carries over into the policy conversation, and
2 there is this distinction -- in part there is this
3 distinction because that's what Medicare set out to do.

4 DR. DEAN: In some ways it's reassuring. I mean,
5 it testifies probably to the value of Medicare.

6 DR. CHERNEW: First of all, I want to support what
7 Peter said, even though he's running away, about the
8 population focus to some extent. But the question I had is:
9 You've structured this where you've gone through our normal
10 payment thing that we just went through on our long march
11 yesterday, but you didn't have anything about managed care
12 payment. Is that outside of the scope of how you think
13 about payment adequacy?

14 DR. STENSLAND: It has been so far. For this
15 report we haven't --

16 DR. MARK MILLER: There's a little more advanced
17 answer to that.

18 [Laughter.]

19 DR. CHERNEW: It was not a normative question. It
20 was a clarifying questions.

21 DR. MARK MILLER: Yeah. The Commission certainly
22 considers managed care. If you read the mandate, we've read

1 this to be asking us to pretty much focus on fee-for-
2 service. It's providers of services -- Jeff and Adaeze, I'm
3 blanking a little bit on the language. But your first plain
4 reading is tell us about fee-for-service, is sort of the way
5 we saw it.

6 MR. HACKBARTH: And I think that is a sensible
7 focus for this. Tom, do you have any further clarifying
8 questions?

9 DR. DEAN: I just wanted to follow up a little
10 more on the mortality rates. Are those risk-adjusted? I
11 mean, I guess the thing that comes to mind is that we see a
12 fair number of people with complicated illness who have
13 received a majority of their treatment in major centers, and
14 when the implication -- or when the effect of that treatment
15 has sort of run its course, they come back and we take care
16 of them. And if it's a terminal illness, they tend to die
17 in our facility. And so they, you know, come home to die.
18 It isn't huge numbers. Of course, we don't have huge
19 numbers. It's a very small facility. But it is a
20 phenomenon that we see, and I wonder if that is reflected in
21 these numbers.

22 DR. STENSLAND: We're using the AHRQ risk

1 adjustment method, which is based on the 3M method, so it is
2 risk-adjusted. But I guess you're asking is there some sort
3 of omitted variable where there's some sort of severity of
4 illness which isn't picked up in that risk adjuster which
5 also sorts people that rural folks are more likely to go to
6 the hospital to die than urban folks? It is possible.

7 MR. GEORGE MILLER: I think what Tom is asking is:
8 Is there a way to track where that person got care? If they
9 got the majority of their care in an urban area and then
10 chose to come back and die -- they didn't choose to, but
11 they came back to the rural facility and died there, the
12 majority of the care was given in an urban area. Is there a
13 mechanism or a way to track the census track or another way
14 to track where they got the majority of their care? I think
15 that's the genesis of Tom's question.

16 DR. DEAN: I think if I -- and, I mean, you can
17 tell me if the statistical logic is right, but I think that
18 would tend to -- as a proportion of our total activity, the
19 total care we give, I think that would make our mortality
20 rates look higher.

21 MR. GEORGE MILLER: Correct. Isn't that the
22 genesis why the MS-DRGs were changed so that the severity of

1 the care -- yeah.

2 MR. HACKBARTH: [off microphone] -- would this be
3 beyond what you would capture through that sort of severity
4 adjustment.

5 DR. BORMAN: I certainly don't know any data
6 source for that, but having been on the receiving end at the
7 intake to come for the big care, I guess I would say back to
8 you that it's oftentimes extraordinarily hard to get those
9 people back to their originating care area. So that while I
10 absolutely accept that in your practice and experiences
11 you've seen the traffic in that direction, I assure you that
12 it also stays -- there's a fair amount of them that stay.

13 So I would hope that, by and large, it's a wash
14 because I think this would be incredibly hard to tease out
15 the motivation for a transfer. It's kind of like trying to
16 figure out people that made -- a family or a patient made a
17 decision to withhold or withdraw care we can't really tease
18 out very well from the mortality. I think this would be
19 incredibly hard to ascertain, and I think it goes both ways.

20 MR. HACKBARTH: Well, that's what I was just going
21 to say. There's also potentially some sorting not detected
22 by severity adjustments going the other direction. There

1 are patients that are especially difficult and challenging
2 that, you know, on paper it looks like the same MS-DRG, but
3 the clinicians are saying, "Boy, they really need to go to
4 the urban hospital."

5 DR. DEAN: I'm saying it's those patients who have
6 had their care in the urban center and have reached a point
7 where the decision has been made --

8 MR. HACKBARTH: I understand that. You're saying
9 that the rural mortality may look artificially high because
10 of that sorting --

11 DR. DEAN: Because they're coming back after --

12 MR. HACKBARTH: But it also could be true that
13 there are patients in a rural hospital that are sent to
14 urban centers because of the difficulty and they die there.
15 That makes the rural mortality look lower.

16 DR. DEAN: As Peter said, you know, I'm sure it
17 works both ways, but at least in my experience we certainly
18 see the former.

19 DR. HALL: No comments.

20 MR. KUHN: I want to thank both of you for a good
21 year of work, and this is a wonderful summation of kind of
22 where we are. And I think picking up on something that Jeff

1 said at the end of his presentation that the underlying
2 story has changed from the report that was produced in 2001
3 to the one we're going to produce in 2012. And I think as
4 we sit through and listen to the recitation of all the
5 reports and a summary of the data that we've seen in the
6 past, I think there's a good story to be told here that
7 Medicare has brought a lot of stability and a lot of
8 predictability to the rural areas and rural care that's out
9 there.

10 And I can see a report that could be constructed
11 where we could catalogue the changes that have occurred over
12 the last decade and perhaps not a lot of recommendations.
13 We might have some. We see the information here on
14 dialysis. There might be some others. But rather than
15 folks that thought this might be a report that's real robust
16 with a whole new set of recommendations that will be the
17 road map for the next decade of all these changes in rural
18 health care, that might not necessarily be the case given
19 some of the data that we've looked at and some of the areas
20 that were there.

21 But having said that, you know, one area that
22 might be helpful for us to look at in this report as we

1 continue to go forward is as a little bit of predictive of
2 what we might see in rural care over the next decade and, in
3 particular, access, picking up a little bit of something
4 that Glenn had made an observation to one person's question
5 or comment, is that, you know, we look at the data in terms
6 of on access, and we know we have a deficit of providers,
7 particularly physicians in rural areas, but care is
8 basically equal because people are willing to travel to get
9 care that's out there.

10 One of the things I know I raised when you
11 presented that data the first time is was there a way we
12 could stratify that data by physician age, the notion being
13 that perhaps a lot of these physicians that are practicing
14 in rural areas are a lot older than in urban areas. We've
15 done some of that work in Missouri, and it is indeed the
16 case. And so we will probably start to see some retirements
17 over the next decade, and could that lead us to a position
18 where we might have even greater access issues that are out
19 there?

20 Picking up a little bit on what Glenn said in
21 terms of primary care access with APNs and PAs, you know, I
22 go back to some of the data we looked at in the December

1 meeting when we were looking at access, when we were looking
2 at physician payment, and the survey we did of the Medicare
3 beneficiaries and those that were below Medicare, but fully
4 a third were now getting primary care from an APN or a PA.

5 So as we go through this report, if it's not going
6 to be a real major robust report with a whole lot of policy
7 recommendations because that may be directionally where we
8 don't need to go, one of the things that might be helpful, I
9 think, for the rural community overall but for the Medicare
10 program is if there is any kind of predictive modeling we
11 can do in some of these areas, particularly in access, and
12 look at what might be out there, at least give some
13 policymakers some things to begin thinking about. Are there
14 different ways that we might want to think about medical
15 education or different aspects to make sure that we deal
16 with that inevitability that's going to occur in that space.

17 MR. HACKBARTH: So as we go around in the second
18 round, one thing that would be helpful to get people to
19 react to is the plan for this report, and our sense right
20 now is that we will report data responding to the specific
21 questions asked in the mandate. We will outline principles
22 but not have bold-faced recommendations on which we vote.

1 So that's our plan to this point, and I'd invite people to
2 react to that.

3 Then just a question about the physician age
4 issue. Are there reliable national sources of information
5 on physician age that could be used to look at that?

6 DR. BORMAN: A huge number of the specialty
7 organizations are already reporting that for various
8 purposes, and I suspect the AMA Master File also would be
9 places. But there's aging of physicians and a whole bunch
10 of things both in terms of location and in terms of
11 specialty. So I think those data are pretty accessible.

12 MR. HACKBARTH: Well, I have often heard the point
13 made that Herb just made, that this is a particular issue in
14 rural areas. It sounds like you've done it in Missouri. If
15 we can shed some light on that on a national basis, that
16 might be an important contribution.

17 DR. NAYLOR: Let me just echo much of what Herb
18 has just said. I think that this is a good story for
19 Medicare, and I would highlight where you can, it's a good
20 story for MedPAC, and maybe thinking about superimposing
21 when recommendations went into play right on top of where we
22 began to see these migrations in margins I think would be

1 terrific.

2 I think Peter's point about this being a story
3 about post-acute care and where there are lessons learned
4 here about the capacity to substitute other services, so not
5 having IRFs doesn't mean that people can't get access,
6 because your big story is about quality. And I think that
7 the quality measures and satisfaction measures look good.
8 So does that mean that there are opportunities here for a
9 continuum of post-acute services, et cetera?

10 I do think, picking up on the hospice, both access
11 on one hand and little utilization on the other is an area
12 for further exploration.

13 And the recommendations about, you know,
14 predictions of the future and future directions I think is
15 really important because in your proposed efforts around
16 targeting payment where we're continuing to see maybe great
17 opportunities that are on the one hand unmet and
18 opportunities for savings where we have duplication of
19 payment, you know, options or two hospitals right next to
20 each other I think are very, very important.

21 I would also say this is a good-news story for
22 Medicare and HRSA because HRSA has placed a tremendous

1 amount of its attention on building the primary care
2 workforce, and one of the reasons we have 33 percent APNs
3 and PAs but many more proportionally in rural areas is
4 because of the kind of combination of efforts on the payment
5 and workforce delivery effort. So I think it would be great
6 to highlight that as well.

7 MS. BEHROOZI: I think you've done a great job of
8 organizing the discussion and stating the principles in ways
9 that I think we can all support. And I know that this is
10 not something that you can change -- you know, the horse is
11 already out of the barn on this one, but, you know, kind of
12 consistent with Scott's question, it's not really a
13 comparison between rural versus urban. It's rural versus
14 everybody else. And in that 80 percent there is a huge
15 amount of variation both in terms of where people live and
16 what their access to services is. And I fully recognize
17 that, you know, this was a congressional mandate and there
18 were important reasons that MedPAC made the recommendations
19 that it did, lots of which had to do with access and quality
20 for beneficiaries living in areas where they didn't have
21 sufficient levels of access and quality. But as we, you,
22 all move forward, I wonder if there will be an opportunity

1 to consider truly urban areas where there are problems of
2 access and quality, there are problems of low health status
3 because of socioeconomic status, because of conditions that
4 people live in, and really separate out the high-density,
5 low-socioeconomic status areas from, you know, greater
6 metropolitan statistical areas and suburban areas and places
7 like that that I think probably bring that overall so-called
8 urban, the everybody else level up, and it's great to bring
9 urban -- I'm sorry. It's great to bring rural to that
10 level, but it would also be really good to bring true urban
11 up to that level.

12 Thank you.

13 MR. GEORGE MILLER: Yes, I concur with everything
14 that has been said. I think this is, although it's
15 mandated, it's still a very good report and I think it is
16 fair and balanced and it certainly deals with what Mitra
17 just illuminated, dealing with the issues of access and
18 quality for rural areas, and I certainly want to thank the
19 staff for the efforts that have been done to date.

20 I would agree with Herb in that I'm not sure there
21 necessarily needs to be recommendations, but certainly fine
22 tune around the edges. And I also agree that this is a

1 success story not only for the Medicare program but for
2 MedPAC recommendations. If you look back to 2000 and where
3 we are today, and again, except for tweaking around the
4 edges, I think there are successes, and particularly to the
5 point about mid-level practitioners. In most rural areas,
6 we live and die with mid-level practitioners to certainly
7 help augment and support the physicians who provide care in
8 the area. That also is a success story in many ways. Where
9 we can't recruit physicians, mid-levels have stepped into
10 that gap, still supervised and overseen by the physicians,
11 but still provide a valuable service.

12 I think the other thing as we move down this path,
13 what Mitra said, is that -- and I agree with her, because
14 she hit right in my sweet spot, dealing with disparities and
15 inequities and pockets, whether they be in urban areas,
16 rural areas, or wherever they be. We certainly should pay
17 attention to those beneficiaries that may fall through the
18 cracks or are not meeting that same standard of access and
19 quality no matter where that beneficiary is, and certainly
20 at some point we'll focus on that, as well. So thank you.

21 DR. CASTELLANOS: I just want to comment that I
22 totally agree with what's said. I just go back to

1 yesterday's discussion. I think maybe this is a good
2 example of a targeted approach to solving some problems in
3 the Medicare system and we may want to consider that in the
4 safety net hospitals, et cetera. I know that was a real
5 concern yesterday concerning care, as George said and as
6 Mary said, as Mitra said.

7 MR. GRADISON: I think it's wise to stick with the
8 principles rather than recommend specific changes in the
9 programs. However, having said that, I think this
10 information will not only be responsive to the Congressional
11 request, but also extremely helpful to us as we have to deal
12 each year with decisions by the silos, because it gives us a
13 little more color, a little more flavor and detail about the
14 rural, frontier, and the other categories of non-urban
15 institutions or non-urban settings than we might otherwise
16 have. So I think we're going to get a lot of value out of
17 it here, but it may not be so much from just looking at
18 rural as it is looking at SNFs or looking at hospice or
19 other categories.

20 DR. BORMAN: After almost six years, I'm sort of
21 out of adjectives and adverbs to say what really fine staff
22 work this represents, and it is just another example of

1 that. We should celebrate that ongoing work.

2 I think we also celebrate this as a success story
3 of identifying a problem that interventions -- that we
4 recommended things. Interventions were undertaken, albeit
5 perhaps in a patchwork quilt way, as so often health care
6 policy is, and yet we have a good outcome, and we should
7 celebrate that in this instance, the process will work well.

8 I think that maybe the view to take of where we go
9 next is really more a phase of refinement and to think of it
10 in that way, and that because of the success, we can now
11 focus on refinement. So refinement is things like Herb
12 mentioned. What are the things that are high points to
13 monitor for the future? Where do we think the flash points
14 may be, so that we don't end up so far behind the eight-ball
15 that we did that led us into this era, this phase of
16 activity that we've had. So that would be one.

17 Secondly, I think the targeting the dollars to the
18 best effect is something that we've tried to look at
19 pervasively in all the areas of the program, and I think to
20 the extent that we can comment on that in this particular
21 report in a very positive way -- we've done the experiment
22 here where we've done a number of kinds of programs. Where

1 have been the best results and how best do we target to
2 ensure that?

3 And then, finally, I think that as we're in this
4 refinement phase that we've shown, somewhat surprisingly in
5 some areas, perhaps, that, by and large, we are providing
6 equivalence as a result of these good interventions. So now
7 the driving metric, it seems to me, is quality. And as
8 we've defined, what are the appropriate -- or how do we
9 appropriately say what applies in these different population
10 efforts, and I think I continue to support the urgent versus
11 non-urgent services as good a break as we can come up with -
12 - there will be no perfect one -- that now we -- as long as
13 we monitor that access is still out there, then I think the
14 important thing that we follow is being more rich or more
15 deep about quality, making sure we've got that part right,
16 making sure that we're incentivizing as we look to targeted
17 payments and all the other things that we do, make sure that
18 those now incentivize quality appropriately in these areas.
19 That would be the driver, I think, that we would want to
20 conclude, also, for going forward. But this is really great
21 work.

22 MR. ARMSTRONG: So I, too, I don't have the six

1 cycles that Karen has of going through this, but would
2 affirm that the report that you've pulled together is really
3 outstanding.

4 I also would echo that it seems that we had an
5 issue. We targeted solutions through payment policy and
6 we've had a real impact, and I think we have a lot to learn
7 from that.

8 I would, however, just acknowledge that the
9 payment structures we have for rural markets are really
10 complicated and kind of confusing and that I have to believe
11 that there's inefficiencies in it and that the principle
12 that you have with respect to avoid duplicating payments, I
13 think, is a little light. I think that while we've gotten
14 to where we are right now, in the years ahead, I think we
15 should aspire to rationalizing and simplifying without
16 screwing up what we've done. So I just would want to add
17 that point.

18 And then, second, our point of view around rural
19 services seems to be how can we through our payment policy
20 keep it from being -- keep our beneficiaries from being,
21 like, harmed by the special concerns that care delivery
22 providers have in rural communities. And at some point, I

1 would hope we could flip that a little bit and recognize
2 that care delivery systems in rural communities actually
3 achieve spectacular results given limited resources and that
4 there's probably a lot to be learned from that.

5 I mean, Tom and others have talked about the
6 creative use of mid-level providers, you know, kind of
7 actually replacing post-acute services, one for the other,
8 depending upon what's available and what really works. I
9 mean, some of those kinds of things, I think in the years
10 ahead, could actually offer insight into the ways in which
11 we evolve our payment policy in urban areas, and so just a
12 thought on that.

13 DR. BAICKER: I agree with Scott that the
14 principles make a lot of sense and could even be dialed up,
15 that we want to, even better than parameterize, rationalize,
16 as you said, the payment structure. These overlapping
17 payments can't be efficient and aren't particularly good at
18 targeting. As you pointed out, the goal is to target sole
19 providers, and I might add in, with the explicit goal of
20 guaranteeing access or promoting access, that it's not just
21 because you're one, it's because you're what stands between
22 the beneficiary and not getting access to care of acceptable

1 quality and that that acceptable quality may vary across
2 circumstances, emergency versus non-emergency. But to
3 harmonize those payments so that we are effectively
4 targeting that particular goal would make the policy much
5 more effective.

6 MS. UCCELLO: Yes. Agreeing with Scott and Kate,
7 although there's a lot of good news in here, we have shown
8 that we're not -- we could target better. We could refine
9 things so they are more empirically justified, you know,
10 base things better. So it's not like there's nothing to
11 worry about here. There's still some room for improvement,
12 and so we need to keep that in mind.

13 But I agree in general with just sticking to these
14 principles and laying those out and I think the ones that
15 you've listed here are really excellent.

16 And just adding to the chorus of everyone here,
17 thank you so much for the tremendous work you've done over
18 the past year-and-a-half or longer working on this stuff.
19 It really shows.

20 MR. BUTLER: Okay. Enough of this
21 congratulations. I want to set the bar even higher for the
22 final draft --

1 [Laughter.]

2 DR. MARK MILLER: [Off microphone.] It looks like
3 we're out of time.

4 [Laughter.]

5 MR. BUTLER: But let me tell you why. I'm
6 reminded frequently that we're working for Congress, and in
7 an area like this, this was not just the normal business.
8 This was a specific request by a lot of important members of
9 Congress, Senators that represent primarily rural States,
10 Representatives that sit in primarily rural areas. I think,
11 so more than ever, think about the final draft as something
12 that is not only addressing the points, but something they
13 can use for a communication vehicle for their
14 Representatives, or if they were to come out and sit with a
15 SNF administrator or a hospital administrator or a community
16 group, it would kind of make sense to them.

17 And that's kind of one of the reasons I mentioned
18 the post-acute profile. Make it -- this is a great
19 opportunity to cast just a little different light on it and
20 make sure it can be used effectively in many forums, because
21 these are a lot of important people in Congress and the more
22 you can kind of -- I won't say "dumb it down," even though I

1 just did, because I don't really mean that because it's
2 complicated and it does need to include the kinds of points
3 Scott made, as well, if you want to dive deep around there.
4 But I think it is a great opportunity to make the best of a
5 chapter and go beyond addressing a technical policy issue
6 and communicating a message.

7 DR. DEAN: I certainly agree with the principles
8 that were laid out. I think that they really direct
9 appropriately the direction that our inquiry should go.

10 I appreciate, obviously, what Scott just said, but
11 I'd make the point that -- and one of the things that I have
12 found appealing about rural practice is there are things you
13 can do in small systems that are very much more difficult in
14 larger systems, and the net effect of that is that they are
15 tremendously dependent on whatever capabilities or
16 leadership or whatever is there in that particular setting.
17 And if you have those capabilities, you can do great things
18 relatively easily. If you don't have it, things can get
19 real bad in a hurry.

20 For instance, in our own setting, every morning,
21 we meet with all the physicians, the nursing staff, physical
22 therapy, and social service. We all get together and we go

1 over every patient in the hospital. And our readmission
2 rate is somewhere around four or five percent and I think
3 it's due to that issue. We all know what's going on. If
4 there's a problem, we'll -- you can't do that in most
5 facilities. I mean, it's just out of the question.

6 So I think that we have some opportunities that
7 have nothing to do with the particular capabilities but just
8 it's possible to do things in that kind of a setting that
9 you can't do in bigger facilities.

10 I guess having said that, I do have some concerns
11 about some of the statements. I'm not sure that just
12 measuring number of services is really the answer in terms
13 of defining access. I think it certainly is an important
14 measure, but it doesn't say anything about the timeliness of
15 those services and how quickly people reach. I mean, for
16 instance, I would say that, basically, everybody in most
17 rural areas that has an MI eventually gets the care. The
18 question is, do they get there in ten or 15 minutes or do
19 they get there two or three hours later? There's all kinds
20 of ways you can do it. But I think to really determine
21 access, I think we need to tie it to some kind of outcome
22 measures, as well, to validate that and to see if it's

1 important.

2 Also, as Peter said, there really is tremendous
3 variation and I think we probably need to get to look at the
4 range of variation across the country, because there are a
5 lot of geographical differences and we've tended to look at
6 averages, which I've mentioned before, which frustrate me,
7 but which are sometimes useful, but I think also can hide
8 variation. We need to look at how much variation there is
9 in each one of those measures, from the best to the worst,
10 and determine if that's a narrow span, then the
11 generalization is clearly justifiable. If there's a wide
12 span, then I have a little more concern about it.

13 I think we looked at some of the cost issues
14 related to Critical Access Hospitals, and as I've said
15 before, the CAH program has been a tremendous boon and I
16 think has really stabilized care in many rural areas. At
17 the same time, it has been criticized, legitimately, because
18 there probably are a number of facilities that qualified
19 where you could really question whether they met the basic
20 intent.

21 Also, I think sometimes we jump to the conclusion
22 that, well, if they have cost-based reimbursement, they're

1 automatically financially stable. The numbers are that a
2 substantial portion of CAHs also have negative margins,
3 something like 40 percent of them was the number I saw.
4 That's not immediately an issue, but I think we just can't
5 assume that they are automatically living easily, or that
6 it's an automatic sort of gravy train, because there are
7 still stresses out there. And I think the concern has been
8 raised that that takes away any pressure for cost control.
9 I don't think it's that simple. Certainly, I know in our
10 setting, our administration does worry about cost
11 considerably because they do have negative margins about
12 half the time.

13 Finally, I guess the other thing which I have
14 raised before, in some of these, especially the home health
15 area, which I'm sure you're tired of hearing me talk about,
16 we really need to look at the total spectrum of home health
17 agencies and not just freestanding ones. In South Dakota,
18 and you've heard me say this before, there's two-thirds, at
19 least, of our home health facilities are associated with
20 Critical Access Hospitals and aren't even included in the
21 analysis that we do in terms of margin. Now, I understand
22 there are problems with measurement, but to make the

1 generalization that rural home health agencies have the same
2 margin is, I don't think, accurate. At least, it's not
3 accurate in the areas that I'm most familiar with. So I'm
4 not exactly sure how you do that, but in South Dakota,
5 freestanding facilities only exist in about ten percent of
6 the counties and the rest of the State is all dependent on
7 provider-based facilities. So I just think there is a
8 deficiency. I'm not sure just how to solve it, but it is a
9 concern.

10 Overall, I agree. There's a lot of very useful,
11 and I think there's been a lot of progress. And clearly,
12 the recommendations that have been made have moved the whole
13 state of rural health care forward considerably and it's, in
14 general, much more solid than it was when I started practice
15 quite a few years ago.

16 The recruitment issue is a real worry, but it's a
17 worry across the country. That's not a real -- isn't
18 uniquely rural, although it is a particular concern because
19 we are so dependent on primary care physicians and they are,
20 obviously, as everybody knows, the group that's in most
21 demand and in smallest supply.

22 So, anyway, I'll stop there.

1 MR. HACKBARTH: Tom, the point about variation,
2 which I don't disagree with, for me, the challenge is
3 figuring out how to deal with it. So one approach to not
4 just talking about rural averages is to subdivide rural into
5 subcategories -- micropolitan, adjacent to urban, not
6 adjacent to urban. We sometimes use the frontier
7 classification to try to give a flavor for the varieties of
8 ruralness that exist.

9 Another more sort of statistically-minded approach
10 to variation is to, with everything, report not just the
11 median or the mean, but the standard deviation and all that
12 stuff. I'm not sure that that really helps a whole lot of
13 readers. There are certain readers that look at that and
14 it's very meaningful to them. It isn't particularly
15 meaningful to me. And if you have to do that for every
16 statistic reported, you've got this incredibly challenging
17 to present and read document.

18 So I agree with your basic point. I don't know
19 how to solve it.

20 DR. DEAN: I guess I would respond that we have
21 done this in some just reporting 25th and 75th percentiles
22 or something along those lines, in terms of whether it's

1 utilization or whatever. I think that's sort of the first
2 cut and that may or may not qualify with these other
3 categories, you know. We sort of assume that the more
4 sparsely populated, the worse it would be. In some cases,
5 that's clearly true, but obviously, in other cases, it's not
6 true, and --

7 MR. HACKBARTH: [Off microphone.] Jeff, can you
8 put up Slide 11? Oh, I'm sorry. So it could be any one of
9 these tables.

10 DR. DEAN: Yes.

11 MR. HACKBARTH: So if we now subdivide, in this
12 case, the rural into three categories and show -- are these
13 means or medians here? Are these medians, Jeff, the
14 Medicare margin numbers?

15 DR. STENSLAND: Aggregates, because we're adding
16 together all the payments -

17 MR. HACKBARTH: Oh, that's right, because we're
18 just combining them all together. Yes. So with that
19 approach -- I'm statistically challenged here. So you can't
20 even report the 75th and the 25th percentile here. This is
21 the aggregate of the whole pool.

22 DR. STENSLAND: Yes. We could also present the

1 75th and 25th as a separate way of doing it. It would just
2 triple all the numbers in here.

3 MR. HACKBARTH: And that's the point that I'm
4 headed to. If you imagine for every table that we're doing
5 that, do we have a document that is readable? Mike, can you
6 help me out?

7 DR. CHERNEW: Well, it might be useful, and maybe
8 not for all of these, to have a sort of scatterplot or some
9 other type of graph that just shows the range, because what
10 you really want to know -- I think what the comment is, is
11 if there's big outliers one way or another that's pulling
12 these averages down. So if you saw they're basically the
13 same but there's a few in some weird place, you could
14 actually look at them.

15 I don't think that's useful for the report, but
16 what it might be useful to do is to look at so then when
17 someone asks a question, you can say, this looks like
18 distributions that are just shifted, which is sort of what
19 you get when you think about it, or they're pretty much on
20 top of each other with a few outliers, particularly the one
21 that has the 17 and the 13 observations and you can't tell.
22 If you looked at where they were distributed, you would get

1 some sense of whether they're really just systematically
2 different distributions or there's just something going on
3 with the sampling. But once you know what the answer is
4 substantively, I would then simplify it for the
5 presentation.

6 DR. DEAN: Yes, I would agree with that. I think
7 as a test to see, for instance, these three criteria,
8 micropolitan, adjacent, and non-adjacent, is that really
9 telling us what we need to know? I think as an example, in
10 the chapter we looked at, I guess it was last time, about
11 home health, there was that table that listed 23 of 25, or
12 whatever it was, most expensive areas were all rural. Well,
13 that was -- they were also all located in a very close
14 geographic area, and I think the problem was not that they
15 were rural, it was that they were in a particular geographic
16 area because -- so I think we -- it's just as a measure,
17 because I think if you looked at those same data, there was
18 a wide spread in terms of cost.

19 MR. HACKBARTH: The point about the home health
20 margins, I very much agree with you. To me, that seems like
21 a little different issue --

22 DR. DEAN: Yes --

1 MR. HACKBARTH: -- and to me, that's one --

2 DR. DEAN: [Off microphone.]

3 MR. HACKBARTH: Yes. Well, actually, I think it
4 is a major issue, and my comment when it got around to me
5 was going to be that I think one of the things that should
6 be really highlighted here is the artificiality of this
7 urban-rural distinction, and there is a huge amount of
8 variation. For example, this home health statistic, the
9 regional variation swamps the urban-rural variation.

10 DR. DEAN: [Off microphone.] That's right.

11 MR. HACKBARTH: And we have these policy
12 categories that are driving lots of dollars that in some
13 ways are artificial.

14 MS. BEHROOZI: Well, and then isn't it the same
15 thing on the rural side --

16 MR. HACKBARTH: On the urban side.

17 MS. BEHROOZI: I'm sorry, on the urban side.

18 MR. HACKBARTH: Yes.

19 MS. BEHROOZI: So if you're going to compare
20 apples to apples, I mean, you're still going to get the
21 washout of urban being a bigger group, but then you should
22 also do 25th to 75th on the urban side. You can't just do

1 25th to 75th on the rural side and compare it to the average
2 on the urban side.

3 MR. HACKBARTH: Right. Right. Right. Yes.

4 [Off microphone discussion.]

5 MR. HACKBARTH: Okay. Were you finished, Tom?

6 Any other points, Bill?

7 DR. HALL: Pass.

8 MR. HACKBARTH: Bob?

9 DR. BERENSON: I was going to make the same point
10 about the regional variations being very striking and not to
11 minimize that. I guess what I'd say is where a sub-analysis
12 looking at the variation is very revealing of something,
13 then it goes in, but not routinely. In other words, where I
14 have -- based on everything I've heard, I have great
15 confidence that you guys have control over this paper and
16 would be able to identify those instances where that kind of
17 an analysis would actually add something versus -- and just
18 not doing it routinely, just as a matter of statistics. But
19 I think this is in very good shape.

20 MR. HACKBARTH: Okay. Thank you very much. Very
21 good work.

22 And we'll now have our public comment period.

1 [No response.]

2 MR. HACKBARTH: Okay. I think we are done. Thank
3 you all. See you in March.

4 [Whereupon, at 11:52 a.m., the meeting was
5 adjourned.]

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