

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:  
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MICHAEL CHERNEW, PhD, Vice Chair  
SCOTT ARMSTRONG, MBA, FACHE  
KATHERINE BAICKER, PhD  
PETER W. BUTLER, MHSA  
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HERB B. KUHN  
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MARY NAYLOR, PhD, RN, FAAN  
RITA REDBERG, MD, MSc, FACC  
CRAIG SAMITT, MD, MBA  
CORI UCCELLO, FSA, MAAA, MPP

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

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

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

12 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

7 DR. HAYES: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

1 Statistics.

2 BLS collects data on the earnings of workers in  
3 most, if not all, occupations. However, in work for this  
4 report, we found that the data on physician earnings are:  
5 first, sparse at the level of individual specialties in  
6 smaller urban areas; second, limited by having censored  
7 responses at upper-income levels -- those greater than  
8 \$187,200 per year; third, the data include wages only and  
9 omit benefits; and, fourth, they include earnings of  
10 residents and fellows.

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

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

22 The first analysis compared physician earnings in

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

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

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

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

17 For internal medicine physicians, we see a similar  
18 result: an average wage index of 1.06 in rural areas but  
19 0.99 in metropolitan areas.

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

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

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

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

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

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

22 The data have limitations: censoring, earnings of

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

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

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

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

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

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

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

8 Kate will now discuss another alternative to the  
9 work GPCI.

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

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

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

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

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

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

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

1 rationale for adjusting wages geographically.

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

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

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

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

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



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

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

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

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

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

1 care.

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

12           So you might be surprised that we do not see an  
13 effect of the work GPCI on access to care. To help explain  
14 that finding, this is the chart that Kevin showed you last  
15 month that shows the impact on spending of the work GPCI  
16 with its upwards and downwards adjustments. Overall, the  
17 average change in payments due to the GPCI is around 1.2 to  
18 1.4 percent. The maximum change is plus four and the  
19 minimum change is around minus three percent. That is  
20 excluding Puerto Rico. So the relatively small size of the  
21 adjustment may be the reason that we don't see any real  
22 differences in access across low and high GPCI areas.

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

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

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

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

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

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

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

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

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

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

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

1 earnings.

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

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

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

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

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

1 system.

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

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

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

8 [Laughter.]

9 MR. HACKBARTH: So ordered by the Chair.

10 [Laughter.]

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

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

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

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

12           So that was my summary. Is that accurate?

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

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

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



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

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

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

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

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

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

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

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

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

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

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

22 DR. HAYES: Yes. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 DR. HAYES: That's --

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

12 Then a follow-up question to that is to what  
13 extent is the GPCI already baked into the differences that  
14 we're seeing between rural and urban here, in the sense that  
15 the pattern is a little reversed from what we would expect  
16 to have seen and what we do see in the reference professions  
17 --

18 DR. HAYES: Mm-hmm.

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

21 DR. HAYES: Right.

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

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

3 DR. HAYES: Yeah --

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

6 DR. HAYES: Yeah. I would say that it's too  
7 small, in general, to worry about in the sense that -- and  
8 the data here, once again, are not as current as we'd like  
9 for them to be, but physicians vary in the extent to which  
10 their revenue stream is dependent on Medicare, and it  
11 varies, say, by specialty. So the data we have now on this  
12 go back ten years anyway, but specialties such as family  
13 medicine, internal medicine, are more in the area of 20 to  
14 25 percent of their revenue is coming from Medicare,  
15 whereas, as you would expect, other specialties, such as  
16 orthopedic surgery, ophthalmology and cataracts, are more in  
17 the area of 50 percent.

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



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

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

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

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

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

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

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

19 MR. HACKBARTH: Facilities --

20 DR. HAYES: Pardon me?

21 MR. HACKBARTH: Facilities --

22 DR. HAYES: Facilities, resources and facilities,

1 call, that kind of thing.

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

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

10 MR. HACKBARTH: Yes.

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

13 MR. HACKBARTH: It does.

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

16 MR. HACKBARTH: Right.

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

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

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

8 DR. HAYES: The floor was in the Medicare  
9 Modernization Act of 2003 and actually implemented in 2004.  
10 The before and after look was -- the before look was our  
11 access report, our rural report in 2001, I believe, with  
12 1999 data -- correct me if I'm -- okay. And then the more  
13 recent analysis was in our July 2012 report, and that was  
14 based on data in 2008, I believe.

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

17 DR. HAYES: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

10          DR. HAYES: Yes.

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

14          DR. HAYES: Yes.

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

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

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

9           DR. HAYES: Right. So for those five workers, my  
10 understanding is that the BLS would adjust upward all the  
11 wages for all five workers and say, Okay, well, if they had  
12 -- depending on the actual hours that they worked, if we  
13 inflated them up to a full annual rate of hours worked at  
14 2,080, what would they have been paid? What would their  
15 annual earnings have been?

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

19           MR. GEORGE MILLER: Right, okay.

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

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



1 everything equally?

2 MR. HACKBARTH: Apples to apples.

3 MR. GEORGE MILLER: Thank you.

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

8 MS. BLONIARZ: It is.

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

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

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

17 MS. BLONIARZ: That's right.

18 DR. CHERNEW: And then this is the 9th to the  
19 10th, but this is done, if I understand correctly -- that's  
20 my question -- without the floor?

21 MS. BLONIARZ: That's right.

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

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

3 MS. BLONJARZ: That's right, that's right.

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

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

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

17 MR. GRADISON: Thank you.

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

20 MR. HACKBARTH: The one quarter.

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

1 MR. GRADISON: Thank you.

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

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

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

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

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

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

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

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

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

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

4 DR. COOMBS: Thank you.

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

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

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

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

21 MR. HACKBARTH: Very good, Craig.

22 [Laughter.]

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

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

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

1 I'd be nervous even about market fees.

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

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

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

1 that I would advocate for.

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

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

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



1 compensation survey approach. Cori?

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

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

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

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

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

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

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

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

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

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

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

1 options.

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

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

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

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

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

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

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

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

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

1 about it. Rita?

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

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

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

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

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

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

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

9 DR. HALL: Okay. Thank you

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



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

9           The other point that I want to raise is that  
10 eliminating the floor, which is understand the context, but  
11 that's still a half million dollars -- a half billion  
12 dollars, if I remember the number correctly, a half billion  
13 dollars. And for those of us who use those dollars to  
14 recruit physicians, with that going away, the graph on page  
15 8 shows that there seems to be equity in payment, or maybe  
16 even rural physicians may get even a little more money than  
17 those that you listed. With this going away, what would be  
18 that impact? Because that's a half billion dollars we will  
19 not have with the floor going away.

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

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

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

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

16 MR. GEORGE MILLER: Right.

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

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

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

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

12           On your first question, George, about visits not  
13 being the only way to measure access, we do measure access  
14 as part of our update analysis using different tools,  
15 importantly a beneficiary survey. So each year we survey  
16 4,000 Medicare beneficiaries about their access to services  
17 and 4,000 people who are in the age group just before  
18 Medicare eligibility, and then we do some breakdowns of  
19 that.

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

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

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

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

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

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

21           DR. HAYES: Which surveys are you referring to?

22           DR. MARK MILLER: Telephone.

1           MR. HACKBARTH: The telephone surveys of Medicare  
2 beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

9 DR. CHERNEW: Thank you.

10 [Laughter.]

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

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

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

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

1 several reasons for this.

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

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

12           MR. GRADISON: It would go away.

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

15           DR. MARK MILLER: What goes away.

16           MR. HACKBARTH: Yeah, so --

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

19           MR. HACKBARTH: Okay.

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

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

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

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

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

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

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

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

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

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

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

1 would take about \$30 off that payment amount.

2 MR. HACKBARTH: Okay.

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

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

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

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

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

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

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

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



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

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

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

1 areas that have demonstrable problems.

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

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

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

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

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

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

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

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

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

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

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

18           MR. WINTER: March.

19           DR. MARK MILLER: March.

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

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

3 MR. HACKBARTH: Okay --

4 MR. WINTER: -- during the discussion --

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

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

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

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

1 that correct?

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

12 So that's a quick summary. Yes.

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

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

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

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

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

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

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

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

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

22           Second, patient severity may differ between



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

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

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

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

1 program spending as well as beneficiary cost sharing.

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

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

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

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

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

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

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

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

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

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

1 more so than does the Physician Fee Schedule.

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

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

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

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

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

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

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

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

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

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

9           The second column shows that if this service is  
10 provided in an OPD, total combined payments from the  
11 Physician Fee Schedule and Outpatient PPS is \$319, which is  
12 123 percent higher than the total payment in a free-standing  
13 office.

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

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

3           And we have performed simulations of the effects  
4 of the payment policies illustrated on the previous two  
5 slides. Aggregate effects of these policies include that  
6 program spending would decline by about \$900 million per  
7 year and beneficiary cost sharing would decline by about  
8 \$250 million per year.

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

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

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



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

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

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

22           Obviously, these 100 hospitals would lose more

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

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

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

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

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

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

22           A second issue is that some have argued that the

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

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

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

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

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

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

21           DR. ZABINSKI: That's correct, yes.

22           MR. HACKBARTH: And then hospitals with fewer than

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

3 DR. ZABINSKI: Correct, yeah.

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

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

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

13 DR. ZABINSKI: It did not.

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

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

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

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

10 DR. ZABINSKI: That's right.

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

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

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

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

3 DR. ZABINSKI: Yes.

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

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

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

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

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

22 DR. ZABINSKI: Yeah.



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

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

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

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

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

18           MR. BUTLER: When they're not employed.

19           MR. HACKBARTH: Yeah.

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

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

5 MR. HACKBARTH: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14           DR. STENSLAND: Basically the same story.

15           MR. BUTLER: So there's no --

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

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

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

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

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

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

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

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

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

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

10 DR. COOMBS: Okay, thank you.

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

16 Slide 13. One of the most really important pieces  
17 of data that you presented related to the E&M was the  
18 difference between free-standing and hospital outpatient  
19 cost beneficiary cost sharing. And so, your Slide 13 is the  
20 first that I'm beginning to put an appreciation on what that  
21 might mean. I'm wondering, is this Group 1, Group 2, the  
22 250 million estimate, and can we begin to also understand it

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

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

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

12 DR. ZABINSKI: Yes.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

16 MR. KUHN: Got it.

17 DR. MARK MILLER: Is that okay?

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

1 echocardiogram, et cetera. I think as we know, a couple of  
2 years ago, there was a change in terms of payment for  
3 imaging services where the productivity adjustment went from  
4 50 percent to 70 percent, or something like that.

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

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

14 MR. KUHN: Right.

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

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

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

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

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

1 we've identified.

2 I'm looking at the list quickly. I don't see any  
3 CT codes on the top 20. There are no CT codes in the top  
4 20, but it might affect some that are lower down. So we'll  
5 have to get back to you on that.

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

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

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

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

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

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

13 MR. KUHN: Okay.

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

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

19 [Laughter.]

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

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

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

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

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



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

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

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

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

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

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

8 MR. WINTER: Yes.

9 MR. GRADISON: I want to call attention to Page 13  
10 and comment briefly upon the second point here, beneficiary  
11 cost-sharing would be declined by \$250 million. I accept  
12 that's correct. I think, however, it's useful whenever this  
13 comes up to point out, as the background document does, that  
14 about 90 percent of this is actually covered by MediGap.  
15 Therefore, the out-of-pocket costs -- out-of-pocket savings  
16 on these assumptions is \$25 million to the beneficiary and  
17 \$225 million, at the outset initially, to the insurer, and  
18 then if that gets folded back into lower rates, that's  
19 spread across all of the policies, not just the people who  
20 were involved in this particular type of care.

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

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

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

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

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

1 potentially be pretty large.

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

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

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

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

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

6 MR. GEORGE MILLER: Yes, I liked Peter when he  
7 said -- and I agree -- if a physician practice was purchased  
8 by a hospital and that same work was done in the hospital,  
9 no-brainer, it shouldn't be any difference. But on Slide 11  
10 -- and I think there may be all the numbers in the package --  
11 -- I'll speak for one rural hospital -- I am able to bring  
12 physicians from out of the community to provide services in  
13 my community to my patients. So if I understand the  
14 analysis, \$389, if it's done in a physician office, of that  
15 \$389, \$217 of that is for practice expense, correct? Am I  
16 correct?

17 DR. ZABINSKI: Is that something in the paper?

18 MR. GEORGE MILLER: It was in your --

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

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

21 [Laughter.]

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

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

6 DR. ZABINSKI: Correct.

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

12 DR. ZABINSKI: In this case, yes.

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

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

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

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

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

8 MR. GEORGE MILLER: Okay, I'm not arguing that  
9 that payment may be too high, and that's part of the  
10 argument. You said we should right-size the payment. I'm  
11 not arguing that it should be too high. But your philosophy  
12 ought to be consistent that if you're paying for a practice  
13 expense for someone who is not using those resources in  
14 someone else's facility and paying \$30 versus \$187 of the  
15 \$359, you're saying the payment shouldn't change for the  
16 physician.

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

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

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

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

3           DR. MARK MILLER: Oh, I see --

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

5           MR. GEORGE MILLER: That's exactly right. I agree  
6 with you, if it's -- because it doesn't make any difference.  
7 If it's employed and still done in their office. I'm  
8 saying, like me, I bring in a cardiologist to do a  
9 procedure, or I bring laser surgery in my facility, you're  
10 going to pay me \$30 for that facility fee, but you're still  
11 going to pay him as part of that \$389, or her, \$187 of the  
12 \$389 for their practice expense.

13          MR. HACKBARTH: So -- yeah?

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

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

19          MR. GEORGE MILLER: Employed, right.

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



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

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

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

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

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

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

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

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

18 MR. GEORGE MILLER: Well, the facility --

19 MR. HACKBARTH: You have --

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

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

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

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

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

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

13 MR. HACKBARTH: Yeah.

14 MR. GEORGE MILLER: Yeah?

15 [Laughter.]

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

18 MR. GEORGE MILLER: Good luck with that.

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

22 MR. GEORGE MILLER: Where does this happen now

1 currently?

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

5 MR. GEORGE MILLER: Okay.

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

7 [Laughter.]

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

11 [Laughter.]

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

14 [Laughter.]

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

19 MR. WINTER: Yes.

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

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

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

5 DR. HALL: Within the --

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

14 DR. HALL: That works through the hospital?

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

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

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

1 DR. HALL: No, that's not important. So here, let  
2 me just ask you -- I think this is the question I asked  
3 before. We've all been alluding to the fact that it's  
4 outrageous to pay for the same service a different fee if  
5 there's nothing different other than ownership. But,  
6 roughly speaking, what percentage of these acquired  
7 practices -- in a way, I guess I'm trying to think of --  
8 they're all basically being paid the same way within this  
9 35-mile radius. Is that right?

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

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

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

1 DR. HALL: Okay.

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

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

7 MR. WINTER: Probably were.

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

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

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

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

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

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

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

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

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

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

15 MR. WINTER: Right, they don't have to have an  
16 emergency room. So when CMS created the rules that allow  
17 hospitals to bill for other entities as if they were part of  
18 the hospital, you know, they had two kinds of categories:  
19 one category would be entities that are on the main campus  
20 of the hospital; another category are entities that are off  
21 the main campus of the hospital, but they have to be within  
22 35 miles. And they did try to create some -- draw some



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

13 DR. REDBERG: I also had a question. On Slide 13,  
14 when the assumption was program spending would decline by  
15 \$900 million, is that assuming constant volume? Because  
16 isn't it true that often when payment rates drop, volume  
17 increases?

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

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

1 16, the 100 hospitals that would see the largest payment  
2 reduction, most of them were smaller than 100 beds, I  
3 thought. So does that mean they would not actually see the  
4 payment reduction because of the hold harmless provision?

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

7 DR. REDBERG: I see.

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

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

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

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

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

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

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

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

1 rates for ED visits.

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

8 DR. REDBERG: Thank you.

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

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

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

19 DR. ZABINSKI: Oh, outpatient/physician pot.

20 DR. HOADLEY: Whatever the appropriate denominated  
21 would be.

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

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

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

9 DR. BAICKER: Just a quick one. Can you give a  
10 few more examples of the types of things that are packaged  
11 that are making the difference between the Group 1 and Group  
12 2 and whether we want them to be packaged. Is this an  
13 efficient bundling of things that should be encouraged? Or  
14 is this stuff that's just being added on? Or is this stuff  
15 that could just as easily be done independently?

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

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

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

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

7 DR. ZABINSKI: Yes. Yes.

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

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

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

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

1 bit. My second question --

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

5 DR. SAMITT: Okay.

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

11 DR. SAMITT: My second, I was going where Scott  
12 was, and when we talked about this last, I thought that a  
13 50-percent threshold also seemed high. So my question -- I  
14 think I know the answer -- is: Do we have data to compare  
15 these percentages between OPD and physician from MA plans  
16 versus fee-for-service? Because I would imagine we would  
17 reveal some additional significant differences in a value  
18 environment than we would in a volume environment between  
19 what's done in the physician offices and what's done in the  
20 hospitals.

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

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

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

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

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

10 [Laughter.]

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

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

19 [Laughter.]

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



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

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

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

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

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

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

18 [Laughter.]

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

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

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

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

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

6 But the principle of equal pay for equal services,  
7 I think, is a really important one, and I think taxpayers  
8 should know more about how much they're paying in one site  
9 versus another for the same access to the same high-value --  
10 [Turned off microphone.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

19 DR. DEAN: I'm not surprised.

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

1 DR. DEAN: Right. Yes.

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

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

9 MR. HACKBARTH: Yes. Jack.

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

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

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

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

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

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

21 [Laughter.]

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

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

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

5 DR. SAMITT: Okay. Great.

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

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

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

1 those letters seriously.

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

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

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

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

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

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

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

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

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

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

1 imaging and everything.

2 Thank you.

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

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

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



1 outpatient departments.

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

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

17           Thank you.

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

1 to understand the impact of the Commission's previous  
2 recommendations to cut payments to the ten E&M services by  
3 \$1 billion annually. This proposal could result in  
4 beneficiary access problems and a reduced level of services  
5 for the public overall. And now MedPAC is talking about  
6 recommending even more cuts. These are deep cuts to retain  
7 outpatient services that are integral to the service mission  
8 of hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

22 There are three kinds of SNP plans. There are the

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

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

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

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

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

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

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

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

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



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

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

10 Before reviewing information on what we know about  
11 the quality of care in SNP plans, we should discuss why we  
12 are comparing SNPs to non-SNP plans in evaluating their  
13 quality. To reiterate what we said about current law, SNP  
14 plans will be allowed to continue in the MA program after  
15 2013, but they can only operate as general MA plans. If a  
16 SNP continues as an MA plan, its enrollees will not be  
17 disenrolled from the plan, but will continue as members of  
18 the general MA plan.

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

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

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

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

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

1 readmission measures, as do some D-SNPs.

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

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

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

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

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

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

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

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

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

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

1 the effectiveness of the SNP program.

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MR. HACKBARTH: Okay.

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

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

3 MS. AGUIAR: Exactly.

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

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

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

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

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

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

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

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

17 MS. AGUIAR: Exactly. So what we call the  
18 financially integrated D-SNPs, we estimate there are about  
19 25 of those. We are unable to quantify how many fall into  
20 the bucket on the right side. It is my sense, though, that  
21 the majority of D-SNPs would fall under the other category  
22 where they're mainly coordinating benefits.



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

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

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

1 beneficiaries?

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

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

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

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

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

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

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

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

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

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

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

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

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

6 [Laughter.]

7 MR. ARMSTRONG: Was that his calculator?

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

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

15 MR. ARMSTRONG: Okay. Thank you.

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

19 MR. ZARABOZO: Yes.

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

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

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

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

2 MR. ZARABOZO: C-SNPs bid lower.

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

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

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

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

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

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

1 is getting a bonus, yes.

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

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

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

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

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

6 MR. ZARABOZO: Well, one thing about the measures  
7 is that many of them are for certain age categories. For  
8 example, the measures for diabetics are for diabetics  
9 between -- that are in the HEDIS measures, diabetics 18 to  
10 75. So after age 75, because there's apparently no standard  
11 way of treating diabetics, there's not a measure that people  
12 can agree on for that group, there has been a push to get  
13 more measures for the older population, which many of the  
14 measures now, for example, the fall risk management,  
15 discussing fall risk, treatment of urinary incontinence,  
16 discussing physical activity in older adults, osteoporosis  
17 management, there are several, they are moving towards more  
18 measures towards the very old. For the very young, there  
19 still need to be more measures, particularly on mental  
20 health measures. But within the measures, it's a little bit  
21 difficult to do, to look at it and say that diabetics 18 to  
22 75, if you want to look at the 20 to 25, that's a big



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

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

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

10 MR. KUHN: Thank you.

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

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

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

20 [Laughter.]

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

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

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

9 DR. NAYLOR: Let me ask one more, maybe, unless  
10 Glenn has already asked it. Twenty-five of 300-some plans,  
11 22, are financially integrated. Your sense on -- thank you  
12 for an excellent report -- why so few.

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

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

8           There are just many reasons why states are perhaps  
9 not able to or would rather just not coordinate with SNPs to  
10 capitate the long-term services. Maybe some of the  
11 behavioral health services that would get those plans to be  
12 the financially integrated, and I think that's why there are  
13 so few.

14           The question sort of now on the table is how will  
15 the states' interest in using the SNP as a vehicle for  
16 integrated care continue given that there are these  
17 demonstrations, because far more states have sort of become  
18 interested in that, at least about 25, 26, than have really  
19 become interested in using -- that were interested in using  
20 the SNPs as that vehicle for integrated care.

21           DR. COOMBS: Thank you very much. I'm glad you  
22 mentioned Massachusetts.

1           One of the things I noticed in the appendix on  
2 Table A5, there's this trend of, you know, the best -- say  
3 the poster child for performance, and I noticed that, you  
4 know, they're the same ones who actually applied for the  
5 part one of the demonstration project, and I've actually  
6 spoken with some of the people involved in the Massachusetts  
7 demonstration, and one of the things I was looking at and  
8 comparing is just the amount of resources that are available  
9 and what percentage of these states that are here actually  
10 have Medicaid waivers as well in terms of them being able to  
11 be innovative. I know that was really important because,  
12 you know, we have 98 percent coverage in Massachusetts in  
13 terms of insured or covered in some fashion and that they  
14 wanted to look to see how they could bring down costs,  
15 specifically with the dual eligibles, and do innovative  
16 things with both sides of, you know, the LTCHs and then  
17 being able to manage outpatient diseases as well.

18           So I was wondering specifically, have those states  
19 had the level of investment to look into Medicaid waivers?  
20 You know, I don't see Mississippi or any of the Southern  
21 crescent region where we talked about some of the poor  
22 performance.

1 MS. AGUIAR: I just want to make sure I  
2 understand. So is the question how many of these states are  
3 pursuing the demonstrations with CMS?

4 DR. COOMBS: No, just in terms of having  
5 simultaneous waivers to go along with their score. Did you  
6 see any trends with their score?

7 MS. AGUIAR: Oh, I see. With whether or not they  
8 have Medicaid waivers.

9 DR. COOMBS: Yes.

10 MS. AGUIAR: You know, I think we could work on  
11 pulling that. We don't have yet in-house whether or not  
12 they have the waivers, but I believe we should be able to  
13 find that fairly quickly.

14 DR. COOMBS: Thanks.

15 MR. ZARABOZO: The other point about these states  
16 -- and for the benefit of the audience, these are the states  
17 that were on the slide, which is Massachusetts, Minnesota,  
18 Wisconsin, and also California. Many of these plans are  
19 very longstanding plans that have been operating for a long,  
20 long time, specializing in duals.

21 MS. AGUIAR: And can I just ask Alice just to make  
22 sure, are you interested in any waivers, or waivers

1 specifically on like long-term care and home and community-  
2 based services or for the dual population in general?

3 DR. COOMBS: The dual population.

4 MS. AGUIAR: Got it.

5 MR. BUTLER: There are about 1.5 million members  
6 in these collective plans, and that number has changed which  
7 way over time?

8 MR. ZARABOZO: I think up over time.

9 MR. BUTLER: But a lot of growth or --

10 MR. ZARABOZO: I can't answer that off the top of  
11 my head. I think about the same rate, and maybe higher.  
12 I'm looking at Scott. Perhaps higher than the general  
13 trend.

14 MR. BUTLER: Okay. And the geography is a little  
15 strange, with Puerto Rico and then relatively few states,  
16 and then almost all of these are in the HMO style Medicare,  
17 MA plan. What about ownership of these? Are these in  
18 publicly traded for-profit health plans that we know about,  
19 or are some of them -- is there something different about  
20 the sponsorship in these that would be significantly  
21 different than the rest of the MA population?

22 MR. ZARABOZO: Well, you have two groups. You do

1 have publicly -- like UnitedHealth is involved in the I-  
2 SNPS. They are the people that was Excel Health, and that's  
3 the regional C-SNPs. AmeriGroup, Health Spring, which was  
4 purchased by --

5 STAFF: Cigna.

6 MR. ZARABOZO: Cigna, thank you. But at the same  
7 time, you have, for example, the Minnesota plans that are  
8 smaller plans. In California, you have the county-based  
9 plans that are SNP plans. So it's quite variable. You have  
10 both extremes in terms of what kind of plans we're talking  
11 about.

12 MR. BUTLER: But no systematic pattern that says  
13 something different about these enrollees and their sponsors  
14 than other MA plans?

15 MR. ZARABOZO: Well, I would say the ones that  
16 have been operating a long time, I mean the ones that were  
17 the demos, the Minnesota and Massachusetts were nonprofit  
18 plans, relatively small plans. But we can look into -- we  
19 can sort of do a distribution, if you'd like.

20 MR. BUTLER: I'm just trying to get at motives and  
21 likelihood of responses and a number of -- I'm just trying  
22 to understand the landscape of --

1 MS. AGUIAR: I would just add -- and I don't know  
2 if this is -- I don't believe we brought this up last April  
3 when we were discussing the demonstration programs with CMS  
4 between the states -- that there has been some more  
5 consolidation among both the -- in the insurance market for  
6 the plans that -- between the plans that focus more on MA  
7 and those that focus more on Medicaid managed care. And our  
8 understanding is that part of that was in response to these  
9 demonstrations and the response to a perception out there  
10 that the duals is really sort of the next great population  
11 that will be perhaps moved more heavily into managed care  
12 that is going to be continuing of the focus of it. So there  
13 has been quite a bit of both interest from plans in  
14 participating in these demonstrations, even though there has  
15 been concern about whether -- that the rates might be lower  
16 than they would get if they were just MA plans. And there  
17 also has been some consolidation about that, around that,  
18 too.

19 MR. ZARABOZO: And one point that we may have  
20 mentioned is the duals can enroll month to month. Every  
21 month they can go in and out of fee-for-service and MA  
22 plans. It was the D-SNP that was attractive for that reason



1 to a variety types of organizations so that outside of the  
2 October to December open enrollment you can be enrolling  
3 people in your plan.

4 DR. SAMITT: On Slide 9, I guess my question is  
5 less about the SNPs and more about the general MA plans.  
6 What is the sentiment by the general MA plans about whether  
7 they have an interest in facilitating offerings of I-SNP and  
8 C-SNP? Because that's certainly an option, is that -- is  
9 there desire there, or is there no comment or no interest?

10 MR. ZARABOZO: Well, many of the I-SNPs are  
11 United. The Evercare plans are United. Whether -- we have  
12 not talked to them about how would you integrate -- is it  
13 possible to integrate the I-SNP into a general MA plan? For  
14 the C-SNP situation, to do a benefit package that is, say,  
15 only for diabetics, it would require a different approach to  
16 bidding which says yes, for some people you can have a  
17 different benefit package than for other people. So that  
18 would be an issue to look at.

19 DR. BAICKER: Can you give me a better sense of  
20 what some of the barriers are to achieving the benefits that  
21 were hoped for from, say, improved coordination for these  
22 complicated patients or coordination across the duals in a

1 regular MA plan? I know that, you know, if one were to go  
2 the route of letting these expire but trying to free up some  
3 of those regulatory issues, what would they be? And is the  
4 selective enrollment of the targeted populations a necessary  
5 component of that strategy?

6 MS. AGUIAR: So we did -- again, as Carlos  
7 mentioned, we spoke with managed care plans that offered  
8 regular MA plans and D-SNPs, and most of that was really  
9 sort of to try to get at this. You know, do you need the D-  
10 SNP product in order for them to be able to do what they do?  
11 You know, what we found out is that the benefit is that the  
12 D-SNP benefit package can be tailored to their population,  
13 and a regular MA plan wouldn't be able to do that. We were  
14 given some examples of, you know, being able to offer  
15 assisted devices for plans that really focus heavily on  
16 maybe some of the more disabled beneficiaries that need  
17 those services. So a regular MA plan I think would be --  
18 it's not that we think that they wouldn't be able to serve  
19 them. It's that they wouldn't have that benefit of being  
20 able to tailor their benefit package or of their  
21 supplemental benefits. And then I think that they would  
22 also have the same limitation that the D-SNPs that have

1 coordination agreements with the states have, which is they  
2 are able to sort of assess these beneficiaries for the  
3 Medicaid services and refer them to those services. But  
4 since they don't have responsibility for them, there's  
5 always going to be that limitation into how much they really  
6 can truly integrate those benefits. But as Carlos  
7 mentioned, there's quite a large number of duals in MA plans  
8 currently.

9 DR. BAICKER: Just to make sure I understand,  
10 suppose you have a particular set of benefits that's  
11 attractive to -- or that's intended to be targeted at  
12 somebody with a chronic condition, and you say if you have  
13 this condition, you get this benefit, you could still do  
14 that if you let all enrollees come, and people who don't  
15 have that condition wouldn't be participating in that aspect  
16 of the benefit. So what's the additional type of tailoring  
17 that's not possible under that kind of structure? Or am I  
18 missing some -- what am I missing?

19 MR. ZARABOZO: Well, you could not say, for  
20 example, cost sharing for diabetics is different from cost  
21 sharing for non -- you cannot say that currently. That  
22 would require a change in the approach.

1 MS. AGUIAR: And I would just refer to this -- we  
2 could expand upon this if you would like to. In the mailing  
3 materials what we referred to the GAO report that did look  
4 at the supplemental benefits, and they said -- you know,  
5 they did notice that while the D-SNPs tend to offer fewer  
6 supplemental benefits, they were more comprehensive. And,  
7 you know, sort of looking at that, you could really sort of  
8 see, you know, a general MA plan may find it valuable to the  
9 beneficiaries to offer like gym memberships and some things  
10 that are valuable to a non-dual eligible; whereas, the D-  
11 SNPs would tend to be focusing a little bit more on the  
12 specific population.

13 DR. BAICKER: And you can't say if you're  
14 diabetic, one of your benefits is a gym membership, but if  
15 you're not it's not. That's not possible.

16 MS. UCCELLO: So in a sense, this is getting at a  
17 VBID approach, but it's doing it by separating the  
18 populations and designing the benefit packages  
19 appropriately.

20 We're focusing a lot on D-SNPs, for good reason,  
21 but I was puzzled at why enrollment in the C-SNPs is so low  
22 considering the high number of people who must have chronic

1 conditions. And is it because, you know, plans aren't  
2 available, they're not aware of plans, they're not  
3 interested in those plans? You know, what's going on?

4 MR. ZARABOZO: Well, I think the issue is that you  
5 can also be in a general MA plan and get the same. I mean,  
6 it's not -- part of it also is the availability is not as  
7 great as general MA plans.

8 MS. UCCELLO: And if there are -- if they're going  
9 to an general, a regular MA plan, then are those kind of  
10 benefit design issues not really -- I don't know -- all that  
11 valuable?

12 MR. ZARABOZO: It probably depends on what the  
13 benefit package of a general MA plan looks like. For  
14 example, if they have very low cost sharing in general for  
15 everybody, then, you know, not too much of a difference  
16 between one and the other.

17 DR. HOADLEY: These are some really interesting  
18 questions, and it's a good paper with a lot of provocative  
19 information. A couple of my questions have already been  
20 dealt with, like the sponsorship question. I'm glad you  
21 could talk about that.

22 The one I'll raise came up in connection with your

1 issue of cross-subsidy between the state and Medicare. Is  
2 it true that all the supplemental benefits have to be paid  
3 through rebate dollars? Or can these SNPs also go into  
4 premium dollars? And if so, who's paying the premium?

5 MR. ZARABOZO: They can go into premium dollars,  
6 and the state can pay the premium if the state wants to pay  
7 the premium, yes.

8 DR. HOADLEY: But not automatically.

9 MR. ZARABOZO: Not automatically. You would have  
10 to -- yeah.

11 DR. HOADLEY: Do you know how much -- to what  
12 extent supplemental benefits are being paid by which route  
13 at this point?

14 MR. ZARABOZO: I don't think we know that. I do  
15 know that Alabama, for example, will pay the Medicare  
16 Advantage premium for duals to join a Medicare Advantage  
17 plan. I'm not sure what the -- but that was one of the  
18 states that -- because there is a specific provision that  
19 says you may do this, you may enroll these people and pay  
20 the premium on their behalf, if there is a premium.

21 DR. HOADLEY: And what about the question of how  
22 much of the supplemental benefits are being done on the

1 rebate side versus premium side? I know that's hard to  
2 calculate, at best.

3 MR. ZARABOZO: Yeah, I have a feeling that right  
4 now it's mostly the rebate side, much less of an arrangement  
5 with the state that says, yes, you pay us, we will provide  
6 these benefits.

7 DR. HOADLEY: Thank you.

8 DR. DEAN: What is the logic about the prohibition  
9 of marketing the combined benefits?

10 MS. AGUIAR: My understanding of it is I think it  
11 was more -- so, for example, we looked at the document that  
12 details how the marketing materials have to look like, and  
13 the way that they're set up is for any SNP. They describe  
14 their Medicare benefits in one section and then the Medicaid  
15 benefits that the beneficiary is entitled to in a separate  
16 section. So if you have a SNP that's not actually covering  
17 Medicaid benefits, that's fine. They see what they'll get  
18 from the SNP, and the Medicare benefits there are in a  
19 different section than the Medicaid. But when you have a  
20 SNP that's combining both, they are not allowed to in the  
21 same place say this is actually a package that you could get  
22 from us combined, from that SNP combined.

1           And so I think it was -- my understanding is it's  
2 more just sort of the way that the marketing materials were  
3 developed and less as a prohibition per se. And it's just a  
4 limitation for those plans that are actually covering both  
5 sets of the Medicare and Medicaid, they can't market it as a  
6 joint product.

7           DR. DEAN: Okay. Another question. And the  
8 payment for MA has always been confusing, but for those  
9 states that do not have a contract with Medicaid, how does  
10 Medicaid pay for this particular plan? Is it fee-for-  
11 service or -- I guess I don't understand, if there isn't a  
12 specific agreement, how do they do that?

13           MS. AGUIAR: Right. So at this point, all D-SNPs,  
14 in order for them to continue as D-SNPs, have to have a  
15 contract with the state.

16           DR. DEAN: Okay [off microphone].

17           MS. AGUIAR: The variation is what that contract  
18 actually covers, and so it is less likely to cover  
19 capitation for that -- the state to give capitated payments  
20 to that D-SNP to cover long-term care, behavioral health  
21 services, maybe a little bit more likely for them to cover  
22 some wrap-around benefits and cost sharing. And then there



1 are some contracts that really are more sort of an agreement  
2 to coordinate across the two benefits, but there's no  
3 capitation of services involved.

4 DR. DEAN: There has to be a contract, but there's  
5 no definition about what the contract has to require. Is  
6 that --

7 MS. AGUIAR: No, and there has been some attempt  
8 to put a little bit more specificity around what that  
9 contract should look like. But sort of there's -- I think  
10 neither Congress nor CMS has or perhaps is able to tell the  
11 states, you know, you have to contract with these plans for  
12 capitated services.

13 MR. ZARABOZO: Was your question how providers  
14 might be paid for services rendered?

15 DR. DEAN: How the plan [off microphone].

16 MR. ZARABOZO: Okay.

17 DR. REDBERG: Thanks. So I wanted to explore the  
18 C-SNPs a little bit more because I read this morning that 80  
19 percent of Medicare spending is for the 20 percent of  
20 beneficiaries with chronic diseases. So I would like to  
21 just -- if you had a better feeling for why these plans  
22 didn't perform as well, and also, was there any

1 differentiation, because there were a lot of different  
2 chronic conditions, congestive heart failure and diabetes  
3 and dementia and HIV? Were there C-SNPs for all of those  
4 and did they all perform at the same level, or were there  
5 some that seemed more successful because there's potential.

6 MR. ZARABOZO: Yeah. There is a big difference in  
7 the C-SNP performance indicators between the regional plans.  
8 We mentioned a couple times that the C-SNPs that are HMOs  
9 perform actually pretty well, and in particular, a couple of  
10 organizations do very well on many of the measures.

11 DR. REDBERG: [Off microphone] -- SNPs for all of  
12 those conditions?

13 MR. ZARABOZO: C-SNPs, there are 15 conditions  
14 that they are permitted to offer and then they can do a  
15 combination for five more, and then they can do their own,  
16 you know, an approved combination of various. Not all  
17 permitted conditions are covered. For example, alcohol and  
18 drug dependency is one, but there is nobody offering that.  
19 Stroke is another one that's available but nobody is  
20 offering that. End stage liver disease is another one.

21 DR. REDBERG: What were the more popular chronic  
22 diseases that were offered?

1           MR. ZARABOZO: Diabetes, congestive heart failure,  
2 COPD, lung disorders.

3           MR. HACKBARTH: Bill, can I just pick up on Rita's  
4 question just for a second? So one of the statistics we all  
5 hear a lot is what percentage of Medicare spending goes to  
6 patients with chronic illness. And in particular, what high  
7 percentage goes to patients with multiple chronic illnesses.  
8 And so, I just wanted to pick up on what Carlos was just  
9 saying. I've had, probably inaccurately, this notion in my  
10 head that each of the C-SNPs was specialized in a particular  
11 disease, which has always been sort of jarring with me  
12 because often the patients come not with one chronic  
13 disease, but two or three or four or five.

14           I thought I heard you say, Carlos, that, in fact,  
15 plans, C-SNPs offer combinations of diseases. Did I hear  
16 that correctly?

17           MR. ZARABOZO: Yes, they can offer a combination  
18 of diseases, but when they do that, the person has to have  
19 at least one. So, for example, they can do diabetes and  
20 congestive heart failure. So somebody with CHF can join  
21 that plan, somebody with diabetes can join that plan. You  
22 don't have to have both conditions to join the plan.

1 MR. HACKBARTH: Okay. Bill?

2 DR. HALL: Kind of like a Chinese menu.

3 MR. HACKBARTH: Right.

4 DR. HALL: Help me understand how it would work if  
5 we allowed the legislation to expire and current D-SNP  
6 people are told that you can join the regular MA plan. Most  
7 of them, by the time they're in that plan, have kind of  
8 special needs. They're not like the large number of people  
9 in the MA plans. Would they suddenly have to start paying  
10 premiums, or do you think this would be a no-premium  
11 insurance product?

12 MR. ZARABOZO: It depends on the -- sorry about  
13 that. It depends on the area. For example, many areas of  
14 the country have always had very low premium plans, zero  
15 premium plans, rich benefit packages. So there are areas  
16 where premiums had been charged historically, and so it's  
17 possible that people would -- that what is left is a  
18 situation where the plan has to charge a premium, which  
19 potentially means -- unless the state is willing to pay the  
20 premium for these people, then that may be a problem.

21 DR. HALL: So I guess to sort of drop this down a  
22 little bit more, D-SNPs and variants of D-SNPs like Unlock,

1 the PACE programs, are very much a work in progress, it  
2 seems to me. There are tremendous administrative barriers  
3 even in the best of circumstances to coordinate all of the  
4 benefits from two paying agencies, or sometimes even more  
5 than that.

6           The benefits that -- the innovative benefits that  
7 are offered are often somewhat unconventional. Not many MA  
8 enrollees, for example, think of getting bused to a day care  
9 center as a benefit that they wish to pay for. They'd much  
10 rather go to a health fair or something.

11           But I think ultimately, some form of this is going  
12 to become an important component of the health care system  
13 for Medicare patients. I'm not sure what it's going to be  
14 called. Of course, we have to hold the D-SNPs to the same  
15 quality standards, but I guess I like the option -- maybe  
16 I'll leave this for Round 2 -- but I think there are some --  
17 let me just say this.

18           I think to abandon the program now and turn it  
19 over to kind of an optional plan that doesn't have more  
20 coordination might be a mistake in the long run. And so, I  
21 guess the options of allowing a temporary period here for  
22 better quality measurements kind of appeals to me, but I'll

1 maybe talk more about that later.

2 MR. GEORGE MILLER: Yes. Fascinating reading and  
3 thought you all did an excellent job. Thank you very much  
4 for this material. One of my questions, and I've got two  
5 first round questions, deals with quality outcome data and  
6 its impact on other providers' data. For example, is there  
7 any indication that the SNPs have had, because of SNPs or a  
8 coordinated plan, has had an impact on hospital data like  
9 readmission rates?

10 And without the SNP for that population of  
11 patients, the example I used was readmission rates, would  
12 have been higher or different or has it made a difference?  
13 Is there any studies to look at a coordination of how a  
14 totally integrated plan would work because of the SNP being  
15 available?

16 MR. ZARABOZO: Well, we did look. That does  
17 happen to be a measure that is collected, the readmission  
18 rates, and as noted in the material, the I-SNPs in  
19 particular perform very well on the readmission rates.

20 MR. GEORGE MILLER: Okay.

21 MR. ZARABOZO: Some C-SNPs also and some D-SNPs  
22 also, but there's a lot of variation, again, in the plans.

1           MR. GEORGE MILLER: But to follow Bill's point  
2 then, if we let the authorization expire and there would not  
3 be any C-SNPs -- be any SNPs -- then it could have an impact  
4 on downstream quality measures or readmission rates in COPD.  
5 Is that fair?

6           MR. ZARABOZO: Well, if, for example, this --  
7 let's say everybody continued in a general MA plan and the  
8 general MA plan performed as well as the SNP plan did for  
9 the people that were already enrolled in that plan, then you  
10 would presume that they will perform -- or would hope that  
11 they would perform just as well for these populations.

12          MR. GEORGE MILLER: Okay. Well, then a follow up  
13 then. What we heard reported on the PACE program, it seems  
14 that that population did a much better job of coordinating  
15 care because they could uphold the benefits of both Medicare  
16 and Medicaid and use resources -- use their resources for  
17 things that are not covered and expand it.

18                 So I guess as we evaluate this, one of my  
19 questions would be, what value do we put on coordination of  
20 care, case management, social service and those things as we  
21 evaluate this program outside of the quality outcome  
22 measures that we're talking about.

1 DR. MARK MILLER: See, I think the difficulty in  
2 answering the question is this kind of -- you're asking the  
3 counter-factual, like if we let this go, then shouldn't we  
4 anticipate some impact? And I think why we're stymied in  
5 answering the question is, is the one fact point that we can  
6 see in the quality data so far, and particularly as it  
7 relates to readmissions, which is what motivate -- or part  
8 of your question --

9 MR. GEORGE MILLER: Yeah, yeah.

10 DR. MARK MILLER: -- the I-SNPs seem to have some  
11 evidence of that.

12 MR. GEORGE MILLER: Some?

13 DR. MARK MILLER: Right. Everywhere else -- and  
14 again, there's all kinds of arguments, it's not the right  
15 measures, you haven't got -- but so far, it doesn't seem  
16 that the SNPs more broadly distinguish themselves from MA.  
17 So I think what Carlos is saying -- we'll see -- was that  
18 one, you know, hypothesis is, something is going on here and  
19 there's good things happening, but we can't measure it yet.

20 And by the way, that's what a lot of people are  
21 arguing why you need the demonstration, is because somebody  
22 needs to examine evidence and see what's going on. And we



1 have all kinds of issues there, but just let's pretend and  
2 move past that for a minute.

3           The other thing that I think Carlos is saying is,  
4 is one of the likely things to happen if this goes away is  
5 that the person drops into MA, and his point is, is if MA  
6 performs as well as the SNP did for these particular  
7 populations, then you may be worse off. But then, of  
8 course, there's the whole sets of issues that we've talked  
9 about, is how much flexibility does MA have to go in and  
10 tailor those programs, and that's yet another unknown.

11           MR. HACKBARTH: So on the performance issue, if  
12 Mike were still here, I think one thing -- an observation  
13 that he would make is that we're trying to compare two  
14 categories, the regular MA plan and the SNPs.

15           DR. MARK MILLER: Right.

16           MR. HACKBARTH: And within each of those  
17 categories, there's lot of variation in performance.  
18 There's some outstanding performers and some poor  
19 performers. And so, we're looking at averages around which  
20 there's a lot of variation. And so, in all likelihood,  
21 there's probably more overlap in performance than the  
22 averages -- looking at the averages from up high.

1 MR. GEORGE MILLER: Well, to that point --

2 MR. HACKBARTH: So it makes it difficult to assess  
3 how much are we losing if this goes away.

4 MR. GEORGE MILLER: No, no, that's a very good  
5 point. And the last part of my question is, have you  
6 noticed if there are -- do we see the same variation across  
7 MA -- excuse me -- across SNP plans that we've seen in other  
8 areas that we've studied with regional variation as far as  
9 the quality outcomes are concerned?

10 MR. ZARABOZO: There's a lot of regional  
11 variation, but within a region, there's variation among  
12 plans.

13 MR. GEORGE MILLER: Okay. And still a problem.

14 MR. HACKBARTH: So let me try to nail down a  
15 couple other points. Bill, in his comment, talked about  
16 some non-SNP plans like PACE organizations that care for,  
17 you know, potentially overlapping populations, and one of  
18 their distinctive characteristic is that they combine  
19 medical and social services.

20 My recollection is that for the special needs  
21 plans and other MA plans, there are restrictions on our  
22 ability to use Medicare dollars for non-medical services.

1 Am I correct?

2 MR. ZARABOZO: That's correct, yes. There's a  
3 little bit of leeway for the fully integrated dual eligible  
4 SNP plans to use those dollars, but very limited.

5 MR. HACKBARTH: Okay. So I just wanted to make  
6 sure of that. A second clarification I need, so what I hear  
7 is that there are two principle differences between being a  
8 SNP and being a regular MA plan. You're paid the same, but  
9 there are different enrollment rules and there are different  
10 rules about how you can structure your benefit package.

11 On the enrollment side, what I understand to be  
12 the differences is that there's continuous open enrollment.  
13 It doesn't just happen once a year. It can happen month by  
14 month. And plans can also establish limits, capacity-type  
15 limits on their enrollment. Are those the basic enrollment  
16 rule differences?

17 MR. ZARABOZO: The open enrollment for duals and  
18 other low-income people applies to any MA plan, so the D-  
19 SNPs. But the thing about D-SNPs is they have a benefit  
20 package that is tailored for these people, and therefore,  
21 presumably duals would be more attracted to that kind of  
22 plan. But there are 900,000 duals in regular MA plans,

1     however.  Those are not --

2             MR. HACKBARTH:  Yeah.  So the C-SNPs, there, there  
3     is continuous open enrollment, but not for Medicare  
4     Advantage plan people that have chronic illnesses?

5             MR. ZARABOZO:  The C-SNP situation is that if you  
6     have one of the conditions, you may enroll at any time.  You  
7     have an open enrollment opportunity if you have a condition  
8     to enroll in the C-SNP.  But it's a one-time opportunity  
9     only.  So you can --

10            MR. HACKBARTH:  A one-time opportunity?

11            MR. ZARABOZO:  Yes.  You can enroll in July  
12     outside of the open because you're a diabetic, you go to the  
13     C-SNP, you're enrolling in July.  You have -- that's your  
14     end of any open enrollment.

15            MR. HACKBARTH:  Okay.

16            DR. MARK MILLER:  Can you dis-enroll?

17            MR. ZARABOZO:  No, you have to wait for the --

18            DR. MARK MILLER:  You're locked in?

19            MR. ZARABOZO:  You're locked in.  You have to wait  
20     for the open enrollment period to change.

21            DR. MARK MILLER:  And the same rules for the I-  
22     SNP?

1           MR. ZARABOZO: The I-SNP, no. Institutionalized  
2 people can enroll on a month-to-month basis.

3           MR. HACKBARTH: So what I'm trying to get at in  
4 these questions is, how much of an advantage is there, in  
5 fact, conferred by these special rules? Do we know about  
6 how many people, for example, diabetics, enroll off-cycle,  
7 take advantage of that feature? Do we know anything about  
8 how much benefit is derived from these special rules?

9           MR. ZARABOZO: We don't know that, but I think we  
10 can find that out. I mean, it is an interesting question,  
11 how many people are enrolling under the special enrollment  
12 provision. So we can attempt to find that out.

13          MR. HACKBARTH: And then on the benefits side, I  
14 like the way Cori characterized it. It's sort of like,  
15 Well, want to have VBID sort of flexibility, and the way  
16 we're choosing to do that is by creating a whole new type of  
17 plan as opposed to giving more flexibility to standard  
18 Medicare Advantage plans. It seems like a rather kludgy,  
19 awkward approach to achieving a desirable goal.

20           Why don't we just offer Medicare Advantage plans  
21 more flexibility to do value-based insurance design?

22          MR. ZARABOZO: I assume that's a rhetorical

1 question.

2 [Laughter.]

3 MR. HACKBARTH: Yes.

4 MR. ZARABOZO: I'd like to use that language, you  
5 know.

6 MR. HACKBARTH: Okay, Scott?

7 MR. ARMSTRONG: Okay. So to be frank, I'm not  
8 exactly sure what the question is that I'm answering here  
9 except to comment on the policy options that have been laid  
10 out, in that I guess what I would just tell you is that I  
11 don't have much advice for you that would improve on or  
12 change the approach that you're describing taking, but I  
13 know what you were hoping for was some limitation on a  
14 really broad range of questions that you plan to answer and  
15 I'm having difficulty sort of narrowing the scope. I have  
16 to be frank.

17 I'm an advocate for MA, Medicare Advantage plans  
18 and SNPs seem to be a great vehicle for expanding our  
19 experience and expanding the benefits of these plans to  
20 beneficiaries in the Medicare program, but we've just  
21 described a whole series of real issues that are kind of  
22 confounding and it's difficult to know.

1           I have to disclose my own experiences that I run a  
2 big Medicare Advantage plan, but I have also been running a  
3 C-SNP that has top, top quality scores that we will be  
4 closing January 1st because we've decided, for a variety of  
5 different reasons, but we've decided that really through our  
6 MA plans, we are better able to serve the patients' needs  
7 and the benefit flexibility doesn't outweigh other issues,  
8 in particular, the risk of very small enrollment in some  
9 real extraordinarily expensive patients.

10           And so, I'm confounded. I wish -- I like the idea  
11 of SNPs. The other point I would make is that D-SNPs seem  
12 to be a very different thing from a policy point of view  
13 than the rest and maybe we need to just declare that and  
14 we'll kind of approach these questions about what our  
15 recommendations might be for D-SNPs separate from all this  
16 other stuff.

17           So I regret the fact that I can't offer more kind  
18 of a focus to the ongoing work, but generally speaking, I  
19 think they're exactly the right questions we should be  
20 asking.

21           MR. GRADISON: I'm pretty sure -- I'm pretty close  
22 to what Scott just said. Conceptually, I think of these

1 plans as true demonstrations or experiments not intended to  
2 be permanent, but to inform MA plans and others how they can  
3 better serve these populations without necessarily having  
4 them in separate categories.

5 I worry sometimes, too, about whether there are  
6 folks that may have very similar chronic illnesses, for  
7 example, as the ones that are in the C-SNPs but aren't in  
8 them. I mean, they develop these things, but choose just to  
9 stay under the regular plans. It's almost like the MA plans  
10 are running two different tracks with these people with very  
11 similar, maybe even identical, needs and conditions.

12 So I'm certainly open to recommendations on this,  
13 but I do think it would be well to think of this as a  
14 transition towards folding these into the general MA  
15 arrangements.

16 DR. NAYLOR: I, first of all, think that this is a  
17 really important time to pause and learn all that you can  
18 and we can from what's going on with SNP, the kind of  
19 lessons that came, advance the demos and so on, and I don't  
20 think that these realize the expectations, at least as the  
21 data would suggest. PACE is a clinically and financially  
22 integrated program. And so, the fact that so few of these



1 are that is something that I think we need to focus on.

2 That said, I think, you know, the care  
3 coordination component which you describe which has already  
4 been a part of the care management of those that are  
5 enrolled in especially the D-SNPs, but I assume all SNPs, is  
6 something that I am concerned about moving or transitioning  
7 those individuals from.

8 And so, what I think I would lean toward at this  
9 point is on the D-SNPs, a time limited re-authorization that  
10 gives us a chance to learn from demos, that gives us a  
11 chance to learn what those groups that are really looking at  
12 quality measures for dual eligibles are doing, and at the  
13 same point, I would not be -- I think that we would not  
14 transition the people that are on the current programs to  
15 something else until we know what the something else is,  
16 better.

17 DR. MARK MILLER: Just for one second, in case  
18 this helps you, because I realize there was a lot of things  
19 put up and, you know, we even had a summary slide at the end  
20 trying to say there's all this. So maybe this will help  
21 you. Okay? And if not, I apologize.

22 You know, you could think about this a couple of -

1 - in a broad, couple of broad stroke ways. There's not a  
2 lot of evidence to Glenn's point. There's so much variation  
3 between MA and SNPs that may -- and, you know, the money  
4 involved is not insignificant, but it's not large, that  
5 maybe you say, they go on because maybe there's still  
6 something to be learned here and maybe the Commission says,  
7 Not a lot to say, but, you know, let them go on either time  
8 limited, whatever the case may be.

9           Another area you could be thinking about, and this  
10 is not mutually exclusive with the third thing I'm going to  
11 say, is you could trigger this question of VBID inside or  
12 VBID outside, and should we be thinking about MA and the  
13 flexibility with inside MA to tailor to specific  
14 populations? That could be another path to go down.

15           The third way to organize information is to say,  
16 Okay, well, maybe they do continue, but you try and get some  
17 narrowing of focus on them. So on I-SNPs, to George's  
18 point, there is some evidence here, so maybe there's  
19 something going on there.

20           For D-SNPs, there is another policy consideration.  
21 It brings together these Medicare and Medicaid integration  
22 that we kind of like and maybe we could talk a bit about

1 what integration means and say, You can let them go forward  
2 if they at least do -- and we figure out how to fill in the  
3 blank.

4 C-SNPs, we would admit and it seems is the hardest  
5 to track on. One thought there in terms of narrowing is, is  
6 the list of diseases. You know, these are diseases that are  
7 so generalized throughout the rest of the MA population, and  
8 I can handle them in my own plan anyway, maybe there's not a  
9 lot of distinction there and it's more an issue of, well,  
10 for ESRD or AIDS or something where you have a clear  
11 population that's driven very hard by their condition, not  
12 unlike the I-SNP situation, you say, Okay, we go forward on  
13 that basis.

14 So one more time and quick, but there's not enough  
15 information here. You just let them go. Two, we focus on  
16 MA and we think about the rules of the road in there or  
17 within the three categories, is there some way to narrow  
18 some of the things that are going on. That's at least the  
19 way I kind of organized it in my head.

20 DR. NAYLOR: It sounds like a path to integration.  
21 I mean, we also have people that may leave this to go to  
22 fee-for-service. So it's not -- I mean, we don't know what

1 decisions will be made. So I think, thinking about a path  
2 that a program is responsible for people over time, and  
3 their needs change over time, whatever path we have that  
4 gets to that I think makes sense.

5 MR. HACKBARTH: Alice?

6 DR. COOMBS: Mark, that was very helpful.

7 DR. MARK MILLER: I don't see how, but okay.

8 [Laughter.]

9 DR. COOMBS: So as I mentioned before, I'm  
10 listening to the discussion and what I want to walk away  
11 with is some kind of pro/con analysis of what this big  
12 picture means. If he could package it for me, put it on a  
13 plate, and deliver it, it would help out tremendously.

14 I do think, after hearing the discussion, you  
15 really have to treat each one and tailor some of the  
16 recommendations to the D-SNPs, the C-SNPs, and I-SNPs  
17 differently. It's actually based some of the demands and  
18 requirements for each one of them. I think they're  
19 characteristically different enough that they require a  
20 different kind of solution. So that's what I would  
21 recommend.

22 MR. BUTLER: So having read and listened, I would

1 lean towards letting it expire like current law, although  
2 I'm open to something gentler. But if I were to flip it the  
3 other way and said, All we have are MA plans, what would you  
4 do in addition? Would you do I-SNP? Would you -- which one  
5 of these would you start up now if we didn't already have  
6 them? And I'm not sure I would start one of them up, which  
7 is another way of looking at it.

8           So are we hanging on because we're looking for a  
9 glide path to combining or are we pretty darn sure that, you  
10 know, if you started over again you would put one of these  
11 in place? And I'm not convinced you would.

12           MR. HACKBARTH: Okay. So let me just push on that  
13 using Mark's framework a little bit. And you would say that  
14 even about the dually eligible SNPs, which they have this  
15 unique characteristic of trying to bring together people  
16 that are covered under two separate insurance programs?

17           MR. BUTLER: But not convincingly, even in my own  
18 mind. So I'm not putting a big stake in the ground.

19           MR. HACKBARTH: Well, certainly if they've fallen  
20 short of hopes in terms of achieving that integration.

21           MR. BUTLER: Yeah. And that's why I'm not  
22 convinced that it had a shot.

1 MR. HACKBARTH: Yeah. Okay. Craig?

2 DR. SAMITT: I had trouble sort of painting all  
3 three groups with a common brush, and I tried to think of it  
4 as are any of these truly distinct enough populations that  
5 we would seek to preserve it, either because we want to see  
6 if something innovative can be generated or that the  
7 population truly is distinct enough. And, you know, I came  
8 up with a preference for three different scenarios for these  
9 three different groups.

10 My sense is I probably would reauthorize I-SNPs  
11 because they seem distinct enough. For C-SNPs, I would let  
12 it expire because I guess, similar to Scott's, our group's  
13 experience is that, you know, what's good for the C-SNP  
14 population is really good for all of MA population. And  
15 even if you narrow the disease states a little bit further,  
16 you have a substantive enough population that you would  
17 imagine you'd raise all boats if you practiced one form for  
18 both the general MA as well as C-SNPs. So for C-SNPs, I  
19 would let it expire and have chronic disease be an expertise  
20 that MA plans really should develop for their entire  
21 beneficiary group.

22 MR. HACKBARTH: Craig, just in the interest of

1 full disclosure, so you have an MA plan?

2 DR. SAMITT: We don't have an MA plan; however,  
3 we've experienced, even in the world of ACO, that to seek to  
4 design a special care model for a subset of your population,  
5 we're finding that that really doesn't make a lot of sense,  
6 that we would want to apply the principles that we generate  
7 for a subpopulation to the entire population. Otherwise,  
8 you miss an opportunity in those that are not in this  
9 narrower group. And so we're not an MA plan, yet at least,  
10 but that has been our experience nonetheless with Medicare.

11 And then for D-SNPs, this is the one that I really  
12 like the notion of only reauthorizing those who can  
13 demonstrate integration, because I think it's forward  
14 compatible with where we want to go. I also think this is a  
15 distinct enough population that I'd want to give it a little  
16 bit more time to see if there is creativity and innovation  
17 that cares for a very distinct needy population. And to  
18 fold it into general MA, I'd be a little concerned that we  
19 would lose the opportunity to develop new skill sets there.

20 MR. HACKBARTH: In that same vein, obviously we're  
21 entering into a period with lots of experimentation, joint  
22 federal-state experimentation around the duals, and

1 potentially keeping D-SNPs alive as a vehicle for that as  
2 that experience unfolds. There may be a case for that.

3 DR. BAICKER: I wish I had a better handle on why  
4 the plans that aren't working aren't working so well. It's  
5 a very different story to say, you know, there are these  
6 great ideas that work well for a C-SNP population but  
7 actually work well for everyone, and the reason the C-SNP  
8 isn't working is because we're working -- you know, it's a  
9 giant success in some other program so we don't need it,  
10 versus these tools just aren't working and no one's using  
11 them at all. And that to me has pretty different  
12 implications for the hope of a lot of the bigger picture  
13 strategies for driving towards, you know, higher-value care,  
14 more coordinated care, et cetera.

15 So I'm torn. If you had asked me ahead of time  
16 would a C-SNP work, I would have thought that if you could  
17 have some special tools to manage diabetics that you  
18 couldn't tailor to that population in a general MA plan, if  
19 you have these -- you know, if you can change the co-  
20 payments to really tailor to the kind of care that's of  
21 particular value for diabetic patients, you should be able  
22 to do a better job -- we hope you should be able to do a



1 better job in delivering high-quality care to them, and if  
2 it didn't work or it wasn't attractive to enrollees, is  
3 there something about the -- you know, are the risk  
4 adjusters not right, or are the patients not getting the  
5 information they need, or are the tools not developed yet  
6 and they could work, or is this whole endeavor just doomed  
7 and that's not the right way to go to try to get higher-  
8 value care for them?

9 Without having a better sense of answers there, I  
10 don't know whether to -- which direction to go, so I feel  
11 conflicted on that front.

12 I hope that was helpful.

13 [Laughter.]

14 DR. SAMITT: Can I also just clarify? For me, for  
15 C-SNPs, it really would be Option 4 that I would want versus  
16 Option 2, which is to allow the MA plans flexibility to  
17 develop disease-specific benefit designs. So it wouldn't  
18 just be allowing the authority to expire, but also allow MA  
19 plans to do as Kate described, a little bit more freedom to  
20 do innovative things.

21 MS. UCCELLO: Yeah, I'm frustrated as well with  
22 this, and I'm going to sound whiny, but it's -- if none of

1 them worked well, it would be an easy decision, right? But  
2 there's so much variation, and so some plans are doing quite  
3 well. And so if we just said no more, you know, what  
4 happens to those people? Are they going to, if they move  
5 into another MA plan, really continue doing well or not?  
6 And it's not clear.

7 I like Craig's idea of just thinking of the three  
8 different SNP types differently. And with the D-SNPs, I  
9 think, you know, if we move forward with a reauthorization,  
10 tightening up the requirements regarding integration I think  
11 is important.

12 The C-SNPs, you know, I don't know. And if  
13 Scott's experience is it just doesn't make sense to have a  
14 separate plan, well, then maybe -- I think, regardless, we  
15 need to think more about how to allow just general MA plans  
16 to have some kinds of different benefit designs,  
17 flexibility.

18 And for the I-SNPs, it looks like they do have  
19 some very positive outcomes, so, you know, I worry about  
20 just getting right of them.

21 That's my thought at this point.

22 DR. HOADLEY: I feel like in a sense I'm saying

1 "ditto" because I think everything I was going to say has  
2 been mentioned somewhere, and I think I agree with a whole  
3 lot of what has been said. I'll just go through several  
4 things really quickly.

5 I definitely like the idea of thinking of the  
6 three in different ways. With the C-SNPs, one of the things  
7 I keep focusing on is there's only 220,000 people, and it's  
8 just -- it's not a lot going on there. So, I mean, getting  
9 rid of them isn't a huge impact. It's not like there's this  
10 whole body of people that has to be moved around.

11 And the idea of sort of focusing only on ESRD and  
12 AIDS, from your table there are 4,000 people enrolled in  
13 plans for those two diseases, so, you know, that could be a  
14 fine thing for those 4,000 people, but, again, it's a  
15 really, really tiny thing. With the I-SNPs, again, it's  
16 50,000 people. So if they're working, you know, that's  
17 great and, again, it's not going to have a big cost impact  
18 sort of anywhere because even though they're expensive  
19 people, there are just not many of them.

20 I definitely like the idea of figuring out a way  
21 to get the value-based insurance design principles that are,  
22 in theory at least, being tested here but not probably very

1 tested, given the small numbers of people. And I think  
2 about that also in the context of the drug benefit side of  
3 this where all that repeats again.

4           And then on the D-SNPs, again, the two concepts  
5 that struck me is, one, thinking about how this interacts  
6 with the dual demos and not throwing it out if there's an  
7 opportunity to let that -- here we got real people because  
8 we're over a million people. It's something like one in six  
9 of all the duals, if my arithmetic is right. But also to do  
10 it in some way that insists on some level of integration  
11 makes a lot of sense. To just allow a D-SNP to be a D-SNP  
12 and not really do much, then have this sort of token  
13 contract doesn't seem to make much sense. So pushing them  
14 all to do better on that would make sense if we're going to  
15 -- I mean, that would be a good tradeoff in a  
16 reauthorization.

17           DR. DEAN: Just like Jack, probably everything I  
18 have to say has already been said. But my first reaction  
19 was very similar to Peter's, that, you know, this is so  
20 unclear, you really wonder are we really accomplishing  
21 anything. And I guess the basic question is: Is there  
22 something unique about the SNP structure that really can

1 solve some problems for us? And the data so far is, you  
2 know, mixed at best.

3 I guess my inclination, I don't see much  
4 justification for the C-SNPs. Those are things -- those are  
5 such broad populations and such a basic part of good care  
6 for the elderly, I just don't see where it has a role.

7 Maybe if -- you know, I guess I could support the  
8 idea that maybe integration for the duals, that's something  
9 that we clearly haven't accomplished very well, and maybe  
10 there's some potential here, and so maybe that's worth  
11 pursuing. But I guess, you know, I think there's just not  
12 much here that's very convincing.

13 DR. REDBERG: I certainly also agree with a lot of  
14 what has been said. The fact that -- I mean, they seem like  
15 good ideas, but it seems so difficult to administer and  
16 difficult to understand. And the fact that enrollment is so  
17 low, I just wonder if it was hard for beneficiaries to have  
18 so many choices and figure out what was the right plan, too.  
19 And so, in particular for the C-SNPs, it seems that it might  
20 be better just strengthening, certainly from what we've  
21 heard, Medicare Advantage to give them more flexibility and  
22 address that really important population with chronic

1 diseases and then perhaps continuing the I-SNPs and  
2 integrating the D-SNPs just seemed like good ideas. In  
3 theory, it all seems good. Just in practice it's hard -- it  
4 seems they got very hard to evaluate and implement.

5 DR. HALL: Well, I've been very much informed by  
6 the written materials. I really appreciate the analysis you  
7 put together and also the discussion here.

8 I guess what I've taken away from it so far is  
9 that a lot that is involved in C-SNPs has become part of  
10 basic good medical practice. Maybe it wasn't when these  
11 were put into place, so that that would make logical sense,  
12 as Scott has said, and many others, to put them back into a  
13 regular MA.

14 I do have trouble with the D's only in the sense  
15 that I guess my lens on Medicare from a clinical standpoint  
16 is that there isn't a typical Medicare patient. It's a  
17 little like saying that children are just little adults. We  
18 have a large, robust segment of people over age 65, but then  
19 we have an increasing, almost a tsunami proportion of  
20 individuals into their 80s and 90s that we will be living  
21 with for 30 to 50 years -- many of us will be hopefully  
22 joining that population someday. We don't know how to take

1 care of these patients. What we do know is that they need a  
2 different kind of integration and care management than we've  
3 been able to effect so far, and not only from the clinical  
4 standpoint but from the many social aspects and the multiple  
5 payment sources that may or may not be available to them.

6           So I come down saying that I think we should find  
7 some way to preserve the D-SNP program for a limited period  
8 of time, put whatever sort of quality benchmarks there to  
9 make sure that we're heading in the right direction, but I  
10 think to abandon it now after so much work has gone into  
11 figuring out, at least partially, how to deal with this, the  
12 population that MedPAC 20 years from now is going to be  
13 spending all their time on, I think we would be  
14 shortsighted.

15           MR. GEORGE MILLER: I want to echo what a great  
16 job the staff has done, and the information was very  
17 enlightening, and I join my colleagues that have all spoken  
18 eloquently before me. I have just a couple of things.

19           I do agree with Craig about dividing these into  
20 three groups. I agree that the C-SNPs can be integrated. I  
21 think we should reauthorize I-SNPs. And I am still in favor  
22 of keeping D-SNPs, but I can be persuaded. But the reason I

1 would be persuaded to keep D-SNPs and try to fold them into  
2 an integrated model is because of the complexity of the  
3 program and the information we've read. And having someone  
4 fully navigate and integrate and make sure that population  
5 takes advantage of all the benefits and services in a  
6 coordinated and integrated way I think would be beneficial  
7 and have some benefit in the long term.

8 I'll leave it at that.

9 MR. HACKBARTH: Actually, I heard more sort of  
10 agreement on general direction than I thought we might at  
11 this point, so that's good.

12 Just two quick questions, observations. A number  
13 of people said -- and I agree with this -- well, if we're  
14 going to have D-SNPs, they really ought to do something in  
15 terms of integrating the Medicare and Medicaid benefits.  
16 That was the stance we took a number of years ago.

17 What ensued was less than we had hoped, and my  
18 perception is the reason that's challenging is that it's not  
19 just a matter of Congress passing a law or CMS writing a  
20 rule, because it involves another party -- namely, state  
21 government. And the demo approach tries to deal with that  
22 in a very different way, engage the states actively as



1 partners and setting up demos. I'm still not entirely clear  
2 how outside the demo approach we bring this other party, the  
3 state, into this active agreement to integrate, fully  
4 integrate, under the D-SNPs. So that's one question. And  
5 we don't need to answer it now, but I want to learn more  
6 about that.

7           The other idea is a small one that I want to also  
8 think a little bit more about. We had observed that -- Bill  
9 did mention it earlier -- there are plans that have the  
10 ability to combine medical and social services. There are  
11 restrictions on Medicare Advantage plans' ability to do  
12 that. It has never been entirely clear to me why we should  
13 restrict Medicare Advantage plans in that way. If they are  
14 fully responsible for the patient, both financials and  
15 clinically, why shouldn't we give them the flexibility to  
16 say, you know, I want to pay for your transportation if that  
17 helps assure that you get to the right place when you need  
18 the care. Why the rules? Why do we care how the dollars  
19 are spent if they have full financial and clinical  
20 responsibility? And so if we were to clear out that sort of  
21 -- some of that regulatory underbrush in Medicare Advantage,  
22 restrictions on benefit design, restrictions on the use of

1 dollars, we may be able to accomplish some of the good that  
2 we're trying to accomplish with the SNPs more readily in  
3 basic Medicare Advantage.

4           Okay? All right. Thank you very much. Good  
5 work, Christine and Carlos. So we are now on to our last  
6 session, which is on Medicare payment for ambulance  
7 services. And as the staff come to the table to present,  
8 let me apologize to people in the audience who have been  
9 inconvenienced by my decision to move this from the first  
10 item today to the last item. And as I said in our morning  
11 session, send the e-mails to me, the complaints to me, not  
12 to Mark. This is my doing.

13           MR. HACKBARTH: And David, Zach, you can begin  
14 whenever you are ready.

15           MR. GAUMER: Okay. Good afternoon. This session  
16 is the third presentation of our work in response to a  
17 Congressional mandate to report on Medicare payment policy  
18 for ambulance services.

19           At our April and September meetings, we discussed  
20 Medicare ambulance coverage and payment policy. We walked  
21 through the results of our claims analysis and also  
22 discussed a variety of policy options.

1           In today's presentation, we will briefly review  
2 the framework the Commission has applied in evaluating  
3 policy options for all three of the mandated reports  
4 required by Congress. We will provide responses to a number  
5 of questions Commissioners have raised at our September  
6 meeting. We will then go over the key policy issues raised  
7 by our analysis and present a set of draft recommendations  
8 developed by the Chairman for the Commission's discussion.

9           To evaluate policy options for this report, the  
10 Commission will apply a framework consisting of four basic  
11 questions. These are the same as the ones you saw earlier  
12 in the day. Under the framework, we consider how the policy  
13 option would impact Medicare program spending above the  
14 current law baseline. We also consider whether the policy  
15 will improve beneficiaries' access to care, whether it will  
16 improve the quality of care beneficiaries receive, and,  
17 finally, whether the policy will advance payment reform away  
18 from the current fee-for-service system and towards a more  
19 integrated delivery system.

20           As a part of our mandate, in February, the  
21 Congress directed the Commission to conduct a study of the  
22 Medicare ambulance fee schedule and specifically required

1 the Commission to examine the three temporary ambulance add-  
2 on policies, including their appropriateness and their  
3 effect on ambulance suppliers' and providers' Medicare  
4 margins, and also required the Commission to consider  
5 whether there is a need to reform the ambulance fee schedule  
6 generally.

7           The formal due date for this report is June 15,  
8 2013. However, the temporary add-on policies will expire  
9 under current law at the end of this year. Therefore, the  
10 Commission has been working towards giving the Congress the  
11 information it needs to make a decision about whether to  
12 end, extend, or amend these policies by the end of 2012.

13           At our September meeting, you asked several  
14 follow-up questions in response to our findings. More  
15 detailed responses to these questions are included in your  
16 October mailing materials and I would be happy to discuss  
17 these more specifically on question. But for now, I will  
18 just provide you with a brief summary of what we have  
19 brought back to you.

20           First, Rita, Bill, and others inquired about the  
21 characteristics of dialysis beneficiaries. Overall, more  
22 than half of dialysis beneficiaries had at least one

1 ambulance transport in 2011, and the growth rate in  
2 dialysis-related transports was faster for beneficiaries age  
3 80 or older.

4           Herb, Glenn, and others inquired about  
5 beneficiaries who were dually eligible for both Medicare and  
6 Medicaid. We found that duals were more likely than non-  
7 duals to use ambulance services and even more likely than  
8 non-duals to have a dialysis-related transport. In  
9 addition, the share of dialysis-related transports that were  
10 attributed to duals varied considerably by State.

11           Alice, you asked us to evaluate whether high-  
12 spending States might be associated with an absence of a  
13 Medicaid transportation benefit. As it turns out, Medicaid  
14 transportation benefits are present in both low- and high-  
15 spending States. However, it is unclear the extent to which  
16 these transportation benefits are used in each State.

17           Kate and others asked us to compare State-level  
18 ambulance spending to other State-level utilization  
19 measures, such as inpatient use and hemodialysis treatments.  
20 What we found is that States in the lowest levels of  
21 ambulance spending for dialysis beneficiaries in 2009 also  
22 tended to have low levels of utilization in these other

1 measures. However, States with high ambulance spending did  
2 not have consistently high levels of utilization in these  
3 other measures.

4           Glenn and others inquired about the  
5 characteristics of dialysis beneficiaries. Dialysis-related  
6 transports were shorter than other types of transports in  
7 terms of their average distance traveled. And further, over  
8 the last five years, dialysis transports have become shorter  
9 while the distance of other types of transports have  
10 remained relatively constant.

11           In addition, the average payment for a round-trip  
12 dialysis transport was two times higher than the standard  
13 bundled base payment rate a dialysis facility receives for a  
14 single dialysis treatment.

15           Now, finally, you asked for an update on the 2012  
16 GAO report on ambulance industry margins. GAO's report was  
17 released Monday of this week and it concluded that the  
18 median ambulance supplier and provider margin for 2010 was  
19 negative one percent, excluding the temporary add-on  
20 payments. This finding represents an improvement of  
21 approximately five percentage points from their 2007 report,  
22 which found a Medicare margin of negative six percent.

1           In addition, their 2012 estimate of the median  
2 margin -- Medicare margin, excuse me -- without the add-on  
3 payments ranged from about negative eight percent to  
4 positive nine percent, a wide range including both positive  
5 and negative margins.

6           We will now turn to the four specific ambulance  
7 policy issues at hand. As a part of each issue, we will  
8 provide you with a description and a summary analysis of the  
9 issue itself, the Chairman's draft recommendation, and the  
10 implications of the stated recommendation.

11           The first issue concerns the three temporary add-  
12 on policies now in effect and whether or not these should be  
13 extended or allowed to expire. To remind you, these add-ons  
14 are supplemental to the fee schedule, and mechanically how  
15 this works is that they are increased, either the base  
16 payment or the mileage payment of a given transport. One of  
17 the temporary add-ons supplements payments to all ground  
18 transports. A second supplements payments for urban air  
19 transports that were grandfathered as being rural. And one  
20 supplements payments for ground transports originating in  
21 areas that are designated as super-rural. These temporary  
22 add-ons expire at the end of 2012 and extending any of them

1 will increase spending relative to current law.

2           To extend the temporary add-ons and increase  
3 spending beyond the baseline in current law, we would need  
4 clear evidence that doing so is required to ensure access  
5 and improve quality. On the contrary, in regard to the  
6 first ground ambulance add-on, we found no evidence of  
7 access problems. We observed growth in spending on  
8 ambulance transports and growth in the use of ambulance  
9 services per beneficiary. However, much of this growth is  
10 in the BLS non-emergency transports, and we want to ensure  
11 access to emergency transports. We discussed one way to do  
12 this on the next few slides.

13           In addition, we observed growth in the number of  
14 ambulance suppliers overall, and particularly for-profit  
15 suppliers. We also observed the recent entry of private  
16 equity firms into this industry. In addition, the new GAO  
17 report concluded that industry margins were higher than in  
18 previous reports. Taken together, there does not seem to be  
19 clear evidence to increase payments for ground transports.

20           Second, the super-rural add-on increases a real  
21 need, the fact that in areas with low population density the  
22 volume of transports may be low and may lead to higher costs



1 per transport. In these isolated areas, higher costs may  
2 be, to a certain extent, beyond the control of the supplier.  
3 But the super-rural add-on does not perfectly target  
4 isolated low-volume areas. This problem requires a better  
5 and more permanent solution, and we will talk about this  
6 later in the presentation.

7 Third, the air ambulance add-on was meant to  
8 transition payments following the redesignation of some  
9 counties from rural to urban status by the Office of  
10 Management and Budget back in 2006. By now, providers  
11 should have had time to adjust to those redesignations.

12 A second issue is that basic life support non-  
13 emergency transports appear mis-valued. Over the course of  
14 the last two public meetings, we've provided you with a  
15 variety of statistics concluding that in recent years, BLS  
16 non-emergency transports have grown more rapidly than other  
17 types of ground transports, particularly for dialysis-  
18 related transports.

19 In addition, we have concluded that a relatively  
20 small group of suppliers and providers focused almost  
21 exclusively on BLS non-emergency transports. These entities  
22 accounted for a disproportionately large share of all BLS

1 non-emergency transports. Further, we also found that  
2 suppliers and providers that began billing Medicare for  
3 ambulance transports between 2008 and 2011 -- these are the  
4 newest suppliers, the newest providers -- were more likely  
5 to provide BLS non-emergency transports than established  
6 entities.

7           In addition, in recent years, for-profit suppliers  
8 have entered the ambulance industry at twice the rate of  
9 nonprofit suppliers. And in 2011, three large private  
10 equity firms made significant investments in the ambulance  
11 industry. The entry of for-profits and private equity is  
12 particularly interesting in light of GAO's estimate of 2010  
13 Medicare margins, which have improved from negative six to  
14 negative one percent.

15           Eventually, one solution to addressing this issue  
16 of mis-valued BLS non-emergency transports would be to  
17 gather current industry-wide cost data from the ambulance  
18 industry and then rebase the ambulance RVU scale using those  
19 more current data. However, in the absence of these data,  
20 CMS could proceed to rebalance existing ambulance RVUs by  
21 reducing the RVU for BLS non-emergency transports by a set  
22 percentage and increasing the RVUs for all other types of

1 transports by a set percentage. In doing so, CMS could  
2 effectively reduce payments for all BLS non-emergency and  
3 hold harmless aggregate payments for all other types of  
4 transports. Specifically, this would preserve payment  
5 levels for emergency transports consistent with current  
6 levels that include all permanent and temporary add-on  
7 payments. This policy would be designed to be budget  
8 neutral. Also, the impact of this policy would be to reduce  
9 the growth in BLS non-emergency transports and reduce the  
10 incentive of suppliers and providers to focus on these  
11 services instead of emergency ambulance transports.

12 Therefore, the effort to rebalance the ambulance  
13 fee schedules RVUs simultaneously addresses the issue of  
14 mis-valued BLS non-emergency services as well as concerns  
15 about preserving access to emergency services, which may  
16 have arisen from the expiration of the temporary add-ons.

17 In the subsequent section of this presentation, we  
18 also address any concerns that may exist about access to  
19 ambulance services in isolated low-volume areas.

20 Combining the two stated issues at hand, the  
21 Chairman's draft recommendation one reads: The Congress  
22 should allow the three temporary ambulance add-on policies

1 to expire and direct the Secretary to rebalance the relative  
2 values for ambulance services from BLS non-emergency to  
3 other ground transports. Rebalancing should be budget  
4 neutral and maintain payments for other ground transports at  
5 their level prior to expiration of the temporary ground  
6 ambulance add-on.

7           Looking at the implications of recommendation one  
8 in reference to our framework, we anticipate no overall  
9 effect on spending with regard to the expiration of the  
10 three temporary add-ons. Further, rebalancing the ambulance  
11 RVUs is budget neutral by design. When coupled with  
12 recommendation number two, which you'll hear about in a  
13 moment, we believe this recommendation results in no net  
14 impact on beneficiary access to ambulance services. We  
15 anticipate no implications for quality of care and no  
16 implications in regards to transitioning away from fee-for-  
17 service and towards a more integrated delivery system.

18           David will now guide us through the next  
19 recommendations.

20           MR. GLASS: Thank you, Zach.

21           The next issue is protecting access by directing  
22 payments to transports from isolated low-volume areas. The

1 GAO found, not surprisingly, that isolated rural areas with  
2 low population density generated fewer ambulance transports  
3 than more densely populated areas, and they also found that  
4 providers with a low volume of transports had higher costs  
5 per transport.

6 We observed that the permanent short mileage  
7 ground add-on policy is not well targeted to help isolated  
8 low-volume areas. Current policy increases the mileage rate  
9 of all rural transports by 50 percent if the distance of the  
10 transport is between one and 17 miles. This add-on broadly  
11 increases payments across rural areas and ends up both  
12 excluding approximately 220,000 super-rural transports with  
13 a mileage greater than 17 miles, which are arguably the ones  
14 from the most isolated areas, and at the same time it  
15 includes over two million transports from rural areas that  
16 are not super-rural. In 2011, this policy accounted for \$42  
17 million in spending.

18 There may be a better method of directing payments  
19 to isolated low-volume areas, and we look at one possibility  
20 on the next slide. This slide illustrates what we mean by a  
21 better policy to deal with the problem of high costs arising  
22 from low volume and isolation. The basic issue is how to

1 better direct higher payments to areas where conditions  
2 create higher costs per transport. We illustrate a four-  
3 step process.

4           The first step is to determine the cost function,  
5 that is, how much cost increases as volume decreases. From  
6 the GAO reports, it appears that a lower volume of  
7 transports leads to higher costs and that costs go up  
8 noticeably below about 600 to 700 transports a year, so that  
9 is less than two a day.

10           The second step is to define the area as some set  
11 radius -- eight, ten, or 15 miles -- around a zip code, or  
12 if the zip code area is large enough, you could just look at  
13 the population density within the zip code.

14           The third step is to compute the population in the  
15 area and the number of ambulance transports that population  
16 would generate, assuming use of the national average.

17           And finally, if the number of transports would be  
18 below the volume threshold, then to increase the payments by  
19 some amount.

20           Whether or not the policy would increase or  
21 decrease spending depends on how much is added for low-  
22 volume areas and what the low-volume threshold is. In

1 developing an illustrative policy, we would use areas for  
2 definition rather than providers because ambulances are  
3 mobile and zip codes are the areas used in the payment  
4 system. We would not want to look at supplier location to  
5 determine the isolation or the individual volume because,  
6 for example, there could be two small providers next door to  
7 each other causing each to have a low volume of transports.  
8 This policy is designed to replace the current rural short  
9 milage payment add-on.

10           The Chairman's second draft recommendation is as  
11 follows. In order to target payments in rural areas to  
12 protect access, the Congress should replace the permanent  
13 rural short mileage add-on for ground ambulance transports  
14 with a new adjustment directing increased payments to ground  
15 transports originating in geographically isolated low-volume  
16 areas. This would replace the permanent add-on, which adds  
17 50 percent to the ground ambulance mileage rate if the  
18 transport starts in a rural zip code and is between one and  
19 17 miles, with one that better directs additional payments  
20 to geographically isolated low-volume areas because  
21 providers serving those areas face circumstances beyond  
22 their control that increase their cost. In other words, it

1 would better direct extra payments to areas that need them.

2           Looking at the implications of this  
3 recommendation, the design of the new low-volume policy will  
4 determine its effect on spending. It may cost the same as  
5 the current \$42 million short mileage add-on or it could be  
6 less if more focused on areas that need the help, because by  
7 definition, those areas have very few transports. So even  
8 if the add-on is relatively high, it won't be applied very  
9 often.

10           Key variables of the add-on: Percentage, the low-  
11 volume threshold, and the determination of payment areas and  
12 population density.

13           The recommendation should maintain access in  
14 isolated areas with low population density where suppliers  
15 face circumstances that increase their average cost per  
16 transport. And we see no implications for quality or  
17 payment reform.

18           DR. MARK MILLER: [Off microphone.] Dave, can I  
19 hold you for just a second?

20           MR. GLASS: Sure.

21           DR. MARK MILLER: I just want to pause here for a  
22 second and pick up with a conversation that some of you were



1 having earlier, you know, the notion that concerns about  
2 unintended consequences and a heavy focus on access, and  
3 Alice, you were making some of these points. But it was on  
4 everybody's mind.

5           You can look at data and try and figure out  
6 whether access is affected or not, but the other way you can  
7 go at it is through policy. And the reason I wanted to stop  
8 it here is just to draw your attention to two things here.  
9 So if the add-ons go away, there's a natural concern of what  
10 happens with access, and there's two things in here to keep  
11 track of.

12           One is the rates for the emergency transports and  
13 the ALS non-emergency would be held at their current rates  
14 as of today. And so if we aren't experiencing access  
15 problems, and we've had no indication of that, that should  
16 not be compromised. And the rate that we're taking down to  
17 take into account the removal of the add-ons is the non-  
18 emergency transports, and we can talk about that more on  
19 question.

20           And the second piece to assure access is take the  
21 dollars that are currently for rural areas and better -- for  
22 short mileage -- and better target them to the providers who

1 are truly serving isolated areas and make that add-on  
2 actually larger so that the actual profitability -- or they  
3 can overcome their fixed cost and have a better shot at  
4 being a profitable provider.

5           And so the point here -- I wanted to pause because  
6 we're about to shift gears and get into some program  
7 integrity stuff. But in trying to focus on access, these  
8 things are being built into the recommendations and the  
9 policies directly. And this is something that was on your  
10 mind earlier and I wanted to make sure it got back to you.

11           MR. GLASS: Thank you, Mark.

12           Well, the last issue is the rapid increase in  
13 dialysis-related transports and inappropriate billing for  
14 non-emergency transports in general. You remember from  
15 September this graph and the fact that transports to  
16 dialysis have been growing twice as fast as other  
17 transports. We presented some new information in response  
18 to your questions but are still left with the finding that  
19 there is tremendous unexplained variation across the States  
20 and Medicare spending for ambulance services for  
21 beneficiaries on dialysis, and we've isolated the six States  
22 with the highest spending in red, the ones in the middle in

1 yellow, and the ones at or below the median in green.

2 We note that there has been high growth of  
3 transports to dialysis relative to other kinds of  
4 transports, roughly double the growth rate. We found wide  
5 variation across States, as shown on the previous graph.  
6 The spending in some States is three times the national  
7 average and 20 times that of the lowest-spending States.

8 There are continued IG findings of inappropriate  
9 billings for transports that do not meet medical necessity  
10 requirements and prosecutions for fraudulent billing.

11 And finally, there is a need to resolve  
12 inconsistent local claims as it's used by the claims  
13 processors.

14 You suggested that one approach would be to more  
15 clearly define the circumstances under which ambulance  
16 transport to dialysis facilities are medically necessary,  
17 hence, the Chairman's draft recommendation three. The  
18 Congress should direct the Secretary to develop and  
19 promulgate national guidelines to more precisely define  
20 medical necessity requirements for both recurring and non-  
21 recurring, non-emergency ground ambulance transport  
22 services. To support those guidelines, the Secretary should

1 develop a set of edits to be used by all claims processors.

2 But this recommendation by itself is unlikely to  
3 solve the problem of inappropriate billing and wide  
4 variation, hence the Chairman's draft recommendation number  
5 four. The Congress should direct the Secretary to identify  
6 aberrant patterns of use by geographic areas and provider,  
7 and then use his or her statutory authority to address  
8 clinically inappropriate use of basic life support non-  
9 emergency ground ambulance transports with an emphasis on  
10 transports to and from dialysis facilities. This directs  
11 the Secretary to use all of her authorities to eliminate  
12 clinically inappropriate use. The Secretary could look at  
13 patterns of use and concentrate on areas or providers with  
14 aberrant patterns of use. We emphasize transports to  
15 dialysis facilities, but transports to other facilities,  
16 such as community mental health clinics, have also been the  
17 subject of IG investigations.

18 We look at the implications of recommendation  
19 three and four together. We would expect these  
20 recommendations to save money. We estimate reducing  
21 spending for transports to dialysis facilities in high-  
22 spending States at the level of the national median would

1 save over \$400 million a year. Curtailing inappropriate  
2 transports to other facilities would result in additional  
3 savings. Appropriate access would be maintained, and we did  
4 not see implications for the elements of the framework.

5 We can respond to questions or clarifications of  
6 the analysis and look forward to your discussion of the  
7 Chairman's draft recommendations.

8 MR. HACKBARTH: Okay. Thank you, David and Zach.

9 Let me -- for those of you who just joined us in  
10 the audience, let me just say a word about the process and  
11 our framework for looking at these issues. So you've heard  
12 draft recommendations that I'm offering to the Commission.  
13 We'll talk about the draft recommendations today. Between  
14 this meeting and our November meeting, we'll make any  
15 necessary modification in those draft recommendations and  
16 then have our final votes at the November meeting.

17 In examining this issue on ambulances and two  
18 other reports that Congress has asked us to do, one on the  
19 physician payment system and the other on outpatient  
20 therapy, we are trying to apply a consistent framework which  
21 says that if we are to recommend expenditures above the  
22 current law baseline in these three areas, we should do so

1 based on evidence that the increased expenditure would  
2 result in improved access to care, improved quality of care,  
3 or facilitate movement to new payment systems. So that's  
4 the basic test we're applying across each of the three areas  
5 where Congress has asked us to do reports.

6           So let me kick off the clarifying questions with  
7 one of my own, and that is for you, Zach. You talked about  
8 potential for rebalancing the rates for non-emergency and  
9 emergency transport. If the goal is to maintain the rates  
10 at the current level, including the temporary add-ons for  
11 emergency transport, how much, roughly, would the non-  
12 emergency rate have to decline?

13           MR. GAUMER: In terms of percentage, we'd be  
14 looking at about a 5.7 percent decline in the BLS non-  
15 emergency transport. And on average, across all of the  
16 other services, ground services, there would be an increase,  
17 an offsetting increase of about 2.8 percent. So that would  
18 include all the emergency as well as ALS non-emergency. So  
19 it's BLS emergency and all other.

20           MR. HACKBARTH: So let me just make sure, because  
21 we have the payment levels that exist as we speak with the  
22 temporary add-ons, and then we have payment levels that

1 would exist on January 1, after the expiration. I just want  
2 to make sure we don't get confused.

3 So when you say an increase in the emergency  
4 transport, you're referring to an increase relative to the  
5 January 1 rate that would otherwise apply.

6 MR. GAUMER: What we're doing is we're looking at  
7 rates currently with the add-on, and so those non-BLS non-  
8 emergency, everything else, their payments would get raised  
9 up to a level that would include the temporary ground add-on  
10 that essentially would be expiring. Now, the super-rural  
11 would expire. The air add-on doesn't apply in this case.

12 MR. HACKBARTH: Yeah --

13 MR. GLASS: If I may, what we're manipulating is  
14 the RVUs.

15 MR. HACKBARTH: Yes.

16 MR. GLASS: So we reduce the RVU for BLS non-  
17 emergency --

18 MR. HACKBARTH: Yeah --

19 MR. GLASS: -- by 5.7, and then the other, have to  
20 increase the RVUs for the other ground transports, and by  
21 doing so, their payments will be the same as they were  
22 before the --

1           MR. HACKBARTH: And that last phrase is the one I  
2 want to zero in on and just make sure that we're all using  
3 the terminology the same. So, currently, we have -- the  
4 major temporary add-on is the three percent rural, two  
5 percent urban add-on to the rates, and my recollection is  
6 that accounts for, like, \$134 million of a total of roughly  
7 \$190 million in all of the temporary add-ons together. So  
8 it's the big hitter. That's where the money is in the  
9 temporary add-ons that we're reviewing.

10           And what I think David just said is that the  
11 reconfiguration, the rebalancing of the relative values  
12 would allow us to keep the emergency rates at the level that  
13 they are with the three and two percent add-ons, and then  
14 that would be made budget neutral relative to current law on  
15 January 1 by taking down the non-emergency relative values  
16 by 5.7 percent. Are we saying the same --

17           MR. GLASS: Yes. That is correct.

18           MR. HACKBARTH: Okay. George, clarifying  
19 questions.

20           MR. GEORGE MILLER: I'm glad you cleared that up.  
21 That was very helpful, to explain that.

22           And I was just wondering, based on your draft



1 recommendations, if we had looked at how do we determine  
2 it's an emergency. Although you would you change the  
3 payments to -- for emergencies. But, how do we determine  
4 it's an emergency?

5           And this is anecdotal information. Our ER  
6 sometimes gets busy, and folks wait, patients can figure out  
7 how they can get above the line by calling 911 and being  
8 brought in. Now in my mind that's not an emergency, but  
9 because they get called by EMS that becomes an emergency.

10           So, in this discussion I would like to maybe make  
11 a suggestion that -- and Tom is not going to like this  
12 statement, but maybe we should have an ER or ED position  
13 attest that that is truly an emergency.

14           DR. DEAN: You're right, George.

15           MR. GEORGE MILLER: So, we have integrity.

16           I mean, again, I'm not saying the EMS would do  
17 anything wrong, but if a patient calls and the local statute  
18 requires no matter who calls you've got to go pick them up,  
19 not a national standard but the local statute. They pick  
20 them up and bring them, and they've got a hang toenail.  
21 They get to go directly in the back and bypass everybody in  
22 the ED. That is not an emergency, but based on this current

1 recommendation we'd have to pay for that.

2 My suggestion is that we have the ED position  
3 attest that it was truly an emergency, then the EMS company  
4 would be able to bill if it's truly an emergency. And, if  
5 it's not, then they go down to the rate we're talking about  
6 in this proposal.

7 MR. HACKBARTH: Zach or David, do you want to  
8 address what the rules are for qualifying for emergency  
9 transport?

10 MR. GAUMER: Yeah, there are a couple of steps  
11 along the way where this can be determined or revised -- the  
12 emergency status. A 911 call is usually what initiates a --  
13 which goes to a dispatcher, and the dispatcher says yes,  
14 this is an emergency; I cannot deny. And the ambulance goes  
15 out.

16 When the crew -- at that point, an ALS emergency  
17 crew, advance life support, is usually sent out, and at the  
18 scene it can also be determined whether or not this is an  
19 ALS emergency or BLS emergency or nonemergency. So it can  
20 be revised at that point. So nothing has been billed at  
21 that point.

22 The ambulance supplier will then bill based upon

1 those two points of determination. But, then there is a MAC  
2 -- the Medicare administrative contractors -- who will also  
3 think, is this an emergency or not an emergency? And  
4 sometimes the claim will get, you know, hung up in there,  
5 and the status might get changed again.

6 MR. GEORGE MILLER: Yeah, even if there's either a  
7 state or local statute that says that you have to respond to  
8 everything, then they can bill as emergency; those still --  
9 those two steps you just described still oversee?

10 MR. GAUMER: The state and the local is what  
11 determines the standard for emergency. So, in the Medicare  
12 regulation, it says, you know, the state and the local rules  
13 will determine, you know, what defines emergency. So it  
14 does vary.

15 MR. GEORGE MILLER: Okay.

16 MR. GAUMER: And, if the EMS crew gets out there  
17 and decides this is person doesn't need transport --

18 MR. GEORGE MILLER: Right.

19 MR. GAUMER: -- then they don't have to get them,  
20 and they don't transport them, and there's no bill to  
21 Medicare.

22 MR. GEORGE MILLER: Okay.

1 MR. KUHN: Can I ask just a follow-up on that?

2 You said the MAC would look at this as well, but  
3 is also this in the scope of work for the recovery audit  
4 contractors? Are they looking at these claims as well?

5 MR. GAUMER: We did talk to some folks over there,  
6 and the RACs do not have this on their radar at the moment.  
7 They look at Part A ambulance claims, but they do not right  
8 now look at Part B ambulance claims. It was told to me that  
9 this might be something they're going to do soon, but they  
10 look at this as a Part A-Part B decision.

11 DR. MARK MILLER: And if you thought it was  
12 important, you know, you should bring it up because a push  
13 from here could also move that along or move it in one  
14 direction or another.

15 DR. HALL: Apropos to George's inquiry, I'm sort  
16 of pessimistic on the idea of trying to control emergency  
17 use by making somebody responsible to certify, honestly. I  
18 think that there's not much of an incentive for an emergency  
19 room doctor to do this, frankly. It just adds on more time  
20 and more pressure on their life.

21 MR. GEORGE MILLER: Check box.

22 DR. HALL: I know. And, if that's all it is, is a

1 checked box, then it's meaningless.

2 I think we just have to change the incentives for  
3 the providers of the ambulance services, and I think this is  
4 starting to go in that -- very strongly in that direction.

5 DR. DEAN: Maybe you already answered that, but I  
6 mean I had some of the same questions that George did.

7 Right now, the medical necessity criteria is  
8 basically met based on local rules. Is that what you're  
9 saying?

10 MR. GAUMER: Yes, there can be local coverage  
11 determinations that are made to define medical necessity.

12 DR. DEAN: So there's no national guideline.

13 MR. GAUMER: There is a very broad definition of  
14 this nationally, and the local coverage determinations do  
15 not consistently weigh in on the definition of medical  
16 necessity and some other key items.

17 DR. DEAN: Do we have any information about  
18 especially the dialysis transports; are those actual  
19 ambulance transports, or are they vans?

20 I mean, I suppose it changes a lot with the  
21 service, but I mean is it truly an ambulance transport?

22 MR. GAUMER: You know, under the Medicare

1 definition, they are ambulance transports, but they're an  
2 ambulance transport by a different severity level. You  
3 know. Usually, the vast majority of them are basic life  
4 support, nonemergency transports, maybe 97, 98 percent of  
5 them.

6 DR. DEAN: Just the vehicle and equipment.

7 MR. GAUMER: There are some differences. I'm sure  
8 that there are --

9 MR. GLASS: But, they have to be certified as a  
10 BLS.

11 MR. GAUMER: Right. It's really a labor  
12 difference. So, ALS staff versus BLS staff.

13 DR. REDBERG: What you would call an ambulette?

14 MR. GAUMER: Those are sometimes referred to as  
15 ambulettes, but Medicare does not see it as an ambulette if  
16 it's an ambulance.

17 DR. MARK MILLER: Unless it's truly outright  
18 fraud, it is an ambulance that's carrying this person.  
19 Otherwise, then they're really billing fraudulently.

20 DR. REDBERG: It's a nonemergency ambulance. It's  
21 very confusing to me.

22 DR. SAMITT: I have two quick questions.

1           In the briefing materials, this is actually  
2 specifically focused on the Chairman's recommendation 2. It  
3 talks about the low-volume add-on policy, and it references  
4 issues that might reduce or increase actually the cost of  
5 this policy.

6           I just wanted to make sure -- it listed a number  
7 of things: the number of transports, estimated utilization  
8 rate per capita -- whether we're pretty assured that we  
9 could develop a methodology that would lower the cost as  
10 opposed to increase it because it seemed as if there were a  
11 number of variables that could actually drive it up, not  
12 down.

13           MR. GLASS: Yeah, you could -- but, you could --  
14 we're pretty sure that you can design it, and we've done a  
15 few estimates.

16           DR. SAMITT: So, design the modeling or the --

17           MR. GLASS: Yeah, we've done some estimates on  
18 this, that we think you can design one that is budget  
19 neutral to, or even less if you want.

20           DR. SAMITT: And my second question is I was  
21 surprised that--

22           MR. HACKBARTH: So, Craig, just on that one, my

1 initial concept was to say let's take -- I think it's like  
2 \$42 million

3 MR. GLASS: Correct.

4 MR. HACKBARTH: -- in the short mileage, permanent  
5 add-on. Let's take that 42 million and redesign it and, by  
6 definition, do it in a budget neutral way.

7 DR. SAMITT: My second question, I was struck in  
8 the draft recommendations 3 and 4 that there wasn't  
9 reference to the notion of actually adjusting RVUs related  
10 to dialysis transport even further downward. So, if we're  
11 adjusting emergency versus nonemergency BLS, would we ever  
12 consider the notion of even saying a dialysis transport RVU  
13 would be even less than nonemergency BLS and whether that  
14 was considered?

15 MR. GLASS: So, create a separate RVU for dialysis  
16 transports.

17 DR. SAMITT: Yes.

18 MR. GLASS: We haven't thought of that.

19 DR. MARK MILLER: And the only thing I would say -  
20 - you know. We are working with, you know given our  
21 timeline and everything else, with what the current  
22 structure is, the four different vectors and then how to



1 adjust the RVUs.

2 The other thing to keep in mind is even though  
3 dialysis jumps out the most and there's been a lot of focus  
4 on it, we also circulated a couple of articles to you guys  
5 in your handouts. I mean, there have been other examples of  
6 like partial hospitalization where nonemergency recurrent  
7 transportation -- even though dialysis is what jumps out the  
8 most, it's probably not the only thing that's going on.

9 Fair enough?

10 MR. GLASS: We wouldn't want to see use migrate  
11 over to yet a new flavor of the month kind of thing.

12 MR. BUTLER: So you cited that this week the GAO  
13 produced profitability numbers. So, cite those again for  
14 me.

15 You said 1 percent negative margin on Medicare  
16 only.

17 MR. GAUMER: And that's without the add-on  
18 payments in there.

19 MR. BUTLER: Without the add-on.

20 Then it's a 5 percent improvement. I mean, it was  
21 negative 5 percent at when? At what point?

22 MR. GAUMER: So it was in 2007. In their 2007

1 report, GAO modeled 2010 Medicare margins, and they came up  
2 with a number that was negative 6 percent across the  
3 industry.

4           Okay, there are a lot of caveats to it that I can  
5 say in a moment.

6           But then in 2012, in that report, they also did  
7 2010 margins, using Medicare margins, using cost and payment  
8 data from 2010, less of an estimate, more of actual number  
9 for -- to get at a number that was negative 1 percent,  
10 median.

11           MR. BUTLER: So my -- you can guess what I would  
12 ask next. Well, how about the for-profit consolidated  
13 companies versus the more rural, publically and municipally  
14 supported ambulances versus the -- is there any -- or, the  
15 really effective ones versus the less.

16           I mean, you go down the whole path, but any  
17 striking patterns?

18           MR. GLASS: Well, I think the most interesting  
19 thing from that point of view is that the sampling frame  
20 remained unchanged between these reports. So they were  
21 looking at established providers, if you will, and so any  
22 recent entrants aren't in their sampling frame.

1           So, since we've shown that the recent ones, or  
2 entrants, more interested in the BLS nonemergency and  
3 concentrating on that, that minus 1 percent number doesn't  
4 include margins for these new providers that are  
5 concentrating on BLS nonemergency.

6           MR. GAUMER: And when David says new, that's  
7 really from 2004-on. So that covers a broad range.

8           And we had shown you some other data that the new  
9 providers, which we defined as those from 2008-on, had  
10 different transport use patterns, you know, more BLS than  
11 emergency, that type of a thing.

12           So, we wonder what's in there too.

13           And the other thing --

14           MR. BUTLER: Well, but -- okay. Obviously,  
15 they're doing right overall or they wouldn't be growing, and  
16 there would be an access --

17           MR. GAUMER: Right.

18           MR. BUTLER: I understand that. I'm just trying  
19 to say, is there evidence that maybe they're also more  
20 efficient and they're maybe even making money off of  
21 Medicare because they just run more efficiently?

22           MR. GLASS: We're saying we don't have margin data

1 on those providers in the GAO report, but one would expect  
2 that their margins would be higher than the ones that are  
3 reported in the GAO report.

4 MR. BUTLER: Why? I mean, they maybe have more  
5 commercial business that's offsetting the Medicare losses.

6 MR. GLASS: Well, because they're doing BLS  
7 nonemergency predominantly and those are much lower cost  
8 transports. The GAO report looking at their sample; they  
9 found that the higher the percentage of BLS nonemergency to  
10 other -- to emergency, the higher the margin.

11 MR. GAUMER: And one other thing that you asked  
12 about, Peter, was stratifying the margin, were we able to  
13 get at different types of organizations?

14 And the answer to that, unfortunately, is no,  
15 because the sample size was so small. They were looking at  
16 about 150 providers or suppliers in both of these analyses.  
17 In the 2012 version and the 2007 version, less than 200  
18 entities were involved. So there's not a lot of  
19 stratification by type or that sort of thing.

20 DR. COOMBS: So I really appreciate you going  
21 around and answering all the questions we had the last time.  
22 You did a great job. And I think because of that I feel

1 very comfortable with the information that is presented  
2 here.

3 I just wanted to talk about one specific --  
4 actually, a couple scenarios that I've seen in my practice,  
5 and one is the transfer from day surgery to the hospital  
6 from a freestanding facility when patients have pain that's  
7 not controlled, or nausea and vomiting, and they need to be  
8 admitted for an observation visit.

9 So those are kind of different than the dialysis  
10 patients in the sense that the more you do outpatient  
11 surgery you may see an increase in that group. Right now, I  
12 think it's incredibly rare and that that's not something  
13 that is a cost driver, but I think going forward it is  
14 something that we should probably just kind of look at very  
15 carefully.

16 And I like the fact that the other question you  
17 asked was in terms of low-cost and high-cost areas in terms  
18 of geographic variation, that it was uncoupled in the high-  
19 cost area, except I saw on that graph that you had  
20 Massachusetts way up there and that seems to be well  
21 matched.

22 MR. HACKBARTH: So let me just follow up on

1 Alice's question. My recollection from the slides last time  
2 that laid out the different RVUs was that there was one that  
3 -- the cited example was a transfer from one hospital to the  
4 other, to another hospital, and it qualified as advance life  
5 support, nonemergency.

6 MR. GAUMER: Yeah. Specialty care transport, I  
7 think, is the highest level. It's like -- I think the RVU  
8 is over 3, yeah. Is that what you mean?

9 MR. HACKBARTH: Well, that's my question. So  
10 Alice's situation is not the hospital but the ambulatory  
11 surgery center to hospital. Any idea where that fits in the  
12 scheme of things?

13 MR. GAUMER: In terms of its growth rate?

14 MR. HACKBARTH: No, in terms of the RVU.

15 MR. GLASS: I

16 MR. GAUMER: Oh, right. Yeah, so it would be high  
17 on the RVU scale.

18 So, if it's a specialty care transport that  
19 requires, you know, a doctor to ride in the cab or something  
20 -- a patient that's extremely ill coming out of surgery --  
21 that's likely going to be an ALS emergency or a specialty  
22 care transport.

1           And we have seen the specialty care transports.  
2   Although they make up a very small proportion of all  
3   ambulance transports, they are on the rise.

4           DR. COOMBS:  So -- and I say that only because we  
5   are shifting from hospital-based kind of procedures and  
6   going to day surgery for a lot of it.

7           But, it's only an ACLS because if I monitor that  
8   patient in the PACU I got them on an EKG so that the ACLS is  
9   needed for someone who is going to be watched in the same  
10  context in one facility as the other facility.  However, if  
11  you would wait for one hour, that patient may be getting  
12  dressed and going home with, you know, their daughter or  
13  son.

14          MR. HACKBARTH:  So, within the framework of the  
15  draft recommendations, since that qualifies as emergency  
16  transport, it would not be taken down by the reduction in  
17  RVUs that's inherent in the draft recommendation.  It would  
18  be protected at the higher level.

19                   Any clarifying questions?  Herb?

20          MR. KUHN:  Thanks.  Just a couple.

21                   One, just to make sure I'm clear -- kind of as  
22  Glenn started out on the numbers, just to make sure I'm

1 clear on the numbers on the baseline. So, with the expiring  
2 authority at the end of the year, if Congress were to  
3 reauthorize, it would basically cost them 192 million in  
4 these 3 temporary add-ons. Is that essentially correct?

5 MR. GAUMER: That's correct.

6 MR. KUHN: Okay. So it's basically no additional  
7 spending based on the recommendations, the 4  
8 recommendations, except for 3 and 4; there might be some  
9 potential savings that could be modeled sometime in the  
10 future.

11 MR. GAUMER: That's right.

12 MR. KUHN: Okay. Second thing, on the GAO report  
13 -- and I know that just came out. So we haven't had a  
14 chance to spend a lot of time looking at it, and I certainly  
15 haven't had a chance to read it yet. But from the 2007 to  
16 the 2010 update did GAO use the same methodology for both?  
17 So, is it a true apples to apples comparison, or is it -- or  
18 are they different?

19 MR. GLASS: Apparently, it's not precisely the  
20 same, and it has something to do with the median versus the  
21 average.

22 MR. GAUMER: There are some differences. I think



1 they tried to make the regression analyses and those types  
2 of things very similar, and they kept the sampling frame  
3 almost exactly the same. So there was an effort to be  
4 consistent, but it looks like there are some differences,  
5 slight ones, to consider.

6 MR. KUHN: Do we know why they might have chosen a  
7 different methodology so that, you know, it's hard to get a  
8 true comparison, why they would have changed it in the  
9 process?

10 Do they think it's just more accurate the way they  
11 did it now?

12 MR. GAUMER: I'm not exactly sure what their  
13 rationale would be.

14 You know, we did talk to the GAO early in this  
15 whole process to understand the 2007 report, and the vibe we  
16 got was that there are just improvements in statistics over  
17 the time period, that they might have gotten smarter about  
18 certain things and changed their processes.

19 MR. GLASS: But, if you would like, we can come  
20 back next month with the specifics.

21 DR. MARK MILLER: And, that's what I would say.  
22 In the midst of all this preparation, we were also trying to

1 read this.

2 MR. GLASS: Right.

3 DR. MARK MILLER: You know, at night. You know,  
4 before you go to sleep, that type of thing. And so, I think  
5 we should spend some time with it and answer your question.

6 MR. KUHN: I thought you all staff were  
7 superhuman. You've just now deflated my view of all of you.

8 MR. HACKBARTH: That's just pathetic.

9 MR. GLASS: Herb, I never sleep.

10 DR. MARK MILLER: Also, I'm moving to strike vibe  
11 from the transcript here.

12 MR. HACKBARTH: Bill.

13 MR. GRADISON: I'm going to wait for the next  
14 round, but at that point I really want to focus a fair  
15 amount of detail on the dialysis part, which I think needs  
16 much more emphasis than is in the current draft of your  
17 recommendations.

18 MR. HACKBARTH: Round 2. And let me also remind  
19 you since we have a draft recommendation here and we need to  
20 finalize a recommendation for a vote, in particular, in  
21 round 2 I would like you to comment specifically on anything  
22 -- whether you like the draft recommendations and, if not,

1 what you would like to see changed.

2 MR. GEORGE MILLER: All right, fair enough. I  
3 like the draft recommendation 1.

4 MR. HACKBARTH: Okay, we're done.

5 [Laughter.]

6 MR. GEORGE MILLER: However, it's not clear to me  
7 yet -- and maybe I'll listen and here more as we -- do you  
8 want us to comment on all four of them together or  
9 individually?

10 MR. HACKBARTH: I think in the interest of time  
11 let's do them all together. I'm sure people will want to  
12 focus on one or other. So, let's just try to get it all in  
13 one round.

14 MR. GEORGE MILLER: Okay. In general, I support  
15 them, but I am concerned about the word we've all used today  
16 -- the unintended consequences. I'm not quite clear yet how  
17 this would affect rural providers, particularly some that  
18 have gone from rural to urban. And I can talk to staff a  
19 little bit later to flesh that out.

20 But, I'm also concerned that maybe one solution  
21 would be to integrate a preauthorization for some of the  
22 concerns of fraud, that maybe our recommendation should deal

1 with that specifically. Maybe we should have  
2 preauthorization, maybe on the renal dialysis side, and  
3 maybe even put a moratorium on those suppliers until the  
4 Secretary can come up with a better methodology in  
5 determination.

6 So, I would like to maybe recommend those two  
7 parts of the -- or one facet of your four recommendations,  
8 to give specificity to the Secretary on how to deal  
9 particularly with the fraud and abuse issues.

10 DR. HALL: I think we've made enormous progress in  
11 trying to dissect out a very difficult and arcane system of  
12 payment, and I'm fully in favor of all the recommendations.

13 DR. REDBERG: And I also am in favor of all of the  
14 recommendations. And, you know, I'm very pleased with  
15 recommendation 3, to try to define the emergency and  
16 nonemergency ground ambulance transport requirements because  
17 I think we had a lot of discussion last time over that  
18 issue.

19 And I would also echo -- I think what Herb  
20 suggested is that we should look in particular perhaps at  
21 those very high-use states and for areas, what's going on  
22 there, because there are certainly suggestions that there's

1 inappropriate use and fraud.

2 DR. DEAN: Yeah, I support the recommendations,  
3 the direction that they're in. I need to look at them a  
4 little more in detail, just about the wording, but basically  
5 I think they're in the right direction.

6 A couple of comments. I would -- I mean Bill made  
7 the comment, it's hard to define emergencies. It really is.  
8 I mean, I think if -- I was in our emergency room at 2:00 in  
9 the morning about a week ago for a young guy that was dizzy,  
10 and he was perfectly stable. And by -- in any kind of  
11 retrospective analysis, it would not be judged an emergency.

12 And yet, this was a family. This guy came down  
13 with a bunch of systems that were frightening. And you  
14 know, I didn't particularly like to be there at 2:00 in the  
15 morning. On the other hand, they -- to them, it really was  
16 an emergency, and I think to deny that is a little hard. I  
17 think we've got to be cautious.

18 And also, I mean, to George's comment about  
19 certifying them, we already have to do that. At least with  
20 the Medicaid program, we are asked: Was this an emergency?  
21 Could this have been handled as an outpatient?

22 And we have to make a judgment about that. We

1 already do that. I don't like doing it, but we already --  
2 and I understand the reason, but I'm not sure it's very  
3 effective.

4           There's no question that transportation is a very  
5 important part of care, and I think that's the thing we  
6 can't lose sight of. I think paying for it through this  
7 manner obviously is not appropriate.

8           But it's very clear -- you know, dialysis is a  
9 good example. There are lots of other services that if  
10 people don't show up and don't give that care on a regular  
11 basis, they get worse and usually the costs go way up to.  
12 So there is a good reason for providing transportation.

13           The question is, how do you get it to people in an  
14 appropriate way?

15           And I wonder if there's -- you know. We need to  
16 think about rolling the payment for that into the payment  
17 for, whether it should be part of the dialysis payment.

18           I talked to the administrator of one of the  
19 nursing homes I go to, just this week, and they have a van  
20 that's on the road a large part of the time because they're  
21 in a community that doesn't have any other local services.  
22 So, every time one of their residents needs an appointment

1 with their physician, they provide it.

2 I said, do you get paid for this?

3 No, they don't get paid for it. It's just part of  
4 the services they provide.

5 And so, I think there are precedents for these  
6 kinds of things. They do it because it needs to be done and  
7 it's part of the service.

8 So, I mean, I think we're -- we need to look at  
9 it. It's a bundling issue, basically.

10 MR. HACKBARTH: Thanks for raising that, Tom.

11 We spent actually a fair amount of our discussion  
12 at the last meeting on that point. And I think in the text  
13 of our report on this one we should flag that as an issue.  
14 It is beyond the scope of --

15 DR. DEAN: Yeah.

16 MR. HACKBARTH: -- what we can reasonably take on  
17 for this report because we're on such a tight schedule  
18 mandated by Congress, but I think we can flag that as an  
19 issue.

20 DR. DEAN: This one last point is that in my area  
21 we do have some potential access problems, but they don't  
22 have to do with dollars. They have to do with the fact --

1 with very low-volume services that rely on volunteer EMTs to  
2 staff them and the increasing demands that are placed on the  
3 EMTs because of state regulatory requirements, state  
4 certification requirements and also employers.

5           You know, if you've got a service that makes two,  
6 three, four runs a week, which is more in keeping with what  
7 ours does, that's not enough where there's any possibility  
8 you can hire full-time people.

9           On the other hand, if you're an employer and your  
10 employees are taking off two or three times a week for an  
11 hour or two at a time, that's something that employers --  
12 you know. Even if they're trying to be cooperative, it's a  
13 burden.

14           And so, again, that's way beyond the scope of  
15 this, but I'm just saying there are other things that lead  
16 to access problems beyond just the payment. So, yeah.

17           DR. HOADLEY: Yeah, I think these are good  
18 recommendations, and I'm in favor of them. I particularly  
19 like on 2 the point that Mark made earlier, that this is a  
20 good way to target access and not just sort of leave things  
21 as they are and try to be more creative in targeting.

22           MS. UCCELLO: Yeah, I'm supportive of all these



1 recommendations.

2           And I want to second what Tom said about how  
3 transportation is needed for these people to get to  
4 dialysis. It's important that they get it, but doing this  
5 through the ambulance systems seems like overtreatment,  
6 especially when the costs are double what the dialysis  
7 treatment is. So, finding another way to do that is  
8 appropriate.

9           DR. MARK MILLER: And I'll just remind you all of  
10 a point that came up last time that we talked about this,  
11 which is within the bundled payment for the dialysis  
12 providers, do we start to talk about the notion of opening  
13 the door to them providing transport.

14           DR. REDBERG: I think that's a great idea.

15           MR. GLASS: Yeah, in the paper, we briefly outline  
16 the idea of simply not prohibiting dialysis facilities from  
17 providing transport. Rather than putting payment for it in  
18 the bundle, just not prohibit them from doing it.

19           MR. HACKBARTH: Prohibition now is sort of based  
20 on the fraud and abuse idea. It's an inducement to use a  
21 particular --

22           MR. GLASS: Yeah, correct.

1 DR. BAICKER: Yes, I'm supportive of the  
2 recommendations, and I think thinking more carefully about  
3 how to build this into a bundle would be a great way to  
4 promote a higher value means of transporting people. And  
5 the transportation is vital, but there are clearly many more  
6 efficient ways to do it.

7 DR. SAMITT: I'd support all the recommendations  
8 as well.

9 The only one that I would have questions about is  
10 Recommendation 4, and I'd wonder whether it's too specific.  
11 And, it referenced a little bit of the discussion that we  
12 had. What I'd hate to see is that we look for clinically  
13 inappropriate use, specifically of dialysis, and then all of  
14 a sudden we're back at the table again looking at clinically  
15 inappropriate use of something else.

16 I also would wonder about, you know, will we see a  
17 shift with the changes due to the other recommendations from  
18 BLS back to other forms of transport, and that should be  
19 observed as well. So I wonder whether it goes beyond just  
20 inappropriate use of BLS and just inappropriate use of  
21 dialysis and whether it should be a bit broader than that.

22 MR. HACKBARTH: So, let me pick up on that. In

1 fact, this is an issue that Kate raised when we talked on  
2 the phone.

3 So one boundary that we focus on is when is it  
4 appropriate to use an ambulance for nonemergency transport.  
5 The guidelines are evidently not very clear or very strong  
6 on that. So we've got a lot of growth.

7 Another issue that I think Craig is just raising,  
8 and Kate had raised with me, is particularly if you change  
9 the RVUs and increase the spread between the rates we pay  
10 for emergency and nonemergency, there might be a temptation  
11 to try to recategorize more things as emergency. And so,  
12 that's a boundary, that you have to pay attention to how  
13 clearly do we define the requirements for emergency payment.  
14 Level payment.

15 DR. SAMITT: And that's, in essence, what I was  
16 referencing. And it may be just word-smithing this  
17 recommendation, but we may want to broaden it.

18 MR. BUTLER: So I'm not going to make additional  
19 suggestions other than what's been made to these  
20 recommendations, but I have a need to say two things.

21 One is that somehow I'm still troubled on the  
22 nonemergency. If you -- in a perfect world, if you had a

1 co-pay, if you had the consumer engaged in this, they might  
2 find alternatives to the transportation that is provided by  
3 the federal Medicare dollars. And we've been down the path  
4 on beneficiary engagement, but the supplemental insurance,  
5 you know, just removes the consumer from this decision  
6 altogether.

7 MR. HACKBARTH: These are Part B services. So  
8 there's already the Part B deductible and 20 percent co-  
9 insurance. So, there are co-pays. This is not like the --

10 MR. BUTLER: Well, 90 percent with supplemental  
11 insurance --

12 MR. HACKBARTH: Exactly.

13 MR. BUTLER: -- is just invisible for the most  
14 part. I can't work it into this recommendation. It's an  
15 observation.

16 The second is that this sounds cold-hearted to the  
17 rural community, and I don't mean to be that way, but it  
18 sounds as if we're going to say we'll pay -- we'll do the  
19 cost analysis and whatever it takes. And it feels a little  
20 bit that way.

21 And these communities right now have a lot of  
22 public dollars or volunteers or something. And, again, are

1 we going to remove any of the local incentive, and are we  
2 going to -- where does it end?

3           You could say, well, the ERs also ought to have  
4 this, and they ought to have a neurosurgeon. Where do you  
5 draw the line in terms of what that standard of access  
6 should be if you're living in one of these remote areas?

7           And, if Mitra were here, she'd be saying the same  
8 thing.

9           What happens if you happen to be in some high-rise  
10 in a downtown urban area and you need support to get from  
11 here to there in an emergency? What about those folks?

12           So it's just -- there's just a little uneasiness  
13 about the federal government providing guarantees for  
14 certain kinds of access in some of these areas that are just  
15 tough no matter what the cost.

16           MR. HACKBARTH: Your point is well taken, Peter,  
17 and it's one of the reasons why I think it's important to  
18 take advantage of the bright red line that exists that are  
19 \$42 million. And, we'll design it around that budget.

20           We're not saying, oh, there's now an open-ended  
21 commitment to federal money to achieve new levels of access.  
22 We're saying, let's just use the current money better.

1           MR. BUTLER: That's why I did not change the  
2 recommendations, but I needed a little therapy.

3           [Laughter.]

4           DR. COOMBS: Yes, I support all four  
5 recommendations, and I especially like recommendation 2  
6 where you took in account this 2 percent increase that will  
7 address some of the standby capacity for areas where, you  
8 know, there may be a short distance.

9           But the other piece of it is that they may not  
10 have a neurosurgeon, and they can get to one if we make sure  
11 there's an allowance for that transport to get them there  
12 and get them to the right place for time-sensitive therapy,  
13 as we discussed before, like code stroke and code AMIs and  
14 things like that.

15           So I think these recommendations really have  
16 addressed the needs of different communities.

17           And for the dialysis -- there was one other  
18 entity, and I think we talked about it the last time, and  
19 that was transport for BLS nonemergent to the doctor's  
20 office. And that was the other thing that I think we  
21 mentioned the last time, which was another --

22           DR. NAYLOR: So I also support the recommendations

1 and hope the text will add the opportunity here to develop  
2 quality measures that really help us to -- I mean, I think  
3 we have a great benchmark here. I do think it needs to be -  
4 - the whole program needs to be monitored. And I really do  
5 think there should be -- even though it's not directly  
6 related to this -- an attention to the critical importance  
7 of quality measures to go forward.

8 MR. KUHN: I, too, am generally supportive of the  
9 recommendations although, as we talked about earlier in the  
10 GAO report and trying to understand that, I think having  
11 that information would just give me more comfort with the  
12 final vote next month. So I appreciate Mark and Zach and  
13 everybody, David, coming back with more information on that.  
14 That will be helpful.

15 Earlier, I'd asked the question about the recovery  
16 audit contractors, and Mark made the observation of I'd like  
17 to make a recommendation on that. I don't think so. I have  
18 some specific concerns with the performance of the RACs  
19 overall right now. I think the strength of recommendations  
20 3 and 4 are sufficient.

21 MR. GRADISON: I support all the recommendations.

22 I do want to take a very close look at whatever

1 language we write with regard to recommendation 4. I  
2 certainly don't want to suggest that all the players in that  
3 area are breaking the rules nor do I want to suggest that  
4 dialysis should be our only concern. But, for example, the  
5 chart that we had up there that showed the levels by state -  
6 - it's just interesting that the one press clip we got which  
7 had to do with a major recovery, millions of dollars, caused  
8 by a whistleblower, was not in one of those top states. It  
9 was Kentucky and Alabama, mostly, for that particular group  
10 of companies.

11           The potential here for -- the potential for fraud  
12 is extraordinary. The transportation costs, as we know from  
13 the data that's here -- the transportation costs round-trip  
14 for each dialysis session are approximately double the  
15 amount of money that the dialysis center gets for the care  
16 that it provides. Now that doesn't mean that it's wrong,  
17 but I think it does raise some interesting questions in  
18 itself.

19           Just to take an extreme example -- and I'm not  
20 saying that this would apply in many cases, if any. A  
21 typical dialysis patient goes in three times a week. That's  
22 3 round trips for 50 weeks. That's 150 round trips.



1           According to the data we have, the transportation  
2 average payment is \$454 per round trip. That's \$70,000 a  
3 year per patient.

4           You wouldn't have to sign up very many in a  
5 particular dialysis center, particularly with the average  
6 distance in the urban setting is six, seven miles or  
7 something, to have a pretty good thing going.

8           So I know we all know everything. I'm just  
9 repeating, but I just am looking for some language there  
10 that indicates that this particular area is -- needs more  
11 attention that it appears to be getting from an enforcement  
12 point of view.

13           MR. HACKBARTH: The numbers that you cite, Bill,  
14 on the magnitude of the transport payment relative to the  
15 dialysis payment caught my eye as well, and my immediate  
16 reaction was, well, the dialysis people would like to see  
17 this folded into their bundle. This would change the whole  
18 dynamic of the dialysis business.

19           DR. HALL: The remarkable thing to me is that a  
20 higher proportion of dialysis patients aren't coming by  
21 ambulances right now.

22           MR. HACKBARTH: Right, right. So, again, an

1 important area. We need to look at some options of which  
2 bundling may be one albeit at a lower rate.

3 MR. ARMSTRONG: I, too, support the  
4 recommendations. The one -- for many reasons already made.

5 One additional point, it's just worth  
6 acknowledging that a relatively small spend -- you know, 5.5  
7 billion. We're actually taking that trend down as we're  
8 pulling out this \$190 million, and yet we're also, inside of  
9 this smaller envelope, rationalizing the way in which the  
10 payment policy really works.

11 And so, I think it's a really, really nice  
12 combination of recommendations.

13 MR. HACKBARTH: Thank you all.

14 Thanks, Zach and David.

15 We will now have our public comment period.

16 Before you begin, sir, could I see -- either line  
17 up if you have a comment to make, or let me see your hands  
18 so I've got a sense of how many commenters we have in total.  
19 Anybody else joining the line? Okay. So we've got two.

20 So here are the ground rules for the public  
21 comment period. First, begin by identifying yourself and  
22 your organization, and I'm going to ask you to keep your

1 comments to just a couple minutes. When this red light  
2 comes back on, that's the end of your time period. And I  
3 would remind everybody that this isn't your only or even  
4 your best opportunity to provide input on the work of the  
5 Commission. The best opportunity is directly to the staff.  
6 A second opportunity is to communicate with Commissioners by  
7 letter, and we do read them. Then the third opportunity is  
8 to place comments on our website where there's a place where  
9 you can for each meeting file comments.

10 So, with that introduction, sir?

11 MR. WILLIAMSON: Good afternoon, Commissioners.  
12 My name is Stephen Williamson, and I am speaking on behalf  
13 of the American Ambulance Association, which represents  
14 ambulance providers and suppliers who provide coverage for  
15 more than 75 percent of the population of the United States,  
16 both in emergency and non-emergency transports.

17 We appreciate the proposal basically to maintain  
18 the current rates in emergency and non-emergency ALS.  
19 However, we're very concerned that all BLS non-emergency  
20 providers would experience lower rates.

21 While there are clearly problems related to  
22 dialysis transports, and while GAO numbers did move up from

1 2007 to 2012, the GAO also stated that it was not  
2 appropriate to draw conclusions that margins actually  
3 improves.

4 In addition, the margin -- again, as GAO noted --  
5 is higher than it would be today. We estimate that as a  
6 calculation the margin would be lower by 1.6 percent.

7 We agree that the system should be reformed, but  
8 we also believe a more appropriate approach would be based  
9 on reform that was based on data collection to identify what  
10 aspects BLS non-emergency may be problematic and if any of  
11 these things, including dialysis, could be looked at. We  
12 recommend this much more direct approach to reduce fraud in  
13 dialysis transports. This includes prior authorization and  
14 a moratorium on new providers in high-fraud areas. This  
15 approach would result in substantial savings, and this would  
16 offset retaining the BLS non-emergency -- legitimate BLS  
17 non-emergency transports.

18 There should be good data. This target or reform  
19 effort -- and repeat -- and not repeat the mistakes of the  
20 past by guessing what the right answers should be. We are  
21 working quickly to provide you with a tool to accomplish  
22 this effort in collecting the data.

1 Thank you.

2 MR. NORTH: Good afternoon. My name is Tristan  
3 North. I am also with the American Ambulance Association.  
4 I'm on their staff and just thought I could provide maybe  
5 some clarification on the GAO report that just came out.  
6 Obviously, it did just come out on Monday, so not a lot of  
7 time for everyone to digest it. We were fortunate enough to  
8 provide information and data to the GAO and assist in their  
9 report over the past year. And a lot of the reason why you  
10 see them going from a mean back in 2007 to a median is, like  
11 yourselves, they are under a very tight deadline. Theirs  
12 was actually shorter. Obviously, they had to have a report  
13 out by Monday. So we actually had Chris Hogan, our data  
14 analyst who was in with us, acknowledge their justification  
15 in using a median rather than a mean. However, had actually  
16 stated that it was more of a time constraint than anything  
17 else.

18 And looking to page 24 and 25 of the report, they  
19 do state that you can't compare the two reports, that by  
20 using a median over a mean as well as such a statistically  
21 small sample size and different providers, that it is  
22 difficult to compare and say that there has been an

1 improvement since the data of the 2007 report being 2005  
2 data, moving to the 2012 being 2010 data.

3           They were also good enough to report some of our  
4 issues that we had raised as far as it being a negative 1  
5 percent when you removed the add-on. While they did remove  
6 just the 2 percent, 3 percent in the super-rural bonus  
7 payments, the typical ambulance add-ons, in the year that  
8 they captured data, 2010, ambulance services also got an  
9 approximately 1.6-percent bump that year as a result in the  
10 change of the practice expense component of the physician  
11 fee schedule. The practice expense component is essentially  
12 the GPCI for the ambulance service and Medicare  
13 reimbursement. So that was not taken into consideration.

14           Also, if you note in their comments on page 24 and  
15 25, there have been increases in cost for ambulance services  
16 over the past two years as well as changes in Medicare  
17 policy that have reduced reimbursement, one being fractional  
18 mileage in which CMS changed the policy in which they  
19 reimburse for miles that are not whole miles. They now go  
20 to the exact fractional mileage, the tenth, rather than  
21 rounding up. So CMS, within its proposed and final rule,  
22 acknowledged that about \$50 to \$80 million is being taken

1 out of the system. We determined that it's about a 0.8-  
2 percent reduction in reimbursement, as well as other changes  
3 in reimbursements since then.

4 So I just wanted to provide a little clarification  
5 on why the GAO may not have looked at means this time  
6 around, as well as changes in Medicare reimbursement and  
7 costs since then. So thank you very much.

8 MR. HACKBARTH: Okay. Thank you, and we are  
9 adjourned until 8:30 tomorrow morning.

10 [Whereupon, at 4:53 p.m., the meeting was  
11 recessed, to reconvene at 8:30 a.m. on Friday, October 5,  
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, October 5, 2012  
8:30 a.m.

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



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1 P R O C E E D I N G S [8:30 a.m.]

2 MR. HACKBARTH: Okay. Good morning. This  
3 morning, we begin with the third of the Congressionally  
4 requested reports, this one on outpatient therapy.

5 For the people in the audience, let me just say a  
6 word about the process and where we are. We've been asked  
7 to provide recommendations to the Congress on three issues,  
8 outpatient therapy, the physician work geographic  
9 adjustment, and ambulance services, and to make final  
10 recommendations by our November meeting. And so today, we  
11 will be reviewing draft recommendations on outpatient  
12 therapy, and after the discussion today, we'll make any  
13 modifications necessary for a final recommendation and vote  
14 at our meeting in November.

15 With that, let me turn it over to Adaeze. Are you  
16 going first?

17 DR. AKAMIGBO: Good morning. The Middle Class Tax  
18 Relief and Job Creation Act of 2012 requires MedPAC to study  
19 the payment system for outpatient therapy services and to  
20 address how it can be reformed to reflect the therapy needs  
21 of the patient. We would like to thank Lauren Matayer, our  
22 RA, for her assistance on this project.

1           The mandate requires MedPAC to come up with  
2 recommendations on how to reform the payment system under  
3 Part B and to evaluate how therapy services are managed in  
4 the private sector. Some of the policies we will discuss  
5 will expire at the end of this year. For those  
6 recommendations to be useful to the Congress, they need to  
7 be produced before the provisions expire. The mandated  
8 report is due June 2013.

9           You've already seen this in two presentations in  
10 our mandated studies yesterday, but just as a reminder, this  
11 is the framework we use to evaluate potential policy  
12 changes. We ask, how does the policy impact Medicare  
13 program spending? Will it improve beneficiary access to  
14 care? Will it improve the quality of care Medicare  
15 beneficiaries receive? And will the policy advance payment  
16 reform? And here we mean, does it move us away from fee-  
17 for-service and encourage a more integrated delivery system?  
18 Each recommendation or draft recommendation is evaluated  
19 using these four criteria.

20           Today, we will begin with a few Commissioner  
21 questions from the September meeting that the staff have  
22 addressed. We won't have time to present on each of them,

1 but Herb, an answer to your question on existing national  
2 and local coverage determinations relevant to therapy  
3 services was included in the mailing materials. Also, Herb  
4 and George, you asked about how the VA manages the benefit  
5 and we wrote up a section in the mailing materials. We can  
6 certainly take additional questions on that today if there  
7 are any.

8 I'll take a minute to address Mary's question  
9 about additional evidence to support the benefits of  
10 outpatient therapy services. Then we will briefly review  
11 the issues with outpatient therapy services and Medicare,  
12 such as spending, growth, regional variation, and the  
13 paucity of needed information to determine the need for  
14 therapy services in Medicare. And then we will review the  
15 Chairman's draft recommendations to address outpatient  
16 therapy services.

17 So there is some evidence in the literature to  
18 support the use of outpatient therapy services. For  
19 example, physical therapy, often used for patients who are  
20 recovering from knee or hip surgery or low back pain, has  
21 been shown to improve muscle function, improve posture and  
22 balance, and improve patients' ability to transfer, and

1 that's such as moving yourself from one position to another,  
2 as well as prevent falls. In the same vein, occupational  
3 therapy interventions have been shown to improve the ability  
4 to independently perform activities of daily living, such as  
5 transferring or feeding one's self. It has also been shown  
6 to be effective in improving IADLs, or instrumental  
7 activities of daily living, for people recovering from  
8 stroke.

9           Now, for speech language pathology, some of the  
10 clinical conditions we may find there are aphasia, which is  
11 an impairment of language affecting the production and  
12 comprehension of speech, and the ability to read or write,  
13 and dysphasia, a swallowing disorder that can affect eating  
14 and communicating. Speech pathology interventions for these  
15 two conditions have been shown to improve speech and  
16 communications functions.

17           But despite the benefits, the strength of the  
18 evidence around these interventions varies from study to  
19 study due to the size of the population studied and the  
20 design of the studies. There's also a concern in the  
21 literature about the lack of targeting treatments to the  
22 right patients, especially in the outpatient setting.

1           This brings us to some of the larger concerns  
2 about the outpatient therapy benefit under Medicare.  
3 Provision of therapy services is sensitive to payment  
4 policy. Utilization is sensitive to changes in caps on  
5 annual amounts specific to therapy, for example. And we've  
6 seen many shifts in utilization in other payment settings,  
7 such as SNF and home health.

8           Second, there's wide regional variation in the use  
9 of therapy services and they remain after adjusting for  
10 health status. Most importantly, there's almost no  
11 information available to CMS to judge whether therapy  
12 services are appropriately indicated for the patients who  
13 get them, what type of therapy and how much they should get,  
14 and once they get therapy, no information to determine their  
15 functional outcomes or improvement as a result of therapy  
16 services.

17           Now, let me talk very briefly about each of these  
18 concerns.

19           We presented much of the detail on spending growth  
20 in your mailing materials in March and in September, but  
21 just as a quick refresher, this chart shows that spending  
22 has been growing rapidly since 1999 despite policy changes

1 to the caps, which are indicated at the top, and changes to  
2 the exceptions process, indicated at the bottom of the chart  
3 in yellow.

4 Caps first took effect in 1999, and as we see,  
5 spending dropped that year. But from 2000 through 2005,  
6 when there were no caps except for a three-month period in  
7 2003, spending increased dramatically according to the years  
8 for which we have data. Caps were reintroduced in 2006.  
9 The exceptions process was introduced that year, although it  
10 was a manual process at first. Spending dropped that year  
11 relative to 2004. But after the exceptions process became  
12 automatic with the KX modifier, spending has increased every  
13 year since.

14 As we see on this chart, adjusting for health  
15 status, mean per user spending among the top ten counties is  
16 over \$2,800, while it is \$477 among the ten lowest spending  
17 counties. Counties in the Southeast region, States like  
18 Louisiana, Texas, and Mississippi, and two large counties in  
19 New York, are among the highest spending areas in the  
20 country. The lowest spending counties are concentrated in  
21 the Midwest, States like Iowa, Minnesota, and North Dakota.

22 In the face of spending growth and geographic

1 variation in spending, there are no functional status data  
2 for outpatient therapy beneficiaries at baseline, at  
3 discharge, or at any time during the course of therapy.  
4 Providers have not been required to report standardized data  
5 on functional status at any point to be reimbursed. This  
6 makes it difficult to determine the progress patients make,  
7 in essence, their functional outcomes once therapy is  
8 initiated. Diagnosis codes are not clear and do not provide  
9 clear information about the clinical condition of the  
10 patient.

11           Now, the Commission discussed all of these  
12 concerns and some policy options to address them back in  
13 September. For instance, the Commission discussed the  
14 option to develop outpatient therapy episodes and pay on an  
15 episode basis. But the lack of good data that would support  
16 this approach in the near term and the concern that  
17 providers could simply generate more episodes led the  
18 Commission to consider other administrative tools.

19           With the overarching goal of preserving access to  
20 therapy services while strengthening CMS's ability to manage  
21 the benefit, the Commission discussed other options, and  
22 some are listed here.



1           The Commission discussed including therapy  
2 services received in hospital outpatient departments under  
3 therapy caps. HOPDs had not been included under the caps  
4 but will be from October through December this year. The  
5 Commission discussed making this permanent.

6           The Commission discussed reducing the  
7 certification period for the therapy plan of care from 90  
8 days to 45 days. The average episode lasts about 32 days,  
9 so this would still accommodate most beneficiaries, but  
10 would encourage physician engagement over the plan of care.

11           The Commission discussed implementing a manual  
12 review process for claims that request exceptions to spend  
13 above caps limits in order to introduce some scrutiny over  
14 the medical necessity of additional therapy services.

15           And the Commission discussed the option of  
16 implementing payment edits to screen for implausible amounts  
17 of therapy delivered to beneficiaries. For example, some  
18 MACs would screen for more than five units or 75 minutes of  
19 therapy in the outpatient setting per day.

20           The Commission also discussed an option to collect  
21 functional status information using a standardized tool  
22 across all therapy types.

1           Ariel will now discuss additional administrative  
2 tools to manage spending.

3           MR. WINTER: Okay. So we're going to talk now  
4 about some administrative tools to manage the therapy  
5 benefit that we did not talk about in September.

6           One important management tool is payment accuracy,  
7 which has long been a priority of the Commission. In a  
8 moment, I'll talk about the multiple procedure payment  
9 reduction, which could be used to improve payment accuracy  
10 for a combination of therapy services provided in the same  
11 session.

12           In addition, there are other expenditure controls  
13 that you may want to consider. One idea would be to reduce  
14 the level of the caps and another idea would be to reduce  
15 payment rates for individual therapy services.

16           Medicare currently applies the multiple procedure  
17 payment reduction to the practice expense portion of the  
18 payment when multiple therapy services are provided to the  
19 same patient on the same day. Now, the practice expense  
20 covers the clinical labor, which, for example, a physical  
21 therapy assistant who's involved in the service, as well as  
22 the supplies that are used for the service. Now, the MPPR,

1 or the multiple procedure reduction, does not apply to the  
2 work RVU portion of the payment, which is what covers the  
3 work of the therapist, and the rationale for this policy is  
4 that there are efficiencies when multiple services are  
5 provided in a single session because certain activities are  
6 not performed twice, such as greeting and gowning the  
7 patient, patient education, and obtaining patient  
8 measurements. And, in fact, there are also some  
9 efficiencies in supplies.

10 CMS found that these efficiencies are often not  
11 reflected in the practice expense values for therapy  
12 services. CMS examined high-volume pairs of therapy codes  
13 that are billed in a single session and found that the  
14 efficiencies justified reducing the practice expense  
15 payments for the lower-paid service by 28 percent to 56  
16 percent.

17 So based on this analysis, CMS initially proposed  
18 a 50 percent reduction for multiple therapy services  
19 beginning in 2011, but there was significant opposition from  
20 providers to this proposal. And in the final rule, CMS  
21 adopted a 25 percent reduction as what they called a  
22 conservative first step.

1           A short time later, Congress intervened and set  
2 the reduction at 20 percent for services provided in non-  
3 facility settings and 25 percent for services in facility  
4 settings.

5           So under the option we're talking about here on  
6 this slide, Congress could increase the reduction to 50  
7 percent in all settings and require that the savings be used  
8 to reduce Medicare spending. This would also reduce  
9 financial incentives for providers to furnish additional  
10 therapy services within the same session.

11           And now, we'll return to Adaeze.

12           DR. AKAMIGBO: The Commission could also discuss  
13 the option to reduce therapy caps to a lower point on the  
14 outpatient therapy spending distribution. The Medicare  
15 outpatient therapy benefit includes annual caps on per  
16 beneficiary spending. There are two caps limits, one for  
17 physical therapy and speech pathology combined, and another  
18 for occupational therapy. Therapy caps are adjusted  
19 annually for inflation, and for the 2012 spending year, the  
20 cap is \$1,880.

21           The mean spending per user under each cap was a  
22 little over \$1,000 in 2011, but the median program spending

1 by each cap was closer to \$600. Overall, mean spending for  
2 all therapy was \$1,173, and the median was \$629.

3 In 2011, 19 percent of therapy users exceeded the  
4 PT speech pathology cap and 22 percent exceeded the  
5 occupational therapy cap, and this has grown over time.  
6 Reducing the cap amounts to a level that accommodates the  
7 needs of most beneficiaries combined with a manual  
8 exceptions process that reviews requests for medical  
9 necessity could assure access to needed care, strengthen the  
10 effectiveness of caps as a cost management tool, and provide  
11 some scrutiny for additional services for medical necessity.

12 This brings us to the Chairman's draft  
13 recommendations for outpatient therapy services. First, to  
14 assure program integrity of the outpatient therapy benefit,  
15 the Congress should direct the Secretary to reduce the  
16 certification period for the outpatient therapy plan of care  
17 from 90 days to 45 days and use PPACA-granted authorities to  
18 target high-use geographic areas and aberrant providers.

19 Now, PPACA granted the Secretary new authority to  
20 address fraud and abuse in geographic areas and among  
21 providers who exhibit aberrant patterns that suggest  
22 fraudulent billing. Under this new authority, the Secretary

1 could place a temporary moratorium on enrollment of new  
2 providers, require providers to re-enroll, or suspend  
3 payments for services that show a high risk of fraud.

4 Third, the Congress should direct the Secretary to  
5 implement payment edits at the national level that target  
6 implausible amounts of therapy.

7 The spending implications of this draft  
8 recommendation would be budget neutral or could lead to a  
9 decrease in program spending. This draft recommendation  
10 would preserve beneficiaries' access to needed services.  
11 And the effect on quality of care is unclear because quality  
12 measures are currently not available for the Medicare  
13 outpatient therapy benefit. This draft recommendation does  
14 not move us from fee-for-service to a more integrated  
15 delivery system.

16 For the Chairman's second draft recommendation,  
17 aimed to assure access to needed outpatient therapy services  
18 while managing Medicare spending, the Congress should,  
19 first, reduce therapy caps for physical therapy and speech  
20 language pathology services combined and for occupational  
21 therapy, and implement a manual review process for requests  
22 to exceed cap amounts, and provide the resources to CMS for

1 this purpose. The Congress should include services  
2 delivered in hospital outpatient departments under therapy  
3 caps and apply a multiple procedure payment reduction of 50  
4 percent to the practice expense portion of outpatient  
5 therapy services provided to the same therapy on the same  
6 day.

7           The components of the second draft recommendation  
8 just described are necessary to effectively manage the  
9 benefit and associated costs while maintaining access to  
10 needed care. The options, however, may result in spending  
11 above current law. If spending is projected to be above  
12 current law and the Congress wishes to reduce spending on  
13 outpatient therapy services to current law levels, the  
14 Congress could employ any of these mechanisms. They could  
15 lower the therapy caps levels further. They could lower  
16 payment rates. Or they could increase beneficiary cost  
17 sharing.

18           Now, for implications. If all components of this  
19 draft recommendation are implementing, spending would likely  
20 increase relative to current law. This draft recommendation  
21 would preserve beneficiaries' access to needed services. We  
22 do expect lower use of services among the highest users, but

1 with the manual exceptions review process, beneficiaries who  
2 legitimately need additional services will be able to get  
3 them. The effect on quality is less clear because, again,  
4 quality measures are currently not available for the  
5 Medicare outpatient therapy benefit. This draft  
6 recommendation does not move us from fee-for-service to a  
7 more integrated delivery system, so there would be no  
8 implications for payment reform.

9           For the Chairman's third draft recommendation, to  
10 improve management of the benefit in the longer term, the  
11 Congress should direct the Secretary to prohibit the use of  
12 V-codes as a principal diagnosis on outpatient therapy  
13 claims and collect functional status information on therapy  
14 users using a streamlined standardized assessment tool that  
15 reflects demographic, diagnosis, biomedication, surgery, and  
16 functional limitations to classify patients across all  
17 therapy types and use the information collected using this  
18 tool to measure the impact of therapy services on functional  
19 status and provide the basis for global payment approaches  
20 in the future.

21           As discussed before, there is a prototype for such  
22 a tool that was part of a CMS study. And as we discussed



1 with a panel of researchers and practitioners this summer,  
2 additional data elements to that prototype would serve as a  
3 good start towards developing such an instrument for payment  
4 purposes.

5           The spending implications of this third draft  
6 recommendation would include some administrative costs to  
7 develop the tool and collect the data, but no direct impact  
8 on program spending. This draft recommendation would not  
9 impact beneficiaries' access to therapy services. With  
10 respect to quality, the goal is that the functional status  
11 information collected using this tool and better clinical  
12 data would lead to an improved ability to measure and  
13 deliver quality care. The use of a standardized instrument  
14 that facilitates the classification of patients by severity  
15 and measures improvement over time would facilitate moving  
16 from a fee-for-service system to a more bundled payment  
17 approach in the future.

18           To wrap up, we would like your reactions and  
19 guidance on these draft recommendations. Some of the  
20 policies we've discussed expire at the end of the year and  
21 Congress has required MedPAC to make recommendations in this  
22 report. For those recommendations to be useful, they need

1 to be produced before the provisions expire.

2 And with that, I'll turn it back over to Glenn.

3 MR. HACKBARTH: Thank you, Adaeze and Ariel. Very  
4 well done.

5 Before we begin the round one questions, let me  
6 just say a few additional words about how I thought about  
7 this issue and why I framed the draft recommendations in  
8 this way.

9 The approach that we agreed on for evaluating  
10 these three issues--outpatient therapy, the physician work  
11 GPCI, and ambulance--is that we should not recommend  
12 increased spending above current law unless we believe  
13 there's evidence that doing so would improve access to care,  
14 quality, or support movement to new payment systems. Here,  
15 we're talking about a package of recommendations that would  
16 increase spending above current law levels. So the obvious  
17 question is, why, and I believe that going to a system --  
18 returning to a system of hard caps, no exceptions, would, in  
19 fact, impede access to needed care for Medicare  
20 beneficiaries. So I think it meets that test.

21 Having said that, I think it's still incumbent  
22 upon us to help Congress find ways to keep that additional

1 expenditure as reasonable as possible and as targeted on the  
2 beneficiaries who most need the services as possible.

3           Adaeze, could you put up Slide 14 for a second.

4 So as was pointed out in the presentation, right now, we  
5 have roughly 20 percent of the people over the caps. And if  
6 you put up the bar graph, Adaeze, the one with the spending  
7 -- there we go. So we're talking roughly \$6 billion in  
8 expenditures in 2011. About 20 percent of that represents  
9 spending over the cap. So we're talking about roughly a  
10 billion dollars or a little bit more than a billion dollars  
11 in additional spending if we don't revert to hard caps. And  
12 so there's a big potential increase in Medicare spending  
13 above the current law baseline if we don't revert to hard  
14 caps.

15           So is that clear? The current law says hard caps,  
16 no exceptions. That would reduce spending by a little over  
17 a billion dollars. And so if we recommend no hard caps,  
18 that's the number that we're trying to work with and reduce  
19 it, make sure it's properly used to assure care for Medicare  
20 beneficiaries.

21           And it's in that context that I offer the specific  
22 recommendations about -- and I'm not going to go through all

1 of those, they were well presented -- it's in that context  
2 that I recommended some things that otherwise might be a  
3 little jarring.

4           So let me just cite one example. My draft  
5 recommendation proposes reducing the caps, and my thinking  
6 on that is that if we reduce the cap but still have  
7 exceptions, albeit manual exceptions, effectively, what we  
8 are doing is saying people can still get access to care if  
9 on manual review it's deemed appropriate, where it's simply  
10 increasing the proportion of beneficiaries who are going to  
11 have their need reviewed before Medicare agrees to pay. So  
12 we're sort of putting a different cut point in the  
13 distribution. It seems to me that's a way to assure access  
14 to needed care while minimizing the budget score with the  
15 approach. I won't go through all of the other specific  
16 elements of the recommendations, but I just wanted to make  
17 sure my thinking, the underlying thinking in my approach was  
18 clear.

19           So with that, let's turn to clarifying questions.  
20 Tom looks ready to clarify.

21           DR. DEAN: Or looks confused.

22           [Laughter.]

1 DR. DEAN: Do we know why P.T. and speech were  
2 combined? I mean, that seems -- how that came about? It  
3 may not relate directly to this. I was just curious.

4 DR. AKAMIGBO: There's no good reason.

5 DR. DEAN: That's what I thought.

6 DR. AKAMIGBO: And there's talk that it was based  
7 on just a missed comma. I'm not sure how. It doesn't sound  
8 right, but there's no good reason.

9 DR. DEAN: P.T. and O.T. are often prescribed  
10 together.

11 DR. AKAMIGBO: P.T. and O.T. are much more  
12 related, yes.

13 DR. DEAN: Yeah.

14 DR. AKAMIGBO: So the combination of the  
15 P.T./speech cap is not clear.

16 DR. DEAN: And the review process, do we have a  
17 sense of how that would work? I mean, would they have to  
18 get authorization before they'd go ahead with additional  
19 treatments? I mean, obviously that's something that CMS  
20 would have to arrange, I suppose.

21 DR. AKAMIGBO: So CMS is actually doing this right  
22 now at the \$3,700 threshold level, and also in the same law,

1 the Middle Class Tax Relief and Job Creation Act, CMS was  
2 required to implement a manual review process once benes  
3 spent \$3,700 for the P.T./speech combined cap or separately  
4 for O.T..

5           And as part of that process, once -- if you're a  
6 provider and you have a patient who has reached or is  
7 approaching that level, you can submit to your MAC, and they  
8 have pretty clear guidance on what you should submit,  
9 information on the plan of care, the referring physician,  
10 their NPIs, the reason why you -- the reason for additional  
11 therapy above that \$3,700 level.

12           And at that point, it's a manual review. It's  
13 someone at the MAC level looking through that information,  
14 and in some cases, they may come back and request  
15 information from the medical record to see if there is true  
16 justification for medical necessity. So they are doing  
17 that. They just started October 1st.

18           DR. DEAN: I guess the concern with me, I mean,  
19 what's the time frame for all this and how long -- I mean,  
20 if you have a therapy in progress, is this going to be a  
21 quick turn-around so it doesn't interfere with the therapy  
22 or are they going to have to wait two or three weeks or

1 whatever to get a ruling, or are they just going to go ahead  
2 and hope they get paid?

3 DR. AKAMIGBO: So this is a pre-payment review.  
4 It's up to the provider to, I suppose, make the decision as  
5 to whether they want to provide the service and then hope  
6 for, you know, that it would pass muster. But it is a pre-  
7 payment review.

8 As the rules state right now for that \$3,700  
9 level, the MAC has ten days to approve or deny. So they  
10 have ten days to issue a decision. It is incumbent upon the  
11 provider to submit that as early as possible. Certainly  
12 these appointments are made ahead of time and they can  
13 track. They know how much their patients are spending at  
14 any given time.

15 So it seems to me it would be in their benefit to  
16 submit that request at the \$3,700 level as soon as they know  
17 that their patients are going to need additional therapy  
18 services.

19 So I guess what I'm saying is, it's been designed  
20 right now to prevent, as much as possible, any delays or  
21 discontinuations in therapy.

22 DR. DEAN: Thank you.

1 DR. HOADLEY: Two quick follow-ups on those  
2 questions. The speech therapy is much, much smaller than  
3 the other two categories. Isn't that right? So, I mean,  
4 just quantitatively in terms of its impact on the cap, it's  
5 got a lot less. So, I mean, that's certainly something to  
6 keep in mind, it seems like.

7 And on this question of the timing of the review,  
8 which I think is an interesting one, I wonder if that's  
9 going to trigger the need for or common use of advance  
10 beneficiary notices in terms of, you know, warning the  
11 beneficiary that they may not -- that they may be  
12 responsible for the cost of this in these situations.

13 DR. AKAMIGBO: That's a good point. They have  
14 done that. As of September 1st, CMS sent a letter to  
15 beneficiaries and then the letter, they basically informed  
16 them of four things. These are beneficiaries who had spent  
17 \$1,700 between January 1st and August 31st.

18 And so the letter says, You've spent this much on  
19 therapy to date. There is a cap, by the way, and you're  
20 approaching that cap. And any additional expenses above  
21 that cap that are deemed to be medically -- for services  
22 that are deemed to be medically unnecessary, you are



1 responsible for. There's also this manual review process  
2 should you approach the \$3,700 threshold.

3 This caused some confusion, concern. Lots of  
4 beneficiaries called CMS. They called their MACs. They  
5 called the providers. They cancelled appointments because  
6 they were afraid of, you know, being responsible if this  
7 were deemed to be medically unnecessary. So it's not the  
8 kind of correspondence they're used to getting from  
9 Medicare.

10 DR. HOADLEY: But that's actually different than  
11 the kind of notice the provider would say that you're going  
12 to be responsible. Is there any evidence of that kind of  
13 notices?

14 DR. AKAMIGBO: ABNs on that?

15 DR. HOADLEY: Yeah, ABNs.

16 DR. AKAMIGBO: I have not heard, but I can check.

17 DR. HOADLEY: Or whether it might under this kind  
18 of --

19 DR. AKAMIGBO: Yeah.

20 DR. HOADLEY: And I guess the other question is,  
21 in the rule for this round from CMS, they've got some data  
22 collection. Then they put some data collection requirements

1 in the rule this time. Can you say anything about that?

2 DR. AKAMIGBO: The proposed rule?

3 DR. HOADLEY: Proposed rules, right.

4 DR. AKAMIGBO: There is some data collection  
5 requirement in the proposed rule. So CMS is required to  
6 collect functional status information from the Middle Class  
7 Tax Relief and Job Creation Act. The proposed rule came out  
8 in June, I think.

9 DR. HOADLEY: Summer.

10 DR. AKAMIGBO: Summer. And CMS put forth a plan  
11 on how -- a proposed plan on how they would do that. And  
12 just to not get mired in details --

13 DR. HOADLEY: Sure.

14 DR. AKAMIGBO: -- basically it says, We're going  
15 to use a series of g-codes to collect functional status at  
16 baseline, or once therapy is initiated at some point during  
17 the course of therapy, and hopefully, if the patient were to  
18 come back for discharge -- for discharge instructions, you  
19 could then complete an assessment and have some discharge  
20 level function.

21 But it's a series of g-codes not rooted in any  
22 particular -- it's not rooted in any particular instrument.

1 There's no consistency in how the patient would be -- and  
2 how different patients would be assessed, for instance, and  
3 it seemed to have a great deal of burden, I think, placed on  
4 the provider to determine whether the patient is functioning  
5 at 10 percent versus 90 percent and how that would be  
6 standardized in reporting back and how it's reported back to  
7 CMS.

8           So I think the general agreement -- not agreement,  
9 but the general sense from the folks who read this and had  
10 something to say, is that this probably will not work well  
11 as it was put forth.

12           DR. HOADLEY: And when is the final rule -- it's  
13 any time now, right?

14           MR. WINTER: End of this month, early next month.

15           DR. HOADLEY: Okay.

16           MR. WINTER: We didn't talk about our concerns in  
17 our comment letter on the proposed rule.

18           DR. HOADLEY: And obviously related to whatever  
19 our recommendations are, if there's anything left in the  
20 final rule.

21           DR. MARK MILLER: At the time, obviously, we  
22 didn't have a recommendation, and I think what I would just

1 say is, in our comment letter, we were concerned that you  
2 would have a bunch of data, but you wouldn't have much  
3 standardization and that it wouldn't lead you to a place.  
4 And then now we've come through with this process, and if  
5 you are all on-board with a different data collection, then  
6 that would be the hope to get to something that's  
7 standardized in general and across modality.

8 To be really clear in answering your question,  
9 this would be saying to CMS, What you're doing shouldn't be  
10 happening. This is what we would prefer to happen.

11 DR. HOADLEY: Okay, good. Thanks.

12 MS. UCCELO: So the reaction that beneficiaries  
13 had to those letters suggests that they were unaware that  
14 caps existed, didn't know that from Medicare materials or  
15 from their providers. So this is just something that  
16 they're just not even aware of. And the exceptions process  
17 was something that went on that they didn't know about?

18 DR. AKAMIGBO: Yeah. So the extent to which  
19 beneficiaries would log on to MyMedicare.gov or Medicare.gov  
20 to get it to access information, the extent to which they do  
21 that I can guess, but I won't. I would -- but it is out  
22 there. So this information is out there. It is in the --

1 they receive, once a year, I believe in the fall, they  
2 receive a Medicare new handbook. I believe this is in  
3 there.

4 It's on the web site through different -- on the  
5 therapy pages, different, you know, sources, different  
6 documents. So it's not that this was hidden, but I suspect  
7 many would not know the details of therapy caps, especially  
8 with the exceptions process. It's not like their providers  
9 have to inform them about this.

10 DR. MARK MILLER: I think that's more of the  
11 point. I mean, the therapist could put the KX modifier on  
12 the claim and continue the process. So again, I'm not  
13 really clear what happens on the ground either, but I'm not  
14 sure it needs to involve the beneficiary in making that  
15 decision. And I think that speaks to your point.

16 MS. UCCELO: Yes. And another question kind of  
17 following up on what Tom said, and I just don't know enough  
18 about the differences between P.T. and O.T., but looking at  
19 the materials from last month, or last time we talked about  
20 this, there is overlap on some of the conditions that each  
21 of these groups of patients are treated for. I'm wondering,  
22 is there ever, Okay, I'm approaching the P.T. cap, can I re-

1 categorize this to O.T.? Is there --

2 DR. AKAMIGBO: So I've spoken to many providers,  
3 both physical therapists and occupational therapists, and I  
4 would -- they wouldn't -- it doesn't strike me that they  
5 would make decisions based on what type of therapy you  
6 should get based upon whether you're approaching one cap  
7 versus the other.

8 It seems that at the point of referral, when the  
9 physician is saying, You need O.T. because you need specific  
10 assistance with a specific ADL or IADL, you would be seeing  
11 an O.T. versus, you know, if you have a total knee  
12 replacement and you need physical therapy to strengthen  
13 maybe the muscles or, you know, to help you with balance,  
14 you would be seeing a physical therapist.

15 So I have not come across decisions based upon,  
16 you know, whether you're approaching one cap versus the  
17 other.

18 MS. UCCELO: Thank you.

19 DR. SAMITT: Great presentation. Thank you. My  
20 question is about Slide 20, which would be the longer term  
21 recommendations. In the advance materials, you talk about  
22 the work you had done to speak with private plans. And one

1 of the pieces of information was that most private plans do  
2 not require the use of a standard tool to collect functional  
3 status either.

4           So I guess, did you get it? Why? So if this  
5 recommendation is going to include collection of information  
6 for functional status, private plans are not doing that  
7 either. So is it an operational challenge? You know, what  
8 is the reason why they're not collecting it today?

9           DR. AKAMIGBO: There's deep concern, I think, when  
10 you talk to the different providers, you know, when you talk  
11 to speech pathologists versus physical therapists. Each  
12 group is wedded to whatever instrument they deem to be more  
13 valuable for their services, and it captures either clinical  
14 improvement or functional disability or impairment more  
15 accurately for their patients.

16           And so, I think what we find in Medicare is  
17 reflected in the private sector as well. And essentially,  
18 it sounds to me like plans that have backed away, also, from  
19 saying, You must use this or you must use that, and they've  
20 just adopted other more administrative tools rather than  
21 requiring the use of, you know, certain instruments to  
22 collect functional. It didn't sound like they saw that as

1 something that was worthwhile given the barriers across the  
2 different providers.

3 DR. MARK MILLER: If I could, one of the things in  
4 all of our conversations that came out to me, and this is  
5 all consistent, you have different modalities, different  
6 tools across modality, and within modality different tools  
7 even. And so, sort of bringing some order to that, you  
8 know, for the last 20 years has been the challenge.

9 Underlying this, since there's not a lot of  
10 evidence-based guidelines that drive things really clearly,  
11 it's really hard to bring this together. But nonetheless,  
12 one of the things that helped me start to think about it is,  
13 what do you need for planning for any given patient? What  
14 do you need for payment?

15 My sense is for purposes of payment, the private  
16 sector has said, I'm just moving to administrative  
17 arrangements here. I'm going to set visit limits and then  
18 ask people to produce evidence, and if you want to use these  
19 different tools to try and produce evidence in the medical  
20 record, fine.

21 And I also want to be clear, from our point of  
22 view in the data that we're talking about here, this would



1 help Medicare move towards a common payment and  
2 understanding what's happening with its payment. But the  
3 providers could still be free to use their different tools  
4 for their own planning purposes.

5 I found that kind of a convenient line to divide  
6 my thinking. What do you need for payment? What do you  
7 need to plan and do their services or their plan of care?  
8 So we wouldn't be saying, You can't use any of your other  
9 tools, but this is the information we need in order to  
10 understand payment in the future. I don't know if that  
11 helps you.

12 MR. HACKBARTH: It might be worth, if you're an  
13 individual private payer dealing with this context where  
14 there's a lack of agreement, it may feel like, I simply  
15 don't have the leverage to alter this situation. And so,  
16 they don't try. It might be a different question, do they  
17 think it should be different than this, and if Medicare were  
18 to try to create some common tools, would that be something  
19 that they would value.

20 So it's a difference between what they would like  
21 to have and what they think is reasonable for them as  
22 individual payers to accomplish. I don't know the answer to

1 that, but it might be worth talking to some private payers  
2 about that question. Do you disagree with that, Craig? You  
3 look like you're --

4 DR. SAMITT: No, I agree with that. I took it  
5 several steps further, which is, this whole concept is  
6 applicable to many other areas as well. I'm, in particular,  
7 thinking about quality measurement. If a common litmus test  
8 is created, it would be wonderful for commercial plans,  
9 private plans to adopt the same. And so, hopefully we would  
10 see that same momentum in other scenarios beyond this one.  
11 But otherwise, I agree with your assessment.

12 MR. BUTLER: My first question is on the regional  
13 variation. You have upper Midwest being light, the  
14 Southeast and pockets in New York being heavy. I suspect in  
15 the upper Midwest it might just be supply, the services, the  
16 therapists aren't there. I don't know. But in the  
17 Southeast and New York, there may be some suspicious  
18 relationships between those who are ordering the services  
19 and those who are supplying the services.

20 But I'm not sure what those look like. Are they  
21 typically maybe nursing home-based services? Are they ones  
22 that are related to home? Is there some way you would

1 categorize the kinds of relationships that you would look at  
2 if you were trying to explain the variation, the high  
3 utilization areas?

4 DR. AKAMIGBO: If I can just step back or maybe  
5 restate what I think I'm understanding, is this being driven  
6 by particular settings? Is the variations, particularly in  
7 a high use area, is being driven by a particular -- or  
8 services delivered --

9 MR. BUTLER: So if you steer somebody to say, Go  
10 find out why these things are so high in utilizing, would  
11 you go to look in nursing homes and home care agencies, and  
12 what kinds of relationships would tend to kind of fuel the  
13 utilization that would be questionable?

14 DR. AKAMIGBO: So maybe I'll let you speak to the  
15 self-referral in a second, but services delivered in nursing  
16 facilities account for about 40 percent of spending.  
17 Services delivered by physical therapists in private  
18 practice account for about 30 percent. And there's some  
19 question as to what really constitutes a physical therapist  
20 in private practice. There are about three different types  
21 of scenarios that we've unpacked so far.

22 But I would look at those two as driving. There's

1 a lot of the utilization we see anywhere, but particularly  
2 in the high use areas. Per bene spending in nursing  
3 facilities is about \$2,400 per beneficiary, and HOPDs is  
4 about \$600. So that's a huge differential.

5 DR. MARK MILLER: Can I ask this just before it  
6 goes to Ariel? Would it answer -- if I understand your  
7 question, would it answer your question if we were able to  
8 cut the data by the proportions of services and setting in  
9 the high and the low areas? It sounds like that's what  
10 you're asking.

11 MR. BUTLER: It might. You might find that, yeah,  
12 the nursing home utilization is three times as high in the  
13 Southeast as it is in the upper Midwest. It might help lend  
14 your way to where you might even apply caps.

15 DR. MARK MILLER: I hear you.

16 DR. AKAMIGBO: Yes, we can.

17 DR. MARK MILLER: We haven't, but we can.

18 DR. AKAMIGBO: Yeah.

19 MR. BUTLER: Okay. My second question is on Slide  
20 7. So my first part of it is simple. Underneath the left-  
21 hand side, you have no exceptions. Well, when there are no  
22 caps, there are automatically no exceptions, right? Is that

1 -- so that really --

2 DR. AKAMIGBO: I was just trying to make a  
3 distinction between when we had exceptions and when we  
4 didn't have exceptions in those --

5 MR. BUTLER: With the noted except in 1999, which  
6 says that these hard caps might work, right?

7 DR. AKAMIGBO: Yes.

8 MR. BUTLER: So there's an important lesson right  
9 there. They work when you don't have exceptions.

10 MR. HACKBARTH: If your only goal is to reduce  
11 expenditures, yes, they work. They work on any service.

12 MR. BUTLER: But you're getting a little ahead to  
13 Round 2, though. Just because you lower the cap to  
14 automatically take some money off the top, it doesn't  
15 necessarily change the trajectory going forward.

16 Now, back to the private plans, which Craig noted  
17 you had in the chapter and I did, too, but it didn't look  
18 like there was many lessons -- they're struggling with it in  
19 the private plans as well.

20 DR. AKAMIGBO: Yes.

21 MR. BUTLER: Yet they have typically hard caps, if  
22 I read it right, of a round number of visits and then co-

1 pays?

2 DR. AKAMIGBO: Yes.

3 MR. BUTLER: Which we typically don't have, at  
4 least in a meaningful way in this. But my guess is that  
5 this chart and the private plans, even though they're  
6 struggling with it, I'm guessing -- maybe you know or don't  
7 know -- is the trajectory in spending in the private plans.  
8 My guess, because of either co-pays or maybe their caps have  
9 fewer exceptions, that the trajectory is less than it is for  
10 Medicare spending.

11 DR. AKAMIGBO: I think so. Depending on where  
12 they are located, the plans we spoke with, they have  
13 experienced some spending, some over-utilization issues in  
14 the outpatient therapy setting, which triggered a closer  
15 look at what tools they could use to manage the benefit. So  
16 their trajectory would look very different, but they've  
17 already done something about it, and that's by saying, you  
18 know, You have 20 visits for the year after which you either  
19 get no more or you are subjected to extensive review, and  
20 you have \$25 co-pays, and in some cases \$50 co-pay per  
21 visit. So for those two reasons alone, their trajectory  
22 would look quite different.

1 DR. MARK MILLER: And the only clarification I  
2 would put in here is, this is when a conversation about a  
3 given employer, whether the data generally in the -- you  
4 know, if you had it that looked across the private sector  
5 looked differently, I'd be much less certain of what to say.  
6 In our conversations where somebody said, I took action and  
7 this is what I did, of course the assertion is, and it  
8 changed the trajectory for my, you know, covered lives. But  
9 that data in the private sector, if you had that trend, I  
10 don't know what it would look like across.

11 MR. BUTLER: I bet you a billion dollars down in  
12 1999 versus six billion in 2011 is a pretty healthy  
13 increase. I don't know if it's gone up. My guess is it  
14 hasn't gone up that fast in the non-Medicare population.

15 DR. MARK MILLER: Again, we have some private  
16 data. We may be able to look at that. I just didn't want  
17 to say it flat out without having looked at it, and I'm not  
18 going to bet you a billion dollars because you already took  
19 half of that off of me.

20 DR. COOMBS: So one out of five, roughly, are  
21 exceeders of the cap overall. In the high cost areas, it  
22 looks like there's some top diagnosis other than the v-codes

1 and it may be more like one out of two, one out of three,  
2 would you say, in those high cost areas?

3 DR. AKAMIGBO: I think I'd try to get back to you  
4 on that. So the share of users who exceed the caps in the  
5 top spending counties is what you're asking?

6 DR. COOMBS: Right.

7 DR. AKAMIGBO: I don't have that data.

8 DR. COOMBS: Because that makes it real -- that's  
9 important for the recommendation that Glenn has offered for  
10 shortening the time span from the 90 to the 45, because the  
11 average is 32, and if that is indeed the case, it would be a  
12 disincentive for the high spending areas, which would work  
13 in some respect, and to preserve some fiscal determination  
14 for areas in which there might be patients with need.

15 And then the other question I have is for either  
16 Glenn or you. The no-cost for introducing a functionality  
17 tool, are we redirecting costs from one area to another?  
18 Because I was just interested in that. There was no  
19 increase in spending on that one, on Recommendation 2.

20 MR. HACKBARTH: Could you put up Recommendation 2?

21 DR. COOMBS: Recommendation 3. I'm sorry.

22 Elimination of v-codes, Slide 20.



1 DR. MARK MILLER: So, Alice, and your question is?

2 DR. COOMBS: There's no direct spending, but there  
3 must be some implementation. Do you include that? Are you  
4 speaking specifically according to billing only for Medicare  
5 services?

6 DR. MARK MILLER: I think if I'm following your  
7 question, and redirect --

8 MR. HACKBARTH: I think I understand Alice's  
9 question. So this calls for the creation of new tools in  
10 collecting information, which of course always has a cost  
11 attached to it. Yet the spending line and the implications  
12 say no impact on program spending. That's what you're  
13 focused on, Alice?

14 And so, there will be some additional cost for  
15 doing these things. I think maybe what the spending line is  
16 referring to is that there's no projected impact on  
17 utilization of services and program spending in that sense.  
18 Am I interpreting it correctly? So there would be  
19 administrative costs, which is -- and I think maybe we  
20 discussed this on the phone.

21 It is always an issue for CMS when we say, Oh,  
22 there needs to be more intensive review. Herb can speak to

1 this better than I can. Those things cost money and they  
2 cost money in a part of the CMS budget that is really  
3 tightly constrained. They don't come out of the entitlement  
4 spending. They come out of the program operations budget  
5 which is annually appropriated. And if I'm saying anything  
6 wrong, Herb, jump in and correct me.

7           And so, they have this really tightly constrained  
8 appropriations budget, and when more requirements are put in  
9 there and they've got to do more stuff, it poses real issues  
10 for them.

11           DR. COOMBS: So my question is, if there are  
12 savings accrued because of what you're doing, eradicating  
13 the V codes and that, is that -- that's a hard ask to  
14 redirect that to the area where you develop a functionality  
15 to assess functionality.

16           MR. HACKBARTH: I'm not sure I followed.

17           DR. COOMBS: So you just can't redirect that -- in  
18 other words, because this is on one side of -- this is one  
19 category. You can't redirect the savings --

20           MR. HACKBARTH: You can't use savings from  
21 entitlement spending --

22           DR. COOMBS: Right.

1           MR. HACKBARTH: -- to finance operations, unless  
2 there's a specific congressional provision that allows you  
3 to do that.

4           DR. COOMBS: Okay

5           DR. MARK MILLER: And I just want to take --  
6 because this is employed, just reinforce this. On the  
7 manual review recommendation, we're also explicit in the  
8 language of saying to the Congress that if you -- you need  
9 to give the administrative dollars to CMS on this because  
10 for this to work -- I mean, in a sense, think of what the  
11 private sector does. It says here's your cap visit. Then  
12 you have to present evidence to go beyond that, and they  
13 fund it. They have somebody who reviews that evidence and  
14 makes that decision. And we're saying here, you know, to  
15 the Congress that if you want this manual review and have  
16 some oversight on the exceptions process, you have to fund  
17 the carriers actually having that view. It's back to this  
18 point of them having the resources to do it.

19           DR. COOMBS: So it might be a good idea maybe to  
20 tack something else on, like this piece as well.

21           DR. MARK MILLER: But the only thing I would say  
22 here is in a sense what we're saying here on 3 and why --

1 and we can do that, but the reason we didn't directly go to  
2 that is CMS is expending administrative resources now to  
3 administer the benefit. We're sort of saying continue to  
4 administer the benefit, use a different instrument. There  
5 will be some resources in developing the new tool, but that  
6 may not involve a completely new operation like the manual  
7 review, which is a very intensive oversight. And that's why  
8 we sort of spoke to resources in one case. Here it might be  
9 more reprogramming of resources that they have already. But  
10 if people feel strongly about this, we can obviously speak  
11 to that.

12 MR. WINTER: There is a one-page form that CMS has  
13 developed as part of a research project, which we think  
14 could be a template for collecting the kind of standardized  
15 functional status information that we're talking about in  
16 this draft recommendation. So there's been some work that  
17 could be -- you know, that has already been done that could  
18 be applied to get at the goal of this recommendation, draft  
19 recommendation.

20 DR. MARK MILLER: He said it better. They have a  
21 running start [off microphone].

22 MR. HACKBARTH: Right.

1 DR. NAYLOR: I wonder if we could look at Slide  
2 14. I just want to make sure that I understand. The  
3 recommendation is to now move from annual per beneficiary  
4 caps of 1,880 to -- are we recommending to the mean?

5 DR. AKAMIGBO: I'll let Glenn take that.

6 DR. NAYLOR: Okay. I'm trying to figure out -- so  
7 it's just an overall recommendation with data provided about  
8 mean and median. Yes, okay.

9 MR. HACKBARTH: Lowered the caps as a way to  
10 reduce the potential cost of this.

11 DR. NAYLOR: Okay. So it's not what --

12 MR. HACKBARTH: But we have not, at this point at  
13 least, said lower it to a specific number.

14 DR. NAYLOR: Okay. And I was wondering if -- and  
15 this I think probably may be addressed by Peter, what you're  
16 doing in response to Peter's question, but trying to  
17 understand not just those that exceed the caps but those --  
18 what's the profile of people that are above the mean and  
19 median in terms of understanding do they look -- and I know  
20 -- I understand from your paper that's really hard to do.  
21 But do they look very different than those that are below  
22 the mean? And so as we're making decisions about reducing a

1 cap, we have a pretty good understanding of what the  
2 difference is in needs and so on. So I don't know. Can you  
3 at all help to uncover --

4 DR. AKAMIGBO: We've tried, you know, but  
5 remember, at this point we --

6 DR. NAYLOR: Have no functional data.

7 DR. AKAMIGBO: We have no functional data. We're  
8 relying on ICD-9 codes that look the same across the board.

9 DR. NAYLOR: Got it.

10 DR. AKAMIGBO: So I don't know that we can bring  
11 more --

12 DR. NAYLOR: So it's not even above the mean or --  
13 you don't see those kinds of differences?

14 DR. AKAMIGBO: You don't see huge -- no.

15 DR. NAYLOR: So maybe it's going to be then  
16 helping to uncover where the service use is, et cetera.

17 And the last thing I'm wondering is the issue  
18 about when to trigger the mandated review. I'm wondering  
19 why it isn't being triggered at cap now. I mean, it's  
20 double the cap that's required.

21 DR. AKAMIGBO: The \$3,700 threshold, that was just  
22 a matter -- that was what was in the law, and \$3,700 is in

1 reference to the -- that's the 95th percentile, exactly.

2 DR. NAYLOR: I guess my question is whether or not  
3 triggering that --

4 DR. MARK MILLER: Earlier [off microphone].

5 DR. NAYLOR: -- much earlier wouldn't have  
6 resulted in something different. I know that's what we're  
7 working toward, but how it would affect what we're observing  
8 here.

9 MR. KUHN: Before I get to my kind of two  
10 technical questions, just to react a little bit to Peter's  
11 question about kind of the variation and maybe a little bit  
12 more nuanced than we need. But going back, I think it was  
13 either in 2005 or in 2006 when CMS discovered that athletic  
14 trainers were actually delivering these services and billing  
15 for these services. And under the law, athletic trainers  
16 are not a recognized provider with the PTs, OTs, and speech  
17 language pathologists, so CMS stopped that. But it seemed  
18 like they were collected pretty heavily in the Midwest and  
19 Upper Midwest that was out there.

20 So one of the reasons we might see a decrease in  
21 that area is the fact that there were a whole set of  
22 providers out there delivering care that were no longer

1 permitted to deliver care in 2005 and 2006 out there. So  
2 just a little bit of a nuance on that.

3 First of all, thank you both for including the  
4 information in the written materials on the VA and the NCD,  
5 LCD process. That was helpful. One question on that, on  
6 the NCD, LCD. You indicated in the paper that there are  
7 very few NCDs, but there seems to be an awful lot of LCDs.  
8 I didn't go through and look at all the various Medicare  
9 administrative contractors. I just don't have that much  
10 time. But I looked at a couple, and I kind of scrolled down  
11 the page in terms of the LCDs, and just based on those two  
12 looks, and if you multiply that by the others, it appears to  
13 me that there's literally hundreds of LCDs out there. Is  
14 that an inaccurate assumption on my part, do you think?

15 MR. WINTER: There are many LCDs. I'm not sure if  
16 there are hundreds. I'm looking to Lauren actually --26?  
17 Okay, 26 LCDs. And that includes Part A and Part B?

18 DR. AKAMIGBO: Yes.

19 MR. WINTER: Okay. So we found 26. Lauren looked  
20 through all of them, and she's really the expert on this.  
21 But what we found is -- she's not the expert? Okay.

22 [Laughter.]



1           MR. WINTER: Among the three of us, she probably  
2 has the most expertise.

3           What we generally found is that they're very  
4 similar and they're modeled after the Medicare Coverage  
5 Manual in terms of outpatient therapy. There are a couple  
6 of wrinkles. There are some MACs that have limits on the  
7 number of time services that can be provided to a patient on  
8 ACO given day or within a given month, for example, five 15-  
9 minute services in OT or PT per day, without going through  
10 medical review. A couple of MACs have that limitation. The  
11 rest of them -- most of them do not. But, generally, very  
12 similar, very broad coverage. There are a couple of  
13 exceptions for things like therapeutic ultrasound, which is  
14 a modality that's sometimes used, but generally similar and  
15 pretty broad.

16           MR. KUHN: Thanks for that research and that  
17 clarification. That's helpful.

18           The second thing I had a question on was the  
19 manual review, a little bit where people have talked about  
20 it, and really kind of looking at the capacity issue for CMS  
21 to do this. So as we show on Slide 14, we've got 19 percent  
22 that exceed the cap for PT and speech language pathology and

1 22 percent for OT. So how many kind of manual reviews are  
2 we talking about here? What's the order of magnitude? Do  
3 we have any sense of what we'd be looking at?

4 DR. MARK MILLER: Do you have a sense of the total  
5 service counts [off microphone] or visits that are provided?

6 DR. AKAMIGBO: It would be at the -- I can get  
7 back to you on that.

8 MR. KUHN: I guess what I'm just trying to think  
9 about is capacity within the MACs and how many FTEs they  
10 would need to do this, to do it, as Tom was kind of -- and  
11 Jack, you know, talking about making sure that it's done in  
12 a timely way and what would be the army of contractors that  
13 would need to be hired to kind of manage something like  
14 this.

15 DR. MARK MILLER: And we can put some thought in  
16 this, and this is a dynamic that, you know, might help you  
17 think about this, and it may also relate to some things that  
18 Mary was saying a second ago. There's probably a situation  
19 where, as you bring the cap down, the percentage of services  
20 subject to review goes up, and there's probably a point --  
21 and you could talk about I want to put the cap at this point  
22 in the distribution, but there's probably an administrative

1 point after which your capacity to review begins to stop,  
2 and that may be the point where the cap sort of settles in a  
3 sense, because at some point your capacity to do this will  
4 just kind of fade away.

5 MR. KUHN: Yeah, that makes sense, and I think --  
6 and as Glenn, I think, when he was responding to Alice's  
7 question, you laid it out very accurately in terms of, you  
8 know, administrative funds that they have and how they would  
9 be able to contract this. So I think it's a good  
10 recommendation. I guess I'm trying to think about the  
11 practicality and feasibility of it. So if there's some  
12 refinements that we can think in that, that might be useful.  
13 But it does make sense that that's something that probably  
14 needs to be done. Just how do we help the agency accomplish  
15 that goal I think is part of our stewardship responsibility  
16 here.

17 MR. GRADISON: I, too, have been concerned about  
18 the manual review process, and in particular, I'm very aware  
19 of the limitations because of the requirement of an  
20 appropriation for certain of these processes. I think these  
21 dollars are going to become harder to get, especially if  
22 there's division within the Congress about various parts of

1 the new health care law. It would be helpful to me and  
2 perhaps to others to have a short memorandum at some point  
3 which just took a look at what are the MACs doing with these  
4 dollars, that is to say, what kinds of activities, and in  
5 particular, to focus on areas that have to do with manual  
6 review. This isn't the first time I think we've talked  
7 about a part of the Medicare program where there's at least  
8 talk, if not action, about having a review process, often  
9 perhaps before care is provided. And so I'd like to  
10 personally get a better feel for how this fits into the  
11 larger picture of what these reviews are intended to  
12 accomplish and the reality about how much can actually be  
13 done along these lines. Even if it would be a good idea and  
14 even if there is a break point, the constraint of dollars  
15 alone could be a very important overriding element. So  
16 that's just a general request.

17 Do we yet have any data from the MACs about the  
18 approval or denial ratios in this area?

19 DR. AKAMIGBO: At the cap level, we don't have  
20 data, but we've spoken with a few medical directors from  
21 MACs across the country. The denial rates have been  
22 classified as low. The denial rates have been classified as

1 relatively low. And this again implicates the fact that  
2 there are few guidelines to help them make a decision about  
3 whether something is truly medically unnecessary.

4 We don't have data at the \$3,700 threshold. That  
5 just started October 1st. The submission of requests to  
6 spend above that threshold started September 18th, so we --  
7 and I was on the call, the CMS call last week, and so we  
8 have a sense of how many -- what those requests have looked  
9 like, and they haven't had the kind of information the MACs  
10 were hoping for. So it's still being refined, but no data.

11 MR. GRADISON: That's really so critical, I think,  
12 to trying to figure out the role of the review process,  
13 because if the word gets out most of them are going to be  
14 approved anyway, it could actually increase the number of  
15 requests. And just the reverse is true, too. I can see  
16 situations in which a provider might like to avoid being  
17 turned down consistently because that might look like an  
18 outlier that would involve further investigation of the way  
19 they're conducting their activities and requesting  
20 reimbursement.

21 Thank you.

22 MR. HACKBARTH: Let me just follow on Bill's

1 questions to help me understand this. Forget the new \$3,700  
2 provision that's just now being implemented. Before that,  
3 we have got nominal caps, but basically we've got automatic  
4 exceptions that are granted based on the provider just  
5 putting a certain code on the claim. So I guess if I am a  
6 contractor, the signal that I'm getting from the current law  
7 is we don't want you to really seriously review this stuff.  
8 Am I missing something?

9 DR. AKAMIGBO: No, you're not. That's --

10 MR. HACKBARTH: And so past experience of review,  
11 when these are the signals that are being sent, may not be  
12 indicative of the future productivity of review if very  
13 different signals are being sent.

14 MR. ARMSTRONG: Bill, I'm glad you asked that  
15 point. It was a point I wanted to make, and I won't  
16 elaborate too much on it. But there have been times when  
17 we've had required caps for reviews and discovered that 98  
18 percent of the time we approved them and decided the  
19 administrative investment wasn't worth it. But so there's  
20 two reasons for this review. One is to prevent requests  
21 from coming forward that would obviously be denied, and we  
22 don't know how much of that happens, but I think that's a

1 good reason for this cap and this review process. But then,  
2 second, if we're going to review these, we should review  
3 them with an expectation and then a system built so that we  
4 can actually deny them if they don't meet our standards, and  
5 that requires clear standards and so forth. So, anyway, I  
6 think those are excellent points.

7 Just one other point to comments that had come up  
8 earlier. Part of the difficulty in comparing this  
9 experience with private plans is that the plans' benefits  
10 vary so significantly depending upon what the employers are  
11 looking for as well. And even in many systems like our own,  
12 our review process and the caps, in fact, depend not just on  
13 the benefit structure but also on where the care is being  
14 provided. We will review against caps when care is provided  
15 outside of our own network, but we won't when it's within  
16 our own network. And so, I mean, I can really imagine how  
17 that would be a difficult point of comparison.

18 Craig didn't ask this, but it would be very  
19 interesting to be able to look at how this compares to  
20 Medicare Advantage plan experience, so for the record, I  
21 will say that.

22 [Inaudible comment off microphone.]

1 MR. ARMSTRONG: And I guess that's all I'll say.

2 MR. GEORGE MILLER: Yeah, again, thank you, both  
3 of you, for the work on this. This was outstanding, and I  
4 really appreciate the information about the VA. I knew  
5 literally nothing about the VA process, and it was very  
6 helpful to read that.

7 On Slide 7, just a technical question. You  
8 probably covered this in September and I just forgot, but  
9 why was there no data for 2005?

10 DR. AKAMIGBO: So for earlier years, we relied on  
11 CMS contractor reports for a lot of this data, and there  
12 just wasn't a report for that year.

13 MR. GEORGE MILLER: All right. And then on Slide  
14 13, help me understand why the difference for 25 percent in  
15 a facility setting and only a 20-percent reduction in non-  
16 facility settings. What was the rationale thinking for the  
17 differences?

18 MR. WINTER: I'm not exactly sure what -- so  
19 Congress came in and when CMS initially finalized their  
20 proposal, it was 25 percent across the board. Congress came  
21 in and said we're going to reduce the hit on non-facility  
22 settings, like therapists in private practice, take it down



1 from 25 percent to 20 percent, but we're going to keep it  
2 the same 25 percent in facility settings. There was no  
3 explicit -- I don't believe there was an explicit rationale  
4 for why there was that distinction.

5 But one of the other things they did that's really  
6 important is the initial policy was budget neutral as it  
7 applied to the non-facility setting. So the money that was  
8 saved as redistributed to other physician fee schedule  
9 services. And when Congress made this change, they took  
10 that money basically out of the physician fee schedule and  
11 used it -- part of the legislation was also to prevent a  
12 steep reduction in the conversion factor under the -- as a  
13 part of the SGR. I forgot if they held it, you know, if the  
14 update was zero percent or a small increase. They had to  
15 pay for it, right? So this is -- making the savings not  
16 budget neutral was a way to pay for some of the cost of  
17 avoiding a steep reduction in the conversion factor.

18 MR. HACKBARTH: So it was based on careful  
19 analysis.

20 [Laughter.]

21 MR. GEORGE MILLER: Yeah, yeah. Or should I play  
22 back the tape from yesterday, what I said?

1 [Laughter.]

2 MR. GEORGE MILLER: All right. I'll accept that  
3 explanation and breathe deeply.

4 MR. WINTER: The option we're talking about would  
5 be uniform across settings.

6 MR. GEORGE MILLER: I understand.

7 [Laughter.]

8 MR. GEORGE MILLER: Help me understand the high-  
9 spend area, if you could put that slide up, the top ten,  
10 please. And I appreciate the Chairman's recommendation. I  
11 guess I'm just a little bit concerned -- well, let me ask,  
12 in the recommendations do they include the average, if you  
13 lower the caps to a mean, the question Mary asked about  
14 where the mean's going to be, so if they include the high-  
15 spend areas, my question would be: Are we penalizing -- and  
16 I guess it would average over -- I think I just answered my  
17 own question.

18 MR. HACKBARTH: So, to be clear, as I said to  
19 Mary, I have not at this point proposed a specific --

20 MR. GEORGE MILLER: Yeah.

21 MR. HACKBARTH: -- for lowering the cap.

22 MR. GEORGE MILLER: Yeah.

1           MR. HACKBARTH: There is this interaction that  
2 we've been focused on where, if you lower the cap, you're  
3 increasing potentially the proportion of claims that are  
4 subject to review, and that creates some administrative  
5 burden, and how many claims can we realistically review,  
6 effectively review. And I'll want to come back to that when  
7 we get to round two.

8           MR. GEORGE MILLER: I will, too. I'll cover it in  
9 round two. Just one quick point. It seems that with these  
10 high-spend areas that's one of the reasons for the cap being  
11 driven down, which makes perfect sense. But I'm just  
12 wondering if we're penalizing some that may be at the  
13 appropriate level but that cap --

14          MR. HACKBARTH: You know, one inference from this  
15 is that in some parts of the country a lower cap would not  
16 result in any review at all.

17          MR. GEORGE MILLER: Right.

18          MR. HACKBARTH: In other parts of the country,  
19 you'd be talking about a high percentage of users being  
20 subject to review.

21          MR. GEORGE MILLER: Right, yeah.

22          DR. MARK MILLER: The only quick thing I would add

1 here is the program integrity recommendations, number one,  
2 also would presumably come in and have greater effect on the  
3 left-hand side of the slide. And so if there were national  
4 edits that said this many services in this time period don't  
5 make a lot of sense, maybe some of that gets worked down,  
6 and the cap is still likely to have a greater effect there,  
7 but maybe some of the real aberrant services are cleared out  
8 through that kind of process.

9 MR. GEORGE MILLER: And I'm sorry, just one quick  
10 thing. In the paper, I was just curious, in your  
11 recommendation for a tool, an assessment tool, why was not  
12 either ethnic or race included in the demographic  
13 information so that we could measure disparities?

14 DR. MARK MILLER: I don't think it was an explicit  
15 decision to exclude it. We were trying to repeat the  
16 information that's on this basic instrument that, you know,  
17 as a starting point for where they could start to collect  
18 information.

19 MR. GEORGE MILLER: Okay.

20 MR. HACKBARTH: To just quickly go back to  
21 George's first question about the multiple procedure  
22 discount, and he asked about the difference between the 25

1 and 20 percent discount for facility and non-facility-based,  
2 and that was in legislation. We were all sort of making  
3 light of that, that it was probably not based on, you know,  
4 a real careful analysis. My understanding, though, is that  
5 there was a significant piece of analysis for the initial  
6 CMS proposal for a multiple procedure discount.

7 MR. WINTER: Yes. If you go back to Slide 12,  
8 you'll see we summarize that.

9 MR. HACKBARTH: Yeah, so I just don't want our  
10 making light of the one to undermine confidence in the  
11 other. Okay.

12 DR. HALL: Wonderful job on this. Can we go back  
13 to 7 again? This is total Medicare spending on services.  
14 So it doesn't distinguish between the actual amount per  
15 recipient versus volume. Is that correct? I just want to  
16 make sure I understand that. This would just be the whole  
17 lump annualized amount that's spent on services. So do we  
18 have any way of knowing whether in some of these cases,  
19 particularly since, say, 2005, that one of the phenomena  
20 here is just an increase in the number of recipients of  
21 services as opposed to increased spending on average per --

22 DR. AKAMIGBO: In September we had the per

1 beneficiary table.

2 DR. HALL: Right, I saw that.

3 DR. AKAMIGBO: And so that basically accounts for  
4 the increase. It takes that out as a factor, the increase  
5 in the number of users. We're just looking at spending per  
6 user. And it essentially follows the same trajectory.

7 DR. HALL: The same, it explains all of it,  
8 because, you know, there have been so many services that  
9 have been introduced since, say, the last ten years that  
10 almost automatically generate physical therapy services. A  
11 good example would be knee replacement. It's doubled over  
12 ten years, and virtually 100 percent of those patients have  
13 rehab services.

14 Anyway, I guess what I'm getting at is whether we  
15 still have a comprehensive picture of this whole very  
16 heterogeneous group of providers -- I mean of service  
17 recipients. You mentioned, Adaeze, that 40 percent of the  
18 services were provided in nursing homes. Do I have that  
19 right?

20 DR. AKAMIGBO: It was about 38 percent, yeah, 40.

21 DR. HALL: Near enough for government work. And  
22 30 percent were in private practice settings or ambulatory

1 settings.

2 DR. AKAMIGBO: Physical therapy.

3 DR. HALL: Physical therapy. That's what I'm  
4 really concentrating on. Where was the other 30 percent  
5 spent?

6 DR. AKAMIGBO: In a variety of settings, so about  
7 10 percent were -- 10 percent of spending occurs in  
8 outpatient rehab facilities. Hospital outpatient  
9 departments account for about maybe another 16 percent, so  
10 that's 26. And then physician's offices account for about 4  
11 percent.

12 DR. HALL: So almost half of these services are in  
13 one venue, nursing homes; is that right?

14 DR. AKAMIGBO: Essentially, yes.

15 DR. HALL: I guess the one thing I'm concerned  
16 about, without this kind of more focused view of the  
17 population, is whether by any system of caps or constraints  
18 on utilization that we might penalize a lot of groups that  
19 don't really need to be penalized, and maybe there's more  
20 bang for the buck if we concentrate in areas where there  
21 seems to be clear-cut issues. We won't say anything about  
22 Queens and Brooklyn County -- or Kings County. I don't know

1 whether that would be of use to us, but it may come up in  
2 round two as well.

3 DR. AKAMIGBO: Okay.

4 MR. HACKBARTH: Bill, let me ask about the first  
5 comment. What would be the policy implications if we were,  
6 for the sake of discussion, to find that an increase in the  
7 number of users as opposed to use per beneficiary was an  
8 important driver of the increase?

9 DR. HALL: Well, I think it would have multiple  
10 causation. Let's just stay with knee surgery for a moment.  
11 There has been some recent commentary in some of the medical  
12 literature about this increase, and we really don't have any  
13 good data on quality of outcomes to justify whether even the  
14 procedure itself is a good one. Well, that's for another  
15 discussion.

16 But I guess I always worry when there has been  
17 such an increase in the use of anything, predominantly  
18 technology, but even maybe services like this that are more  
19 related to increased volume of recipients. That's a  
20 different question than how much we're spending per  
21 recipient, I think.

22 MR. HACKBARTH: We've got, unfortunately, this



1 very tight deadline.

2 DR. HALL: I know. Right.

3 MR. HACKBARTH: And we have to make a  
4 recommendation. We've got a certain number of policy tools,  
5 you know, the dollar value of the cap, manual review,  
6 multiple procedure discounts and the like. I'm trying to  
7 connect the issue that you're raising, which I think is an  
8 important and valid one, and what it might mean for the  
9 configuration of policy options that we recommend to the  
10 Congress.

11 DR. HALL: Well, let's say we found that a lot of  
12 this is due to medical procedures that weren't there, let's  
13 say, in the year 1996 or something like that. I would say  
14 one counter of health care systems might be, well, look, if  
15 you want us to keep these people in the hospital longer  
16 rather than get them out with rehab, fine, but then you're  
17 going to have to pay for this -- or we're going to have to  
18 pay for it, or someone is.

19 I guess I'm more thinking down the line when we  
20 really start pushing, if we do bundling of payments. A lot  
21 of these bundled services, by the way, have a lot to do with  
22 physical and occupational therapy. I hope we don't create

1 problems for ourselves as we go down the road on this. I  
2 don't want to overemphasize that point.

3 DR. MARK MILLER: One thing about your comment on  
4 differential caps which seemed to be --

5 DR. HALL: Maybe.

6 DR. MARK MILLER: Okay, because then I suspect  
7 that you could just be back at this table five years from  
8 now and, you know, the growth has all moved out from under  
9 that cap and moved to the one where there was -- where it  
10 was looser.

11 DR. REDBERG: Thank you for an excellent report.

12 On Slide 20, on the Chairman's draft  
13 recommendation three, I just wanted to clarify. I think the  
14 tool certainly is a good idea, but is the idea that when it  
15 says we'll provide the basis for global payment approaches  
16 that the payment is going to be pegged to the improvement on  
17 the tool or would it be a collecting tool just to know how  
18 it's doing? I wasn't sure what that meant.

19 DR. AKAMIGBO: I think I understand your question.  
20 So the idea is that the tool would be used to do a couple of  
21 things, to collect information on functional status over  
22 time, so from the time the beneficiary starts getting

1 therapy to the time they are discharged, and that based on  
2 that -- so based on what we've learned about their  
3 improvement or their outcomes, we would then be able to --  
4 should we move to an episode base or some more bundled  
5 payment approach, we would have the necessary information  
6 that would -- to help sort of move into that payment  
7 framework. Because I think for a bundled payment, you need  
8 to know --

9 MR. WINTER: [Off microphone.]

10 DR. AKAMIGBO: Yes, essentially how to classify  
11 patients by function -- by severity, by function, by risk.  
12 And so that's what the -- go ahead, Mark.

13 DR. MARK MILLER: I think there's, in a perfect  
14 world -- which, you know, we can all pause for a minute and  
15 decide what that is -- this might do two things, okay. One  
16 is if you were still in a fee-for-service environment, maybe  
17 it gives you another metric to judge whether you continue.  
18 So there's a continued improvement here. I'm hitting a  
19 point. Let's imagine a world in which there are not caps  
20 and that kind of thing and you're sort of saying, look,  
21 there's improvement here. This patient should continue.  
22 This has plateaued and so we're -- maybe. And I want to say

1 that's a real reach.

2 I think what the statement about the bundling and  
3 those kinds of things, we're trying to capture what the  
4 Commissioners were saying last time, which is if you wanted  
5 to try and build this into bundles or help an ACO manage and  
6 you could organize people consistently into more  
7 identifiable groups -- knee replacement surgery, this  
8 appears to be the average amount and the distribution around  
9 that amount -- it might help in constructing either bigger  
10 bundles around a post-acute care period, or alternatively,  
11 an ACO in trying to manage its populations. We drew that  
12 out of conversation that we thought you guys were having.

13 DR. REDBERG: My other question is, can you tell  
14 me, and maybe I missed it, how much does the usual PT or OT  
15 episode cost and is there a lot of variability? I'm just  
16 trying to understand how many episodes these caps would  
17 actually cover.

18 DR. AKAMIGBO: So the per visit payment is around  
19 \$73, and there are, on average, 16 visits per year. So  
20 someone can do the -- it's about a little bit over \$1,000, I  
21 think. So that's roughly how much it costs per episode.

22 MR. HACKBARTH: Okay, so we're to round two and

1 we've got a lot of work to accomplish here in this round.  
2 This has been a very rich discussion. People have raised  
3 important and valid issues, but we need to get to a  
4 recommendation for next month's meeting. That's not  
5 optional. So I'm going to try to really structure this  
6 second round so that we come away with a clear sense of  
7 direction in formulating the final recommendation. So  
8 everybody take out your pen and paper. That's good, but I'm  
9 going to actually break it down to a little bit more  
10 granular level.

11 And the way this is organized in my mind is like a  
12 decision tree. The first decision is do we recommend the  
13 hard caps or not. Current law is, January 1st, we revert to  
14 a system of hard dollar caps, no exceptions.

15 If your answer is, no, we should not revert to a  
16 system of hard dollar caps, if we have no caps and do  
17 nothing else, we're talking about an increased Medicare  
18 expenditure above the current law baseline of roughly \$1  
19 billion a year, \$10 billion over ten years.

20 If you don't want to incur that cost -- recommend  
21 to the Congress that they incur that cost -- which tools do  
22 you support using to reduce that cost? And, frankly, we are

1 not going to be able to eliminate the cost. We are talking  
2 about reducing the budget score for not going back to hard  
3 caps.

4           The items on the table are reduce the cap, the  
5 effect of which would be to mean that more users would be  
6 subject to review.

7           A second tool is intense manual review of all  
8 claims above whatever the new dollar cap is.

9           A third is the multiple procedure discount in the  
10 payment rate.

11           And so those are the ones that are incorporated in  
12 my recommendations, and I'm setting aside -- I haven't  
13 sensed any disagreement about the program integrity pieces  
14 of this.

15           I think, based on the September discussion, I  
16 assumed everybody wanted to put the hospital outpatient  
17 departments under the cap. It didn't make sense to treat  
18 them differently than anybody else, and so I'm not going to  
19 ask for people on that.

20           So we've got three major tools -- lower cap,  
21 manual review, multiple procedure discount -- that I've  
22 incorporated in my recommendations.

1           Then we have the passage that we would add to the  
2 text that says, although this isn't part of the MedPAC  
3 recommendation, if Congress decides that it is unwilling to  
4 accept whatever residual score is left after whatever we  
5 embrace, they, of course, could lower the payment rate to  
6 providers and/or increase beneficiary cost sharing on  
7 services. Those are the other two tools that I did not  
8 incorporate in my recommendations, but they are logical  
9 additional tools.

10           So, again, the questions are -- I have answered  
11 the questions. I don't think we ought to go to hard caps.  
12 I'm unwilling to accept a billion dollars a year in  
13 additional expenditure. To try to reduce that cost, I'm  
14 willing to support a lower dollar cap, manual review of  
15 claims above that cap, and a multiple procedure discount. I  
16 have not been willing to endorse just an across-the-board  
17 reduction in payment rates or increasing beneficiary cost  
18 sharing.

19           So when you go through, if you can sort of  
20 structure, this is what I support and this is what I don't  
21 support, that'll help me in formulating the final  
22 recommendation. And Tom, you are up first.

1 DR. COOMBS: One question I have. The V-codes,  
2 elimination of V-codes, are we going to incorporate that  
3 into our analysis, as well?

4 MR. HACKBARTH: To me, frankly, that's sort of an  
5 obvious one. The V-codes, they ought to be eliminated. I'm  
6 trying to focus the discussion on what I think are the  
7 really major issues that have financial implications, as  
8 well as major access implications. For me, the V-code thing  
9 is a pretty obvious one, frankly.

10 Tom.

11 DR. DEAN: I have another question that probably  
12 really should have been in round one. When these claims are  
13 submitted, is there any attestation about the need for  
14 continued therapy? I mean, does the therapist have to  
15 document their belief that there has been progress and  
16 evidence of continued progress?

17 DR. AKAMIGBO: Yes. The answer is that the KX  
18 modifier, that is what the KX modifier is attesting to, that  
19 there has been -- that there's necessity to continue to  
20 receive therapy services above the cap and that that's been  
21 documented in the medical record by the therapist.

22 DR. DEAN: And they have to sign a statement to



1 that effect, or --

2 DR. AKAMIGBO: That's essentially what that  
3 modifier represents on the claim.

4 DR. DEAN: I'm just wondering if there is a clear  
5 statement that they are responsible for stating that?

6 DR. AKAMIGBO: In the medical record?

7 DR. DEAN: Yes.

8 DR. AKAMIGBO: Yeah. It's essentially --

9 DR. DEAN: Is it just implied or is it --

10 DR. AKAMIGBO: So let me make the finer  
11 distinction --

12 DR. DEAN: -- because if this is reviewed or  
13 audited, is there a way to trace that back to the individual  
14 that made that judgment, or --

15 DR. AKAMIGBO: Yes.

16 DR. MARK MILLER: Tom, are you asking under the  
17 current situation --

18 DR. DEAN: Yes, current.

19 DR. MARK MILLER: -- or the new situation?

20 DR. DEAN: Well, either one. I mean, I was asking  
21 under the current situation, and if it isn't, is that  
22 something that we ought to consider, I guess.

1 DR. MARK MILLER: The only thing I would say about  
2 the new situation is this. If a person comes up to the cap  
3 and says, I want approval to go beyond the cap, in a sense,  
4 they have to justify that to -- not in a sense, they have to  
5 justify that to the MAC. And so, presumably, the therapist  
6 is providing that information, and if the decision to go  
7 ahead is given, then it has been accepted as a valid  
8 service. And so I don't know whether the attestation is  
9 still necessary at that point. That would --

10 DR. AKAMIGBO: This is -- you're speaking, Mark,  
11 you're speaking to current --

12 DR. MARK MILLER: No.

13 DR. AKAMIGBO: This is --

14 DR. MARK MILLER: The future.

15 DR. AKAMIGBO: -- in the future --

16 DR. MARK MILLER: Because I think you're asking  
17 the question as it relates to --

18 DR. DEAN: Just if these are challenged, is there  
19 someone that would be required to take responsibility for  
20 making that judgment, just to make sure that -- you know,  
21 obviously, we do this and we may get challenged, and I think  
22 it's reasonable that if we're saying that there is a reason

1 to move on, somebody should have the responsibility of  
2 saying that, yes, that it was necessary.

3 MR. HACKBARTH: So just to pick up on what Mark is  
4 saying, so if you're applying for services above the cap,  
5 there is, for all practical purposes, an attestation that I,  
6 the therapist, think these are needed services, and then  
7 that request is subject to review. For services below the  
8 cap, there is a requirement that there be a plan of care  
9 developed by the therapist, and I don't know that there's a  
10 formal attestation requirement where you swear at the bottom  
11 that this is an accurate statement. But there does need to  
12 be a plan of care, as I understand this.

13 DR. AKAMIGBO: Yes.

14 MR. WINTER: The plan of care applies to services  
15 both below and above the cap.

16 MR. HACKBARTH: Yes.

17 MR. WINTER: It applies to all services.

18 DR. AKAMIGBO: All therapy services.

19 MR. HACKBARTH: Right. So how much of an impact  
20 on utilization you would get from a formal attestation  
21 requirement, I'm not sure that it would be a whole lot of  
22 additional benefit from that.

1 DR. DEAN: Okay. Well, I guess that was the  
2 question. It's just relatively easy to do, that's the  
3 thing. So beyond that, I support the recommendations. I  
4 think the three approaches you suggested make sense and I  
5 would support those.

6 DR. HOADLEY: So I, too, agree with the basic  
7 framing of the recommendation. I guess I would make two  
8 comments.

9 One is the issue we talked about earlier on the  
10 question of manual review and burden and its influence on  
11 the level of the cap. And the one thing I do remember from  
12 one of the private payers was, or perhaps one of the private  
13 benefit managers had developed sort of an automated process  
14 that could handle some set of reviews that were relatively  
15 routine, and then ones that made it through the automated  
16 would go to a more truly manual, you know, hands-on human  
17 review, and it may be worth talking about something like  
18 that just sort of as a partial way to help address the  
19 burden issue and be able to deal with that.

20 The other thing I do remember from the private  
21 plan experience is some of the interest in per visit payment  
22 and whether that serves as an alternative to the multiple

1 procedure reductions. I realize there's a work been done on  
2 that, so it probably doesn't make sense to go a different  
3 route within the recommendation, but it may be worth at  
4 least a comment that that is an alternative thing that could  
5 address some of the multiple procedures on the same visit,  
6 just a flat per visit rate rather than the per code rates.

7 MS. UCCELLO: I agree with the recommendations as  
8 they're stated. I think you've done a great job kind of  
9 making order out of chaos.

10 One comment on whether -- if we do say something  
11 about where to set the new cap, I would think we would want  
12 to do this in terms of percentiles instead of the mean. If  
13 we think about it, it's now at the 80th percentile, so how  
14 far down from that do we want to go? But I think  
15 percentiles rather than means make more sense.

16 DR. BAICKER: So I also agree with the direction  
17 of the recommendations wholeheartedly. Imposing strict caps  
18 would inhibit access, so that's no good. But then we need  
19 some of these tools. And I think the combination of  
20 lowering the cap and the manual review makes a lot of sense.

21 Scott's point is well taken, that it's hard to  
22 judge the success of manual review by denials. In some

1 sense, if you never have to deny anyone, that is a success  
2 because people have moderated the use that would be denied.  
3 So it's going to be hard to know how to set the cap and the  
4 cost of the manual review that a lower cap would trigger.  
5 That's a balancing act that clearly needs more exploration,  
6 but that seems like the right way to go. And the multiple  
7 procedure adjustment clearly seems very sensible to me.

8 I think there is great potential in the variable  
9 beneficiary cost sharing that you outlined, and I understand  
10 the reasons for not pushing that forward now, and I'm glad  
11 we at least discussed those options, realizing that their  
12 effectiveness is hampered by the current Medigap environment  
13 and that some of our other recommendations about ensuring  
14 that Medigap plans don't push additional costs onto the main  
15 program. If those were in place, then I think there would  
16 be even more potential for that cost sharing to be  
17 successful. But given that the world doesn't do everything  
18 that we say, which seems shocking, I think it's reasonable  
19 to have structured it the way that we have.

20 DR. MARK MILLER: That little discussion that you  
21 just went through could certainly be built into the chapter  
22 and I think would --

1 DR. SAMITT: I also fully approve the  
2 recommendations. I certainly wouldn't want to see hard  
3 caps. There would be untoward consequences there.

4 I do have two small concerns. One pertains to  
5 what we talked about earlier regarding the communication to  
6 beneficiaries of reaching or coming close to a cap, and I'm  
7 worried that beneficiaries would individually choose not to  
8 receive therapy services, even though should they go to  
9 manual review they would be approved. So I'm not sure how  
10 we reconcile that issue. I don't know whether there can be  
11 a prevention of balance billing to beneficiaries. The  
12 providers would fully bear that cost if there isn't medical  
13 necessity. So I feel a little bit uncomfortable about that  
14 because it could lead to under-utilization of necessary  
15 services per the beneficiaries' choice.

16 I'm also a little bit worried about the manual  
17 review and the burden associated with it. Sometimes in our  
18 organization, what we would consider doing, and I don't know  
19 whether there's any precedent here, we'd consider a gold  
20 carding methodology. So either providers who currently  
21 routinely fall below the cap are gold carded in that there  
22 isn't a manual review process. It's monitored offline, but

1 there isn't a manual review. Or that the manual review  
2 applies to all, but after a period of time, should people  
3 never seek out an approval or a manual review, that they are  
4 then gold carded. So that may be a slight modification that  
5 could help to some degree some of the burden.

6 MR. HACKBARTH: And as with Kate's comment, I  
7 think each of these concerns are important things that we  
8 should raise in the text. I'm not sure how we could  
9 properly handle them in boldface recommendation, but that  
10 would be my approach to these issues. Is that okay?

11 Peter.

12 MR. BUTLER: So, actually, I would, surprisingly,  
13 support hard caps, but you didn't make that an option, I  
14 think.

15 MR. HACKBARTH: I want to hear that. I just laid  
16 out my own analysis.

17 MR. BUTLER: And I actually would support cost  
18 sharing, not necessarily because the beneficiary would now  
19 have skin in the game, but we have to remember that Medicare  
20 and supplemental insurance -- what's not covered -- not  
21 everything that is needed is covered by the benefit package  
22 now, necessarily, and so simply to say the value of this is,



1 you know, you could have 50 percent or something covered or  
2 something along those lines and say, why is it -- was this  
3 the next best benefit enhancement? I'm not sure. We limit  
4 the number of SNF days, for example, that are covered by  
5 Medicare now, right? And we don't say they're not needed,  
6 but it's not something that's within the Medicare  
7 expenditures overall. So it's another way of looking at the  
8 cost sharing, not just getting consumers engaged in it, but  
9 is this the value service that we think it should be.

10 But back to the more specific answer. So I guess  
11 my first choice would be a hard cap, but alternatively, if  
12 we have -- I'm supportive of the multiple procedure  
13 discount. So I could support, certainly, the exceptions,  
14 but I'm not really supportive of manual process. I just  
15 don't think it's going to be worth the time and effort.

16 So I'm probably not as clear as you want me to be  
17 --

18 MR. HACKBARTH: Actually, if you support --

19 MR. BUTLER: -- as a tool --

20 MR. HACKBARTH: -- hard caps, there's no budget  
21 score to work off.

22 MR. BUTLER: But alternatively, I would definitely

1 support a cap plus the multiple -- I want to do it through  
2 pricing. I think that the success of trying to intervene in  
3 exceptions process, wherever they are, is laborious and not  
4 all that good. So I'd be happy if you just left the same  
5 exception process in place, had multiple discounts, multiple  
6 procedure discounts, and a lower cap.

7 MR. HACKBARTH: Yes. So I'm not trying to talk  
8 you out of it, push back, I'm just trying to understand. So  
9 on the one hand, you're saying hard caps --

10 MR. BUTLER: That's my first choice.

11 MR. HACKBARTH: But then if we don't have hard  
12 caps, you're saying, well, the only one you really feel  
13 comfortable with -- or only ones are cost sharing and the  
14 multiple procedure discount. Am I --

15 MR. BUTLER: But you took cost sharing a little  
16 bit off the table.

17 MR. HACKBARTH: Well, again, I laid out the menu  
18 and I'm trying to understand as explicitly as possible where  
19 all of you stand. I told you my personal choice, but I want  
20 to understand yours --

21 MR. BUTLER: Yeah.

22 MR. HACKBARTH: -- and I just want to make sure

1 I'm understanding yours correctly. Your first choice is  
2 hard caps. If there are not hard caps --

3 MR. BUTLER: Then I'd do a combination of the cap,  
4 permit the exceptions process, but I wouldn't make it  
5 manual, and I would include coinsurance for going over the  
6 cap plus the multiple procedure discount.

7 MR. HACKBARTH: Okay. Okay.

8 DR. COOMBS: I support the recommendations and I'm  
9 glad you don't have cost sharing and I think that there's a  
10 point where if it's really, you know, deemed necessary for  
11 an extension, that that may, indeed, alter the course for a  
12 patient and get a patient in a better physical status and  
13 decrease morbidity, follow-up morbidity.

14 So I think, for me, the process of having the  
15 manual review in place increases the integrity of the  
16 program and I think it's more important to get the best  
17 product at the end for the patient. I'm more willing to  
18 give on the other end than on the patient cost end because I  
19 think -- I have to believe that there's something good  
20 that's going to result in a better outcome for the patient  
21 in the big picture, even for the less cost burden on the  
22 patient, which makes sense for me.

1           MR. HACKBARTH: Perhaps I should just say another  
2 little bit about cost sharing and why I put it where I did.  
3 I guess my first point would be, in some ways, I think this  
4 is like home health, where there is a significant  
5 discretionary component to it, and all other things being  
6 equal, that says to me cost sharing is an appropriate tool  
7 to consider.

8           I ended up in a different place for two reasons.  
9 One is, unlike home health, there already is cost sharing in  
10 this service. There's a Part B deductible and 20 percent  
11 coinsurance, so we're not starting from zero. But that  
12 wouldn't rule out the possibility that you could have a  
13 restructured cost sharing with higher cost sharing later in  
14 the potentially more discretionary end of the continuum.

15           But then I bump up against the Kate issue. You  
16 know, in the world of our redefined Medicare benefit  
17 package, including the charge on supplemental coverage,  
18 that's a recommendation that would make a lot of sense.  
19 That is not the environment that we're in for purposes of  
20 this recommendation. We're in an environment where whatever  
21 we do on cost sharing is going to just flow through the  
22 supplemental insurance system and it's not going to affect

1 utilization. It's just going to be a straight cost shift to  
2 beneficiaries. It flows through the premiums of  
3 supplemental plans. So I don't see the gain.

4 So that's how I got to -- it's not that I'm in  
5 principle opposed to cost sharing. I just don't see it  
6 working in this context.

7 DR. NAYLOR: Thank you both, and all the team, for  
8 another exceptional report and the update.

9 So I do not support hard caps. In terms of the  
10 tools, two and three listed there, multiple procedure  
11 payment and including services in hospital outpatient  
12 department, I support.

13 I am concerned about decreasing caps, and I -- so  
14 let me just say that the framework we're using is what do we  
15 know about potential impact on access and quality and  
16 obviously on cost. And I think the evidence, albeit  
17 imperfect, points in the direction that we have  
18 opportunities here, and opportunities in improving function  
19 that could have -- are they upstream -- really important  
20 impacts in terms of use of more costly resources downstream.

21 And so I would like to think that maybe we could  
22 also explore keeping the cap where it is, but putting the

1 mandated reviews right in place to see, at least for the  
2 short term as these functional status measures are -- I  
3 mean, that, to me, is the ultimate gain, to get a functional  
4 status measure that's linked to performance, and payment is  
5 linked to performance.

6 So that's where I'd go. If we go with reducing  
7 caps, the idea of percentiles makes a great more sense to me  
8 than thinking about means and medians.

9 And let me just say that this is one area that  
10 Medicare beneficiaries have been really loud and clear  
11 about. As they look to the future, the thing they care most  
12 about is their independence. It's function. And so I just  
13 want to make sure that we get to the right kind of solutions  
14 that are really aligned with what people think are most  
15 important to them.

16 MR. HACKBARTH: You said that at the September  
17 meeting, Mary, and I personally found that very persuasive  
18 and it's one of my most important reasons for not wanting to  
19 do hard caps.

20 DR. NAYLOR: Thank you.

21 MR. HACKBARTH: I think in terms of the quality of  
22 life for Medicare beneficiaries, the ability to get around

1 and be independent, I think they serve often very, very  
2 important services. Herb?

3 MR. KUHN: Glenn, I want to thank you again and  
4 all the staff for the hard work here, and I think pulling  
5 together a lot of diverse ideas and getting us to a position  
6 where we're looking at these three recommendations. So  
7 having said that, I think the recommendations are in the  
8 framework and they work for me. So I'm generally supportive  
9 of those.

10 The manual review, you know, I've raised some  
11 questions about that. I think we'll get some more  
12 information in terms of the resources needed, but it's  
13 pretty clear that the KX modifier is on auto-pilot and  
14 something needs to be done. And short of manual review, I  
15 don't know what other option exists out there to grapple  
16 with that.

17 And on the multiple procedure discount, I'm a huge  
18 fan of that. I was part of that at CMS when we did it on  
19 imaging. I just think that makes a lot of sense. So I  
20 think that's going to work real well.

21 But I would like to kind of ask if we could think  
22 collectively about maybe another option or a refinement of

1 some of the options we have here. You know, as we heard  
2 from Adaeze in her presentation, there are a lot of concerns  
3 about the outpatient therapy benefit under Medicare. As she  
4 kind of rolled out in the slides that she presented, CMS  
5 lacks a lot of basic information in terms of who should get  
6 the benefit, what type, and for how long, and really, we  
7 don't have any information about improvement or level of  
8 improvement that's out there.

9 We also heard today about the fact that there are  
10 very few NCDs in this area, and there are a moderate number  
11 of LCDs. So perhaps I'm over-interpreting this, but it sure  
12 seems to me that the contractors are struggling with  
13 managing this benefit or else they wouldn't be issuing these  
14 LCDs as they go forward.

15 I also know from our conversations, both last  
16 meeting and this meeting, that therapists treat patients  
17 with many different conditions. So it's a complicated issue  
18 and it's in many different settings.

19 So having said that, I was encouraged yesterday  
20 when we were going through the ambulance set of  
21 recommendations and Recommendation Number 3 where we put  
22 forward some national guidelines to kind of more precisely



1 define the medical necessity requirements, so I think  
2 there's a bit of a framework or a precedent here.

3           So the NCD is a blunt instrument. It's difficult  
4 to kind of manage and I just think that would be cumbersome  
5 and difficult for CMS. So maybe an alternative that we  
6 could think about, and the reason why I want to think about  
7 this alternative, because we have these wonderful set of  
8 recommendations, but if we place them on top of a shaky  
9 foundation, I don't think we've accomplished much.

10           So I think we need to kind of move in parallel  
11 here to kind of shore up the foundation a little bit, kind  
12 of like we did on the ambulance recommendation yesterday.  
13 So what I would think about is maybe that we could suggest,  
14 encourage, or even direct the Secretary to ask CMS to kind  
15 of examine the language regarding coverage, and refine it  
16 through a systematic process of reviewing the Medicare  
17 benefit policy manual.

18           I think by looking at the manual, going through a  
19 systematic process, updating the manual, I think that gives  
20 us a better foundation so that as we add these new kind of  
21 activities related to this benefit, it might serve us well  
22 in just performance overall.

1           MR. HACKBARTH: So, Adaeze, could you put up  
2 Recommendation 3? It seems like that could fit in this  
3 context of certain longer term improvements.

4           MR. KUHN: Like I said, it could be another one or  
5 it could be subsumed under that, but either way, I think  
6 that's just the way I look at it.

7           MR. HACKBARTH: Yes. So we'll talk more about  
8 that, but this is where I would be inclined to place it.

9           MR. KUHN: To place it.

10          MR. HACKBARTH: Yes.

11          MR. KUHN: Thank you.

12          MR. HACKBARTH: Bill?

13          MR. GRADISON: I support the recommendations. I  
14 have this nagging concern about hard caps and I want to  
15 explain why. For a time, I served as the director of a  
16 rather large national managed care plan that focused on  
17 worker's comp. And, of course, the circumstances were  
18 different. The population was different in general from the  
19 Medicare population, although as an aside, I think we're  
20 going to see a growing proportion of Medicare beneficiaries  
21 who are working in the future, especially younger Medicare  
22 beneficiaries because of the inadequacy of retirement

1 benefits that we can already anticipate and see happening.

2           What was going on, and it's true today, I believe,  
3 still in the worker's comp area, that they found that by  
4 incurring much heavier costs at the outset, more frequent  
5 physical therapy, more hours a day, more days a week, that  
6 they were able to get people back to work quicker. And that  
7 was the trade-off, because from the point of view of the  
8 employer, they were balancing higher medical costs against  
9 the wage costs.

10           Now, again, that is not exactly our situation, but  
11 the reason I find that that helps inform my thinking about  
12 it is that in a sense, one could argue that the programs  
13 have the same goal, which is to restore maximum functional  
14 status, and even though there isn't the employment tie-in,  
15 in most cases, for Medicare. So that's why the hard caps at  
16 this stage of my thinking don't have much appeal. I think  
17 that's all I want to say on it. I'm supporting.

18           MR. ARMSTRONG: First, I, too, would say I support  
19 the recommendations the way that you laid them out. We're  
20 trying to solve this problem where we know, because of our  
21 benefit structure and our payment policy, that we're  
22 spending who knows how much, but maybe a billion dollars

1 more on this and it's not a good investment of our  
2 beneficiaries -- of the program dollars.

3 But at the same time, there are people who need  
4 way more than the cap, and it's good care, and so we're  
5 trying to strike that balance and I think this does a nice  
6 job of that.

7 Around reducing the cap, in particular, there have  
8 been some concerns about, you know, should we reduce it,  
9 what's the right level. I think it should be reduced and  
10 that the real question is, do you have confidence in the  
11 process by which you can manage that lower cap level, and  
12 it's not that hard. We should be able to figure out how to  
13 do that.

14 I think the last point I would make is that while  
15 I support this, I do think we should be fleshing out kind of  
16 those options that describe, if you really want to make this  
17 budget neutral, what would you need to do. I think I  
18 believe, like many other Commissioners, that the  
19 supplemental plans really mess up the incentives for the  
20 beneficiaries in ways that hurt us.

21 I believe that there should be more out-of-pocket  
22 costs that influence our beneficiaries' decisions than there

1 are given the MediGap plans. I don't know the solution  
2 specific to these outpatient services, however, but I think  
3 we need to use this as another chance to make the point that  
4 there's a real problem in the way MediGap plans disconnect  
5 patients from financial incentives that they should be  
6 connected to, and let's push that.

7 I guess the last point I would make is that the  
8 staff probably get this, but for me, I'm not clear enough as  
9 I could be about how we deal with a whole series of these  
10 ambulatory services and the payment policies and benefits  
11 associated with them. We've referenced home health with  
12 outpatient services and there are many others. It just  
13 seems to me that, at least from my point of view, we come  
14 into each one of them kind of separately and there's like an  
15 emerging set of principles about how we want those benefits  
16 to evolve.

17 I would really benefit, I think, some time from a  
18 little bit of time to put them all in front of us and say,  
19 What's the consistency in how we approach payment policy  
20 that we want to apply to all these different areas? And so,  
21 that that, too, I think, will really help us understand how  
22 each one of these sets of recommendations are actually

1 contributing to the advancement, you know, to a more  
2 reformed payment system.

3 MR. GEORGE MILLER: Yeah, I think Scott just  
4 mentioned one of the points I had on my paper to make.  
5 We're again dealing with a silo versus comprehensive health  
6 care reform, and so when you look at just one silo, this  
7 makes sense and I support the recommendation. It makes  
8 sense in that framework.

9 But I do question the billion dollar statement. I  
10 understand we need to reduce that. But if we looked at by  
11 reducing that, does it have a downstream impact somewhere  
12 else where someone may not get care and then go into the  
13 hospital? And again, Scott made a very good point about  
14 looking at it comprehensively.

15 But since we don't have it on the table today, I  
16 do support the recommendations. I would prefer not to have  
17 hard caps, and then the three things that you illustrated  
18 are important. For today in the context, I believe this may  
19 be the right kind of solution for what we're dealing with.  
20 I want to echo again Mary's point about the quality of life  
21 and giving beneficiaries the option to choose and how to be  
22 very, very active. I believe this set of recommendations

1 move into that context.

2 But I again want to emphasize, when we look at  
3 comprehensive, the entire package, we may look how it  
4 impacts each other. At first, until I read the paper -- and  
5 I'm very pleased with the paper -- was concerned about  
6 increasing co-pays, but I noticed in the paper the VA does  
7 have co-pays and, you know, we already have a payment.  
8 Again, Scott just illustrated the point about the MediGap  
9 payments that kind of blinds -- not blinds -- but doesn't  
10 have the same impact as paying really out-of-pocket because  
11 90 percent of it is covered. So anyway, I support the  
12 recommendation.

13 DR. HALL: Well, I'll join the chorus on this  
14 recommendation as we've said with the plan. I just  
15 emphasize again what Mary and Bill and George said about the  
16 importance of encouraging development of functional  
17 measures.

18 I tried to find a little bit more from a very  
19 cursory reading of the various associations that represent  
20 the deliverers of these services. I was surprised that they  
21 haven't really gotten on board on this and taken the lead in  
22 developing functional assessment tools. They have, but not

1 really linking it so much to a potential payment system. I  
2 think there's just such a crying need for this, so it can't  
3 just be a little one-liner in the text, but has to have some  
4 emphasis.

5 DR. REDBERG: I'll support the recommendations and  
6 I just wanted to add, you know, in particular in thinking  
7 about, you know, our patient-centered focus, we're really  
8 talking about patients so much. It's not treatments. If  
9 you look at what most -- a lot of these therapy services are  
10 used for, a lot of them are back pain and joint pains. And  
11 I think we should kind of apply the whole concept we're  
12 talking about here in looking at functional status to all of  
13 the other treatments we also have for back pains and joint  
14 pains.

15 For one example, we have a lot of back pain  
16 surgical procedures that have never undergone these kind of  
17 tests. They don't show any improvements in quality of life,  
18 and in fact, they probably do -- they do a lot of harms to  
19 our Medicare beneficiaries. For example, we spend -- well,  
20 in 2008, we spent one billion dollars on vestibuloplasty and  
21 keratoplasty which, you know, in a SHM controlled trial in  
22 the New England Journal had no improvement over SHM. And



1 most of that was Medicare beneficiaries and those are done  
2 for back pain.

3           And so, if we're going to apply these kind of  
4 tools for a \$73 dollar an episode physical therapy, which I  
5 think we all think is a good thing for our beneficiaries, we  
6 should also apply those to the other things we do for back  
7 pain. And that, I think, would make it very budget neutral,  
8 budget favorable, and also be a win for beneficiaries  
9 because they would not be subject to harmful procedures that  
10 don't help them and get more of these physical therapy  
11 services which do help them.

12           And the other big pocket I think that contributes  
13 to a lot of these diseases that lead to joint pains and back  
14 pains is obesity. So if we did more on reducing obesity in  
15 the Medicare population, I think that overall would be a  
16 win-win again.

17           MR. HACKBARTH: Okay. Thank you very much and I  
18 appreciate your willingness to fit your comments into my  
19 structure. More on this. I'll be talking to each of you  
20 about this recommendation and the recommendations on the  
21 physician work payment and ambulance before the November  
22 meeting. Adaeze, thank you, and Ariel, thank you very much.

1 Good work.

2 Now we will turn to our concluding session on  
3 population-based measures of ambulatory quality.

4 Whenever you're ready, Nancy.

5 MS. RAY: Good morning.

6 Fee-for-service payment systems reward for more  
7 care and more complex care with little regard to the quality  
8 of that care. In addition, fee-for-service systems create  
9 provider-specific payment silos and do little to encourage  
10 coordination across the silos. The Commission has discussed  
11 various approaches over the years to address these problems  
12 -- accountable care organizations, medical homes, and  
13 bundling, for example.

14 This presentation will explore using indicators of  
15 preventable admissions and preventable emergency department  
16 use as population-based quality measures.

17 And let me just pause for a moment and say that  
18 Sara and I will be using the acronym PPAs to stand for  
19 potentially preventable admissions and PPVs for potentially  
20 preventable emergency department visits.

21 These indicators are intended to reflect access to  
22 and the value of a region's ambulatory care system. Rather

1 than evaluating the performance of providers by silo, they  
2 allow a more comprehensive view of care in the community  
3 from a patient-centered perspective.

4           We last presented on this topic in October 2011.  
5 Today's presentation consists of three parts. First, I will  
6 provide some background on these indicators as population-  
7 based quality measures. Second, Sara will present findings  
8 of our analysis of 2006-2008 Medicare claims data that  
9 measure rates of potentially preventable admissions and  
10 emergency department visits across and within regions. This  
11 analysis was conducted under contract to MedPAC by 3M Health  
12 Information Systems. Sara will conclude the presentation by  
13 discussing next steps.

14           Potentially preventable admissions and emergency  
15 department visits are population-based quality indicators  
16 that measure rates of admissions and ED visits for  
17 conditions that could have been managed and treated in less  
18 costly ambulatory care sites rather than the ED or inpatient  
19 setting. These indicators are not intended to measure  
20 hospital quality. Rather, they reflect access to and the  
21 quality of a region's ambulatory care system. Comparatively  
22 high rates of potentially preventable events, when risk-

1 adjusted for variation in the underlying population mix,  
2 identify opportunities for improvement in a region's  
3 ambulatory care system.

4 PPA's measure rates of admissions that involve the  
5 treatment of ambulatory care sensitive conditions like  
6 diabetes, congestive heart failure, and asthma. Ambulatory  
7 care sensitive conditions are conditions for which timely,  
8 appropriate primary care can prevent or reduce the  
9 likelihood of preventable admissions.

10 The use of PPAs by policymakers and researchers as  
11 population-based quality measures is fairly well developed.  
12 For example, AHRQ's PPA indicators consist of 14 ambulatory  
13 care sensitive conditions.

14 For our data analysis, we have used 3M's PPA  
15 definition. It also based on ambulatory care sensitive  
16 conditions but is more comprehensive than AHRQ's. For  
17 example, 3M's definition includes admissions for conditions  
18 that could have been prevented by using coordinated care.

19 The paper, your briefing materials, provides more  
20 information about this indicator, and we would be happy to  
21 answer any questions you might have.

22 PPVs are ED visits that might have been furnished

1 in less costly ambulatory care settings. Like potentially  
2 preventable admissions, potentially preventable ED visits  
3 may result from lack of access to ambulatory care. There is  
4 also literature that other factors such as the convenience  
5 of the ED is also a factor contributing to the use of EDs  
6 when other ambulatory care sites could have been used.

7 While researchers and policymakers have begun  
8 using PPV rates as population-based quality indicators,  
9 their use is less developed than PPAs.

10 For our analysis, we used 3M's definition of PPVs.  
11 It is based on the ambulatory care sensitive conditions but  
12 exclude visits that resulted in a hospital admission. Those  
13 could potentially be captured in the indicator measuring  
14 potentially preventable admissions. 3M's definition of PPVs  
15 also excludes surgical procedures.

16 Now Sara will report on the findings of our  
17 analysis.

18 MS. SADOWNIK: I'm going to talk about our  
19 methods, results, and next steps. We conducted two  
20 analyses. The first measures rates across hospital referral  
21 regions, or HRRs, for a 5-percent sample of fee-for-service  
22 beneficiaries nationally. The second analysis begins to

1 look at variation within HRRs by analyzing data for 100  
2 percent of fee-for-service beneficiaries residing in six  
3 markets. This analysis looks at the variation of rates for  
4 hospital service areas within hospital referral regions.

5 So let's talk about the difference between a  
6 hospital referral region, or HRR, and a hospital service  
7 area, or HSA. Created by the Dartmouth Atlas, HRRs capture  
8 larger regional markets for tertiary medical care that  
9 require a major referral center. By comparison, HSAs are  
10 local markets for hospital care. They represent where the  
11 majority of the Medicare residents in an area are admitted.  
12 Most, but not all, HSAs contain only one hospital.

13 For both analyses, PPA and PPV rates are risk-  
14 adjusted using 3M's clinical risk groups which account for  
15 underlying comorbidities and beneficiary age.

16 We also performed a regression analysis to look at  
17 how different factors impacted the rates. We looked at  
18 population characteristics of gender, race, disability, dual  
19 eligibility, ESRD status, and the extent to which  
20 beneficiary place of residence is rural, as well as hospital  
21 occupancy rates. The impact of the population's demographic  
22 characteristics is evaluated at the individual beneficiary

1 level, not at the HRR level. For example, for dual  
2 eligibility, we looked at the association between event  
3 rates in beneficiaries who are dually eligible versus those  
4 who are not, as opposed to evaluating the percentage of  
5 dually eligible beneficiaries in a given hospital referral  
6 region.

7 I'm now going to talk about what we found. We  
8 found that PPAs and PPVs accounted for a substantial  
9 proportion of all admissions and ED visits. PPAs accounted  
10 for one-quarter of all initial hospital admissions. The  
11 annual PPA rate was approximately 94 cases per 1,000  
12 beneficiaries, and heart failure was the primary clinical  
13 reason.

14 PPVs accounted for almost 60 percent of all treat-  
15 and-release ED visits; that is, 60 percent of ED visits that  
16 did not result in a hospital admission. The PPV rate was  
17 around 158 per 1,000 beneficiaries. The most frequent  
18 reason for PPV was the category of "infections of the upper  
19 respiratory tract."

20 Rates of PPAs and PPVs varied widely by HRR. For  
21 both PPAs and PPVs, the table here shows cases per thousand,  
22 risk-adjusted for age and severity of illness. The values

1 represent the average of the HRR rates in the top- and  
2 bottom-performing quartiles. For potentially preventable  
3 admissions, the values across all HRRs ranged from about 37  
4 cases per 1,000 to 107 cases per 1,000 beneficiaries. For  
5 potentially preventable emergency department visits, the HRR  
6 values ranged from 14 cases per 1,000 to about 66 cases per  
7 1,000 beneficiaries.

8           To start to look at whether it would be better to  
9 measure and evaluate quality at a more local level than  
10 HRRs, we did a preliminary analysis of the performance of  
11 HSAs within larger HRRs. There are typically many HSAs  
12 within each HRR. While any system-level evaluation will  
13 have higher- and lower-performing providers, evaluating  
14 quality at the HRR level requires averaging the performance  
15 of numerous and diverse hospital systems. Focusing on  
16 performance at more local levels than HRRs may be more  
17 effective for quality improvement. Providers that make up  
18 an HSA may be able to more easily coordinate and implement  
19 initiatives to improve quality. However, evaluating  
20 performance at the HSA level has the challenge of accounting  
21 for patients who live in one HSA, but travel to other HSAs  
22 for care. In addition, inferring differences between HSAs



1 requires greater caution than between the larger HRRs  
2 because random variation is more likely to factor with small  
3 populations.

4           So for our exploration of how HSA rates vary  
5 within HRRs, we looked at six markets. These markets were  
6 Boston, Massachusetts; Orange County, California; Miami,  
7 Florida; Minneapolis, Minnesota; Phoenix, Arizona; and  
8 Greenville, South Carolina.

9           For both PPA and PPV rates, we found considerable  
10 variation between the highest- and lowest-performing HSAs  
11 within each market. Note here that Minneapolis and Orange  
12 County have similar risk-adjusted PPA rates -- that is, 51.7  
13 for Orange County and 52.1 for Minneapolis -- but their  
14 underlying HSAs show very different patterns: Minneapolis'  
15 HSAs range from 36.1 to 112.2, while Orange County's HSAs  
16 range from 42.9 to 60.8.

17           HRRs often encompass highly diverse HSAs. For  
18 example, among the HSAs that make up the HRR for  
19 Minneapolis, one particular HSA has seven hospitals and a  
20 Medicare population of almost 93,000 while another  
21 particular HSA in that same HRR has one hospital with less  
22 than 100 beds and a Medicare population of around 1,000.

1           We also looked at how different factors might  
2 impact rates of PPAs and PPVs. A regression analysis showed  
3 that the effect sizes for all of the variables that we  
4 considered was relatively small. However, some notable  
5 results did emerge. We found that some factors impacted PPA  
6 and PPV rates differently. In particular, disability status  
7 and being over 85 years old were two factors tied most  
8 strongly to higher rates of potentially preventable  
9 admissions. However, this age category had no significant  
10 association with potentially preventable emergency  
11 department visit rates, and disability status had only a  
12 small positive association. African Americans had higher  
13 rates of potentially preventable emergency department  
14 visits, but had no significant association with potentially  
15 preventable admissions. Beneficiaries who reside in urban  
16 regions -- both metropolitan and micropolitan -- had lower  
17 rates of potentially preventable admissions than  
18 beneficiaries who reside in rural areas, but slightly higher  
19 rates of potentially preventable emergency department  
20 visits.

21           Some factors did impact PPA and PPV rates in the  
22 same direction. Being dually eligible was associated with

1 higher rates of both. Looking at occupancy rates, we found  
2 that as hospital occupancy rates decreased, the rates of  
3 both PPAs and PPVs increased. With respect to PPVs,  
4 hospitals with higher occupancy may have busier EDs which  
5 may crowd out the PPV cases, that is, the nonurgent and  
6 primary care cases, whether through patient selection or  
7 hospital strategy. In the context of a population-based  
8 measure, we note that hospitals represent only one of many  
9 providers in a community that affect PPA and PPV rates, with  
10 the ambulatory system feeding into hospitals.

11 In addition, importantly, we saw that while  
12 population characteristics appear to impact the rates for  
13 PPAs and PPVs, variation between regions with similar  
14 characteristics suggests opportunities for improvement.

15 We have also started to look at how access to  
16 ambulatory care in an area impacts that area's rates of PPAs  
17 and PPVs. In conceiving of PPA and PPV rates as community  
18 outcome measures, it is important to be able to consider  
19 different communities' resource availability as well as  
20 whether beneficiaries can and do access these resources.  
21 Firstly, we may continue to look at what services  
22 beneficiaries used in the days directly preceding a

1 potentially preventable event, as well as how care use  
2 patterns may differ in areas with high versus low event  
3 rates. Secondly, we need to define indicators of access to  
4 care in the community. These indicators could include the  
5 number of primary care physicians and specialists in an  
6 area, the number of other community providers, such as  
7 federally qualified health centers or urgent care clinics,  
8 or some measure that does not rely on number of providers,  
9 such as measuring the distribution of where beneficiaries  
10 receive their care. Research should track with a patient  
11 perspective of the beneficiary's ability to have timely,  
12 regular access to a provider.

13           So we've presented early results on how PPA and  
14 PPV rates vary by region and some determinants of these  
15 rates, in considering the use of PPAs and PPVs as  
16 population-based measures of ambulatory care quality. We  
17 have also discussed areas for further research that would be  
18 important in honing the use of PPA and PPV rates as  
19 community measures, in particular, one, measurement and  
20 evaluation at the HSA level, or at a different more granular  
21 level than HRRs; and, two, more robust research on access to  
22 ambulatory care prior to these events.

1           We anticipate that the material reviewed today  
2 will feed into a chapter in the June 2013 report. We plan  
3 to incorporate examples from groups that may be using these  
4 measures and add additional research with guidance from the  
5 Commission. Today we look forward to the Commission's input  
6 regarding the use of PPA and PPV rates to assess the  
7 adequacy of care in a region, as well as directions for  
8 additional research or refinements, particularly on defining  
9 access to ambulatory care.

10           This concludes our presentation, and we look  
11 forward to your questions.

12           MR. HACKBARTH: Okay. Thank you, Nancy, Sara.  
13 Very well done. Rita, do you want to lead off the  
14 clarifying questions?

15           DR. REDBERG: I just wanted to understand a little  
16 better the methodology, because I think the concept of  
17 looking at PPAs and PPVs are good, but I couldn't really get  
18 how they were doing it. And one related to that in  
19 particular, if a PPV was associated with an admission, then  
20 it could not be called a PPA, right? Is that correct?

21           MS. RAY: If a beneficiary went to the emergency  
22 department and it resulted in an admission, then that

1 encounter would be considered as a potentially preventable  
2 event on the PPA side. If the beneficiary went to the  
3 emergency department visit and it did not result in an  
4 admission, then that encounter would be considered in the  
5 PPV analysis.

6 DR. REDBERG: Having just read through, it wasn't  
7 really clear to me what -- I mean, I understood that they  
8 were saying -- or it seemed 3M was saying if there were more  
9 care on asthma care and more care on diabetes care, then it  
10 wouldn't necessarily have to go to the ED. But it wasn't  
11 clear to me how they actually established their criteria for  
12 potentially preventable visits. And I'll let you answer  
13 that, but as a cardiologist, a lot of what I see in  
14 potentially preventable visits is for chest pain, and often  
15 when those -- and they're actually, in my opinion,  
16 potentially preventable visits that turn into admissions,  
17 because then I go down and see them, and they have very  
18 funny kind of chest pain that I don't think even warrants --  
19 you know, normal EKG is not the kind of thing I would admit.  
20 And I say, "Well, did you call your doctor?" And often they  
21 might have tried to call their doctor, but they got a triage  
22 nurse, and triage nurses are just told, "If you hear chest

1 pain, even if it's right-sided chest pain that happens when  
2 you shower, just tell them to go to the ED."

3 And so I would have considered that a potentially  
4 preventable visit and admission, but it doesn't sound like  
5 it would have met it in the 3M criteria.

6 MS. RAY: Okay. So let me try to address your  
7 comments. So the premise behind both potentially  
8 preventable admissions and ED visits, they primarily consist  
9 of what is called these ambulatory care sensitive  
10 conditions, and these are conditions, like asthma, like  
11 congestive heart failure, like diabetes, where ambulatory  
12 primary care, regular access to high-quality regular  
13 ambulatory care could have prevented some of the ED visits  
14 and some of the admissions. But the premise behind this  
15 analysis is that not every ED visit and not every admission  
16 can be avoidable, and that's why it's very important why we  
17 calculate rates of PPVs and rates of admissions and then  
18 risk-adjust for the underlying comorbidity of the  
19 population.

20 So there is not the expectation in this analysis  
21 that every admission and every ED visit for these ambulatory  
22 care sensitive conditions will go away. But there is the

1 potential for a reduction due to better ambulatory care.

2 DR. REDBERG: So did 3M have like a list of  
3 criteria that we could look at? And was it being done by  
4 physicians or nurses, or who was doing their --

5 MS. RAY: Right, so 3M's process did use clinical  
6 panels, and we could provide you with a list of the  
7 conditions that are considered potentially preventable ED  
8 visits and admissions. They are based on AHRQ's 14  
9 ambulatory care sensitive conditions, but there's more  
10 conditions on 3M's list. There was a table in your briefing  
11 materials that provided some examples, but we can definitely  
12 follow up with you.

13 MR. GEORGE MILLER: Yes, this was fascinating  
14 reading, and as you probably discovered, it's complex. I've  
15 got two quick technical questions, and one is, did you  
16 factor in if a patient was brought in by EMS versus someone  
17 who may have just walked in? Was there a differential  
18 between that in your analysis?

19 MS. SADOWNIK: No, we didn't consider those two  
20 sources differently.

21 MR. GEORGE MILLER: Okay. And just on the top of  
22 my mind, wouldn't those be different? If someone was



1 brought in by an EMS and it was not a -- or it was an  
2 avoidable event, it would seem to me that there would be a  
3 difference. And maybe not. Maybe just in my mind.

4 And then the second question I have, did you  
5 stratify the information to look at where the numbers are  
6 falling on a safety net provider or teaching hospital versus  
7 maybe a suburban hospital to see if there's a difference, a  
8 measurable difference?

9 MS. SADOWNIK: We did not look at that. We can  
10 try to look at that.

11 MR. GEORGE MILLER: I am just curious.

12 MS. RAY: Well, and I guess -- the analysis  
13 focuses at the regional level, not at any given hospital  
14 level.

15 MR. GEORGE MILLER: No, I understand that. But  
16 I'm wondering if a safety net provider or a teaching  
17 hospital that in theory may have a different demographic  
18 would have a difference in these two areas versus a suburban  
19 hospital, or one that would not have the same general  
20 characteristics of a safety net hospital or a teaching  
21 hospital. I'm just curious.

22 DR. MARK MILLER: You know, and I do understand --

1 I think I understand what you're saying, and I'll redirect  
2 it if not. This will be a little bit different than -- and  
3 maybe in some ways it addresses comments that people have  
4 been making about, you know, silos versus not silos. This  
5 analysis comes at things a little bit differently, and where  
6 we ultimately want to be, assuming all these steps work out,  
7 and the methods, and we're very much in a developmental  
8 stage. Think of the hospital service area, and there might  
9 be one hospital, but there may be multiple hospitals. What  
10 we're really trying to focus on is what's happening around  
11 those hospitals that creates these events. And then we  
12 would be coming back, at least at first blush, and reporting  
13 how different HSAs behave or seem to shake out, with the  
14 underlying question being what's going on with the  
15 ambulatory care in that area that's resulted in these events  
16 at the hospital. Even though it is -- we're talking about  
17 hospital admissions and emergency rooms. In a sense, it's  
18 sort of focusing outside of the hospital in the area around  
19 it.

20 Now, we can try and tease out where do these  
21 people end up and do they end up more in one type of  
22 provider or another. But the first-blush orientation,

1 notwithstanding that we keep saying hospital, is really  
2 about the ambulatory setting.

3 MR. GEORGE MILLER: I think I got that, and that's  
4 a very good explanation. Then maybe it will modify my  
5 question just a little bit. Would the HSAs have either  
6 safety net hospitals in them and/or teaching hospitals  
7 compared to an HSA that did not?

8 DR. MARK MILLER: And maybe we can begin to -- you  
9 know, once we get the actual widget defined, maybe we can  
10 begin to contrast that.

11 MR. GEORGE MILLER: Right, and I'll tell you why.  
12 In my mind, with no research, no data, there are many  
13 factors that deal with both a patient coming to the ED  
14 and/or getting admitted. And I'm not sure if the data shake  
15 that out at this point, but I'd love to see that. I think  
16 there are social factors, there are a whole host of issues -  
17 - support, transportation, just a whole number of issues  
18 that -- all of this is looking at one segment. I think  
19 there are a lot of other factors that you just described,  
20 and I'm just curious how this is going to tease out. It's  
21 fascinating, though.

22 MR. HACKBARTH: So just to amplify on Mark's

1 point, this is one of those efforts where we try to break  
2 out of the silos and look more at system issues, which is  
3 good. It's further removed from policy recommendations in  
4 the sense that we're talking about community characteristics  
5 that, as care is currently organized, there aren't  
6 accountable parties for the -- at least in most cases, for  
7 the community care delivery system. So this is not research  
8 that we typically do, which is really directly related to a  
9 policy tool and a policy option, but a sort of more basic  
10 understanding of care delivery dynamics.

11 MR. ARMSTRONG: Yeah, frankly, for that reason, I  
12 love this analysis, and it's going to be very interesting to  
13 see where this goes.

14 By the way, I'll just get it out of the way, I  
15 think this is one of those places where if we could compare  
16 fee-for-service to what's actually happening in the MA  
17 plans, and I think --

18 [Laughter.]

19 MR. ARMSTRONG: I actually think you could on some  
20 of these outcomes, you know, some of these high population  
21 rates of, you know, days per 1,000, ED visits per 1,000,  
22 maybe even PPVs per 1,000. We may be able to do some of

1 that. The tricky part, to your point, is this is a symptom  
2 of a system that's either working well or not. Well, how do  
3 you start to then kind of figure out, well, what are the key  
4 variables that drive that outcome? That is, I think, going  
5 to be really interesting, and I know that's not a technical  
6 question, but that's going to raise a lot of questions as we  
7 go forward.

8 DR. MARK MILLER: It is, and it's not unrelated to  
9 what George was saying, because one of the reasons -- I'll  
10 be very quick -- that we're trying to grapple with what goes  
11 on before these events, because what if somebody is  
12 regularly seeking their care at a hospital. You know, it's  
13 because it's the safety net. Then how does that influence  
14 this? Should we expect to see more of these? I think that  
15 is in a sense one of the versions of what you're asking.

16 MR. GEORGE MILLER: Sure, and just briefly, or in  
17 some communities the physicians drive patients to the  
18 hospital after hours or tell them to go there. There's a  
19 lot of factors. That's just one example.

20 DR. REDBERG: And nursing homes, I just wanted to  
21 -- and they did note that in the written materials, but --

22 MR. ARMSTRONG: Just a question I have about the

1 definition of potentially preventable either visits or  
2 admissions. So I assume, first of all, that the numbers  
3 that are labeled PPAs -- let's just stick with hospital  
4 admissions -- is actually a subset of what you would  
5 consider to be inappropriate or unnecessary admissions. And  
6 if there's other reasons why someone would be in a hospital  
7 bed inappropriately, then because it was a potentially  
8 preventable admission -- is that right?

9 MS. SADOWNIK: I think --

10 MR. ARMSTRONG: For example, someone has a social  
11 issue and goes to the emergency room and gets admitted. Is  
12 that a potentially preventable admission, which would be  
13 more like they're not controlling their diabetes and so they  
14 actually should be admitted, but -- and it's appropriate --  
15 but it was potentially preventable?

16 MS. SADOWNIK: Right. Exactly. At the  
17 potentially preventable admissions, it's -- we're looking at  
18 events that could have been clinically prevented with better  
19 primary care, better care coordination, things of that  
20 nature. It's not a -- rather than a comment that the care  
21 itself should not be delivered at that point in time.

22 MR. ARMSTRONG: Okay. Good.

1 MS. SADOWNIK: It's quite the opposite. Yeah.

2 MS. UCCELLO: I'm sorry, can I come in here? Does  
3 it also include, though, things that could have been treated  
4 in other settings?

5 MR. GEORGE MILLER: [Off microphone.] Whether it  
6 was available or not.

7 MS. SADOWNIK: For the PPVs, the potentially  
8 preventable emergency department visits, it's referring to  
9 care that could have been treated at a different setting.  
10 But PPAs are talking about something a little bit different,  
11 which is that the care could have been prevented with better  
12 primary care.

13 MR. ARMSTRONG: Yeah. I think, just as we go  
14 forward, we'll really want to sort through some of the  
15 definitions of these. First, I was thinking PPAs were kind  
16 of the same thing as inappropriate admissions or unnecessary  
17 admissions and I think they really are different things, but  
18 they're kind of overlapping and very -- and we'll just want  
19 to be really clear about that.

20 The last question I had was, these are spectacular  
21 rates. I mean, 25 percent of all hospital admissions are  
22 preventable, and 60 percent of ED visits were potentially

1 preventable. Now, are those -- what's the denominator? So  
2 we've identified -- you know, you've identified diagnostic  
3 categories of populations of patients -- congestive heart  
4 failure, diabetes, and so forth. So is that 60 percent of  
5 patients in those diagnostic categories would have been  
6 avoidable visits, or is it 60 percent of all ED visits were  
7 potentially preventable?

8 MS. RAY: Sixty percent of all treat and release  
9 ED visits are potentially preventable.

10 MR. ARMSTRONG: Okay.

11 MS. RAY: Right.

12 MR. ARMSTRONG: So that's an even more spectacular  
13 number.

14 MS. RAY: Right.

15 MR. ARMSTRONG: Okay. And there, again, as we go  
16 through this, we'll want to really nail down our  
17 understanding of some of these statistics.

18 DR. MARK MILLER: And that would be just the other  
19 thing I'd bring into this conversation. This research is  
20 still very much in progress. So we're making statements  
21 like this on the basis of something that we're still in the  
22 process of defining and kind of coming to some consensus on.



1 So I wouldn't carry that number to the bank and all of that.  
2 But at least so far in the work, that's what's coming out of  
3 it. That's the only caution I would put.

4 And, by the way, two-to-one on the MA stuff. So  
5 you've got to step up.

6 MR. HACKBARTH: I think I saw Craig raising his  
7 hand over there.

8 DR. MARK MILLER: Was he trying? All right.  
9 We'll give him a half-a-point.

10 MR. HACKBARTH: He wanted to launch a preemptive  
11 strike.

12 [Laughter.]

13 MR. HACKBARTH: Okay. Bill.

14 MR. GRADISON: A minor point which may have to do  
15 more with hospital readmissions. How do you characterize in  
16 studies of this kind planned readmissions, which is not  
17 uncommon, I gather. Somebody is being treated, but it is  
18 fully expected at the time of discharge that they'll be  
19 coming back in two weeks or whatever for something -- within  
20 30 days for some additional procedure.

21 DR. MARK MILLER: From what I followed in the  
22 research and that we've gone through in our meetings, that's

1 precisely the types of things that were tried to be taken  
2 out of the definition. So a condition for which you would  
3 expect admissions. Now, you said readmissions, but --

4 MR. GRADISON: Well --

5 DR. MARK MILLER: -- I'm assuming you meant  
6 broadly, if an admission was planned --

7 MR. GRADISON: If at the time of initial hospital  
8 treatment, when the patient is discharged, if there were a  
9 determination at that point that this patient is expected to  
10 be back in the hospital within 30 days, that's what I'm  
11 really trying to -- I mean, I don't think that ought to  
12 count, but I just don't know whether it does or it doesn't.  
13 We don't need to get into it now, but maybe later. I'd like  
14 to learn a little bit more about this. I'm getting  
15 increasingly concerned about the practical fairness of some  
16 of these calculations on hospital readmissions. Thank you.

17 DR. MARK MILLER: I will say this about our work  
18 on readmissions, and we, MedPAC -- and there are other  
19 definitions floating around -- have focused on potentially  
20 preventable readmissions, and I want to understand, that's  
21 not the conversation we're having here. We have  
22 specifically tried to make sure that the definitions deal

1 with cases like that.

2 MR. GRADISON: Thank you.

3 MS. RAY: And I just want to clarify that in this  
4 analysis, most -- the analysis excludes readmissions  
5 following the index admission. I want to be very clear  
6 about that. So if a person was hospitalized on January 1st  
7 for a potentially preventable condition and then was  
8 admitted again on January 15th, that admission on January  
9 15th was not counted in this analysis. So this, again, it's  
10 -- these are preliminary results, but we based it just on  
11 the index admission.

12 MR. GRADISON: I think, then, I want to come back  
13 to perhaps not understanding clearly the response to Scott's  
14 question. My understanding is that a very high proportion  
15 of admits are through the ED, and, indeed, that the  
16 percentage has been rising and it may be close to 90  
17 percent, I have heard, in some cases to date. My  
18 understanding is that if the admit does take place, then  
19 that's excluded from any consideration of the denominator.

20 DR. MARK MILLER: No, I think I would say it  
21 differently.

22 MR. GRADISON: How does it work?

1 DR. MARK MILLER: If you come through the ED and  
2 you are admitted, then you could be in the denominator of  
3 the PPA, but it doesn't necessarily mean that was  
4 potentially avoidable. But you would go into the  
5 denominator. And in a sense, I think with the rules that  
6 they were saying is in defining the denominators for them in  
7 turn computing the potentially preventable, the admission  
8 then passes through the ED and then becomes an admission,  
9 moves over to the denominator on the admission, and then you  
10 ask the question, was this potentially avoidable -- or a  
11 potentially preventable admission. Is that --

12 MS. SADOWNIK: Right.

13 DR. MARK MILLER: Okay. Because I think I'm done  
14 for the day now. I don't think I can do anything else.

15 [Laughter.]

16 MS. SADOWNIK: That's exactly right. And the  
17 admission is counted whether it was through the ED or  
18 whether it was planned or through EMS or any, you know,  
19 however they got to be admitted. We did find that of all  
20 potentially preventable admissions, we found that 60 percent  
21 did come through the ED.

22 MR. GRADISON: But say a little bit more about --

1 that's pretty remarkable. In other words, the ED within the  
2 same institution was not doing an appropriate job of  
3 screening whether an admit was required?

4 DR. MARK MILLER: No, I think that's not what's  
5 being said. So imagine a patient comes in with diabetes out  
6 of control, and this is the distinction in Scott's question  
7 that we were driving at. At that point, it may be  
8 appropriate to admit that person. The question is, is had  
9 they had better care up to that point, could that whole  
10 event, you know, however they got to the admission, been  
11 avoided.

12 MS. SADOWNIK: Sorry, and it was -- I said 60. It  
13 was actually 70 percent.

14 MR. KUHN: I, too, want to let you both know this  
15 is really some terrific work and it was fun to read the  
16 paper. And I think what's kind of exciting about this work  
17 is that it starts to paint a statistical picture of the  
18 multiple tiers of actions out there and care, and I think  
19 that'll be fun for us to look at when we put out the  
20 information next year.

21 I did have some questions about the read ahead  
22 material, and particularly on pages 13 and 14 when we talked

1 about some of the definitions. So kind of three questions  
2 in this area.

3 So the first one talked about the 3M definitions  
4 of PPVs and it talked about the five leading conditions, and  
5 it listed upper respiratory tract infection, lumbar disc  
6 disease, abdominal pain, and respiratory diagnosis. But the  
7 other one, the fifth one, said signs, symptoms, and other  
8 factors influencing health status.

9 So as I think about these things, I think about  
10 actionable items for prevention. So what's the actionable  
11 items against other factors influencing health status? Any  
12 granularity there you could share?

13 MS. RAY: Uhh -- we'll get back to you on that.

14 [Laughter.]

15 MR. KUHN: Okay. So going on down that page, then  
16 it comes down to McDonald and the work that he did for AHRQ  
17 in 2009 and presented at the conference. And on that one,  
18 going on to page 14, it talks about motor vehicle collisions  
19 and drownings. So I'm looking at kind of prevention things  
20 related to that a little bit, or if you can help me  
21 understand a little bit more what we're talking about there.

22 MS. RAY: Right. Now, that, I just included that

1 in the paper just to give a feel for how other researchers  
2 have defined these potentially preventable events --

3 MR. KUHN: Okay. Thank you.

4 MS. RAY: -- ED visits.

5 DR. MARK MILLER: Just so you know, internally, we  
6 had a conversation about this very point, because it's how  
7 do you prevent drowning --

8 MR. KUHN: Yeah. I mean, this one really jumped  
9 out at me as I was reading it.

10 DR. MARK MILLER: And we decided to go ahead and  
11 put it in because it's some of the research out there, but  
12 we had the same hang-up.

13 MR. KUHN: Good. That's kind of what I thought,  
14 but I just wanted to be sure.

15 And then, finally, I would just make the  
16 observation here that the New York University information, I  
17 thought, had real logic and predictability. I thought that  
18 was really interesting work and that might be something we  
19 could look at further. So thanks.

20 DR. NAYLOR: So this is such important work and a  
21 terrific paper, briefing. So one thing that it raises is,  
22 conceptually, how do you measure population health, and you

1 have looked at all of those elements. I understood on page  
2 19 that you were going to do analyses that included both  
3 3M's definition of potentially preventable admissions as  
4 well as -- which excludes readmissions and what happens in  
5 the 30 days -- as well as including that. And I'm wondering  
6 if you have done that and whether or not those findings  
7 would change -- I mean, am I wrong?

8 MS. SADOWNIK: We did do both of those. We  
9 focused on the initial admissions here. We did -- there  
10 were some individual factors that -- where we did notice  
11 some difference, but the big picture was really strikingly  
12 quite similar --

13 DR. NAYLOR: So the major findings you listed  
14 would not have changed dramatically in terms of the factors  
15 that we're trying to uncover that contribute. The reason I  
16 think that this is important is that, conceptually,  
17 population health is all in. It's everything that's  
18 happening to a population. And so the capacity to go beyond  
19 even where others have gone, to think about both including  
20 and not including what happens from admission and  
21 readmission. You're looking also at ambulatory care as what  
22 happens before, and so the chance here is also to look at



1 what happens after and get the real trajectory, so --

2 DR. MARK MILLER: I just want to say, and I think,  
3 in some ways, I ended up driving us to this, because there  
4 was a concern that we were presenting so much information,  
5 it was hard -- the definitional issues alone were hard to  
6 get into people's heads, and then to have multiple  
7 definitions. So I suggested focusing on the initial  
8 admission as just at least a way to bring everybody through  
9 it one time. There has been work including the  
10 readmissions.

11 The other reason that I thought that that made  
12 sense is we have other issues kind of focused on  
13 readmissions and readmissions can begin to enter, well, what  
14 did the hospital do in that process. It still could be an  
15 ambulatory issue, but it could be a hospital issue.

16 But we have this. We can work it into the  
17 analysis and bring it forward. This was really just a  
18 presentation, you know, what to focus on kind of decision.

19 DR. NAYLOR: I think it's terrific. I just think  
20 that the opportunities here are -- you know, this language  
21 of admission and readmission may be changing, and 30 days is  
22 not carved in stone anywhere, so I think that this is a real

1 chance to think about different --

2 DR. MARK MILLER: And there were a few differences  
3 in the regression work that fell out on those two different  
4 measures and we can crank through that and make sure that  
5 that's clear to you guys in the next round of this.

6 DR. NAYLOR: One last question on the table that  
7 began to really uncover the associations, disability and  
8 older age, et cetera. SES, is that a part of the kind of --  
9 we talked about that at the last meeting, but is that one of  
10 the measures that's being looked at here in the regression?

11 MS. SADOWNIK: We didn't look at -- we didn't  
12 define or look at SES in an explicit way. You know, we had,  
13 right, a dual-eligible where you can begin to look at that,  
14 so -- but, yeah.

15 DR. NAYLOR: [Off microphone.] Thank you.

16 DR. COOMBS: So I work with the Boston Health  
17 Disparities Council and two years ago, we actually did an  
18 analysis of ED visits, and what we found was that the  
19 greatest peak for ED visits -- those were preventable ED  
20 visits, and we didn't include surgical, we didn't include  
21 overdoses, we included medical diagnosis, and I noticed the  
22 overlap between 3M and AHRQ in terms of what they have

1 classified as preventable admissions. We found that the  
2 preventable visits to the emergency room occurred between  
3 nine and five and that that was the simultaneous results  
4 that we got in conjunction with the workforce results of the  
5 Mass Medical Society to look at what are the areas and  
6 specialties in terms of primary care and various specialties  
7 that were having critical levels of workforce issues.

8           And it turns out that one of the things that we  
9 assume from that is that the ED functioned as a  
10 decompression device, that when the office was overwhelmed  
11 and they couldn't get a visit within the office. We looked  
12 at critical time periods for when it took for a patient to  
13 actually get in the office, and if it wasn't going to be in  
14 the next two to three days, that the patient was going to  
15 show up on your doorsteps to the ED.

16           So that was a very, very important piece of this,  
17 the timing for which the peak ED preventable visits  
18 occurred. Most of us thought that the visits would occur  
19 three to 11 or even in the night, but nobody comes in in the  
20 dead of the night. They usually come in on the three to 11  
21 shift. That's what we thought.

22           And that's -- it was very interesting, because we

1 looked at public payers and private payers. Although the  
2 public payers were slightly increased, the private payers  
3 followed the same course in many respects.

4           The other thing, as I looked through this, some of  
5 the classifications, such as, I guess, in AHRQ is a  
6 perforated appendix. And so perforated appendix is one of  
7 those diagnoses that I think most doctors would say is not  
8 preventable or avoidable.

9           The intervention of -- the timely intervention is  
10 directly related to resources that are available in the  
11 immediate area. So if they are community health clinics,  
12 neighborhood health clinics, I would look at that, the  
13 number of neighborhood health clinics in close proximity to  
14 hospital areas, and I don't think that Elliott Fisher and  
15 those guys looked at those kind of things.

16           Then the total number of hospital beds, that is  
17 key. That is huge. In New York, New York has X-number of  
18 beds that are readily available, and I think you guys looked  
19 at occupancy, which is another factor.

20           So as I think about the admissions, though, I  
21 think about some of the other features of the admissions,  
22 and the admissions actually are the criteria that they use

1 for admissions, it's -- I think George kind of alluded to  
2 this. The threshold for which someone admits someone has to  
3 do with a lot of things with the inter-hospital dynamics.  
4 And so occupancies is one of those things, and certainly --  
5 but you have to look at for-profit hospitals and not-for-  
6 profit hospitals in terms of what the benchmarks for  
7 admissions are.

8           There are some ones in which they would say, let's  
9 refer this to an ambulatory clinic and they'll follow up in  
10 24 hours. There have been people to actually treat a  
11 febrile neutropenic patient as an outpatient, which I think  
12 is really different. But the follow-up is very good in  
13 terms of the ambulatory setting and they'll give antibiotics  
14 in that setting. There are other people who would admit  
15 someone with a headache and say, I'm going to watch them  
16 for, you know, maybe they have a subarachnoid bleed, I'm not  
17 sure, whatever. We don't have access to other technological  
18 things that we'd like to do to study.

19           So I think the capacity of the institution in  
20 terms of handling things immediately, whether it be  
21 interventions such that you want to do a work up and you  
22 don't want that patient to come back as an outpatient. So I

1 think the hospital capacity is really important.

2           So there are a number of things that I -- and I  
3 can talk with you later about some of the other things that  
4 we found as a result.

5           The African-American status, and as Mary has  
6 talked about, the socio-economic status, those are very  
7 important parameters, but you will find that some of those  
8 things are through the lens of the emergency room in terms  
9 of what happens in the emergency room. For instance, there  
10 are a number of iatrogenic things that occur in the  
11 emergency room, such as volume overload, things that happen  
12 in the emergency room to say, I watched this patient for  
13 four hours and we have a drug reaction because I gave this  
14 drug and things like that. I don't know what that  
15 percentage is, but I know that when I'm in the ICU, I'll get  
16 a reaction to a drug that was given in the emergency room  
17 and so that the patient getting there was unavoidable, but  
18 what happened when they got there had a lot to do with what  
19 we did to them once they hit the door. So I think those are  
20 the kind of important things that I would look at.

21           MS. SADOWNIK: That's a whole new level of  
22 something to look at.

1           MR. BUTLER: So I'm not sure what round we're on  
2 and what the lateness of the hour is. I realize that we  
3 don't have a --

4           MR. HACKBARTH: Yeah. I think, because of the  
5 exceptional thoroughness of our round one questions, we have  
6 lapsed into round two, and we're roughly 20 minutes from our  
7 end time. So feel free to do two as well as one.

8           MR. BUTLER: All right. I'll still try to be  
9 efficient.

10           So I actually think this topic is more important  
11 than readmissions, because here, particularly, you have  
12 situations where I think Rita would say we do things to  
13 particularly fragile elderly when we bring them into the  
14 hospital and they leave worse off than when they came in,  
15 often, in some of these situations. So the more it can be  
16 managed -- unlike readmissions, it's a little more  
17 difficult, though, for a hospital to kind of be the -- begin  
18 to say the hospitals can determine where their post-acute  
19 care goes to some extent. They have less -- so who and how  
20 we engage at the front end is a different exercise here. So  
21 this is something to be aware of.

22           Now, it is great work and the first time, I think,

1 Herb, I've heard the work described as fun.

2 [Laughter.]

3 MR. BUTLER: Fascinating, intriguing, fun. But,  
4 anyway, it is something that is important, for sure.

5 So of your two next steps up there, you've focused  
6 on regions and HSAs. I've been in, like, three different  
7 markets and very different institutions and I would say that  
8 my own anecdotes would say it's much more an intra-region  
9 issue. You will learn less by looking at regional  
10 differences than what's going on within the region. Now,  
11 there are big exceptions. If you're a smaller community  
12 and, say, you go to a town and you look at all the players  
13 and understand, as Glenn was describing, or Mark, that's one  
14 thing. But when you're in a major urban area, it's probably  
15 less helpful to look at a region.

16 So the quick examples I would say is, in one  
17 situation I was in, you had a private nursing home literally  
18 across the street that would kind of at the flip of the  
19 switch send somebody over when they were in trouble. That's  
20 documented in here and you'd see that.

21 Another situation, 25 years ago I was in, where  
22 you had a very highly incented, primary care motivated,



1 capitated Medicare product that they literally -- the ER  
2 doctors called the participating primary care physician to  
3 come in and they would permit them to see them before it  
4 registered an ED visit to help avoid the admission. It was  
5 almost -- it was over the top. And if they didn't get there  
6 within the 20 minutes, it converted to an ED visit. I mean,  
7 it literally was that kind of management, suggesting the  
8 payer incentives do make a difference, to an extreme in that  
9 situation.

10           The third situation, I was in a large capitated  
11 system. We actually had chest pain clinics set up in ED,  
12 not to attract unnecessary -- but to manage the capitated  
13 business to help avoid the admission. Again, payment helps  
14 to align the appropriate use of these things.

15           And then the last example was, I think is also  
16 cited here, where you have either a busy physician office or  
17 an after-hours, not just nine-to-five, say go to the ER,  
18 that's my back-up. And so how you kind of think about those  
19 things and say, okay, how do you change that behavior to  
20 help incentivize this gets the focus on the second bullet to  
21 me being more important and trying to kind of say, where  
22 were they sitting before they came in? Can we bucket those

1 in a way that would help identify some of these patterns of  
2 utilization that we're seeing?

3 DR. SAMITT: So thank you for this. I love this  
4 stuff. This is great. What would only make it better is if  
5 we included MA information in it as well.

6 [Laughter.]

7 MR. HACKBARTH: Partial credit [off microphone].

8 [Laughter.]

9 DR. SAMITT: All right, partial. You know, I have  
10 a question about where to measure this, you know, because I  
11 agree that the region's not the right level. I'm not even  
12 sure the HSA is the right level. I think what you will find  
13 is intra-HSA variation, and I guess where I would start the  
14 analysis, I mean, I think we should mine for the top  
15 performers and where the lowest PPA and PPV rates are,  
16 because I'm not sure we'll really understand what to look  
17 for, for variables that drive the differences until we see  
18 some of these high-performing areas. My guess is you will  
19 find in these high-performing areas wide ranges of  
20 demographics and other changes. And I think what Mark said  
21 earlier, it's what's happen on the outpatient side primarily  
22 in some of these groups or physician offices or what have

1 you that are very much influencing this.

2           So I don't know where to suggest you should look,  
3 but obviously there are integrated delivery systems,  
4 capitated groups, yes, some MA plans but not all of them. I  
5 think if we can find those that truly have the lowest rates  
6 -- and you already demonstrated you can measure variation  
7 within an HRR. I'd even go deeper to say, Where are the  
8 lowest performance levels, and what is it that's different  
9 about these groups or these markets that we should then  
10 study and compare to see if there's correlation for  
11 performance?

12           The other thing I would say is I think this has  
13 tremendous merit as a quality measure if we can get this  
14 right. In fact, I would argue that this is a measure that  
15 should apply to ACOs. It certainly should be one of the  
16 things that would qualify as high performing, you know, if  
17 this is the 34th measure, if it is possible to get this  
18 right, because measurement only gets us so far, we then want  
19 to tie the measurement to some form of incentive or other  
20 way to encourage these organizations to do more of what  
21 reduces these inappropriate admission and visit rates.

22           DR. BAICKER: So these data I think are really

1 informative, and you've outlined some new steps that you'll  
2 take. I'd love to see a more formal decomposition of the  
3 within versus between variation at the HRR level versus the  
4 HSA level once you have -- I know you've only done the HSA  
5 drill-down in select communities thus far, but with the  
6 universe we could really see where most of the variability  
7 was. And I'm as big a fan of the Medicare Advantage  
8 encounter data as anyone, but here's one instance where, in  
9 fact, there are alternative data sources that you could  
10 compare both MA populations and commercially insured  
11 populations from hospital discharge data where we have the  
12 universe of hospital discharges in the HCUP for some states,  
13 and so you could look at the share of those that are not --  
14 you know, you can do those sort of AHRQ PQA, prevention  
15 quality indicators, ambulatory care sensitive condition  
16 type. So it's not going to match exactly this, but it would  
17 have the universe of hospital discharges with enough  
18 granularity that you could have a pretty comparable measure  
19 of ambulatory care sensitive condition discharges. And then  
20 you could take the measures you have and further correlate  
21 them with general spending on Medicare in different bins of  
22 types of care to start to see how this maps into the right

1 system level mix of care and how that can or can't avoid  
2 these kinds of potentially avoidable admissions and visits.

3 So I'd love to see how these measures correlate  
4 with spending in different areas on prescription drugs, on  
5 outpatient visits, on physician services, on  
6 hospitalizations generally. So there's all sorts of  
7 richness that can be layered on to what you've already  
8 developed.

9 MS. UCCELLO: Well, I don't think I'm going to say  
10 I love it, but I am very excited about this work. It's very  
11 important, and I think it's a really nice complement to the  
12 work we're doing on readmissions. In that work, especially  
13 when we're thinking about these vulnerable communities, this  
14 work can really help us understand that better about, when  
15 people leave the hospital, what kinds of supports they're  
16 getting.

17 I'm just wondering, you mentioned about looking at  
18 where people are receiving care in the days before their PPV  
19 or PPA, is there going to be an opportunity to look back a  
20 longer period prior to these events to understand more if  
21 and where these people have regular sources of care. And I  
22 think looking at a longer period can help a little more than

1 just looking at a few days.

2 DR. HOADLEY: Well, I would echo that this is very  
3 thought-provoking, great work. I'm struck by a couple  
4 things. One, sort of inspired by George and Alice's  
5 comments, I mean, there really is a little bit of a  
6 measurement issue on the dependent variable side of -- and  
7 I'm thinking of the PPAs. It's an admission that's  
8 potentially preventable from the point of view of what's  
9 happened before. But it is somewhat contaminated in a  
10 statistical sense by decisions that are occurring at the  
11 point of admission to hospitals, whether it's occupancy or  
12 social circumstances or special programs to help prevent it.  
13 So, I mean, I don't know if there's anything you can do  
14 about that, but it is definitely something to stay aware of.

15 I think more interesting are some of the things to  
16 think about on the prediction side, and you've talked about  
17 a lot of them, and some of them clearly are sort of person-  
18 level things going on, which we were just talking about, and  
19 then community-level things, which you've also talked about.  
20 And I'm struck by, putting my prescription drug hat on, you  
21 know, drug adherence obviously is going to be a factor for a  
22 bunch of these kinds of conditions, pretty important. I'm

1 not quite sure what's the right way to think about measuring  
2 that, and I can try to think more about that. But obviously  
3 if there's something we can measure about adherence going  
4 on, you know, either at a geographical level or at an  
5 individual level, that would be really interesting to look  
6 at.

7           Things that you raised about presence of urgent  
8 care centers, I also think about some of these kind of off-  
9 site emergency facilities and even retail clinics. I mean,  
10 those are things that really are quite different from one  
11 community to another, and it really would be interesting to  
12 see -- I don't know if it's good or bad results always, but  
13 what roles those different kinds -- and community health  
14 centers and the other things people have talked about, how  
15 that's playing in.

16           And then some of the things that have come up that  
17 I think are a lot harder to measure -- I mean, those you can  
18 actually go and count what's in the community, but the sort  
19 of -- this example of what do the primary care doctors do  
20 when somebody calls off hours or when there's no time, and  
21 we've seen in the site visits over the years, you know, does  
22 the message on the phone machine say, "If this is urgent, go

1 to the ER"? Or does it say, "If this is urgent, press this,  
2 and we'll have a doctor call you back within 15 minutes"?  
3 And that alone -- again, it's not on a data set anywhere,  
4 but that kind of thing may drive some of these results, and  
5 then lots of other things like those, and it may be useful  
6 to do -- you know, when you're looking at a pair of  
7 communities like you focused on in the slides to try to go  
8 back and do something more qualitative to see what are other  
9 things going on, being done to try to improve the stories.  
10 A lot of good stuff.

11 DR. DEAN: I would as well echo the interest.  
12 This is interesting and important stuff to try to figure out  
13 how we can use resources in the most appropriate way.

14 A question, just a couple of parameters that I  
15 know have affected my decision to admit people that might  
16 well fall in the category of potentially preventable. One  
17 has to do with caregivers at home. Is that a piece of data  
18 that you have access to? It may be hard to get. But there  
19 are certainly conditions where, if there was somebody at  
20 home that could look after this usually elderly person, they  
21 really don't need to be in the hospital. On the other hand,  
22 they shouldn't be home by themselves. And that comes up



1 fairly often in my practice, and I don't know if there's any  
2 way to get that information. But it is a common factor.

3           The other one in a similar category is how far  
4 away do they live, because there's the same situation, if  
5 somebody lives across the street and they have a condition  
6 that's stable for the moment but could get worse in a hurry,  
7 if they're across the street, I'm okay. If they're 30 miles  
8 away, then I'm uncomfortable. And I might well put them in  
9 the hospital, but it would probably fall in the category of,  
10 because their clinical status at the time they go in,  
11 they're stable.

12           So, you know, these are just situations that are  
13 just -- they don't fit in the model real well, and yet --  
14 you know, not to criticize the model because it's a good  
15 model, but there are some places where those judgments might  
16 be made, and yet there'd still be a perfectly legitimate  
17 reason for these people to be in the hospital.

18           DR. REDBERG: Maybe that's signs and symptoms  
19 influencing health status.

20           [Laughter.]

21           DR. BAICKER: Can I jump in with just one quick  
22 general methodological point? One of the reasons I like

1 looking at these population-based measures is any individual  
2 case, you could definitely say, well, in this instance this  
3 was appropriate, even though it falls in this general bin,  
4 this was an exception; and so applying these measures at an  
5 individual level is pretty fraught. Whereas, when you're  
6 looking at a population measure meant to sort of capture the  
7 quality of care the system is delivering, these things are  
8 going to balance out in a lot of cases.

9           Now, distance to the hospital might not. You  
10 might want to have an area-level measure of how far away the  
11 population lives or something like that. But on an  
12 individual level, if you think that these individual  
13 preferences or idiosyncracies of particular cases average  
14 out over big populations, then these measures are really  
15 valuable and aren't so sensitive to individual wrinkles as  
16 individual cases would be.

17           DR. DEAN: The other comment I would make is we  
18 definitely do not send people to the emergency room if our  
19 clinic is busy because then I've got to leave the clinic and  
20 go to the ER and see them.

21           [Laughter.]

22           DR. DEAN: So we do not do that.

1           MR. HACKBARTH: So here's a half-baked idea.  
2     These measures sort of get to the state, the quality of a  
3     community health care delivery system. We spend, on the  
4     other hand, a lot of time, as people pointed out, talking  
5     about readmissions, and readmissions are challenging because  
6     in some cases they may be within the control of the hospital  
7     and, you know, that's part of the idea for having a  
8     hospital-related penalty. But other cases they are  
9     reflective of what's going on in the community and the  
10    ambulatory resources that are available for post-admission  
11    care.

12           It would be interesting to look at the ratios.  
13    You know, if you have a hospital that has a really good  
14    readmission rate relative to the community, that might be a  
15    meaningful indicator. On the other hand, if you have a  
16    hospital with a very high readmission rate in a community  
17    that has lots of good resources, those ratios may be  
18    intriguing to look at.

19           DR. COOMBS: I just wanted to say one thing. It  
20    might be better for us to shrink the number of preventable  
21    in both categories just so you can get your arms around it  
22    and it would correct for some of the other issues. I'll bet

1 you your diagnosis wasn't congestive heart failure or  
2 anything that remotely relates to that. But it might be a  
3 good idea to maybe do a top ten or a top six or whatever.

4 MR. HACKBARTH: Just to complete my thought about  
5 this, you'll recall at our last meeting when we talked about  
6 readmissions, and we talked about socioeconomic status, and  
7 one of the options that we put on the table was to say,  
8 well, what we ought to be doing is comparing readmission  
9 rates among peer groups. This could be -- and I don't know  
10 if all the analysis and data can work out. This would maybe  
11 even be better than peer groups, because the peer groups  
12 could be very different community circumstances. You could  
13 say, you know, teaching hospitals are in all sorts of  
14 different community circumstances or even public hospitals.  
15 Here, if you could have a ratio between readmission  
16 performance and community characteristics that are really  
17 relevant, it would be sort of an interesting comparison to  
18 make.

19 MR. ARMSTRONG: One other thought on this, too, is  
20 in a way a PPV rate or PPA rate is kind of a sub-variable  
21 within kind of broader population goals, and that we may  
22 also just think about, you know, total days per thousand in

1 a community or in a system.

2 The other thing I was thinking about was that  
3 we're presuming -- we're kind of thinking about this as a  
4 quality indicator, but what we're looking for are quality  
5 outcomes that actually drive lower total costs as well. And  
6 so to see if there's any relationship between kind of your  
7 cost trends and these lower PPAs or PPVs would also be kind  
8 of an interesting question for us.

9 DR. HALL: Are we starting round two [off  
10 microphone]?

11 MR. HACKBARTH: Well, we are actually at a time --  
12 what I was going to do is for the people who were very  
13 disciplined in truly only doing round one, give you a chance  
14 to make any additional comments.

15 DR. HALL: Thank you. So I loved this too, but I  
16 think there was something that was bothering me, and I guess  
17 I understand now what it was, and that has to do with our  
18 obligation to the Medicare population as opposed to all of  
19 humanity.

20 So if we look at this whole issue of preventable  
21 admissions and inappropriate ED admissions, I think I would  
22 parse that out as there are two main causes. One is there's

1 a cohort of the population that simply does not have access  
2 to what we would consider good quality care. So a mother  
3 from the inner city brings her child in every time they get  
4 the sniffles to the emergency room. Well, what else is she  
5 to do? Or brings in her husband with influenza to find out  
6 he didn't have an influenza vaccination. Now we're getting  
7 a little -- the older population. But they didn't know how  
8 to do it, so access still exists in this country as one of  
9 the issues for inappropriate use, but much less so in the  
10 Medicare population because this is, guess what, the only  
11 form of universal health care that exists.

12           There I think we should -- if we're going to  
13 really take this somewhere, we have to look at what I would  
14 call -- I'm trying to use a politically correct term here --  
15 what might be called "inappropriate standards of care" in a  
16 community. Let's do it gently that way. So one of this  
17 could be that there may be elements, and even in the  
18 Medicare population, of real limitations in health literacy,  
19 people who don't speak English as a primary language, people  
20 who really don't read, even -- there's still that  
21 possibility -- or live in an environment where nobody can  
22 help them with reading and all the rest. So that's one

1 whole problem. But I would say that's a relatively small  
2 problem.

3           The real problem is that there are levels -- there  
4 are sort of standards of convenience in any community, in  
5 any health care system, and many of them were mentioned as  
6 we went around the room here. Well, the patient was sent to  
7 the emergency room because the doctor, let's say, on a  
8 Saturday night said this is the standard of care in our  
9 community and that's accepted. And for many hospitals,  
10 that's quite acceptable because maybe, let's face it, their  
11 admissions aren't that great and maybe they want to do  
12 something about that. It gets very complicated from that  
13 point on. And there are many other examples of convenience  
14 here.

15           So if we were to look at, strictly speaking, the  
16 Medicare population, people who in theory have access to  
17 health care, have a means provided to them for a whole  
18 variety of different services, and it doesn't work out, I  
19 would really want to target the standards of care in a  
20 community or in a health care system that allow that to  
21 happen. We know that 10 percent of admissions of Medicare  
22 patients are due to some drug misadventure. That didn't

1 happen by accident. That's just a good example of that.

2 So as we move forward into this, I hope we don't  
3 sort of take on the whole world, because while it's a very  
4 laudable cause, we can't die for all the worthwhile causes  
5 in a day and a half a month.

6 MR. HACKBARTH: I'm tempted to say that's the  
7 concluding note, but is there anybody else who wants --

8 MR. KUHN: I'll send you my comments in an e-mail.

9 MR. HACKBARTH: Okay. It is the concluding note  
10 then, Bill. Okay. Thank you, Nancy and Sara. Very well  
11 done.

12 We'll now have our public comment period.

13 And if you wish to make a comment, would you  
14 please get in line so I can see how many are there? So  
15 we've got what, five, five people? Okay. So for five  
16 comments, I'm going to be really strict about the time  
17 limit. I'll give you each two minutes. Please begin by  
18 stating your name and your organization.

19 And as always, I will remind people this isn't  
20 your only or your best opportunity to provide input on the  
21 Commission's work. The best opportunity is to meet with the  
22 staff. Next best is to send letters to Commissioners, which



1 we do read. And then there's also the opportunity to  
2 present comments on our web site. So when the light comes  
3 back on, your time is up.

4 MS. LEE: Okay. I'm Gayle Lee and I'm here today  
5 speaking on behalf of the American Physical Therapy  
6 Association. We appreciate the thorough discussion today on  
7 outpatient therapy and we commend the Commissioners for your  
8 recognition that a hard cap would be a serious problem. As  
9 a number of you stated, therapy is an extremely important  
10 service for Medicare beneficiaries and it ultimately reduces  
11 costs downstream and improves the quality of life.

12 We also strongly support development and use of a  
13 standardized core data items that would measure function and  
14 be used for payment ultimately. We are taking a lead on  
15 developing such core data items as well as on development of  
16 an alternative payment system for outpatient physical  
17 therapy.

18 We have serious concerns with implementation of an  
19 MPPR reduction of 50 percent. We identified serious flaws  
20 in CMS methodology used to determine if the MPPR reduction  
21 was warranted back in 2011. In particular, the practice  
22 that expends values of these codes were already reduced when

1 these codes were valued through the RUC process. These  
2 additional reductions would get to the point that the cost  
3 of care exceeds payment amounts, and we believe that that  
4 will ultimately impact access to these services.

5 We also have serious concerns with reducing the  
6 therapy cap dollar amount and setting prior authorization at  
7 that lower level. I want to emphasize that to conduct these  
8 reviews takes a considerable amount of resources from CMS  
9 and its contractors and would result in significant delays  
10 in care. We are already seeing major challenges with  
11 implementation of this manual medical review process at the  
12 \$3,700 threshold.

13 We will submit more detailed written comments to  
14 you, and once again, thank you for your thorough discussion  
15 of this topic.

16 MS. HITCHON: I'm Jennifer Hitchon with the  
17 American Occupational Therapy Association. We agree with  
18 many of you in rejecting a hard cap that would make  
19 medically necessity outpatient services inaccessible and  
20 ultimately increase costs, particularly at an institutional  
21 level.

22 We also disagree with a lot of the discussions

1 here about the multiple procedure payment reduction for the  
2 same reasons that APTA mentioned, that the redundancies in  
3 payment for practice expense have already been reduced by  
4 the AMA RUC. And I would like to emphasize some points  
5 related to the manual medical review process that we're  
6 already seeing, and that this body is considering  
7 recommending above and beyond a therapy cap, which would be  
8 lowered, apparently.

9           We are seeing that some providers are having  
10 problems getting faxes received by their carriers, that mail  
11 can take a long time. It's not simply just a ten-day  
12 waiting period that also includes shipping, and providers  
13 don't always get receipt, get proof that their requests have  
14 been received by the carrier.

15           The carriers all have different forms. Their  
16 practices are varied across the line. They can be  
17 inconsistent. The burden for providers in providing the  
18 necessary materials and for the carriers in making these  
19 administrative decisions are high. Some providers, when  
20 they see a patient for the first time, it may be a second  
21 episode in one calendar year. Then after completing the  
22 evaluation, have to submit a request for prior authorization

1 at that time and then wait ten-plus days to begin treatment.

2 I also want to emphasize that these -- that the  
3 manual medical reviews happening now are, like Gayle said,  
4 at the \$3,700 level, and this was a level that Congress  
5 determined. It's the 95th percentile. Congress determined  
6 that this was really the level at which it was feasible,  
7 administratively possible for the carriers to even do.

8 So by reducing that level, I think it would -- the  
9 data seems to suggest that that would become an even more  
10 administrative burdensome process. Thanks.

11 MS. MORTON: Hi. I'm Cynthia Morton. I represent  
12 the National Association for the Support of Long-Term Care.  
13 We are the therapy companies and the therapists providing  
14 therapy primarily in nursing homes. The patients in nursing  
15 homes are subject to the caps and the manual medical review  
16 more acutely than the rest of the beneficiaries getting  
17 therapy.

18 So when the Commission looks at general data and  
19 not by setting, the data really masks the impact to  
20 beneficiaries, especially in the nursing home setting. For  
21 our patients, the cap is arbitrary, and especially by  
22 geographic location. And what I mean is, a patient treated

1 in Massachusetts gets less therapy because of the GPCI, the  
2 high cost labor market there, than a patient, say, in  
3 Alabama. So as is, the cap is very uneven.

4 Our patients in nursing homes are older, more  
5 medically complex, and have more co-morbidities. Because of  
6 these demographics and their conditions, our patients tend  
7 to need P.T. and O.T. together and some all three  
8 disciplines. So they are seriously harmed by the MPPR.  
9 Because of their low tolerance, they can only tolerate  
10 therapy sometimes in several doses in one day. So that's  
11 multiple times in one day.

12 A word about the manual medical review. We're on  
13 day five of MMR over \$3,700 and you're considering lowering  
14 that amount. It's a chaotic mess already on day five. The  
15 MAC have issued denials with no detail for denial, and the  
16 detail is required in the transmittal, so that the provider  
17 doesn't know what to do. They've just spent ten hours  
18 faxing in that medical record and they don't know how to  
19 alter it to seek the review that the doc has said is -- for  
20 the therapy that the doc has said is necessary.

21 One therapist -- and I've heard this several times  
22 -- took 14 hours to get the multiple documents through the

1 fax into the MAC. The MACs just aren't set up to -- they've  
2 required so many documents which is fine for them to do, but  
3 they're not set up to receive them. In fact, one MAC  
4 requires all documents by U.S. mail. Nothing is done by  
5 email. It's fax or U.S. mail.

6 We've also heard that the MACs have rejected a  
7 medical record, you know, for pre-authorization sent in  
8 because they couldn't see the same claim experience that the  
9 facility knew about and they said it was too early for pre-  
10 authorization.

11 My most important point to you is that the nursing  
12 home setting, the patients receiving therapy in the nursing  
13 home setting, is different than when you look at the balance  
14 of patients receiving therapy. And so, your analysis really  
15 should pull data out and pull patients out by setting,  
16 because otherwise, your recommendations are going to have an  
17 obscuring impact to the patients, especially for those that  
18 receive therapy in a nursing home setting. Thank you.

19 MS. LUCAS: Hi. I'm Ingrid Lucas with the  
20 American Speech Language Hearing Association and wanted to  
21 echo a lot of the comments that have already been made by  
22 the colleagues in the other therapy professions. Two things

1 that I'd like to address with the Commission is, one, there  
2 was a comment made earlier about whether or not groups were  
3 developing their own functional outcomes measurement system,  
4 and we have spoken with the Commission and the staff before.

5 ASHA has over 15 years of data on functional  
6 outcomes measures for speech language pathology services  
7 through out national outcomes measurement system and  
8 continued to offer that data and anything that we can  
9 provide with that for speech language pathology services to  
10 the Commission.

11 We understand your desire to reduce inappropriate  
12 utilization of therapy services and support that and are  
13 very happy to hear that you're not going to support a hard  
14 cap. But in your deliberations and as you're discussing  
15 things, we would ask that the Commissioners review what  
16 would happen lowering the therapy caps and also putting the  
17 therapy caps on the hospital outpatient departments and what  
18 that would do with Congressional scoring.

19 We have a fear that there might be some unintended  
20 consequences of not only increasing the score to extend the  
21 therapy cap exceptions process, and also in repealing and  
22 replacing the caps with an alternative payment policy.

1           Additionally, as you're looking at hospital  
2   outpatient departments being under the therapy caps,  
3   historically they were excluded from the therapy caps as a  
4   patient safety net. So if the therapy caps were ever to  
5   come back into place and the hospital outpatient departments  
6   were under the therapy cap, then the patients would be  
7   losing a safety net. Thank you.

8           MR. CONNOLLY: Hello. I'm Jerry Connolly. I'm  
9   representing the private practice of physical therapists  
10  across the country. There's over 4,200 of them. I also  
11  represent PTPN which is a national network of private  
12  practice physical therapists, occupational therapists, and  
13  speech language pathologists.

14           In addition, I represent Focus on Therapeutic  
15  Outcomes which is a national outcomes database in business  
16  for over 19 years. It has functional outcomes status  
17  measures on over three million episodes of care and much of  
18  these measures that they have developed, which are valid,  
19  reliable, responsive, are supported in the literature and  
20  are available at no charge. So they're in the public  
21  domain.

22           Personally, I've been a physical therapist for



1 over 40 years. I was in private practice for 25 years. The  
2 length of time that you spent on Round 1 today tells me that  
3 I think you were kind of struggling with trying to figure  
4 out the benefits, what physical therapy, occupational  
5 therapy, speech does, how those are provided, and where they  
6 are provided.

7           And the provision of particularly private practice  
8 therapy is very well stipulated in the law and in the regs,  
9 and I think that it would really be helpful for all the  
10 Commissioners to have a good grasp and an understanding of  
11 how those services are provided and where they are in the  
12 statute.

13           For example, the combination of the P.T. and SLP  
14 cap is not a drafting error. It is specifically where the  
15 statute was amended, that provision of the statute happened  
16 to combine P.T. and speech and not O.T. in there. So it  
17 wasn't a drafting error, and this is something that I think  
18 the Commission really has to consider.

19           You know, Congress, as we've said, doesn't  
20 carefully analyze things. They really want the Commission  
21 to do these kinds of things. And the Commission didn't  
22 really spend any time today in talking about, well, should

1 the P.T. speech benefit or cap be divided? And I think  
2 that's something that you should really delve into.

3 The benefits of therapy, I think, were cursively  
4 provided in Slide 5. P.T., for example, is much more than  
5 Parkinsonism, total knee, and low back. And the education  
6 and research and practice of therapies are abundantly  
7 supported in the literature and I think it's incumbent upon  
8 the Commissioners to understand that before you make  
9 decisions or recommendations that could have a dramatic  
10 effect on the beneficiaries.

11 So I would ask that rather than urge -- I'd urge  
12 you, rather than to hasten this report, the report isn't due  
13 until June --

14 MR. HACKBARTH: False.

15 MR. CONNOLLY: I think you need to work in --

16 MR. HACKBARTH: You're finished. Thank you.

17 MR. CONNOLLY: Thank you very much. Delay the  
18 report until June and gather this information.

19 MR. HACKBARTH: Okay. Thank you very much. We're  
20 adjourned until our November meeting.

21 [Whereupon, at 12:02 p.m., the meeting was  
22 adjourned.]