MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 1, 2012
9:15 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
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AGENDA PAGE

P R O C E E D I N G S [9:15 a.m.]

MR. HACKBARTH: Okay. It's time for us to get started.

Welcome to those of you in the audience. We have votes scheduled today on three reports that Congress has requested that we complete by this meeting: one on Medicare payment for ambulance services; second, on outpatient therapy; and, third, on geographic adjustment of the work portion of the payment for physicians and other health professionals. We'll take up the ambulance first thing this morning, and then the other two will happen after lunch.

So on ambulance services, David, Zach, go ahead and lead the way.

MR. GLASS: Very good. Good morning. This is the fourth session on our mandated report on Medicare payment policy for ambulance services.

Last month we gave you some additional information you requested and walked through the Chairman's draft recommendations. In today's presentation, we'll briefly review the framework the Commission has applied in evaluating policy options for all three of the mandated reports. We'll recap the mandate and findings today and

provide some new information in response to two questions Commissioners raised at our October meeting.

First, a brief summary of GAO's new report and, second, some results from a possible isolated, low-volume policy to see what that might look like.

More detail on today's information and information provided in the earlier meetings is contained in your mailing materials. We'll then present two draft recommendations arising out of your discussion last month.

We talked about this last month. To evaluate policy options for the mandated report on ambulance services, we applied a framework consisting of four basic questions: Would the recommendation increase Medicare program spending above the current law baseline; whether the policy will improve beneficiaries' access to care; whether it will improve the quality of care beneficiaries receive; and, finally, whether the policy will advance payment reform away from the current fee-for-service system and toward a more integrated delivery system.

You have seen this slide in the past. In February, the Congress directed the Commission to conduct a study of the Medicare ambulance fee schedule and

specifically required the Commission to examine the three temporary ambulance add-on payment policies, including their appropriateness and their effect on ambulance suppliers' and providers' Medicare margins. It also required the Commission to consider whether there is a need to reform the ambulance fee schedule more generally.

The formal due date for this report is June 15, 2013; however, the temporary add-on policies will expire under current law at the end of the year. Therefore, the Commission has been working toward giving the Congress the information it needs to make a decision about whether to end, extend, or amend these policies by the end of 2012.

Here is a summary of the three temporary ambulance add-on policies now in effect. These add-ons are supplemental to the fee schedule, and they increase either the base payment and/or the mileage payment of a given transport. The first of the temporary add-ons supplements payments to all ground transports; the second supplements payments for ground transports originating in areas designated as super-rural; and the last supplements payments for urban air transports that were grandfathered as being rural.

These temporary add-ons expire at the end of 2012, and extending any of the temporary add-ons will increase spending relative to current law.

Summarizing our findings to date: We see no evidence of access problems either through our data analysis or in our conversations with the industry. There has been continued growth in spending and in service use per beneficiary, particularly in BLS -- basic life support -- nonemergency transports. and within that category in dialysis-related transports.

New entrants are more focused on BLS nonemergency transports than established entities, and there is a small group of suppliers that account for a disproportionate number of those transports.

There has been growth in the number of for-profit suppliers, and private equity firms have entered the market and bought the two largest ambulance firms. In short, someone is seeing a profit opportunity in this industry.

We also note that the current add-ons are not well targeted to isolated low-volume rural areas. That is, most of the spending under those add-ons, the super-rural and rural short mileage add-ons, is not going to the areas that

most need it -- those that are isolated and generate a low-volume of ambulance transports. This is important because suppliers with a low-volume of transports have higher costs per transport.

We also note that the temporary air ambulance add-on was designed to help transition following redesignation of areas from rural to urban in 2006. We find providers have had time to adjust to those redesignations by now.

Finally, we find serious program integrity issues, primarily focused on BLS nonemergency transports.

Last month you asked about the new 2012 GAO report on ambulance industry margins. GAO's report was released in October, and we would make the two following points.

First, about margins. The report found that for the sample of suppliers in their survey, the median Medicare margin for 2010 was a positive 1.7 percent with all the add-ons and would have been negative 1 percent, excluding any add-on payments.

When they extended their analysis to the population of suppliers and providers which their sample represented, the range for the estimated median Medicare margin are pretty wide: from about minus 2 percent to plus

9 percent with all the temporary add-ons, included; compared with minus 8 percent to plus 5 percent without the temporary add-ons. The wide range is a result, in part, of the relatively small sample size, about 150, and the wide range of costs reported in the sample.

Note that the population represented is suppliers with no shared costs that were billing Medicare in 2003 and 2010 and still operational in 2012. It does not represent suppliers that have entered since 2004, including many of the for-profits concentrating on the apparently lucrative BLS nonemergency transports.

Second, through a regression analysis, GAO found that higher average costs per transport were associated with lower volume (and they found an inflection point at about 600 transports a year), more emergency versus nonemergency transports (which means that suppliers concentrating on nonemergency transports have lower costs, hence higher margins), and a higher level of government subsidy. We use the finding about a 600-transport-a-year threshold in our illustrative low-volume policy.

Before moving to the description of a new policy for isolated low-volume areas, I want to briefly enlarge on

the finding that the current add-ons are not well targeted.

We find that most of the spending from the short-mileage ground add-on and the super-rural add-on goes to a small set of zip codes with large populations. That means they are not well targeted.

The GAO found, not surprisingly, that isolated rural areas with low population density generate fewer ambulance transports than more densely populated areas and that suppliers with a low volume of transports had higher costs per transport.

The goal of an add-on policy should be to direct extra payments to areas where providers face circumstances outside of their control, such as low volume, that raise their costs. Medicare needs a better method of directing payments to isolated low-volume areas, and we look at one possibility on the next slide.

The goal is to better direct higher payments to areas where conditions (low-volume and isolation) create higher cost per transport. Operationally, that is to rural zip codes with low density and/or population.

This slide illustrates a first estimate of what such a policy might look like. It's kind of a proof of

principle to see if it's feasible.

What we did was identify rural zip codes with a population density of 20 people per square mile or less or with a population of 4,000 or less. Those parameters were chosen so that areas would be expected to generate less than 600 transports a year.

Looking at that set of zip codes, we find it is better targeted than the rural short mileage add-on. The new policy includes 78 percent of all rural zip codes. Those included have an average population of less than 1,500. That size population is expected to generate well below 600 transports a year, which is the low-volume threshold. All together there were 550,000 Medicare ambulance transports from these areas in 2011.

In contrast, the policy would exclude 22 percent of rural zip codes. Those areas have an average population of over 12,000 and accounted for 3 million transports in 2011. A population of 12,000 would be expected to generate more than twice as many transports as the low-volume threshold of 600.

We conclude that this policy is better targeted: It would direct additional payments to areas that need it

because of the conditions that lead to higher cost -- low volume and isolation.

We have constructed this policy to be budget neutral to the short mileage add-on, about $90 million a year. If all those dollars were redistributed using this policy, the average add-on would offset the loss of the temporary add-ons in the designated areas and maintain access. The size of the add-on is sensitive to the definitions of areas and the number of transports affected.

Zach will now present the draft recommendations.

MR. GAUMER: Good morning. Our mailing materials for this month provide a more detailed explanation of the rationale underlying the recommendations we are about to review, but to summarize, there are a few basic points to highlight.

With regard to recommendation 1, we see no compelling evidence to extend the temporary add-ons and increase spending relative to the current law baseline. Specifically, the ambulance industry appears to be attractive to investors. We observe growth in volume and spending, and there is no specific evidence of current or future access problems.

In case the expiration of the temporary add-ons causes concerns about access, we can reinforce access to emergency services by rebalancing the RVUs from BLS nonemergency transports to other ground transports. And in order to reinforce access to ambulance services in isolated low-volume areas, we can re-target the permanent rural short-mileage add-on policy. Both can be accomplished in a budget-neutral manner.

Therefore, draft recommendation 1 reads as follows: The Congress should:

- allow the three temporary ambulance add-on policies to expire;

- direct the Secretary to rebalance the relative values for ambulance services by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on; and

- direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports

with a new budget-neutral adjustment directing increased payments to ground transports originating in geographically isolated, low-volume areas to protect access in those areas.

Looking at the implications of recommendation 1 in reference to our framework, we anticipate that this recommendation will be budget neutral. Taking the components of the recommendation piece by piece, the expiration of the add-ons is current law and will not increase spending. RVU rebalancing is budget neutral by design. And, similarly, the new permanent isolated low-volume policy is budget neutral by design.

We anticipate that this recommendation will maintain Medicare beneficiaries' access to emergency and advanced life support transports as well as transports in isolated areas with low populations. We foresee no implications for the quality of ambulance care. And, finally, we foresee no implications for reforming the payment system.

With regard to recommendation 2, we have observed rapid growth in BLS nonemergency transports, and we have seen new suppliers and providers focusing on these services.

We have also observed wide variation in spending

on these services by state, particularly for transports to and from dialysis facilities.

The HHS Inspector General has identified numerous instances of inappropriate billing for BLS nonemergency transports in a handful of states and cities, and in particular, many, though not all, of these investigations have targeted transports to and from dialysis facilities. Collectively, these findings suggest that stronger national program integrity actions are needed.

In the State of Texas specifically, the Inspector General has identified instances of ambulance fraud, and CMS' Medicare Administrative Contractor has done extensive program integrity work that has limited ambulance-related fraud and ultimately reduced the volume of dialysis-related transports. The example of Texas shows that taking stronger program integrity actions could be feasible and effective if applied nationally.

Therefore, draft recommendation 2 reads as follows: The Congress should direct the Secretary to:

- promulgate national guidelines to more precisely define medical necessity requirements for both emergency and nonemergency (recurring and nonrecurring) ground ambulance

transport services;

- develop a set of national edits based on those guidelines to be used by all claims processors; and

- identify geographic areas and/or ambulance suppliers and providers that display aberrant patterns of use, and use statutory authority to address clinically inappropriate use of basic life support nonemergency ground ambulance transports.

We would expect this recommendation to save money; however, it is difficult to determine how much. We estimate spending could be reduced by as much as $460 million per year if spending in high-spending states for transports to dialysis facilities was brought to the level of the national median or by as much as $150 million per year if spending in high-spending states was brought to the level of the 75th percentile.

We anticipate that Medicare beneficiaries' access to ambulance services would be maintained. We foresee no implications for the quality of ambulance care. And, finally, we foresee no implications for reforming the payment system.

Okay. At this point we are happy to respond to

your questions and look forward to your discussion of the draft recommendations before you.

MR. HACKBARTH: Okay. Thank you, David and Zach.

David, could you put up that first slide that has the four questions on it?

Okay. Thanks. So for people in the audience, I want to highlight these questions. This is a framework that we're applying to each of the areas that Congress has asked us to look at: ambulance, outpatient therapy, and the work GPCI for physicians and other health professionals. And as David summarized earlier, the key points here are if there's going to be an increase in spending above the baseline, it ought to be because there is evidence that that increase in spending would improve access to care, improve quality of care, or facilitate movement towards new payment systems. So that's sort of the discipline, if you will, that we're applying to each of these issues.

And, incidentally, we'll apply the same discipline, the same framework, when we later on consider draft recommendations on special needs plans, the SNPs, which happens, I think -- is that tomorrow, Mark? Yeah, that's tomorrow. So that's point number one.

And then in terms of process, since we've had extensive discussions on these issues to this point, I propose that we not do our usual two rounds where we ask a round of clarifying questions and then comments. We'll just go through one time, and that is your opportunity to ask any final questions or make your comment on the overall recommendations. Then that one round will be followed with our vote on each of the recommendations.

So any questions about the process that we'll use today?

[No response.]

MR. HACKBARTH: Okay. So let's begin our round of questions and comments.

MR. GEORGE MILLER: Yes, on Slide 7, please. Just curious if there was any pattern that you were able to determine one way or the other with the -- it should be Slide 7. I'm sorry. Yeah. Any characteristics that you're able to tease out with the analysis of the estimated range spread for those margins -- rural, urban, anything that you could tell with those margins?

MR. GLASS: Yeah, GAO does break them out separately between urban, rural, and super-rural, and it

looks at the margins before and after.

MR. GEORGE MILLER: Is there any pattern? I guess that's my question. Or is this the same as we've seen before with just there's some geographic variation? Doesn't matter whether it's rural or urban, is there any pattern?

MR. GLASS: There is.

MR. GEORGE MILLER: Just curious

MR. GLASS: By predominant services area. You're talking about the range calculation?

MR. GEORGE MILLER: Yeah, the range -- I mean, that's pretty widespread in margins.

MR. GLASS: Yeah, the range calculation is very widespread --

MR. GEORGE MILLER: Right?

MR. GLASS: -- on all three of them. I think they would say that because the range covers zero in all cases, they can't say that one is significantly different than the other. Am I correct there?

MR. GAUMER: I think that's right. A very wide range.

DR. MARK MILLER: But the other patterns, which you already spoke to, is if you're lower volume, you're less

likely to be profitable. If you have more emergency, you're less likely. If you have higher levels of government subsidy, there are those patterns. Some of the rural areas have a very wide range, but a lower range, and I think the add-on that they're reconstructing in the targeting actually would probably go a longer way than the current add-on to moving them up to a profitable status.

MR. GEORGE MILLER: Yeah, thank you.

DR. MARK MILLER: And it's important to keep in mind, it may be a more concentrated group of people, but the dollar add-on would be much higher than under current law.

MR. GEORGE MILLER: Yeah, thank you. You answered my question. Thank you.

MR. GRADISON: This is a speculative question, but is the anticipated court action with regard to medical or functional improvement likely to have implications with regard to the volume of basic life support nonemergency services, especially for outpatient therapy?

MR. GLASS: Well, we haven't thought it through, but ambulance is not going to improve or your conditions in general, so I don't think it would have any effect on the number of transports in the sense of making -- I don't think

it would change the medical necessity for any of the ambulance transports themselves.

MR. GRADISON: Okay.

MR. GAUMER: If it meant that more people were in SNFs, then it might be reasonable to assume that there might be more volume. But, yeah, I don't see a change.

MR. GRADISON: Thank you.

DR. DEAN: I probably should have asked this a long time ago. I guess as I was reading through this, I realized I still don't know that I have a clear understanding of the distinction between emergency and nonemergency. In other words, say an ambulance gets called to pick up a patient who has a new problem, but it turns out that it really isn't all that significant. Is that an emergency?

MR. GAUMER: What will happen --

DR. DEAN: Or transfers, you know, we use ambulances a fair amount to transfer from hospital to hospital. Now, some of those people are pretty sick. And yet I see in some of the literature it said that maybe that would be classed as nonemergency. I don't know. Can you clarify that?

MR. GAUMER: Yeah, there are a lot of -- or a large share of the transports that go from hospital to hospital are classified as BLS nonemergency; or if you just limited it to nonemergency, mostly that.

I think this is where you're going with this, but if an ambulance is sent out and it's an advance life support ambulance and it's sent on an emergency basis, and they determine that, in fact, the patient is not an ALS case or that it's not as emergent, it can be -- the bill for it should reflect the condition of the patient, so the patient will have -- you know, if they had a BLS nonemergency status, then that's what the MAC would be looking for on the bill.

DR. DEAN: I guess those of us that don't even have access to ALS ambulances -- what about the situation, though, where, you know, our only system is BLS, and there are times when the ambulance gets called, and it turns out that it's not severe, although there are other times they get called -- of course, they can't tell. They have to go. I still don't quite understand how they sort those out.

MR. GAUMER: It's based on --

DR. MARK MILLER: They still get paid. They get

paid a different rate. They can make that call on site when they arrive. And one of our recommendations says, you know, this area is a bit murky, the Secretary should have clear guidance on emergency, nonemergency, recurring and non -- recurring and nonrecurring -- or what the reverse of that is.

DR. HALL: I was concerned about the nonemergent transport for dialysis, which is a big piece of this puzzle. I guess I would argue on balance that although we say there are no quality implications, I think one could make a pretty safe argument that there may be some very positive quality implications in this, namely, that the ease of using ambulances is a path of least resistance in the medical care system. The easiest thing at night, if there's a call, is to go to the emergency room, or if they say, "Well, how am I going to get there?" "I'll send an ambulance." This happens over and over and over again. And there are lots of other alternatives in the health care system that creative, enterprising systems will develop that I think will actually improve the quality of on-site care in the home. And so I think that's going to come out of this.

There was one other point there on this area, but

I guess it's not that important. I'll let it go. Thank you.

DR. HOADLEY: I just have one simple question. The savings that you talked about on recommendation 2, can you express those as a percentage of total ambulance spending?

MR. GAUMER: Okay. You're going to ask me to do math on the spot.

[Laughter.]

MR. GAUMER: $460 million was the estimate for what they could save per year. The total Medicare spending is in the range of $5 billion, so we're looking at a couple of percentage points. But it would be a large impact, I think.

MR. GLASS: About 8 percent.

MR. GAUMER: There you go.

DR. MARK MILLER: Also, I --

MR. GAUMER: Excuse me. Those are not CBO-blessed numbers.

DR. MARK MILLER: Yeah, that's exactly --

MR. GAUMER: These are our --

DR. MARK MILLER: Right, right. Okay.

MS. UCCELLO: I figured I would make a comment while I still have my voice. I just want to say that I support these recommendations, and in particular, I like how this framework kind of follows the framework that we've used for the rural. And, in general, when we're looking at -- when we're making extra payments or add-on payments and making sure that those are appropriate targeted, and the recommendations that we're making improve the targeting of the payments we're making, I think that's really important. And, you know, I think we're going to talk about that in other sessions coming up over the next couple days.

And I also want to highlight something regarding the dialysis. I especially liked in the text -- we didn't really talk about it, but thinking through some other potential options for dialysis patients of making sure that they have access to dialysis, but transportation that maybe is a little more appropriate than an ambulance. And I just want to highlight that the text makes the point of noting that, you know, one of these options is kind of removing or loosening the prohibition of dialysis facilities to provide transportation, but noted -- and I think this is an important kind of caveat -- that, you know, doing so would

not or should not increase any bundled payments to that effect. I think that there are other ways to appropriately get these patients to the dialysis facilities that don't involve kind of extra payments, because that I don't think would be the right way to go.

MR. BUTLER: So, again, this wasn't a topic that we selected but were asked to do, and as I read the material, again, I was struck again by how impressive the staff work has been on really what turns out to be a very complicated topic. I've learned a lot about ground transport, air transport, rural, urban, municipally supported, private companies, BLS -- the whole lingo. And I say that because I think that the chapter is as important as the recommendations here. I think there's an incredible wealth of information that kind of -- depending on -- no matter where you want to land on the issue, you have data that is all collected in one place that can tell, you know, a story of what's going on. And, obviously, the nonemergent BLS business has grown, and we're choosing to use a fairly crude repricing to kind of contain that growth, in effect, is what we're doing, and trying to more accurately reflect pricing, which is probably the best way to go. So I'm

supportive of the recommendations.

I think if we had more time, we would probably fine-tune that a little bit more and zero in on dialysis specifically. But we don't have that time, so my only regret is probably the recommendations are a little bit kind of more generic than we otherwise might do had we had more time. But then, again, I'll restate, for those that want the data to support a different methodology, it's in the chapter.

So, again, thanks to the staff for doing good work.

MR. HACKBARTH: Okay. Would you put up the recommendations, David? It's time now to vote on recommendation 1. All in favor of the recommendation, please raise your hand and hold them up for just a second. I think we've got everybody. Okay.

[Hands raised.]

MR. HACKBARTH: Okay, no -- opposed to recommendation 1? Abstentions?

[No response.]

MR. HACKBARTH: Okay. Recommendation 2. All in favor of number 2, please raise your hand.

[Hands raised.]

MR. HACKBARTH: Okay. No votes on number 2? Abstentions?

[No response.]

MR. HACKBARTH: Okay. Thank you very much. Good work.

So now we change gears for a little bit, move away from our mandated reports to focus on home health care and specifically reducing the hospitalization rate. And, Evan, you can start whenever you're ready there.

MR. CHRISTMAN: Good morning. Today, I'm going to discuss reducing hospitalizations and home health. We will look at hospitalizations from a few different perspectives today. First, we will review the causes of hospitalization and take a brief look at the interventions available to reduce them. We will review the recent experience with hospitalization rates in home health. Finally, we will look at some key design decisions for a payment policy to reduce hospitalizations in home health care.

Such a policy would be appropriate for many of the same reasons that we have recommended policies to improve quality in other sectors. First, Medicare pays for volume,

not quality, in home health. Providers with high and low performance receive the same payment. This is perhaps particularly troublesome for home health because avoiding hospitalization is a main goal for home health patients.

Home health care is also unique in that some beneficiaries are admitted from the community without a prior hospitalization. So establishing a policy could be an opportunity to reduce both initial admissions to the hospital and readmissions.

The rate of hospitalization has not declined in home health care since Medicare started tracking it in 2004. About 30 percent of stays are hospitalized and reducing this rate could improve beneficiary health and save Medicare money.

Finally, a policy for home health would align it with the Commission's recommendations for other sectors. The Commission has recommended a policy for hospitals and SNF for readmissions, and Medicare recently implemented a readmissions penalty program for hospitals.

Home health patients are hospitalized for many of the reasons commonly attributed to community dwelling Medicare beneficiaries. The top three reported causes of

hospitalization include respiratory infection, urinary tract infection, and heart failure. These conditions are all considered ambulatory care sensitive conditions, which means that hospitalizations should be avoidable through community-based care. One review indicated that up to 30 percent of the hospitalizations in home health in the first 30 days were potentially preventable.

Factors other than patient care also play a role, and problems with the care provided by home health agencies have been found to contribute to hospitalization in home health. Medicare has launched a number of initiatives and demonstrations to lower hospitalization in home health, but overall, they have had limited effects and the national rate has not declined.

Several interventions are possible that could potentially reduce the rate of hospitalization for home health patients, such as these examples on the slide. A financial incentive tied to hospitalizations would encourage agencies to review these interventions and implement those that are most appropriate for the population they serve.

Any policy for hospitalizations in home health should reflect an understanding of the trends in agency

performance. We contracted with the University of Colorado to design a measure of hospitalization. The measure uses claims to identify hospitalization. It includes those that occur during or up to 30 days after the end of the home health stay and it has a limited set of exclusions for hospitalizations that are part of a normal course of care. These include things such as inpatient cancer treatment, procedures related to organ transplant or surgical device implants. These rates have been risk adjusted using data on patient characteristics from the home health patient assessment tool.

Perhaps the most important finding is that there was significant variation in the performance of home health agencies. The agency at the tenth percentile had a hospitalization rate of 20 percent, while the agency at the 90th percentile had a rate of 37 percent.

There was also significant variation in length of stay among providers. Freestanding providers performed slightly worse than facility-based providers, while nonprofit providers performed slightly better than for-profit providers. The rates for urban and rural agencies were also similar in most regions.

The broad variation in performance suggests that there could be a significant reduction in hospitalizations if agencies with higher rates could get their rates closer to better performing agencies.

We also examined the characteristics of the lowest performing agencies. Agencies in the bottom quartile of hospitalization averaged a rate of 39 percent. They tended to provide more episodes per beneficiary, have a longer length of stay, and be freestanding and for profit. A majority of these agencies came from the Southwest region, which in this example includes Texas, Louisiana, and Oklahoma, three States with high average home health length of stay and high hospitalization rates from home health.

There are a few key design decisions for establishing a hospitalization penalty for home health. First would be the size of the financial incentive. Medicare margins in home health have exceeded 15 percent since 2001, so any incentive would have to be large enough to influence behavior for the many agencies with high margins.

The period of the home health stay to include in the hospitalization measure is another decision. Including

all of a stay would be important to maximizing the accountability of home health agencies for the services Medicare provides.

Another consideration is the conditions to include in a measure. A home health measure could follow an all cause potentially preventable hospitalizations approach conceptually similar to the one the Commission discussed for the hospitalization readmission program in September. Under this approach, all home health stays would be monitored, but only those hospitalizations considered potentially preventable would be included in the rate.

And finally, Medicare may want to take steps to strengthen the integrity of the data it collects given home health history of program integrity problems. A recent report by the IG found that many agencies are failing to report required patient assessment information. This data is useful for risk adjustment. So strengthening penalties for not reporting might be appropriate.

To give you a sense of how these design decisions might fit together, we developed an illustrative penalty policy. Under this example, the base payment for all episodes would be reduced for agencies that had risk

adjusted hospitalization rates above the national average. Agencies above the national average would be ranked into deciles based on their hospitalization rate, and the penalty would increase from the bottom to top decile by half a percent. For example, the minimum penalty would be half a percentage point for agencies in the bottom decile and five percentage points for agencies in the top decile.

The measure of hospitalization is the one I used in the slides previously. It would be claims based, include all of a stay plus a 30-day post-stay window, and exclude some hospitalizations that are planned for unrelated procedures. And again, this measure was risk adjusted using patient characteristics from the patient assessment tool.

We excluded agencies with fewer than 20 home health episodes in 2009.

This table provides the summary of the impact. Agencies in these examples have been weighted based on the number of stays they provided. Because of the design of the incentive, 50 percent of agencies would be subject to the penalty and the average penalty would be 2.1 percent. For-profit agencies had slightly higher rates of penalty and a higher average penalty amount. Facility-based providers had

fewer agencies subject to the penalty and slightly lower penalty amounts. Rural areas had slightly more agencies subject to the penalty and a higher average rate of penalty, but this was driven by rural agencies in Texas, Louisiana, and Oklahoma. Without these areas, the rural impacts would have been lower.

This example is just one way a home health policy could be designed. It is meant to be illustrative. But overall, the data suggest that home health agencies could do more to reduce hospitalization in home health. The broad variation in performance among agencies and the lack of improvement in the rate for many years suggests that a change in payment policy might be appropriate. Developing such a policy would involve at least four key decisions, and we have offered potential approaches for addressing them. The Commissioners should consider whether these approaches seem reasonable, any additional analysis they would like to see on this topic, and whether they would be comfortable pursuing a recommendation for a hospitalization penalty for home health care.

This completes my presentation. I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Evan. Now we'll revert to our usual format of a round of clarifying questions and then a second round of comments. Scott, do you want to kick off clarifying questions.

MR. ARMSTRONG: I don't have any.

MR. HACKBARTH: Craig.

DR. SAMITT: I have a question on Slide 9 and it mostly pertains to the size of the penalty. My sense of this incentive would be a bit different than a hospital readmission in that for hospital readmissions, you could envision the hospitals would be concerned about compromised revenue. So this is a scenario where the incentive needs to be substantive enough to align with the right behavior.

But in this particular case, a readmission, or an admission to a hospital would not reduce the home health revenues. So I wasn't quite sure I understood, even if their margins are large, why even the smallest incentive wouldn't reward a focus on reducing hospitalizations. I don't know if I worded that correctly, but --

MR. CHRISTMAN: Okay. So it is true that when a patient goes to the hospital, it doesn't somehow automatically increase the payment to the home health

agency, and so that's true. I guess one concern we've had is if a patient going to the hospital results in the patient remaining on home health care longer, when they come back from the hospital they require more than they might have otherwise had if the hospitalization had been avoided, they will use additional 60-day episodes. So that's, I think, one piece. But I don't think I was tracking on your whole question.

DR. SAMITT: No, I just -- I didn't get the sense that we needed to achieve a certain minimum size of penalty the same way that would be important on a hospital readmission incentive.

MR. CHRISTMAN: I guess there's always some judgment in this question. To give you an idea of perspective, what we're talking about, the maximum penalty under this illustrative policy would be an average of somewhere around $140 to $150 on a typical home health episode payment. You can imagine that a -- the last time I checked, an average hospitalization clocked in at around $9,000. So the size of the penalty that some agencies would bear, the maximum size, will be relatively small to the cost the Medicare program incurs when that patient is

hospitalized.

MR. HACKBARTH: Evan, I thought one of the points was that if you look at the magnitude of the penalty in the context of the magnitude of the margins, that also may influence how strong the incentive is. Did I understand that point --

MR. CHRISTMAN: Right. Right. So we've put out five percent as an example. In 2010, the margins were about 18 percent. So you can see that that's a little less than a third of the average agency. For the agencies in the top 25 percent of financial performance, the 75th percentile was somewhere around 27 percent, so a quarter of agencies do better than that. So that's kind of a little bit of the challenge here and I think we were perhaps cheating a little bit higher on the range of penalty we were suggesting. You know, if you were to look at the providers at the high end of performance, some might want a higher penalty amount.

MR. HACKBARTH: Clarifying questions. Jack.

DR. HOADLEY: Yes. I wanted to ask about -- you only alluded briefly in the presentation, but you had more in the paper about the reporting requirements and the gaps in how much they report and I just wanted to get a little

better sense of -- it's a bonus system, as I understand it. So they're not required to report patient assessment, or how does that work? Can you just walk through a little bit of how that works?

MR. CHRISTMAN: Sure. The Deficit Reduction Act established a paper reporting requirement in home health. In order to receive the full payment update in a given payment year, they're required to report quality information, which in the case of home health takes the form of them reporting the patient assessment information they report in this tool called the OASIS. And so, in theory, they're supposed to be reporting this information for all the patients they serve because it's how -- for those of you familiar with MDS in the SNF setting, it's kind of the same situation where they want to track quality of care.

In practice, the way CMS has implemented this is in a given year, an agency has to submit one patient assessment to get the full update, and so the IG did a report that they published in the spring and it found that the vast majority of agencies were missing at least some OASIS information and some agencies were missing a lot.

From a practical perspective, this matters to us

for two reasons, because -- well, two spins on one reason. The OASIS is the only source of patient functional data the Medicare program has. So if you want to track things like functional improvement or functional decline, we need it. And it is also a gold mine for doing risk adjustment when you want to build either a case mix system or a hospitalization measure. So the integrity of that information and what's happening to the patients they're not reporting on is important, and one of the things the Commission could consider is advising Congress or the Secretary to bump up that requirement so that agencies are submitting complete information.

MR. HACKBARTH: It --

DR. HOADLEY: I was just going to say, are there some agencies that don't report at all?

MR. CHRISTMAN: Very -- my understanding is it's very, very few.

DR. HOADLEY: Okay.

MR. CHRISTMAN: And when you consider the cost-benefit trade-off there, it's, you know --

DR. HOADLEY: Right.

MR. CHRISTMAN: -- it's worth their time to submit

one.

MR. HACKBARTH: Yes, if you can get away with one.

Any idea, Evan, why CMS made the threshold so low to qualify for --

MR. CHRISTMAN: I haven't gotten a good answer on that. They're certainly aware of this problem, but I haven't gotten a good answer as to why they haven't raised it. The OASIS information is collected through a completely different set of information systems. It's not tied directly to the payment systems and they're just sort of crossing the threshold of saying, we've always required this to happen over on the OASIS side. Now maybe we should tie it to payment and make sure that we only make payments to agencies that are meeting all of these requirements.

MR. HACKBARTH: Okay. Cori, clarifying questions, Kate.

DR. BAICKER: So there was a lot of suggestive evidence in the variation in hospitalization rates and in some of the correlates, and in the paper you got into some of the evidence that we have of two further steps that I think we'd want to know. One, does the home health agency's practice actually cause a difference in the hospitalization

rates, and then, second, are there specific things that we think that they should be able to do to lower those hospitalization rates. And it seemed from my trying to read between the lines of the evidence presented that there was some suggestive evidence from not so well controlled studies, but that the only studies that were actually randomly assigned and really worked carefully at the causal inference didn't seem to show the causal connection.

So I guess my question is, what is your reading of the evidence of those causal pathways that seem like a necessary prerequisite for incentives to have any effect downstream?

MR. CHRISTMAN: So your point is taken in the sense that -- and I think Mary can probably talk to this point better than I can -- but there haven't been too many randomized studies with looking at interventions. I think what there is a sense of is that there is a gap between what people have identified as best practices and what agencies are doing. I think there are a lot of -- some folks in the industry who feel very strongly that there are a number of things that aren't being done, and there are some limited experiments where people have achieved positive results

through simple things like feedback. The interesting thing is that a lot of these strategies involve -- the bigger problems are organizational change and not infrastructure investments, like how you time services in an episode and the protocols you use, do you take the time to educate caregivers, things like that.

So I think there's a couple of things that folks might point to, some limited evidence for things like tele-health and advanced practice nurses and beneficiary coaches, that people have done some of the more rigorous studies of. But I think that, more, there's a sense of there's some best practices out there that haven't been fully applied.

DR. NAYLOR: Well, we did a systematic review of the body of evidence and the work, as Evan has suggested, focused just on randomized clinical trials, showed that there is an opportunity to improve the care and outcomes. But it is, for many, limited -- not limited, meaning it's something that spans hospital to home. So it's not just home care. It's care of people over the continuum. It's targeted to high-risk individuals. It includes some of the strategies that Evan has talked about. And it is limited in the review to people receiving home care as post-acute care,

which we have a fairly substantial number of people who are receiving home care that's not part of a post-acute service. So I think we know actually quite a bit about what to do for targeted populations over episodes of illness that span hospital to home.

MR. HACKBARTH: And on that point, I think Evan indicated in his presentation one of the reasons for doing this is to align home health agencies with hospitals in terms of trying to deal with these issues. It often is the transition. We want to make sure that hospitals have an active, willing partner with both the skilled nursing facilities and home health in working on these issues. The alternative path, of course, is bundling, and we're pursuing that, as well. But short of bundling, this approach of aligning the incentives, I think, makes some sense.

Rita, clarifying questions.

DR. REDBERG: I wanted to pick up on Jack's question on the reporting as my first question. So just to drill down a little further, it seems like there's an opportunity, keeping in mind our framework of quality, obviously, that we need to have quality measures in order to look at quality and they obviously need to be reported. It

is a particular concern, particularly the hospitalization rates, if the non-post-acute, following post-acute care, essentially, is something happening in home health care that's causing hospitalization if they hadn't been coming from a hospital. And I'm wondering, are the measures publicly reported and is it publicly available and is that some additional feedback?

MR. CHRISTMAN: Sure. You know, that's a great set-up, Rita, because next month, you will see those measures. The CMS established public reporting for Home Health Compare in 2004. They have publicly reported about a dozen measures, hospitalizations, ER visits, and then they have usually between eight to ten functional measures that they report. So those are generally improvements in things like ADLs, walking, transferring, things like that. There are, gosh, probably about three dozen other measures that are also tracked but not -- they're available to gearheads, I guess, and they get reported to agencies. The publicly reported measures are all NQF approved and have been in place for some time. So there's been a lot of work in that area.

DR. MARK MILLER: Also, so you know, Rita, what

we've also tried to do here is develop measures for each of the areas that are more outcome oriented. So, for example, in the skilled nursing facility area, also with the University of Colorado, I think we've developed measures of rehospitalization, discharge to community, that type of thing, so that we have our own measures in addition to the things that are out there on Medicare Compare, et cetera, and this is some of what Evan has been doing, as well.

MR. BUTLER: So I'm trying to adjust to a kind of a new lens on this issue. We've been focused previously first on hospital readmissions, and then we've talked a lot about post-acute care options and brought in nursing homes as part of the readmission kind of issue, and we know that home care is a pretty cheap alternative when it can be substituted.

But this starts at a little different place. It starts not with readmissions, it starts with admissions, period. And I suspect a lot of these admissions are not, you know -- I mean, you started your care in the home setting. You didn't start in the hospital and get discharged. So I'm having a little bit of a hard time looking at it through all admissions versus the readmission

issue.

And then I'm also not quite clear on the -- if there are, in fact, economic incentives. You've addressed this a little bit. I mean, there are economic incentives for hospitals and nursing homes kind of to pass patients back and forth, in a sense. I don't know of any direct incentives here economically that would say, it's a good thing to have more admissions for a home care program.

MR. CHRISTMAN: It's true that the Medicare payment episode is a 60-day rate and the -- so if the patient goes to the hospital during the period, you know, for seven days in the middle, and then they come back, there's not a new episode payment that generally starts. That's the expectation.

MR. HACKBARTH: Evan, before you leave that point, this was going to be one of my questions. What exactly are the rules about when a new payment period starts when a patient leaves home health care to go to the hospital and come back? How big is the window that it still counts in the original episode?

MR. CHRISTMAN: It's always 60 days. So let me give you an example.

MR. HACKBARTH: Okay.

MR. CHRISTMAN: If the patient is hospitalized and comes back on day 35, the agency has two choices. They can say, we knew the patient is coming back and we're not going to end the original home health episode that started because we know they're coming back.

If, for some reason, perhaps, there is some question about whether they'll come back to that agency, they could discharge the patient when the patient is hospitalized and the agency would get a prorated payment of the 60-day payment. So, for example, if they're hospitalized on day 30, they'd get half, 30 over 60, of the 60-day payment. And then if the patient comes back after that hospitalization, a new 60-day clock would start.

So the idea is that the home health agency cannot trigger two full 60-day payments within a 60-day period. On day one when it starts, they're going to get one payment or a prorated share and they won't get a new payment unless they either accept a prorated payment for the original episode or they hold the patient past 60 days.

MR. HACKBARTH: So I think I understand that. But thinking in terms of the incentives that the agency has, so

they get a payment for the 60-day period. Once they're outside the LUPA period, they're going to get paid for the whole episode. If they hospitalize a patient, that means they're providing presumably fewer visits than they might otherwise, which would increase their profit margin on the episode.

MR. CHRISTMAN: And I think that there's two things that kind of mitigate against that --

MR. HACKBARTH: Okay.

MR. CHRISTMAN: -- and one is that the absence of patients when they're not at home health and they're in the hospital is reflected when we build the case mix. So if they're not there, in case mix groups, you know, people are gone, say, for an average of two or three days when we build our case mix groups, we're picking up -- the payments will kind of reflect that a patient was not there for a few days.

The second piece that mitigates --

DR. MARK MILLER: Evan, but that's not a real time adjustment.

MR. CHRISTMAN: It's not a real time adjustment. It's --

DR. MARK MILLER: Okay. So you're saying that

when somebody rebalances a late at the national level --

MR. CHRISTMAN: Right.

DR. MARK MILLER: -- down the line --

MR. CHRISTMAN: Right, it --

DR. MARK MILLER: -- and there's a lot of it going within any given category, that might eventually show up. But the incentive in front of the person is not a real time -- I mean, is --

MR. CHRISTMAN: It's not a real time incentive, right.

DR. MARK MILLER: Okay. I just want to be clear that --

MR. CHRISTMAN: Right. The second piece that can mitigate against that is that home health visits tend to be stacked up or more intense when a patient immediately reenters the benefit from being at the hospital. The patient comes home. They're a little iller [sic]. They require a more intense level of services. So you can almost see it as a curve as you go out in the weeks. The patients get admitted and you start falling off in the visits as time goes on, and then if they have a hospitalization, it's like a sawtooth pattern. It just pops right back up and they'll

kind of be right back at the beginning of that cycle. So the agency can incur some additional costs.

DR. MARK MILLER: And the way I think about costs is that some of this depends on kind of inside the episode where the hospitalization occurs and how long you think it's going to be. So if you think it's toward the end of the 60 days and the person exits to the hospital, that may be that last period, you basically are getting paid and not providing many services. If it happens right in the middle, there's a period that you're not providing any services, and you might think, oh, well, this is good, it's a good incentive. But if the patient comes back during that episode, you may be hit with a higher level of services.

So, you know, it depends, I think, where it falls in the episode as to whether there's a real strong incentive or not.

DR. SAMITT: Is there any sense of real-time choices? So what percent of the agencies will pro rate versus allow the 60 days to flow through in full in the setting of a hospitalization?

MR. CHRISTMAN: Right, and I will confess to not having looked directly at this issue, but it's called a

partial episode payment when the agency pro rates, and the rate of that is relatively low. It's somewhere in the single digits. I would have to look at that. But it's a less frequent occurrence. We haven't looked at how it's related to things like profitability.

MR. HACKBARTH: As I understood how you described the pro rating option, that's totally within the discretion of the agency to either discharge and pro rate or let the episode run?

MR. CHRISTMAN: Yes.

MR. BUTLER: So, anyway, that's a very helpful clarification. At a minimum there are certainly no incentives to keep the patient home, I would say, if there's a patient that's in trouble, nor do you want to overincentivize that, either.

Okay. My other question/comment comes back to the thought that you want to have -- you say 18 percent profit and, therefore, you have to have the penalty fairly large, maybe 5 percent. I don't get that link. Let's say people followed through and rebased and had these rates more reflective of costs and the margins were now 2 percent. Does that mean we would change the penalty and have a

different amount? I wouldn't think we would link those two.

MR. CHRISTMAN: You know, I guess the concern, at least at the current rate, is it's not clear how much those rates are going to come down. But certainly your point is taken that we have recommended that. And maybe that's not the best linkage to draw.

I guess one other approach is, you know, again, you look at what this costs Medicare when the folks get hospitalized, and then it becomes, I think, a more subjective discussion about how big of an incentive you want to create without, you know, creating problems.

MR. HACKBARTH: I'm not sure what I think on this point. On the one hand, I understand the logic that if there's a big cushion in the payment rates, a small penalty may not have much of an impact. On the other hand, the precedent of saying our penalties are linked to margins strikes me as potentially an awkward one that could lead us to, if nothing else, a lot of complexity when you start thinking about what that means in the context of hospitals, where we're reporting negative margins yet have penalty, you know, what does the algorithm look like, relates penalty size to profit margins.

DR. CHERNEW: Hospital-specific margin [off microphone].

MR. HACKBARTH: Yeah, right. So we'll think more about that.

DR. NERENZ: My main question, I guess, is essentially the same as what Kate asked about what we know about the underlying causal paths and the mechanisms through which an admission occurs for these patients. Maybe I can just elaborate on that a little bit. The question is related mainly to a couple points on Slide 4.

The fact that these admissions can be labeled as ambulatory care-sensitive conditions rings a little bit of an alarm bell to me that maybe the failures are actually literally ambulatory care failures, and that if the service area of a home health agency overlaps with an area that has some weakness in ambulatory care or primary care, it will look like a home health failure, but it's not. And I'm just curious what we can know about that.

The fact that the demonstrations haven't shown much effect just, again, it's a little bit of a warning signal that the causal mechanisms are not so easy to change or improve. So now the question.

In the analysis, given all the rich resources we have with various sort of Dartmouth Atlas things we can overlay, have we been able to look at supposedly good or bad home health performance and lay it up against things like hospital beds per thousand, hospital occupancy rate, propensity of primary care physicians to admit? What do we know about any of that?

MR. CHRISTMAN: I think there's probably two pieces to your question. You know, one, when we -- we haven't looked at it in terms of sort of market factors like that, with the hospitalization beds or physician shortage or elements like that. I think that, you know, we do see a lot of variation across the country. The hospitalization rates tend to be higher in the West -- excuse me, lower in the West and higher in the South, and that generally lines up, frankly, with home health utilization. It's higher in the states, frankly, between Texas and Florida. There's something about touching the Gulf of Mexico that seems to push up utilization.

The other point I guess I would make is that certainly, you know, home health -- it's unique in the sense that people will also be being treated by other sources in

the community, and those will play an important role in the outcome. But I think that's contemplated in the design of the home health benefit. You know, care coordination is something home health agencies are expected to play a role in. You know, they may not be able to, frankly, fully compensate for deficiencies or problems with other providers in the community. But, you know, Medicare doesn't restrict access to ambulatory care when someone's in home health for most things. They can go to the doctor. It's not like a SNF where a lot of things are bundled, for example.

And so, you know, sort of figuring out how to -- to folks who kind of are proponents of lowering hospitalizations and home health, you know, encouraging agencies to figure out how to do that better is one of the things that a policy might be intended to do.

DR. NERENZ: Just to make sure my question's clear, I'm not presuming any restriction in the home health benefit arena, say, on access to care. I'm just observing that if there are just high propensity to admit in the community, that is not -- the home health agency may not be able to control or prevent that, regardless of whatever else good or bad they're doing on their own.

MR. CHRISTMAN: I guess, you know, there's been some discussion of anecdotal policies to get exactly at that kind of situation. And, you know, it sort of relates to, you know, at a micro level, care practices. And working with beneficiaries to say, you know, if you're not doing well, call us before you go to the hospital, call us before you call your doctor in some instances. You know, these are agencies doing things like after hours and weekend coverage and things like that. There may be much more afoot than simply that, but I think there is a sense that, you know, there are some things agencies could do to deal with the kinds of situations you're talking about.

DR. MARK MILLER: The other thing I'll mention just in terms of other work that's gone on -- and I can't remember whether you were here for it -- we also had a session on potentially preventable ER and potentially preventable admissions, and we're trying to kind of work some measurement up on that, which gets, I think, to at least one portion of your question, which is if you knew that by market, how does this compare? And so we're trying to work something up on that.

And then just to reinforce the Dartmouth part of

your question and his answer, the Dartmouth variation, you know, our work -- and we can give you this; this is before your time as well -- suggested that a lot of that is explained by post-acute variation, and that what you see in home health very much follows the Dartmouth pattern, in fact, explains a lot of what's going on, not just home health but post-acute care in general.

DR. NERENZ: And not to belabor the point, do we know in that relationship analysis which is chicken and which is egg? Or do you know what the drives the other?

DR. MARK MILLER: Do you know? [off microphone]

[No response.]

MR. GEORGE MILLER: Yeah, this is a certainly fascinating discussion and information. The chapter was very good to read. I guess I want to turn to Slide 7 because I agreed with Craig's comments, Kate's comments, and Peter's and David's comments concerning the effect. I guess my question is: Are we attacking the right problem with Peter's comments about the margins and tying a penalty to a margin? If the margins were 2 percent, would we have a penalty of 5 percent? I think that's a very good question for us to ask. But on Slide 7, how much of this information

do we know about the demographics of each one of the group, particularly dual eligibles or inner-city folks? Is there demographic information to tease this out? And does that explain --

MR. CHRISTMAN: This slide gets at at least some piece of that. The fourth line down looks at the share of an agency's stays provided to Medicaid patients, and it's not terribly different. You know, the agencies, again, who tend to do worse tend to be in a handful of regions and tend to be rural.

The demographic split, I'm sure we have it. I haven't looked at it. But, you know, that's sort of what we know about the lower performers.

MR. GEORGE MILLER: But as I will preempt Tom in that there are some areas in rural areas that have very low margins, and if the goal -- if the penalty would be on a low-margin facility, I'm not clear how this would affect it. I would think that the goal here is to incentivize better care coordination and better quality. While I wouldn't disagree that looking at hospitalization rates would not be a catalyst for improvement, I'm wondering if that's the best catalyst for improvement in light of what's already been

said, particularly around the penalty and the margins issue. It's more of a comment than it is a question.

MR. GRADISON: Yeah, I'm just trying to think through your response, your excellent response to Rita's question. Let's assume I'm a discharge planner for a large urban hospital. I have a patient who has been hospitalized for COPD. Would I be able to get facility-specific data on home health agencies in my region on a condition-specific basis to help me make a judgment the best place to try to steer that person in order to reduce the chances of a readmission?

MR. CHRISTMAN: You know, the short answer is right now Medicare doesn't provide that information. It's certainly possible that a home health agency could engage somebody to develop that kind of rate. What Medicare reports now is, you know, a rate that covers all conditions, with certain exclusions for things that aren't preventable. But, you know, they don't focus on the 30-day period the hospitals are going to be focused on.

There's been some discussion about, you know, going down that path, but I think folks are still -- you know, a lot of these pieces are moving around. But

Medicare, you know, isn't currently doing that.

MR. GRADISON: Well, then, for a high-volume hospital, they could over time begin to develop their own experience based upon where discharges -- where those who are discharged were before they were readmitted and form some rough judgments of their own, but they couldn't do it from currently available or anticipated-to-be available CMS data, right?

MR. CHRISTMAN: Right.

MR. GRADISON: Thank you.

DR. MARK MILLER: But, Evan, on Medicare Compare, there's a general hospitalization rate. So it's not condition specific, but there is a general hospitalization -- so there's a rudimentary indicator there. Whether the discharge planners pay attention to it, different question.

MR. GRADISON: Frankly, I would expect they would begin to, if they haven't already, in these high-volume cases to avoid the penalty, and the data could be built in, particularly if they're going to an electronic system. So that, you know, over time they might have enough volume. It may be a rough judgment. It may even be an unfair judgment. But it may be better than using no data at all.

DR. DEAN: On the slide that's up there, especially the first line, those are risk-adjusted numbers?

MR. CHRISTMAN: Yes.

DR. DEAN: And I guess my question is: How good do we think the risk adjustment is? I guess the concern would be that unless it's pretty reliable, one unintended consequence might well be that you'll have agencies just simply saying I don't want this patient because they're a bad risk. Has that been talked about?

MR. CHRISTMAN: Right, and we talk about this, I think, a little bit in the paper. You know, people have been building models around the OASIS for many years. You know, this is sort of a dichotomous outcome model. You know, it's commonly reported using a C statistic. You know, this one came out in the range of previous models that have used this data on some alternative measures. This measure was -- you know, explained roughly 15 percent of the variation in hospitalization risk.

I think, you know, part of the challenge is how much of this is related to patient characteristics. You know, you look at a lot of systems, 15 percent is a pretty good predictive rate for some things. The MA risk

adjustment, as I recall, comes in at around 10 or 11 percent, for example.

DR. DEAN: Really?

MR. CHRISTMAN: So I think this one performs pretty well. The conversations I've had with the industry suggest they're focused more on the rate and doing better and not -- you know, I haven't heard any direct concerns about the quality of the risk adjustment and whether that's treating them unfairly.

You know, the policy we're talking about has a couple of safeguards that, you know, when we've proposed potentially preventable conditions, so that softens it a little bit.

DR. DEAN: That would be separate from that risk adjustment, you're saying.

MR. CHRISTMAN: Right, right.

DR. DEAN: Okay.

MR. CHRISTMAN: So there are some bumpers in there that, you know, I think the risk adjustment doesn't have to be perfect to kind of protect agencies.

DR. DEAN: What percentage -- and I think this is probably in the paper and I just don't recall. What

percentage of admissions to home health are post-acute as opposed to directly from the community? And I'm sure that probably varies a lot across the country.

MR. CHRISTMAN: So on the basis of the 60-day payment episode, about 30 to 35 percent of those 60-day episodes are preceded by a hospitalization or an institutional PAC stay.

DR. DEAN: So it's a minority then.

MR. CHRISTMAN: Right, right.

DR. DEAN: I guess I didn't realize that.

MR. CHRISTMAN: You know, the trick is that -- or the thing to understand is that the rate of hospital-admitted patients initially, where they first come from when they begin like a long spell, that's higher for the hospitalization piece. But as you look at just the payment episodes, there's a lot of people who get admitted from the hospital and then go on to have a lot of extra episodes.

DR. DEAN: I see.

DR. HALL: As long as we have Slide 8 up there, I guess I'm intrigued by the 81 percent in the Southwest region. Is it possible to break that down with and without Texas?

MR. CHRISTMAN: We could. I would suggest that Louisiana and Oklahoma are mighty contributors.

DR. HALL: They are. All right. Thank you. I'll leave that alone t health inequities.

I have kind of a semantic issue here. In this slide, for example, we use the term "longer home health stays," and throughout the narrative we use "length of stay" quite a bit. I find this a foreign concept to me because length of stay is so integrally attached to acute care in the hospital. If you ask most health care providers what does length of stay mean, they wouldn't even think of any other venue other than acute hospitalization. And I wonder if there's a better way of putting this together. It reads to me like someone who was writing this when English wasn't their primary language. And maybe some of the other physicians might want to comment on that, but I had a little bit of problem with that. Maybe it's just minor. Maybe it's just me.

MR. KUHN: Evan, a couple of comments or questions. In the paper, you talked a little bit about some program integrity issues, and particularly the fact that there are some agencies that seem to be able to manipulate

the OASIS data and talked a little bit about kind of the risk assessment, you know, the risk assessment of the patient and that activity. So I guess when I think about the size and the order of magnitude that we're talking about, the penalty, how much of this is really related to performance of the whole issue of hospitalizations, performance either by some of those agencies in that one column versus perhaps program integrity issues? How much of it is kind of quality performance versus program integrity? Do you understand my question?

MR. CHRISTMAN: I think. I mean, I guess, you know, the concern is that it's easy for us to spot suspicious patterns of utilization. It's much harder for us to sort of draw a clear line and say, well, this is probably some, you know, malfeasance of some sort.

You know, the areas we see high hospitalization rates include areas that have had some program integrity concerns -- you know, Texas and Oklahoma. But it's not always -- you know, it's sort of pervasive, and it's hard for us to say, well, is this people using home health differently in more of a long-term care model, that's why we see these longer stays? Or is this people gaming the

system? That's a much harder determination for us to make.

You know, I think that one thing we can see is that if you pulled out those higher utilization areas, the higher home health utilization areas, what remains is lower hospitalization rates. And it seems like, you know, something unusual is happening in the areas we would expect.

MR. KUHN: So I guess one would think that as we continue to move forward on this work, it would be more than just a payment penalty, but presumably some additional program integrity recommendations --

MR. CHRISTMAN: Right. I think, you know, that -- and CMS is proceeding down this path. One of the things they're doing is they will start to cross-check whether a claim has a matching OASIS, and that's, you know, a start. But obviously we've made recommendations in other areas, and as you're aware, they have other tools for going after the fraudulent actors.

MR. KUHN: The other thing I was curious about is we continue to move forward, I mean, ultimately the goal is to try to get to bundles, payment bundles, where I think a lot of these issues get addressed, I think, more effectively. So is there a way that we can begin to kind of

do some alignment where we can look at regionally across the country those areas that -- you know, again, I'm mixing hospitalizations versus readmissions, but those that have high readmission rates with hospitals or low readmission rates, the same thing with SNFs and then the same thing with home health, so we could kind of see some patterns here, because as we know from our work on the rural report, what we found is that if you had higher utilization in urban areas, you also had it in the rural areas.

Are we seeing it across all those settings? And if we had that kind of information, ultimately that might be helpful as we continue to think about bundling opportunities as we go forward? So just something maybe to look at it a little bit differently.

DR. MARK MILLER: I just want to put a marker down for us on the staff, because I'm taking a couple things from that comment and some of the earlier ones, trying to look, you know, more broadly at how this relates to the rest of the market around it and, you know, we can do that.

But the other thing I think we should start thinking about is reporting the data both with and without the aberrant states so you can sort of see, to your point --

that's not program integrity per se, but at least you have a sense of the impact of the very high utilization states and how much it's influencing the numbers. Just as a matter of course to keep that in front of people.

DR. COOMBS: So I have a lot of questions, and just to start with, it seems like there's two different things we're trying to deal with. One is looking at margins of home health care, and the other is actually looking at just the entity in terms of what happens and throughput in terms of, you know, the admission rate. And I think that logically for us to deal with one versus the other at the same time in the same venue is kind of difficult. So that's part of the issue.

The first thing, you know, David brought up, which is very interesting, the diagnosis of respiratory infection -- and I have a personal connection with that -- and patients with COPD for a health agent to, you know, a caretaker to say, "I need to admit this patient," I think the threshold might be very varying depending on what agency it is. So, first of all, I'd like to say that, you know, being an ICU doctor, those patients with COPD who get admitted earlier, you can have interventions that actually

drive the cost of care down tremendously. I might put someone on a BiPAP rather than intubate them, and intubating them is a cost driver that drives your budget right out the wall, so for someone to have a lower threshold with an emphysematous patient. So I'm really interested in the respirator infection piece of this.

Congestive heart failure is a different animal because we know that they can be managed quite easily as outpatients, but the driving diagnosis that was written in the paper -- you did a lovely job writing this paper as well -- is infections and COPD. And then the other one is UTIs, and a lot of these patients will have chronic indwelling catheters, and if they develop early signs of bacteremia and sepsis secondary to their urinary tract infection, it probably is a good idea to get them in early, too.

On the other side, if I have a patient who's in septic shock from urinary tract infections and we got them early enough, there's a way in which you could probably, you know, institute antibiotics within six hours, and you can circumvent a lot.

So I'm ambivalent about how we approach home health care in the sense that you can actually have greater

cost savings by them being interventionalist early on and admitting those patients. So, you know, that piece of us getting our arms around at what threshold they're actually sending that patient to the hospital is really huge. And so those diagnoses by themselves lend themselves to a lot of perturbations.

So the other thing I was wondering is that if we were to talk about penalties, as an accountable care organization, you can get your Cadillac version, you know, Geisinger Clinic, people will take any version, I would like for us to kind of walk ourselves through what the penalty would look like for a highly integrated system, if you will, and you may or may not kind of have this information, versus a very uncoordinated system in an urban area and implementing penalties. And I think a lot of people have kind of alluded to it around the table. What does the penalty do to the behavior?

I would argue that what we're trying to get at, maybe this penalty isn't really doing what you want it to do, and those are the few questions I had specifically around the accountable care organization. And I agree with the notion that, you know, in an integrated health care

delivery system, that is the best product that we could possibly have, that this would work well because there would be feedback and influence from the many bodies within the integrated health care delivery systems that said your report card in this area is failing, what can we do?

And then the last question is: Have we looked at this whole notion of navigators in any of the systems for which we have the worst performers in?

MR. CHRISTMAN: I guess there's a few points I would make, and sort of starting with your point that some of these things, an early hospitalization might be appropriate. I think the way we've envisioned this certainly is that the target hospitalization rate is certainly not zero.

To give you an example, under the thing, the example we've put up here, hospitals with -- excuse me, home health agencies with 28 percent hospitalization rates wouldn't have a penalty. So there is an expectation that some are going to go. But I certainly appreciate your concern that for some agencies and some patients, there might be some problems with not all ambulatory care sensitive conditions may be preventable or appropriately

avoided.

In terms of how this penalty ties in with more integrated systems of care, like an ACO, I'll admit that that's not one we've -- I've thought about. This is running -- we think of this as being on traditional fee-for-service. Certainly, under a more integrated system, using the flexibilities for the various demonstrations in law, they might go to different sets of incentives within their integrated system.

And then, again, the design of the penalty, I guess, in part, that's picking up on sort of the -- we have a penalty in place for hospitals and some sense of alignment, sort of picking up on that example. That's sort of -- it's also similar to the way we thought about the skilled nursing facility policy.

DR. NAYLOR: Thanks, Evan, for great work that stimulated a lot of questions. Slide 7, I was wondering if you took a look at the tenth and 90th percentile in terms of variations in risk adjusted hospitalization based on the 30 to 35 percent for whom this is a post-acute visit following an indexed hospitalization versus the 65 to 70 percent, and I appreciate the track that you describe people on who are

using this home health agency for community services. I don't know if you want me to give you my questions.

And then the second had to do with a table in the paper on page 17, Table 6, which looked at rates of hospitalization at 30 days by length of hospital stay. So -- and that's to Bill's comment. But at one week, over a quarter -- it looks to me, as I'm reading this, that the share of stay -- about a quarter of the beneficiaries have a one-week share of stay and a rehospitalization rate of 46 percent. And so I'm wondering, again, how that would break out if you were to separate these two groups. And, secondly, does it suggest -- if a lot of this is post-acute care, does it suggest accountability maybe for the hospital during the first seven days post-discharge and/or a need for a dose intervention in order to effect the changes that you see later.

MR. CHRISTMAN: Okay. So there's, I think, two pieces to your question, and one is just sort of what is the post-acute and community-based split. And in general, when we've looked at that, the post-acute rate, it's been a little lower, but, frankly, it's been a while since I looked at that split and so we should get back to you on that.

The second piece is about Table 6, and what this table shows is it shows the hospitalization rates for sort of different lengths of stay. And you can kind of imagine a U-shaped curve where the frequency of hospitalization is relatively high early in a stay, say, the first four weeks, and then it goes down as length of stay increases. And then it starts to go back up again around the 30- or 60-day mark. And I think the theory here is that it peaks early in a stay because of the issues Mary alluded to, the notion of somebody transitioning to the home, and I don't -- we haven't looked at that by the post-acute community care split, but I think the concerns about the high rates of hospitalization are sort of two things: How much of it is on the hospital and how much of it is on the home health agency for those post-acute care episodes.

And I hear your concern that on one part, certainly some of this is the hospital. I think another piece of that high rate early in the stay is agencies making careful decisions about who they can really serve and who they can admit. So we certainly see -- I think the agency can play a role in that, too. But we can look at that split and see how that curve changes for post-acute care versus

community episodes.

DR. NAYLOR: I think the literature on you need a dose of an intervention to see an effect may also be helpful in helping us to interpret that, as well. Thanks.

DR. CHERNEW: Several questions have focused on how this relates to bundled payment things, and I just have a quick question about that. Do the current ACO rules count home health visits towards assignment? In other words, if you have a -- if you are in home health and that home health care agency is not part of the ACO, would those visits assign you away from the ACO? Conversely, if the ACO owned the home health agency, would you get into the ACO, in part because of those?

DR. MARK MILLER: [Off microphone.]

DR. CHERNEW: So the home health visits don't count?

DR. MARK MILLER: [Off microphone.] I don't think so, no.

MR. HACKBARTH: Does somebody want to verify that?

MR. CHRISTMAN: Somebody just told me it's all primary care visits.

MR. GLASS: [Off microphone.]

MR. CHRISTMAN: It's primary care.

DR. SAMITT: So home health, the plurality of primary care visits doesn't count --

DR. CHERNEW: No, but my question was, home health doesn't count as a primary care visit, then. Okay. That was my question.

MR. HACKBARTH: Okay. Is that the only one?

So I'm going to kick off round two here. Dave and Alice both raised points that I think are really important and not easy to answer, but -- so don't expect at the end clarity on this. But I do have a couple thoughts.

So Dave's point, or one of his points was your rate, if you are a home health agency, could be affected by your environment in which you operate, and I think we all agree that that can be true. And one of Alice's points was that, in some cases, an early admission is not only good for the patient, it can also save money. And so to treat all admissions as they're potentially negative is really not quite right, either. And I think both of those points are valid.

Ultimately, if I could design the world, what I would have is that integrated delivery system that we refer

to so often and not have decisions driven by separate payment systems, have global capitation and then have clinicians making decisions about when the early admission may be a good thing and help the patient and save money. Also, if you have that, you might also have a little bit more control over your environment because you've got all the pieces assembled together. You're not working in the fragmented, potentially incoherent environment. And so I suspect that there is a lot of agreement among us about what a better world might look like.

Of course, the challenge that we face is we don't live in that world, and part of the task for us and for the Medicare program and for the Congress is to map a path to get from where we are to where we should be.

If we allow a fragmented fee-for-service environment to continue to exist with basically little accountability, if you make that world financially viable and you don't apply pressure to it, we probably will not get to the integrated globally capitated world that we seek. And so a consistent theme of ours over years now has been, if we want to get to that new world, we have to apply pressure on the fragmented fee-for-service silo-based

payment world to create an impetus for people to say, well, I don't like my environment. Maybe I ought to be part of a system where there's more control, more coherence in the environment. Or this environment's not creating the right incentive about early hospitalization of that patient. Maybe we ought to be in a system where those incentives are better.

So, strategically, we need to apply pressure to the fragmented silo-based payment system to get people to think, hey, maybe there's a better way and I want to be part of the better way as opposed to continuing to persist in the old way. Now, that's not to say that this particular pressure point is the right one, but I just wanted, since both Alice and Dave are new Commissioners, I just sort of -- this is a theme that we've been working on and I just wanted to make sure that you understood the context in which we sometimes evaluate these interventions in the silo-based payment systems.

DR. CHERNEW: That leads exactly into the questions that I have, and I agree with that completely in the theme of my second round comments. Really, I have two relatively small method points, but relate to whether or not

this particular type of approach pushes us towards that world or not.

So I have several concerns, some of which have been mentioned. I'm concerned about the ability of people to manipulate the coding in the risk adjustment and the risk adjustment matters a lot. So even if it looks stable when it wasn't counting for money, as soon as you make it count for money, you change the way in which some of the coding goes and I'm worried about that.

I'm worried about it discouraging agencies taking on potentially high-risk folks and discouraging hospitalizations that we think might be appropriate hospitalizations.

And perhaps more broadly than all of those general concerns is I'm concerned that trying to get this all right and work through all these nuances becomes a big distraction for energy that might be otherwise spent by the time we get the size of the bonus right and worrying about some of the other issues.

So those are my main concerns. And I guess the one thing I would like to know relates to what Kate asked in her clarifying question and others picked up on, is sort of

how much is this really attributable to things that the home health agency does and how much might just be random variation. So, for example, I would like to see -- and you asked, Evan, what else empirically we might like to see -- is how stable are these rates over time in a given agency? If you're looking bad on this chart over one period, do you look bad over another period? And do you look poor relative to other people in your area, or do you just happen to look bad because in your particular area people don't do well or you have a particular other type of demographic that we couldn't adjust for?

So those are my concerns. I think that we seldom get to see a policy which is ideal, and conceptually, actually, I agree with holding providers in general responsible for the financial and clinical results associated with patients. I'm just not yet convinced that the home health agency is the right one for people in home health care, but I could be convinced. And I think the spirit behind it, I'm sympathetic to. I just worry about some of the particulars.

MR. ARMSTRONG: So first, I'd just start by saying, Glenn, your comments were right on and, frankly, I

consider them to be kind of a pep talk because I was beginning to wonder, I think inside your comments, Mike, you know, how much of our attention do we dilute to trying to -- it's kind of like Whack-A-Mole, to try to fix this issue here knowing some other issue is going to pop up somewhere else.

I do -- I would say so much of what we're dealing with is in a fee-for-service defined payment structure. To the degree that one antidote is to, frankly, accelerate our pace of investing in real bundling or more bundling proposals, the extension of ACOs to include some of these services, the migration of patients to MA plans, I would just say, let's remember that those are important agendas for us every time we feel frustrated by some of the concerns that we're raising around this particular set of recommendations, or at least this direction.

I support going forward with this. I think the only final thing I would make, rather than commenting on a variety of concerns about whether this is exactly the right lever to pull and whether the outcome we'll get will be consistent with what we're trying to do, is that I think, to the point Glenn made, we're trying to create pressure on a

system that's just not working very well, and I would say, let's create the pressure even if we don't know everything about what the consequence will be, and that acting and moving forward is better than getting bogged down in too much analysis around these various implications.

DR. SAMITT: You know, I'm not entirely sure I agree with Scott on this one. I think one of the lessons that I've learned in kind of redesigning incentives for providers over the years is keeping it simple is important. And I'm worried about the conflicting nature of independent incentives for all of the various parts of the system as opposed to sort of an indirect incentive or a balance incentive. It feels like we're circling the wagons as opposed to creating a more simple, elegant solution. And what I mean by that is, you know, this incentive is compatible with other incentives we've talked about, so the post-acute care incentive, the avoidance of readmission incentive, the potentially preventable admissions and potentially preventable visits. So I wonder whether it's best for Medicare to create this incentive or whether we have delivery systems create the pressure upstream or downstream, depending on how you think of it.

So we've had experience with this on the commercial side to get the attention of home health agencies and of SNFs and others. We didn't incent them to practice differently. We essentially said, we're going to monitor your performance and if your performance isn't high performing, we're not going to send you referrals any longer, which was the greatest incentive of all to really achieve alignment further downstream.

So I just -- I wonder whether we can improve this performance by improving the other incentives we've already talked about in prior meetings.

DR. MARK MILLER: [Off microphone.] Let me just make one point that has also -- and maybe this is also for some new folks, it's come up in this conversation, and Mike, at least, has made this point -- it's really important to keep in mind, and maybe your point should be taken as this is a different direction that Medicare could go in. You have the ability to do that. You can say, I'm not going to give you one more referral if you behave this way. All this takes place in 75 percent of Medicare, which is, Mike's term, wild West fee-for-service, and that limitation is not there.

And so one way to take your comment is perhaps that should be a direction that we should be thinking about, as well. But just for most people to understand, or for everybody to understand, currently, those kinds of decisions, Medicare can't make, can't say, you can't go to that particular provider, and that's the catch.

DR. SAMITT: So if Medicare does incent hospitals regarding potentially preventable visits or admissions, the question is, does the hospital that drives these referrals then influence the behavior by these home health agencies?

DR. MARK MILLER: [Off microphone.]

DR. HOADLEY: So we're putting lots of really challenging issues on the table and I think this is all good reasons to keep working on this and keep thinking about it.

I guess I'll just go back to the point I made in the other round, which is there are still these crazy sounding gaps in the reporting of the patients' estimate measures and that may be a piece of low-hanging fruit that we could speak to as part of probably something bigger or even by itself. You know, whether that means go to pushing CMS to say that you only get this full payment or the bonus, however you want to describe it, if you report everything,

or there's some kind of range of payment penalty or payment bonus based on you're at some threshold or another, but it just seems crazy that we're not getting the patient assessment data and that, in turn, causes lots of other problems. So I'll make that my comment for now.

MS. UCCELLO: I agree with most of the comments already said, even those that might not agree with each other. I think they're both right.

[Laughter.]

MS. UCCELLO: But in terms of kind of some of the questions that were laid out, assuming that we move forward with this and how to do that, I want to kind of key off of something that Herb said in terms of I was thinking about this period of home health stay to include in this, some of these 90-plus-day stays versus these other stays and do we use 30 versus 90 and things like that. And I just want to caution us as we think about that in particular and maybe things more broadly, try to separate out what we think are program integrity issues versus other issues and making sure we're using the right lever, that we can't -- you know, if something is program integrity, then some of these types of financial incentives might not be the right tool to get at

those. So just as we think through these, kind of addressing that, I think, is important.

DR. BAICKER: Yes. I would echo what Cori was saying and also think about -- this seems like a manifestation of the tension that we see in lots of the debates about, in a much better system, we wouldn't have it structured this way at all, but we're not in that much better system, so how do we use these levers, and there's this tension between wanting everything bundled but then not wanting to pay for the very short stays and what do you do with these interrupted stays and all of that. So I'm supportive of the general direction and share the trepidation about some of the specifics, but what we're doing right now isn't so good that we should stick with it even in the face of -- because of any uncertainty, that doesn't mean we should stay where we are.

DR. REDBERG: I also agree with the previous sentiments, that we're trying to exist [sic], you know, pressure. It is a little like Whack-A-Mole in this and a lot of things because the system pays for quantity and it doesn't pay for quality and we're trying to move it towards paying for quality in a system that is inherently a fee-for-

service kind of wild system and focus it back on the patient.

So specifically for home health care, and to all the issues about risk adjustment that were raised, which you're right, we have to address them in the current system, but they are very difficult to address and they do take a lot of time and probably in the long run that's not the best use of our time, but I was wondering specifically in terms of absolute versus relative risk, because if we set those targets for the percentiles, perhaps then it will just happen that people will stop treating the very ill patients and just -- because one way to get good results is to treat people that don't -- you know, put people in categories that don't really need it, the healthier beneficiaries, and so that we might consider having absolute targets, or even more complicated, absolute and relative targets in terms of paying for quality just to avoid that sort of cherry picking way of getting to better numbers instead of really giving services to people that would benefit from them.

MR. BUTLER: I'll make three points. The first is on home health overall. It seems a lot of our discussion has typically been at update time and we wring our hands

over the profits they make and talk much less about the importance of their role in serving Medicare beneficiaries. And as I said in my earlier remarks, I think that whether you're involved in bundling or ACOs, you will look much more aggressively as this as an option in the future than you are today. So the more we understand about it, the better we're going to be, because I think it is -- it's a lot cheaper option than the institutional settings that sometimes are the alternatives.

My second point is that as I reflect on as we've looked at updates over the years, I'm very encouraged how we've not just begun to look at just the prices themselves but the collateral impact on the other pieces of the continuum. And so -- and that's a way of bridging these silos that we say, why can't we do it? So the more we can draw attention to the impact of the behavior within one silo and what it has on another silo, the more we're going to educate and help us all manage the continuum much better.

So in that sense, I'm very supportive of having even perhaps next month something related to this. Now, what we're struggling is we're not ready on a methodology to kind of say, you're going to get a five percent penalty if

you do that. We're -- I just don't sense we're there.

But maybe we consider something like public listing of admission rates for all home health agencies, for example, something that would say, okay, at least now you've got data out there and if you are involved in the continuum you have some places that you can begin to look to study further to understand what might be going on. I don't know if that's a good suggestion or not, but it's a way that you kind of get us into this world of looking at what's going on without, you know, making at this point any financial consequences with it. But it creates the dialogue and further looking and it provides a tool for those that are trying to understand the continuum better. It's something to look at.

DR. NERENZ: I think my concern in this was maybe obvious in the question I raised earlier, and that is the applying of a penalty to one entity in an environment where many entities, or at least several entities, are acting. And, Glenn, you are very eloquent in your description about how we may just have to do that in an imperfect world that's not the ideal environment we might imagine.

But there might be a couple other things that we

could do in the imperfect world of silos and disconnected systems. One would be to think explicitly about spreading the penalties around so that rather than just penalizing the home health agency, there might be penalties for any other clinical entities that had been involved in the patient care during that time. Now, clearly, that's complicated and the details to be worked out, but it at least would address the issue of why do you just go one place when others are involved.

The other approach, which actually I had occasion to mention this summer -- I labeled it a crazy idea at the time, it still may be, but over the months I'm thinking maybe not so much -- and that is at explicit points in the patient trajectory, if providers could submit a billing code -- and this, again, in a purely siloed environment -- that by submission of that code would formally claim responsibility for some range of cost and outcomes for some later period of time in the trajectory.

That submission of that code would do two things. One, it would trigger, actually, some kind of care coordination payment, which would make it attractive. But also, it would then link formal accountability for any of

these penalties to that entity. So if the home health agency, for example, submitted a code saying I am now responsible for whether this patient gets admitted in the next month, if a penalty is to be applied, it follows that code, but it doesn't follow the absence of a code.

I think CMS has actually taken a little step toward that already with the PCP care coordination payment following acute care discharge. I don't know that it links to a penalty of any kind, but at least we might think of it that way.

So this is not going to be an immediate thing to come up here, but it seems like a way to address this question of why you penalize one entity in an environment where no entity is clearly responsible. At least you could take a step at that ambiguity.

MR. HACKBARTH: And thanks, Dave. I really welcome the approach you just took of, I'm uncomfortable with A, here are some other paths that might be used to address the same issue.

On your first point, that don't just apply it to home health, apply it to others so there's some synchronization, if you will, of motivation, in fact, that's

part of what brought us to this conversation in that there are penalties on hospitals for readmissions and that led us to think about a comparable incentive for the others who affect those readmissions, including skilled nursing facilities and home health agencies. Now, that's not to say that, oh, that makes this the right thing to do, but it was precisely that logic. What we want to do is get people pulling in the same direction. We want willing partners to deal with problems that span multiple providers when we can't do that through a global payment. Global payment, in my book, is the preferred way to get people working together, but so long as we're not there, are there other ways that we can synchronize those incentives so they say, hey, let's have a meeting and figure out how we can each avoid our penalties, or alternatively, each get our reward.

George.

MR. GEORGE MILLER: Thank you for that clarification because I think that does drive the issue, at least to help us focus on the right policy to take. I, too, am not comfortable with the notion that we need to move forward and do something and that this is imperfect, we just need to get something on the table. But because we are

leaders and have the responsibility of trying to forge ahead the right set of mechanisms and triggers to pull everything together, I think we should take this opportunity to try to find the right data to drive the right quality, to drive the right outcomes. Because one concern would be -- and I think it's been articulated before -- that we could have agencies selecting patients that are well or would not fall in this category, could penalize somebody else. And so I think Dave's comments are very well taken and very well on point by bringing the whole continuum of care together to positively reinforce and drive all the data we need to get the right outcomes, and then to penalize those for the entire system versus one segment that we're talking about here today.

So if it means taking just a little bit more time to get it right or to get this set of principles right to be consistent with what MedPAC is all about, I think that would be important as well.

MR. GRADISON: I guess I'm sort of unreconstructed on the point I'm going to make, and, believe me, I'm not set in concrete on this. But I have questions in my mind about the current policy with regarding to dinging the hospitals.

MR. GEORGE MILLER: Hear, hear.

MR. GRADISON: And the reason I say that is that I'm not sure what impact this may have on quality. It seems to me I did read a study, which is large, as one might hope, that suggested that lower readmission rates are associated with higher mortality. Now, I'm not asserting that as a fact, but that's the ultimate test of quality, I suppose. And, furthermore, the way the hospital data is analyzed and the reduction in payments are based, it is my understanding, assumes you're kind of always moving against a target which will be going down. In other words, at any given point, half the hospitals are going to be above the median, even if the median itself is going down.

So at the present point in time, I am not aware that people are being seriously harmed by the current policy. I suppose there's enough evidence that readmissions can safely be reduced. But I wonder how long that can continue. Indeed, if in the short run it's effective in reducing those rates, it may create additional qualitative issues down the line.

So that's why I'm a little bit concerned about our stated objective of trying to find a way to reduce the

readmissions from home health agencies or other post-acute care without an awful lot of thought to what, if anything, does this mean from a qualitative point of view. It should save money. I don't doubt that. I think that's how we got to where we are. But I just wanted to express that my concern goes back to the basis for this, which really is the hospital readmission rate from which we draw or attempt to draw -- attempt to develop policies to apply to various post-acute settings.

DR. DEAN: I think most of the things I would say have probably already been said. Certainly the goal is to try to get all the players working together, and how you do that is obviously a complex issue. Bundling is appealing, but obviously it's complicated to get started, though that would be my preference.

You know, it occurred to me just as Bill was speaking, we focus so much on the cost of hospitalizations, and if you look at international experience, most of the countries that spend substantially less on health care use hospitals more than we do. And so it would -- they have much longer lengths of stay, more frequent admissions, and so forth. And so you wonder. Are we overemphasizing that?

But that's obviously kind of an aside.

I think the fundamental issue is we need to figure out ways to get all the players working together, and obviously it's not easy, but that continues to be, I think, the goal that we should be looking at.

DR. HALL: Well, I guess I'm reassured that a lot of the Commissioners have had some issues here. I've had a lot of issues with this. Not from the technical standpoint, Evan. This has been extremely well put together. But it seems to me that home health care is one part of the health care system that takes on responsibility for things that they have no control over. If a home health care agency decides that they can't take care of a person in the community, the only alternative is to then turn to the rest of the system, which often does not support them in any particular way. And so the only solution is to send a patient to the emergency room -- by the way, in a BLS-certified nonemergent ambulance.

[Laughter.]

DR. HALL: And almost always incur the costs of an acute hospitalization. This is a recurrent scenario that's played out at every hospital anywhere in the country, even

in the Southwest.

So I'm wondering just in terms of alternative approaches that we could take to this, given the fact that it's an imperfect system. Let me, just in case there's any confusion on this issue, when I want to do a discharge plan and get a home care program for one of my patients, we'll call in the agency, and they will do an analysis. They have a 100-percent right to refuse that patient. They don't have to accept any patient I send them. And the most common reason for refusing is the patient is too complex.

So now if we put in a system that drives a penalty, if I'm an enterprising CEO of a home health care agency, I'm going to use that trump card a lot, and I'm just going to say, "Well, I'm not going to take those patients anymore because then my statistics will look better, and I will not be subject to that penalty." They don't have any other solution.

So I'm wondering, is it possible that as we look at this, could we think about, rather than penalizing the bad, to incentivize the good? For example, would it be better to encourage a careful analysis of -- and you've done that to some extent -- the kinds of patients that do get

either readmitted or de novo admitted from home health care? And exactly what resources would the home health care agency have to have in order to reduce that rate of hospitalization? That I think would be exciting and would really start to move the dial until nirvana occurs and we have this different kind of health care system.

But I think that concentrating too much on penalties for people who have responsibility with no authority just kind of bothers me.

MR. KUHN: Evan, let me add my thanks for some good work, and I think this has been a helpful conversation -- helpful in a lot of ways, but particularly the fact that I think collectively there is, continues to be great discomfort around this table, and I think with everybody who watches health care, about the passive nature of the Medicare program, and so passive that they just simply pay the claims when people get sick or when they come through the door. And this really is an important pivot point for us to really begin thinking about Medicare becoming an active purchaser of care. And there's a lot of ways to create an active purchaser, and I think we've heard a number of different flavors of those around the table today, so I

think that's good.

As we continue to look at this option, maybe a little something that Dave talked about in the first round and a little bit what Bill was talking about is the notion of risk adjustment and the fact that you want to make sure that you don't wind up with cherrypicking as part of the process. And so we had a wonderful discussion at least of the hospital readmission policy at the September meeting where we began to look at some refinements to the risk adjustment. A lot of things were talked about. Some of us raised issues about the SES component and different aspects there. I'm just wondering, as we continue this conversation, if there's any portability in terms of some of the conversation we had there that could help influence some of this conversation to deal with issues like Bill has raised, and others, so we can look at all aspects of this as we continue to go forward.

DR. COOMBS: I was thinking about just the Southern Crescent Association with higher admission rates from the home health service and just thinking about the paradigm that exists between providers within that Louisiana-Mississippi area. And as it turns out, it's well

known that there's less primary care doctors there, but it's also a different type of practice from the usual primary care practice that you would see in the Northeast with all the bells and whistles. And I think as some of the systems that are there are less integrated, so that a physician who is a primary care doctor might be more dependent on home health services. I'm uncomfortable with charging ahead because one of the things I don't know and I'd like to know is if there was a perfect system, what would an acceptable admission rate be from the home health services? I don't know that. And if there was a benchmark that we could kind of establish, then I think we could go from there and feel really comfortable with saying this is if all things are great, and then you could say, well, you deviate by how many standard deviations from what the best practice would be in our mind's eye until we get to the perfect place in this world. Because I think that if you squish on both ends in terms of the physician who's in the trenches doing the work, in terms of them admitting people more likely from their office directly to the hospital, whereas they might say I'm going to send a home health aide agency and they will help me to keep this patient out of the hospital. And you squish

on the hospital side with penalties from, you know, the admissions, and then you squish the home health agency in the sense that you say you're taking the most complicated patients with all these co-morbid conditions, and you're trying to manage these patients, and yet you're being penalized because you have a higher admission rate. And the socioeconomic status has got to be in the equation somewhere along the line because it has a lot to do with a lot of the bouncebacks.

As an internist, I remember one patient that I had that would come back to the emergency room constantly, but it was dietary indiscretion. It was this whole notion of this -- if I could have a medical home back then, you know, 30 years ago, that would have been a thing that would have made a big difference.

So I think looking at the total sum picture of what we do for our beneficiaries, I think we need more information. And I would like to be more innovative because I think there are some things that we can do that are a little bit more innovative than just penalties. And penalties may be an end product of what we're doing, but there might be something that's a little bit more innovative

in terms of public listing, in terms of looking at what an ACO does that actually brings a better result. And so that's what I'm looking at in terms of a wish list, if we could get to a better place other than, you know, just penalties.

DR. NAYLOR: So I actually started at one place, but I'm ending at a different one.

[Laughter.]

MR. HACKBARTH: That's good.

DR. NAYLOR: Yeah, that's good. Thank you all, Commissioners, yes.

I do think that keeping our eye on the opportunity here in relationship to the good of the Medicare beneficiaries and the good of the program is exceedingly important. And I do think preventing avoidable hospitalizations, preventing avoidable rehospitalizations is to the good of both, because the data show pretty compellingly that older adults don't fare well in our acute care systems. I mean, it's just not a good place for them.

So to the extent that you can create the levers that enable any part of our sector to substitute as a less intensive, less costly, and better place for people, I think

we should think about that. And I do think, as Peter has suggested, more and more partners are looking to home health. Patient-centered medical homes, which are now incented to provide care coordination, are looking to home health. And all our bundled payment initiatives are looking. So I appreciate the sensitivities, but I do think we should pursue this path.

And I think one option that I hope we could think about is that we'd look at potentially two causal paths, that we have a group of people in a community who get home health care who don't start at a hospitalization. And I think that the causal path in terms of what happens to them and what we might expect in outcomes is different than for the third that we're talking about that start with an index hospitalization.

So I'm wondering if in the next iteration we could try to separate a little bit more robustly that we're maybe talking about two different groups here with maybe the potential for two different levers to influence preventable hospitalizations for the first preventable rehospitalizations or other acute care services for the second.

So thank you, Commissioners, for taking me down another path.

MR. HACKBARTH: Just a couple concluding thoughts.

It seems to me that we have raised issues at very different levels of abstraction, if you will. Sort of the most basic question is: Is reducing admissions/readmissions a good thing to do? There will always be -- as Alice pointed out, there will always be cases where maybe an admission is a good thing. I think we all recognize that.

I am convinced, however, that we have too many admissions and readmissions in the aggregate, and there is an opportunity not just for cost saving but for care improvement in that. I think there's abundant research to support that, including work that Mary has done over the years on care transitions and the like. So I think, you know, we're barking up the right tree, or one of the right trees.

A second issue raised is this question of accountability, and in a fragmented system, even good people may be party to admissions or readmissions that could be avoided, but they simply are in an environment where it's very difficult for them to change that.

I think that's a tough issue. I think it's an artifact of the fragmented care delivery system that we've fostered in this country for decades, and it's not going to be easy to get away from that.

As I said earlier, I do believe, though, if you allow people to say, "I'm not accountable, somebody over there is," we'll never get out of it. There's got to be some creative tension in the system if you want it to move forward. Even if the tension isn't always perfectly aimed and there are some innocent parties adversely affect, there's got to be some tension in the system to make it move forward to better alternatives. So I'm reasonably confident on those two points.

The next two issues I find much more difficult to wrestle with. The next one is, you know, how do we accurately measure, how do we properly calculate the incentives, how do we risk-adjust, sort of the technical aspects of these things. And I think they're very difficult issues, even if we're barking up the right tree, very difficult issues in those areas to address.

And related to that I think is Craig's point about complexity. As you try to perfect each of those things,

these systems get ever more complicated, and there's a price to be paid for that, a price in terms of coherence in care delivery, a price in terms of cynicism among providers who feel, you know, just yanked around, and I worry about that. And I worry about that increasingly as, you know, we try tinkering with all these payment systems. What is the cumulative impact on our care delivery system?

And then the last issue is related to that, and that's the effect on CMS and the ability of CMS to effectively manage these ever more complicated payment systems when they're not given the necessary resources. So those last two things sort of interact with one another, compound one another potentially.

So, in general, to sum up, I think, you know, admissions, unnecessary admissions and readmissions, are a problem. It's a quality problem as well as a cost problem. I think we can do way better. I think there's lots of evidence of that. We need to create some tension in the system if we're ever going to do better. But, admittedly, this is tough stuff when you get down to the nitty-gritty and the details.

A last thought, related, at least distantly.

Sometimes I think that maybe at our next retreat what we ought to do is require everybody to read the Medicare statute and, you know, just to really get a grip on how complicated all of this has become. And I sometimes imagine, you know, what if I were given a clean sheet of paper here and said, you know, you can rewrite this. How much of it would I retain and how much of it would I throw away? And I think there are big pieces of it I would be inclined to throw away. But, you know, as my friend and former MedPAC Bill Scanlon used to say, there is no reverse gear in government. It's always we add on, we add on, we add on, almost never take anything out. And that's a problem.

So that's my soapbox speech for today. On that note, we will have our public comment period. Thank you, Evan. Good work getting us moving on this discussion.

[Pause.]

MR. HACKBARTH: Seeing nobody moving towards the microphone, we will adjourn for lunch and reconvene at 12:45.

[Whereupon, at 11:34 a.m., the meeting was recessed, to reconvene at 12:45 p.m. this same day.]

AFTERNOON SESSION [12:44 p.m.]

MR. HACKBARTH: Okay. It's time for us to begin the afternoon session. We begin with two of our Congressionally requested reports, first on outpatient therapy and then on the work geographic practice adjustment for physicians and other health professionals. And, Adaeze and Ariel, are you ready to go? Let's do it.

DR. AKAMIGBO: Good afternoon. The Middle Class Tax Relief and Job Creation Act of 2012 requires MedPAC to study the payment system for outpatient therapy services and to address how it can be reformed to better reflect the therapy needs of the patient.

I'd like to thank Lauren Metayer and Shinobu Suzuki for their assistance on this project.

The mandate requires MedPAC to come up with recommendations on how to reform the therapy system under Part B to better reflect the therapy needs of the patient. The law also requires MedPAC to evaluate how therapy services are managed in the private sector.

The Commission has discussed in great detail spending, utilization, and the key policy issues relevant to outpatient therapy services in March, September, and in

October of this year. Some of the policies we've discussed will expire at the end of the year. The Commission's final recommendations today will be useful to the Congress before their deliberations begin. The mandated report is due June 15, 2013, and will include a full discussion of the issues, our analyses, and the final recommendations.

As a reminder, this is the framework we use to evaluate potential policy changes. We ask, how does the policy impact Medicare program spending? Will it improve beneficiary access to care? Will it improve the quality of care Medicare beneficiaries receive? And will the policy advance payment reform, and here we mean, does it move us away from fee-for-service and encourage a more integrated delivery system? Each recommendation is evaluated using these four criteria.

Today, we'll begin with a few Commissioner questions from the October meeting that we've addressed. They are listed on this slide and I'll go over them in a moment. Then we will very, very briefly review the issues with outpatient therapy services and Medicare and review the three draft recommendations to address outpatient therapy services.

Mary, you asked about the demographic characteristics of the beneficiaries who exceed each cap. This slide shows the characteristics of all physical therapy/speech language pathology users and occupational therapy users. As you might expect, beneficiaries who exceed the cap tend to be older and are slightly more likely to be women.

Focusing on the last column for a second, occupational therapy users who exceed that cap tend to be older -- 32 percent of them are 86 years and older -- compared to 26 percent of those who do not exceed the cap.

Those above the cap are also more likely to be dual eligibles. Sixty-two percent of occupational therapy users are dual eligibles and are more likely to receive all their care in nursing facilities.

Peter, you asked about the billing sites that account for spending by the highest and the lowest end of the distribution. This chart from the September meeting shows the break-out of overall spending in 2011. Nursing facilities accounted for about 37 percent of total spending. Physical therapists in private practice accounted for 30 percent. And HOPDs and outpatient rehab facilities

accounted for 16 and 11 percent, respectively. At the lowest end of the distribution, the bottom ten percent, HOPDs account for 56 percent of spending among users, followed by physical therapists in private practice, which account for 19 percent, and by physicians in private practice, which account for 11 percent. At the highest end of the spending distribution -- this is the top 10 percent -- nursing facilities account for almost 60 percent of spending. They are followed by PTs in private practice at 18 percent and outpatient rehab facilities at 11 percent.

Alice, you asked about the share of beneficiaries who exceeded therapy caps among the top spending counties. This is a list of the top spending counties in your mailing materials from September, ranked from highest to lowest by mean per user spending, adjusted for health status. While overall 19 percent of all therapy users exceeded either cap -- that's the last row on the table -- in the Louisiana counties displayed on this chart, more than 30 percent of users exceeded either cap. And in Kings County, New York, with more than 40,500 therapy users in 2011, almost 40 percent of those users exceeded therapy caps using the automatic exceptions process.

And Jack, you asked about the use of ABNs for outpatient therapy services. As a quick background for everyone, Advance Beneficiary Notices inform beneficiaries that Medicare may not consider therapy services medically reasonable and necessary for the patient in a particular instance. The information contained in the ABN allows beneficiaries to make an informed decision about whether to receive additional therapy services and accept financial responsibility for those services if Medicare does not cover them. CMS does not require therapy providers to issue ABNs on a routine basis, but CMS encourages providers to issue ABNs at the initiation of therapy and as the beneficiary approaches their cap limit. It's not known or assumed that ABNs are issued often by providers, particularly given the automatic exceptions process that's existed.

Now, if a clinician provides therapy services, bills Medicare, and the services are deemed to be medically unnecessary and, therefore, not covered, the beneficiary can only be held liable if an ABN was issued. Without having provided a valid ABN to the beneficiary, which the beneficiary should have signed to show that they understand their responsibility, the provider may not bill the

beneficiary and would then assume financial responsibility for those services.

So, we've covered Commissioners' questions from the October meeting. Let me turn to the policy environment facing Medicare beneficiaries.

Current law provides for no exceptions to the caps. So on January 1, 2013, therapy users would be faced with hard caps and no exceptions to those limits. In discussions since March this year, the Commission is greatly concerned that hard caps will interfere with necessary treatment. Many therapy users who need additional services above cap limits do benefit from those services. With appropriate clinical judgment about the type and frequency of therapy services, outpatient therapy can improve and restore function and facilitates beneficiaries' ability to live independently.

But let me reiterate some of the concerns about the outpatient therapy benefit under Medicare. First, provision of therapy services is sensitive to payment policy. Utilization is sensitive to changes in payment policy such as caps on annual amounts specific to therapy. And we've seen these shifts in utilization in other payment

settings, such as SNF and home health.

Second, there is wide regional variation in the use of therapy services and they remain after adjusting for health status.

Most importantly, there is almost no information available to CMS to judge whether therapy services are appropriately indicated for the patients who get them, what type of therapy and how much they should get, and once they get therapy, there's no information to determine functional outcomes as the result of therapy.

The Commission has discussed all these concerns in March, September, and October of this year and also discussed some policy options to address these concerns. The Commission's work has culminated in draft recommendations, which I'll now go over.

So the Commission discussed these draft recommendations during the October meeting and we've gone back and made some adjustments based on your feedback. The first draft recommendation, which is aimed at program integrity, reads: The Congress should direct the Secretary to reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days and develop

national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use PPACA granted authorities to target high-use geographic areas and aberrant providers.

Now, for the implications of this recommendation, based on the experience of recent program integrity activities with respect to outpatient therapy, we would expect that reduced unexplained geographic variation in the provision of outpatient therapy should reduce unnecessary program spending. But the amount has not been confirmed by the Congressional Budget Office. We do not expect this recommendation to have an adverse impact on beneficiaries' access to necessary outpatient therapy services, and there are no agreed upon quality measures to assess this recommendation's impact on quality, so we say no implications.

This draft recommendation does not move us from fee-for-service to a more integrated delivery system, so there would be no implications for delivery system reform.

The second draft recommendation, which aims to assure access to outpatient therapy services while managing

Medicare's costs, reads: To avoid caps without exceptions, the Congress should reduce the therapy cap for physical therapy and speech language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index. And, direct the Secretary to implement a manual review process for requests to exceed cap amounts and provide the resources for CMS for this purpose. And, permanently include services delivered in hospital outpatient departments under therapy caps. And, apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.

Before I talk about implications, let me mention a few things. This table shows the effect of reducing the cap to $1,270 in 2013. This new amount accommodates the needs of most therapy users. Sixty-seven percent of physical therapy/speech language pathology users as well as occupational therapy users would be unaffected by the cap. That is, two-thirds of all therapy users would not spend an amount that reaches this threshold under each category. For the one-third, or 33 percent, of users whose spending

reaches the cap amount, they can expect to use 14 visits for physical therapy and speech language pathology services and another 14 visits for occupational therapy services before they would need to obtain exceptions to exceed this amount. In essence, therapy users could incur up to 28 visits for all therapy in a calendar year before they would need medical review to determine if additional services are medically necessary, although I caveat this by saying the benefit is not administered as a combined cap. Now, when beneficiaries reach 14 visits under each category, the manual medical review process at this point would assure access to an additional block of visits while providing some scrutiny for the medical necessity of those additional services.

Manual reviews performed at the $3,700 threshold recently began in late September and there have been some concerns with the current process. There was some effort on the part of CMS to provide a smooth process in the short term in the short time they had to set up this review process. But currently, providers are only able to submit requests and supporting documentation via mail or fax. Both of these options can be very time consuming, and in some

cases, providers do not get confirmation that their request has been received, reasons for rejections or denials are not clear, and some have reported that their requests have taken more than ten business days to generate a response.

At the same time, CMS has indicated that some providers have not completed their requests accurately, missing key information, such as the beneficiary's name, providers' names or national provider numbers, or the reason for the providers' requests to exceed the $3,700 threshold. These all contribution to delays in processing and potential breaks in therapy care delivery.

We talked with several provider groups and CMS since our last meeting in October and the industry had constructive suggestions about ways to improve the manual review process. To conduct a streamlined manual review once per user spending reaches the cap amounts, the Congress would need to allocate additional resources to CMS. To streamline this process, CMS should develop a system to accept requests for medical review electronically in addition to the current mail and fax options. Providers should receive immediate confirmation that their requests have been received and are under review. Requests should be

processed within ten business days, and within that time frame, the Congress could allow two additional visits for beneficiaries for which the therapist would bear financial responsibility while CMS considers the medical necessity of those additional requests. As a final suggestion to streamline the process, the Congress could consider one or two max to conduct all manual medical reviews nationwide for a more consistent approach to reviews, correspondence with providers, and final resolutions to deny or approve requests.

Now, the implications. We expect that this recommendation will result in an increase in Medicare spending relative to current law under which the exceptions process would sunset at the end of the year. But again, the spending impact has not been confirmed by the CBO. This recommendation will also require an increase in CMS's administrative budget to conduct manual reviews of requests for exceptions to the cap limits.

We expect an increase in the number of outpatient therapy services provided relative to current law, which again provides for no exceptions to the cap, because beneficiaries who need higher amounts of outpatient therapy

will be able to receive it via the manual exceptions process. However, utilization is expected to be lower than it would be if an automatic exceptions process were to be extended.

We cannot assess the impact of this recommendation on the quality of therapy services because, again, there are no agreed upon quality measures in this sector.

We do not anticipate that this recommendation has a significant impact on delivery system reform.

The components of the second draft recommendation just described include reducing caps and manual review. But since the October meeting, we have met with several groups from the industry who have expressed concerns with manual review. And, again, there is general consensus that there are few good options here.

We heard from a handful of industry representatives that in lieu of manual review, they would prefer higher caps, less manual medical review, coupled with lower provider rates based on the length of an episode. This option is similar to what we presented last month that identified three tools listed on this slide available to Congress to further reduce spending on outpatient therapy

services.

The third draft recommendation, which aims to improve management of the benefits in the longer term, reads: The Congress should direct the Secretary to prohibit the use of V-codes as principal diagnosis on outpatient therapy claims, and collect functional status information on therapy users using a streamlined standardized assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status and provide the basis for development of an episode-based or global payment system.

As discussed before, there is a prototype for such a tool that was part of the CMS study to develop outpatient therapy payment alternatives. And as we discussed with the panel of researchers and practitioners this summer, additional data elements to that prototype would serve as a good foundation towards developing an instrument for payment purposes.

The spending implications of this third draft

recommendation would include some administrative costs to develop the tool and collect the data, but this recommendation will have no impact on program spending.

We do not expect that this recommendation will have an adverse impact on beneficiaries' access to needed care. Over the long term, we expect this recommendation to allow clinicians and the program to better assess the effect of these services on functional outcomes and tie reimbursement to those outcomes.

The recommendation is consistent with the Commission's goal of reforming the delivery system by allowing Medicare to construct larger payment units for outpatient therapy services and eventually tie payments for these services to the patient's functional outcomes.

To wrap up, we look forward to your discussion of these draft recommendations. Some of the policies we've discussed expire at the end of the year and our goal is to finalize these recommendations before the provisions expire in December.

Thank you, and with that, I'll turn it back over to Glenn.

MR. HACKBARTH: Thank you, Adaeze.

As we did this morning on ambulance services, what we'll do is just have one round of comments before the vote, and if I may, I will offer the first set of comments.

I'd like to begin by reminding people in the audience of the framework that we are using for evaluating our recommendations on these three Congressionally requested reports on outpatient therapy, ambulances, and on the work geographic adjustment for physicians and other health professionals. The framework that we've applied across all three is that in order for us to recommend an increase in Medicare spending above the current law baseline, we ought to be convinced that there is evidence that doing so would either improve access to care, improve quality of care, or facilitate movement to a reformed delivery system, new payment methods.

In this case, outpatient therapy, the recommendations that Adaeze just outlined would, in fact, result in an increase in Medicare spending above the current law baseline. Without estimates from CBO, I can't give you a precise number on what that increase would be, but it is substantial. It's in the billions of dollars over the ten-year budgetary horizon.

Incidentally, this, as you might imagine, is quite a busy time for CBO, with all of the issues that they have pending before the Congress, and so it's understandable that it's perhaps a little more difficult to get our estimates than usual.

So the question is, within our framework, why recommend an increase in spending for outpatient therapy above the current law baseline? And for my part, it's because I'm convinced that going back to hard caps without exception, as would happen effective January 1 under current law, would, in fact, impede access to necessary and useful care for Medicare beneficiaries.

Mary and Bill and some others in previous sessions have spoken, I think very persuasively, about the importance of these services to Medicare beneficiaries, to improve their function or ability to live independently, interact with their families and grandchildren and great-grandchildren, and the idea that there would be a hard dollar cap beyond which no additional services would be available, I think, is inconsistent with the goal of assuring appropriate access to important services for beneficiaries. So that's why I think it meets our test and

the framework that spending above baseline is appropriate here.

Having said that, we all recognize the importance of doing whatever we can to limit Medicare spending, especially in the current context. And so in formulating these recommendations, what I have tried to do is strike an appropriate balance. Do away with hard caps yet take steps to manage that cost insofar as possible and, in effect, have a level of spending that is -- a rate of spending that is lower than is happening as we speak. Currently, we have a system effectively with no caps because there are open-ended exceptions to the caps. So that's the current high level of spending, if you will. If we allow hard caps to go into effect, there would be a dramatic drop down beginning January 1. I'm looking for a line somewhere in between those two levels that can help assure appropriate access to needed services while keeping the cost below an unrestrained level of spending.

To do that, I've recommended and we've discussed now several times using a number of different tools, including a lower, albeit soft, cap, one above which there could be additional services provided once they've been

reviewed and authorized, as well as a reduction in the payment per unit of service when multiple services are provided in the same day.

I think those are reasonable steps, but based on our previous conversations, I think we all recognize that they are not easy steps. And for me, the question is, are they better than the alternatives, and personally, I'm convinced that they're better than either reverting to hard caps or continuing with the current rate of spending, which I think is difficult for the Congress to accept in the current environment.

So to sum up, one way to characterize this is I support what is basically an expansion of outpatient therapy activity and benefit above the current law of hard caps that takes effect January 1. So this is an expansion, although it is not an open-ended benefit, and I think that's necessary to manage the cost.

So that's my perspective. Let me turn to Mary for another perspective.

DR. NAYLOR: Another, Yeah. So, first, I think that, Ariel and Adaeze, you've done a fantastic job, not just in -- in all the work leading up to this and certainly

in your responses to the questions that we've raised that really have helped.

First of all, let me just say I support recommendations related to program integrity. I support the goal of avoiding caps at all costs, and I support the recommendation regarding better management of the benefit, especially as it relates to getting that quality measure of functional status that we critically need to understand how well our programs are going, going forward.

As people know, I've struggled under recommendation 2 on reducing the therapy cap to the limit, and I've struggled with this in the context of making sure that we had a manual review process that would enable people to exceed the cap and to be able to continue to receive timely services. So those are some struggles.

I just wanted to share with you some perspectives on my struggles, and I'm going to listen to the rest of the Commissioners, but I think therapies generally, collectively, the different types of therapies, represent for us, for the individual Medicare beneficiary, and for the program a less intensive, less costly way to get to much better outcomes.

There has been a pretty substantial body of work that when someone comes in the hospital and is an older adult, by the time they leave their functional status is decreased. This is Ken Covinsky and others. There's a huge body of work that community dwelling and institutional older adults are at very high risk for falls as a result of problems in gait and balance that are directly affected by therapies, and falls represent for us as a society one of our biggest cost issues. Both in terms of human and economic perspectives, the consequences are extraordinary.

So I struggle with this notion that, if optimally applied, these therapies represent tremendous alternatives, especially given some of the alternative surgical procedures that Rita has talked about in the past, et cetera. And that said, I don't have a better alternative, meaning I think that we absolutely cannot go to hard caps, and especially when you look at the data you presented about who's using those caps now: the most vulnerable, the older adults, the group that we're trying to prevent functional decline so that they don't use our more costly resources. And it seems to me that it would be a huge error for us to not create -- "soft cap" is the first time I've heard it, but to avoid all

of those caps.

And so on the framework, I think I don't have concerns about spending or access, but on quality, because we don't know what's the right dose of investment in these kinds of services to get the best quality for the beneficiaries and the program. I struggle -- and I'm just being honest with you -- with the reduction in cap that's recommended and have concerns about the manual review process, but support the goal.

DR. COOMBS: Adaeze, thank you very much for the presentation, and thank you very much for answering our specific questions.

I think Glenn and I talked about one issue, and that was making sure that CMS has the infrastructure to really do the manual review because that was something that needs to be -- cannot be overstated in the final report. So thank you very much.

MR. KUHN: A couple quick comments. One, from the last meeting to the current meeting, I've been doing some reading by -- some of the letters and things that we've been receiving, and one of the questions that was raised has to do with the multiple procedure payment reduction and the

practice expense component of that, and where the RVUs have already been adjusted to capture multiple payments. Can you kind of walk me through that a little bit? You know, there has been some concern that maybe we're double counting with the 50-percent reduction. I just want to make sure that I understand what's going on there.

MR. WINTER: Sure. So in the final rule, where CMS adopted a 25-percent cap, which is now 20 or -- sorry, a 25-percent payment reduction, which is either 20 or 25 percent in current law, depending on the setting, CMS addressed the comments raised by many members of the industry, among which were that the RUC has already accounted for duplicate practice expenses when they valued timed therapy services. And the contention is that the RUC assumed that there were three services per visit for a typical visit, two procedures and one modality, and that they accounted for duplicate practice expense inputs for those services.

CMS' response to that is that the typical case used by the RUC did not represent many of the combinations of therapy services that they actually found, and, in fact, they looked at the -- they calculated the median number of

services on claims of multiple units of service, and they found the median number was four and the RUC had assumed it was three. And so you should be spreading those inputs across more units of service than the RUC had assumed.

They found in their own analysis, where they looked at five high-volume payers of codes, that there were substantial efficiencies that were not -- over and above, beyond what the RUC had accounted for in their process, and that those efficiencies that CMS identified justified a reduction of between 28 to 56 percent in the practice expense component of the lower-cost code, the lower-cost codes in a group of codes.

MR. KUHN: Thanks. That's helpful to get some better understanding of that, so I appreciate that.

The second issue, I would just say what others have said and Alice mentioned as well, and the emphasis that was on the presentation here that CMS have adequate resources due to the manual review. I can think of nothing more frustrating to a set of providers to be bogged down into a process like that. And to maintain the integrity of that system, that has to be key. So I think our emphasis on that -- and I think that will be reflected in the report --

is a good thing.

The final thing I would just kind of comment on here, a little bit outside the scope here, but just something that's been on my mind -- and perhaps others' -- is the decision last week on the improvement standard case, the settlement agreement, and the fact that now we're going to have in the future a different standard in terms of not only benefits in outpatient therapy but skilled nursing and ultimately in home health. And I was trying to reflect whether the recommendations we're making now would capture or did we have to think differently. Obviously, that settlement agreement is going to play out over four years. It's going to very overseen by the judge. CMS is not even going to start the educational process on that until next year. So there's really nothing that I think we can do in this to anticipate, because we don't know.

But what I would just say is that as I look at what we put together here, whether it's encouraging CMS to look at national guidelines I can help in that process, whether it's a better review process can certainly help in that as that comes forward, and then obviously the program integrity components of our recommendations.

So I think there's elements in here that make it very portable to help support that or at least forward-think on that as we go forward, given the unknown nature of that case.

I would just say, just as an aside, that I know different people are looking at that and reviewing that case. I think it's an extremely impactful decision, and I don't know what the dimensions of this thing are going to be, but in my own mind, I think it now established the de facto long-term care benefit under Medicare. And I think it's going to be much more powerful than I think a lot of people realize when it's fully implemented.

DR. HALL: Dittos on what a wonderful job you've done on this. It's a wonderful document, I think.

I guess I'm particularly happy about recommendation 3. One is we're getting rid of the V-codes, which is, I think, a blow for justice all the way around. But, also, this is one of the strongest statements I think I've seen in my brief tenure on the Commission where we really say that functional status evaluation is the key to making rational decisions in Medicare payment. It has come up a couple of times already this morning, and this is a

very straightforward, hard-hitting exposition of that particular position. So I really applaud you for that.

The other thing that maybe is a little less obvious, I think, is that we like to think of how things proceed in science and medicine as there's a basic science and a lot of work is done in the laboratory, in rats and in mammals, and that eventually comes up to people and informs clinical decisionmaking.

In point of fact, particularly in terms of care for the elderly, the process is totally reversed. Something doesn't become scientifically important until we prove it has clinical utility, and these days, not only clinical utility but is cost-effective. So already we're seeing in this functional assessment arena that suddenly there has now been -- there's a proliferation of very basic science and trying to understand how muscles work, how the genes are influencing this. And all of these things start to fall into a pattern, I think, which is very important. So in case you missed it, I really like this.

MR. KUHN: Nicely done.

DR. DEAN: I would echo most of the things that Bill just said. I'm wondering, about the concern of the

people that will exceed the caps, I mean, we know that there's a huge difference in utilization in different areas. I wonder what portion -- if you took out the really high-use areas, I suspect the proportion of beneficiaries that are likely to exceed the cap would be significantly smaller. Is that a fair assumption?

DR. AKAMIGBO: Yeah, I mean, there would be a lot of areas you would have to take out.

DR. DEAN: I mean, it isn't going to affect this. Just curiosity.

DR. AKAMIGBO: Yeah. But, yes, that would be a fair assumption.

DR. DEAN: Okay. And the reduction in the practice expense, what portion of the fee for the average treatment is in the practice expense portion? Are we talking about a small portion? Or is it a substantial portion of the average fee?

MR. WINTER: Yeah, it would depend on the code. I looked at a couple of high-volume codes, and it's substantial, but I think it's less than the work component.

DR. DEAN: Okay, so 30, 40 percent?

MR. WINTER: Let's say the work component is, you

know, $40, the PE, practice expense, might be $30 or $35. But I can get you more specific examples, and we can add that to the text.

DR. DEAN: Well, I guess I was just trying to get a sense of how big a hit this would take. But I think that's reasonable.

Finally, to follow up on what Herb was saying, I wonder about the whole manual review process given the elimination of this improvement criteria. To me that is probably the fundamental criteria that would be used in those reviews. I would think without that -- and, again, it doesn't really affect what we do here, but I would think that that's going to make the review process much more difficult. Does that make sense?

DR. MARK MILLER: When we had some discussion of this, and declaring that I'm not an expert in it, what the settlement will turn on is that there's a need for a skilled service, so that would continue to be a criteria, and then you would see presumably the MAC judging, you know, whether there's an improvement or that's what would have happened before the settlement. After the settlement, the MAC would have to consider whether that skilled service was needed to

either maintain or improve. And so we would see the MAC making the judgment based on the new standard that came out in the manual issuances, assuming the settlement is approved and goes forward, which it looks like it's going to do.

DR. DEAN: I guess, you know, I still would -- as Bill said, I think that doing functional assessment and documenting that is vitally important, but it seems to me that the whole review process is going to be much more difficult when the criteria are going to be much less precise, it would seem to me. But, again, that's not -- doesn't relate to these recommendations, but it does make the whole problem more challenging.

MR. GRADISON: I've got the same concern -- and I wanted to mention it -- that Herb and Tom have mentioned. In particular, on Slide 22, I suggest under the quality paragraph that you take another look at the use of the word "improvement" because my reading of this is that the measurement that we're suggesting is an improvement in functional outcomes, and -- or at the very least have some text in there to indicate that if the court goes from and so forth and so forth, that that no longer would be the test. It may be today.

DR. AKAMIGBO: We actually ended up adding an end note or footnote in the paper, which I think was sent out the day the court case -- the settlement was announced. So, yeah, this will -- it will reflect that change.

MR. GRADISON: Good [off microphone].

MR. GEORGE MILLER: Thank you, Adaeze, and I thought this was very well written. I enjoyed reading it and certainly would echo what the other Commissioners have said concerning this is the right thing to do. So I support the principles of the recommendations and certainly appreciate the Chairman's analysis of dealing with the caps. So I appreciate that discussion.

I also want to echo Herb and Tom on the concern, as Jack mentioned, about appropriate resources to make sure this can be implemented, because there's nothing more frustrating to a provider than to have a set of rules but there are not enough resources at CMS to implement.

I have one technical question before I make a comment, and that is, what was the original reason for the differentiation with the 20-percent fee in the -- excuse me, the difference between the 20 percent for non-facilities or private settings and the 25-percent difference in payments

for facilities? What was that rationale originally? And I realize the recommendation is saying go to 50 percent, but help me understand what the original rationale for the difference in the --

MR. WINTER: Right. So when CMS implemented the change, it was 25 percent, regardless of setting.

MR. GEORGE MILLER: Right

MR. WINTER: 25 percent multiple procedure reduction regardless of setting. Then Congress came along a few months later, and in a piece of legislation where they prevented a steep reduction in the physician conversion factor, they implemented a 20-percent reduction for therapy services provided in private practice settings and 25 percent -- they kept 25 percent in facility settings. They made both changes not budget neutral, so they were able to use that savings from other purposes.

I don't believe there was a justification -- certainly in the text of the bill there's no justification or explanation for why they, you know, had a distinction. And when CMS did its analysis and explained the policy, they kept it the same across settings because in their interpretation of the statute, they set the physician fee

schedule rate for therapy services that are provided in physician fee schedule settings -- that is, physicians' offices and therapists in private practice. Those rates also apply to facilities, but those are not considered physician fee schedule services. Those are, rather, considered institutional settings that are paid under Part B.

So whatever they decide is paid on for private practice settings for therapy, those rates just by statute automatically applied to outpatient departments and nursing facilities.

MR. GEORGE MILLER: So do you anticipate this will stay at the 50 percent based on our recommendation, or will that same methodology -- who would predict what Congress would do? Maybe I should just back off.

MR. WINTER: I'm not going to go there.

DR. MARK MILLER: Ariel does not know the answer to that one.

[Laughter.]

MR. GEORGE MILLER: Thank you.

DR. NERENZ: Just a quick question on the bit about reducing the certification period from 90 to 45 days.

I appreciate the program integrity rationale for that, but also appreciate the fact that there's a smallish fraction of episodes to which that would actually apply.

I think in September I mentioned sort of a concern about just the hassle factor of that. It's just more paperwork without obvious benefit.

In the text of the background paper, it mentioned that physicians or a non-physician provider actually does the authorization. So as a way of minimizing hassle and streamlining, in practice can a nurse practitioner or PA or case manager or someone other than literally a physician do this?

DR. AKAMIGBO: Yes, a nurse practitioner can certify the plan of care.

DR. NERENZ: Case manager?

DR. AKAMIGBO: Not a case manager. I think a nurse practitioner, physician's assistant, or a physician.

MR. BUTLER: So thank you. On Slides 7 and 8, you responded to my questions. Now I just want to understand it a little bit more where you've shown the high end and the low end. So 7 basically says that the hospital side, if that's where the user is getting the service, they're in the

bottom 10 percent of spending per user, right? And then the next slide shows the nursing facilities, the high end one. So back on the hospital, I'm just trying to -- could you speculate why that is? I mean, obviously you're an ambulatory patient, so it requires you to be transported, or you have to get to the hospital facility; whereas, in the nursing home or the nursing facility, you're sitting there, and so that the ability to provide the services is easier. But is there something about those -- would you speculate?

And then one other, and then I'll let you answer. You said, you know, two-thirds of the people are under the cap, and, again, so I suspect in this hospital setting, virtually all those people are under the cap, right?

DR. AKAMIGBO: Probably, yeah.

MR. BUTLER: Probably.

DR. AKAMIGBO: I can't speculate as to why the low -- so when you look at the distribution of spending for HOPD, you find that the spending per beneficiary who uses therapy services in hospital outpatient departments is probably the lowest among all these other settings, $500, $600, and highest --

MR. BUTLER: Hospitals are usually not the low end

of these things, too.

DR. AKAMIGBO: But these are outpatient departments.

PARTICIPANT: I know.

DR. AKAMIGBO: And they don't have to be located -- - what you just alluded to, maybe getting to the hospital. They could be located throughout -- in various forms across an environment.

MR. BUTLER: But the patient is not living where the service is --

DR. AKAMIGBO: But they don't live --

MR. BUTLER: Right.

DR. AKAMIGBO: I think there's a big difference in service provision between -- for therapy services between nursing facilities and just about every other setting. But since we're talking about HOPDs, HOPDs having a resident in a nursing facility, they tend to be long-term care residents, potentially with multiple needs --

MR. HACKBARTH: Is there anyway, Adaeze, to determine whether the clinical problems of the patient are different in the two settings? You know, I could imagine --

DR. AKAMIGBO: Yeah.

MR. HACKBARTH: -- that a patient seen in an outpatient department might be more likely somebody coming in for a few sessions, a follow-up to some procedure that happened in the hospital.

DR. AKAMIGBO: Yeah.

MR. HACKBARTH: As opposed to a nursing home resident having long-term multiple problems.

DR. AKAMIGBO: We tried to do that, and --

DR. MARK MILLER: In the discussions with the industry, I think what they would say is that in the nursing facility it is what Glenn is alluding to, and that there are multiple -- more likely to be multiple modalities given to the patient during the stay there, and that that probably accounts for some of what's going on.

MR. BUTLER: I suspect some of the very best of these services and some of the very worst in terms of inappropriate utilization is occurring in the nursing facility side of the equation. But I don't base that on any data. I just -- okay.

So just a couple quick comments on -- not on these slides, but we had striking data last month that showed that the caps cut spending in half in one year, which I suspect

was not necessarily fewer users but the fact that you just had a cap, and so less use per user. And then it has kind of gone up since then exponentially -- not exponentially, but at a rapid rate, is why we are where we are.

So I was more in line with kind of almost the hard cap, but I understand that that was fairly brutal. So I guess I'm suspicious, like a lot of you, that the effort, the resources, and the logistics of manual reviews is going to be tough. But I don't have a better answer than what we've got on the table, and I think it is artfully crafted.

DR. REDBERG: Thank you for an excellent presentation, and I just wanted to comment, you know, keeping in mind our framework in general, I think it's great that we have in the recommendations to collect the data on quality of care, because it's very hard to assess whether we're improving quality of care when we have no idea. And so that's great. And I think, you know, as always, but perhaps particularly for this, you want to get this care to the beneficiaries who will need it, but there's this terrible problem of program integrity and fraud and abuse, and I think that's why really the soft caps with manual review is the best way to address that.

I was just wondering, because you have addressed the timeliness, and I can understand certainly we'd want to be timely with the ten days and have electronic and not have to have people mail and fax. But after that, did you have a feeling for why there was continued objection to manual reviews by the groups that talked to you?

DR. AKAMIGBO: Maybe I'm misunder.... -- so besides the timeliness of getting responses?

DR. REDBERG: Right, which you have addressed --

DR. AKAMIGBO: Other objections?

DR. REDBERG: -- so is there something else?

DR. AKAMIGBO: Well, the process of submitting the claims, it's not automated in any way. They do rely on -- the only options they have are via mail, not e-mail.

DR. REDBERG: But you addressed that, too.

DR. AKAMIGBO: Yeah. So I think I covered the range of issues brought to us by the industry in your materials.

DR. REDBERG: Right and that was my question.

DR. AKAMIGBO: Okay.

DR. REDBERG: Besides what you've already addressed, having it be easier to submit the information,

being able to do it electronically, and getting a response quickly, and then getting a final decision in ten days, was there anything else? Because it seems like it has all been addressed.

DR. MARK MILLER: I think what they would say -- and if they had the microphone in the public session they will, so -- but in our discussions, I think -- and I want to say that there were some members of the community who came in and I think were very constructive and very helpful. So I want to say that, and we spent a lot of time talking to a lot of different permutations of them.

So I think this list, which we got through consultation with them, helps if there's a manual review. Nonetheless, I think they would say things like if the resources aren't there, this is going to be a problem. And I think we have said this ourselves and tried to reinforce repeatedly that without the resources there will be a problem.

I think they're concerned that any time a cap gets lowered, it runs the risk of an interruption and/or a denial, and so they, you know, higher, better, if it has to be at all. And I think they might start with, well, there

was an automatic exceptions process, and that was fine. And so, you know -- well, I'm just trying to speak to what I would think they would say.

And I also thought it was significant -- and Adaeze pointed this out in her presentation. This is not an industry-wide view, but some said, "I would rather take a lower rate than a medical review." And, again, I think it's the hassle and the potential that if the resources aren't there, it doesn't execute smoothly. And I don't think any of us here or anyone out there is thinking that manual review is a great process and everything works really smoothly. It's really just what we have.

DR. REDBERG: There wasn't a sense they'd rather there be a cap than a manual review?

DR. MARK MILLER: Yeah, but, you know, and I'd tell you --

DR. REDBERG: Because that was really the choice.

DR. MARK MILLER: -- for the constructive people who came in, they said rather than a hard cap, this is preferable. A lot of people just came in and said, well, you know, there shouldn't be any hard cap and there shouldn't be any medical review, and there shouldn't be

anything else. And so, you know, I didn't know what to do with that.

MR. HACKBARTH: So let me just make sure that I'm clear. The steps on this slide that came out of a conversation with at least some people involved in the therapy world are not incompatible with our recommendations. These are steps that could be taken within the framework of our recommendations to smooth the process, make it less burdensome, less of a barrier to needed care. Correct?

I also wonder whether we need to change our language. You know, "manual review" has the connotation of a clerk waiting for the mail to come in, there's a dump on the desk, and opening envelopes. And certainly the spirit of this is, in fact, to void that scenario and try 21st century communication techniques. So we may want to modify the phrase "manual review."

DR. BAICKER: Maybe you should call it a customized review or a personalized review.

[Laughter.]

MR. HACKBARTH: Right, a personal review.

DR. BAICKER: That's right. An individual review.

MR. GEORGE MILLER: Excuse me, Kate. I apologize.

Since you brought that up, how many reviews do we think would happen with the lower cap?

MR. HACKBARTH: Would you put the relevant slide up, Adaeze? At the proposed cap of $1,270, about one-third of the users have use above that level. So about one-third of the users would be subject to the review.

DR. CHERNEW: But sometimes the existence of the review discourages the --

MR. GEORGE MILLER: Yeah, yeah.

MR. HACKBARTH: Yeah. And to give you another point of comparison, George, at the current level of the caps, which is overridden with the basically automatic exceptions, the $1,880 level, that's about 20 percent of the users exceed that level.

DR. MARK MILLER: And also, I think this is obvious, but I'll just say it just in case. It's not that each and every visit is reviewed, but you get, you know, approved to go ahead for another block of -- right.

MR. GEORGE MILLER: No, I got you [off microphone].

MR. HACKBARTH: And as indicated here in this table. So at this level, $1,270, a patient would have about

14 visits before they would be subject to any review.

DR. BAICKER: So that actually leads right into my question or thought, which is I think this seems like a very reasonable way to balance the competing interests of wanting to be sure that people have access to needed services but not have completely ungated use of services with questionable value. And in knowing whether we've picked the right cutoff point in thinking about the onerous review process that this might entail, I think it would be helpful to show a PDF, a density function to show what share of claims and what share of dollars fall under each dollar amount, so $1,270 hits 67 percent of people, what share of dollars does that hit? And then if you dial that up to, you know, $1,300 or $1,350, how many fewer claims would you have to review and how many of the dollars would you lose? And that, to just back up, this is the right place to draw that cut point, because if you set the dollar amount too low, you impede access and increase the burden. If you set it too high, then you're not imposing any kind of discipline. So in picking the dollar amount, I think those statistics would be helpful.

DR. MARK MILLER: And I do want to say we did some

discussion of this, and we either have or will develop a table that shows you the distribution of the beneficiaries and the distribution of the dollars. As you suspect, the dollars are a little fatter in the right-hand tail than the beneficiaries. But the distinction is not as much as you might think. And it is true that you could raise the cap, hi, you know, 70-some-odd percent of the beneficiaries and still hit a large block of the dollars, but it's not as much bang as you think.

The other thing I would say to you and to the public is obviously if the Congress feels and CMS feels that there's some better cut point that this all works, I mean, our point is trying to strike a balance between a hard cap and an open-ended cap.

DR. HOADLEY: Part of what I was going to ask I think has just kind of been answered in this discussion of this slide, which is I think there's a real value in that kind of data because not only does it help justify what we did, but it also gives the Congress a sense of the impact of different options.

The other thing I wanted to just clarify on this -- and it was said, I think, in your comment, Glenn -- one

should be careful not to misread that number of visits under the cap 14 isn't -- we're not setting a cap of 14. That's just the average that you can calculate from those dollar -- that's correct, right? Because I think that one is tempted to misread that if you're not being careful.

My other comment, this has been great staff work, and I think we're in the best place we can be given all of our qualms about the tough place that we're put in. And I just wanted to make one other comment along those lines, which is ideally we would know a bunch of other information, including the fact that starting in October we've got a real-life experiment going on. And, you know, if Congress was in a position to be able to wait and see what happens, there's even a GAO report that's due out in May. Obviously, they couldn't start that any earlier because the policy didn't start early to look at the impact of manual reviews, and ideally we'd like to know how many reviews took how much time, you know, and not even do it with sort of the current rules but maybe the streamlined process, which is a really useful perspective. You know, how many end up getting approved because they go past the ten days? How much is the ABNs used and all these other kinds of things? What of

patients -- I mean, to really make good policy, we'd like to know all that. Obviously we can't. We're not in a position to wait for that, and the Congress may or may not be. They obviously could choose to, but may well not be able to wait.

So I think it's really important that we emphasize the point of the CMS resources, and that whatever we can do with the numbers to sort of show the impact of that will be great.

MR. HACKBARTH: Just to put a sunny face on it, what we've heard anecdotally is that the experience of the last several weeks has been difficult, since October 1st, and if nothing else, perhaps that will make it clear to the Congress that if you want to go down the review path, you really do need to provide the resources and, to CMS, you really do need to focus on the sort of streamlining that's discussed, because we've got some real-world experience that suggests those things are important.

DR. SAMITT: Great job. Very well done.

You know, while I recognize the concerns about the manual medical reviews and the lowering of the cap, as you described, Glenn, it's certainly much more preferable than hard caps. And so if we're between a rock and a hard place,

this is where I'd much rather be, and I support the recommendations.

Two things. I want to congratulate you for taking what I think was a great recommendation and making it better by elaborating on some of the concerns regarding the manual medical reviews and how this could be -- the ease of use could be improved for the providers themselves, which I think should hopefully make this better from a provider perspective.

Then my last comment really pertains to Slide 22, and it's less about this recommendation and more about just the broader mission of the Commission. This is the first one that I think focuses on moving forward with delivery system reform, and I'd love, if possible, every recommendation to have some element of moving us further toward delivery system reform. Most of them have been no impact. But I think there are some elegant elements of this that move us in that direction, and if we could do that with each of our recommendations, I think we'll be well served.

MR. ARMSTRONG: So at this point, there's little more to say. I do think this strikes a great balance between the issues that Mary did a very good job of laying

out. Actually, we have tended to talk about how this is kind of a compromise, we're kind of between a rock and a hard place, and so forth. I actually think this is a really great going-forward plan and believe that if you do buy the argument, which I really do, that investing in these outpatient services is a great investment with a terrific return on better health for the beneficiaries, then I also think it's an investment through CMS you should be making and checking after 14 visits, how is this going and is this contributing to the quality and health of the beneficiary?

And so it's a discipline that we apply to many other products and insurance plans, and I think it's actually a step in the right direction for us to apply to this group of beneficiaries as well.

I understand the operational concerns, but it seems for all the resources that we invest in CMS, this would be one that would be better use of those resources than a lot of other things that I think the CMS budget is spent on.

One last question I have, which I'm not concerned about, but I remember in our previous conversations, and actually in one of our slides we referred to it, if this is

still too expensive, there are some alternatives, one of which was additional beneficiary cost sharing. And it seems like after our last conversations that just kind of went away. And I don't know -- it was the third of those three ideas, but --

MR. HACKBARTH: Yeah, could you put up the relevant slide, Adaeze? We do plan on having, continuing to have that list. Right here. So that will be part of what we send to the Congress and part of what we publish in our June report.

MR. ARMSTRONG: Okay. Just remind me then, our thinking about this was that, first, there's already the 20 percent co-pay, tends to be mitigated through supplemental plans. It wasn't clear to me if we had done much thinking about, you know, any advice or parameters we would offer as this goes forward. My recollection was we weren't very specific about any of that, and I guess there's a question there: Is that true? And do we need to be any more specific about that?

MR. HACKBARTH: Specific about what specifically?

[Laughter.]

MR. ARMSTRONG: Specific -- I'm thinking -- so

what kind of additional out-of-pocket -- what kind of recommendation would we make so that that the out-of-pocket costs actually helped to advance the outcomes that we were pursuing? I don't really know what that would be. And my sense was that we didn't really offer any advice about that either other than that's just one possibility that should be considered.

MR. HACKBARTH: We have not. And, you know, when we talked about this much earlier in our discussions of this issue, two types of concerns were raised about increased cost sharing for beneficiaries. One is that current law already includes cost sharing, the Part B deductible, 20-percent coinsurance. So unlike home health where a couple years ago we recommended a co-pay be added, because there was no cost sharing at all, here there already is cost sharing. And there were some Commissioners who expressed concern about the added financial burden on beneficiaries.

Another issue that arose was the interaction with supplemental coverage, and in fact, absent change in supplemental coverage, an increase in the required cost sharing would not have any effect on utilization because the co-pays would be paid for by the supplemental coverage, and

it would be just a matter of shifting the program cost to beneficiaries that would then be paid through their supplemental premiums going up. And we couldn't expect any utilization effect.

Now, in the longer term, MedPAC has recommended that the benefit package overall be restructured, and I know you well know this, Scott, but for some of the new Commissioners. And a fundamental change in how the co-pays are structured, add catastrophic, and then also add a charge on supplemental coverage to reflect at least a part of the cost that the program incurs from higher utilization of beneficiaries that have supplemental coverage.

If that were all in place today, then, in fact, we might see a different sort of supplemental product that would be much more compatible with where we want to go here, which is cost sharing that is focused on encouraging high-value services and discouraging lower-value services. But, unfortunately, we're not quite to that point yet.

MR. ARMSTRONG: So that really answered my question. I remembered that our conversation had gotten up to that point. I thought we had concluded that there wasn't really much we could do. And yet it still kind of connected

to our recommendation, and I'm fine with that. I just didn't know if there was more to it.

MR. HACKBARTH: The last word [off microphone].

DR. CHERNEW: Yeah, so -- I don't know if I want the last word, but I feel like many people, I think. I support these recommendations, although I don't like them. I think that was the tone of some of what you said, Glenn. There's a few things.

I'm not a big fan of added administrative costs, and I think even with the streamlined approach and with more resources, it's still a burdensome, imprecise process that's just, you know, not ideally the way the system would work if we had a system that we wanted. And I think, you know, in my happier moments, I hope that it will work well and will drive out bad care and keep good care. And I worry that we won't do that as well as we would like. But, again, let me start where I was before.

I support the recommendation because -- it might have sounded like I didn't.

MR. HACKBARTH: It might have.

[Laughter.]

DR. CHERNEW: Because the situation is so

difficult where we are. So there's a few things.

The first thing is I think this illustrates the danger of having temporary provisions of the law, and sometimes there's temporary provisions in the law because there's a particular thing that you want to transition for something and you want the transition to go away. Other times I fear your have temporary provisions in the law for perhaps other reasons. You know, it seemed cheaper to start or something like that. And I think that just becomes problematic to manage, and we find ourselves in this awkward situation where the status quo that we have is not what the current law will have in the future. And it's a very difficult thing to manage, and I think it's worth noting how difficult it is across a series of things when you have these temporary rules that don't have a particular rationale so you could say, well, that rationale has gone away, let's get rid of the proposal.

The second thing I think is true is ideally moving to some sort of broader bundled payment system would, I think, clearly be better where you could internalize this and have the decisions made closer to the ground and closer to the care. So I would encourage somewhere in the text to

maybe think of -- for example, if you were in an ACO, we might have an exceptions process or something, where if you had the right incentives, I wouldn't necessarily push everybody through all of these manual reviews. And so I think in the spirit of our last criteria, thinking -- I wouldn't change the recommendation because I think it becomes distracting. But thinking of ways to minimize the burden if people can transition to payment systems or other models where the incentives are aligned and we can get rid of this administrative burden would make me generally a happier person.

MR. HACKBARTH: On that last point, as you know, Mike, actually there is some precedent where we've said if care is provided in the context of a risk-bearing ACO, the rules should be different because they've assumed financial and clinical responsibility for a defined population.

Okay. It is time for us to vote. Would you ut up the first recommendation, please? Okay. All in favor of recommendation 2, please raise your hand?

[Hands raised.]

MR. HACKBARTH: No votes? Abstentions?

[No response.]

MR. HACKBARTH: Okay. Recommendation 2. Wait until we get it up there. Okay. All in favor of recommendation 2?

[Hands raised.]

MR. HACKBARTH: Okay. No votes? Abstentions?

[No response.]

MR. HACKBARTH: Number 3. All in favor of number 3?

[Hands raised.]

MR. HACKBARTH: No votes? Abstentions?

[No response.]

MR. HACKBARTH: Okay. Thank you very much. Good work on this.

Okay. We are now moving on to geographic adjustment of the work portion of the rate for physicians and other health professionals.

[Pause.]

MR. HACKBARTH: We'll wait just a second. We have a shift change occurring behind us.

Okay. Kevin, whenever you're ready?

DR. HAYES: Thank you. Good afternoon, everyone.

The mandate for this report was in the Middle

Class Tax Relief and Job Creation Act of 2012. It directs the Commission to consider whether certain payments under the physician fee schedule -- these are payments for the work effort of physicians and other health professionals -- whether those payments should be adjusted geographically.

In fulfilling the mandate, the Commission is to assess whether any adjustment is appropriate to distinguish the difference in work effort by geographic area and, if so, what the level of the adjustment should be and where it should be applied. The Commission must also assess the impact of the current adjustment, including its impacts on access to care.

The Commission's report on these matters is due June 15, 2013. It will include full discussion of the issues, our analysis, and a recommendation. However, a temporary floor on the current adjustment expires on December 31st of this year. With that date in mind, we will present a draft recommendation at this meeting.

To fulfill the mandate, we are assessing policy options by considering issues of spending, access, quality, and delivery system reform. The framework was reviewed during previous sessions so I won't go over the specifics

again.

For today's presentation, we will begin with a brief recap of points made at the meetings in September and October. Recall that the fee schedule's geographic payment adjustment for work effort is the geographic practice cost index for work.

By way of recap, we will review the GPCI's purpose conceptually and how it has been implemented. We will also review the Commission's findings.

Our second topic for today is to respond to questions raised at the October meeting. To conclude the presentation, we have the draft recommendation, which is based on discussion of the Chairman's draft recommendation presented at the October meeting.

Briefly recapping where you have been for this report, the theory relevant to the GPCI is the theory of compensating wage differentials, which says that the wage paid for a unit of work should be equivalent in terms of the goods and services that can be purchased with that wage regardless of the geographic area where the wage earner works.

Factors that vary geographically and believed to

influence wage differentials include cost of living and amenities. Earnings data, therefore, would include the effects of both of these factors.

Data specific to the earnings of physicians and other health professionals can be influenced by three additional factors listed on the slide here: market concentration of providers and insurers; the volume of services; and the return on investment received by practice owners.

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

The work GPCI is constructed with data on the earnings of professionals in selected occupations. Specifically, CMS uses data from the Bureau of Labor Statistics on the earnings of professionals in seven reference occupational categories such as the category, architecture, and engineering.

As you discussed at the September meeting, this

method for implementing the GPCI raises two issues.

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

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

In response to the mandate, the Commission has conducted a series of analyses to see if there is empirical evidence to support the validity of the work GPCI as it is currently constructed.

The first finding is that, to the extent conclusions can be drawn from the limited data available, the work GPCI is not well correlated with physician earnings.

Second, there is some correlation between the work GPCI and a cost-of-living index, but it depends on the level of reference occupation earnings.

Third, the work GPCI is highly correlated with the

hospital wage index.

Details on these findings are in your materials for the meeting, but, of course, we would be happy to answer any questions that you have.

Per the mandate, we do not find that the work GPCI has an impact on access to care. Kate will have more on this in just moment. For now, let me just say that the findings to date are that, in comparing payment areas, the GPCI's impacts on payments are modest -- in a range from minus 3 percent to plus 4 percent

Considering supply as a measure of access, growth in the number of physicians and other health professional billing Medicare is similar when comparing low GPCI areas and high GPCI areas.

Considering service use as a measure of access, there is much geographic variation in service use, but the variation does not appear related to the GPCI. And comparing service use in urban areas with service use in one type of low GPCI area -- namely, rural areas -- and doing so with data for time periods before and after the floor on the work GPCI floor was implemented, the Commission's findings are consistent, which suggests that the floor has not had an

impact on access. However, extension of the floor would have a budgetary impact, a one-year impact in the range of $500 million.

Shifting gears now to questions raised at the October meeting, we begin with a question Cori asked about the earnings of professionals in the work GPCI's reference occupations. Depending on occupation, professionals, including physicians and other health professionals, may value cost-of-living and amenities differently. Cori's question was: If we consider the reference occupations separately, are their earnings correlated? The implication being that, if reference occupation earnings are not correlated, those earnings may not be a good reference point for constructing the GPCI.

The findings are:

First, if we put pharmacists to the side for the moment, the correlations are moderate to high, in a range from 0.41 to 0.69, depending on the pair of occupations compared. And the correlation of pharmacist earnings with registered nurse earnings is toward the low end of that same range at 0.43.

However, the correlation of pharmacist earnings

with the earnings of the other five reference occupations is much lower -- in a range from 0.13 to 0.24.

Kate will take over now and start by addressing questions raised at the October meeting about access to care.

MS. BLONIARZ: So we also looked at the rates of visits across rural and urban areas within the same statewide locality. You could think of these statewide localities as a natural experiment where areas that have this different underlying input prices receive the same GPCI. If the GPCI significantly affects service use, we should see differences between rural and urban areas in statewide localities. The bottom line is that we don't see large differences between urban and rural areas in those statewide localities -- the first line on the slide.

And, furthermore, the small difference in service use between urban and rural in statewide localities is basically the same as it is in non-statewide localities. And you can see that across both types of localities, the difference between urban and rural is small -- about a half a visit per beneficiary.

This is consistent with the findings in the

Commission's rural report. There are significant differences in service use across regions of the country but little difference between rural and urban beneficiaries' service use within those regions.

Another topic you've discussed is the potential impact of a change in fees on access, and a Center for Studying Health Systems Change study provides some insight here.

A Medicare fee cut in 2002 did not result in a higher share of beneficiaries reporting access problems. And beneficiaries in areas with a high fee differential between Medicare and private insurance were no more likely to report access problems than those in areas with low fee differentials between Medicare and private.

On Medicare's specific programs for improving access, there's the HPSA bonus, which is a 10-percent increase in the fee schedule amount for all fee schedule services provided in a primary care health professional shortage area, or HPSA. HPSAs must have a low provider-to-population ratio as well as having individuals that face insufficient access to care, using measures such as wait time or the share of providers accepting new patients. The

HPSA bonus has been in effect since 1991, and payments were about $200 million in 2008.

The primary care incentive program also makes a 10-percent bonus to primary care services delivered by providers in certain specialties who specialize in delivering primary care services. The PCIP is along the lines of the Commission's 2008 recommendation for a payment adjustment for primary care services. And payments under this program were about $560 million in 2011, and the program will expire in 2015. The Commission could undertake further analyses of these programs to see how they could be better targeted.

So switching gears a bit, an argument brought forward in supporting a floor on the work GPCI is that it will aid in recruiting physicians to areas where access is constrained. But the floor applies to many large urban areas that may not face trouble in recruiting.

The areas with a work GPCI of above 1 (and so not subject to the floor) include some large metro areas such as Chicago, Baltimore, Washington, and others listed on the slide.

However, areas below 1 -- so those that are

subject to the floor, also includes some large metro areas, such as Miami, Phoenix, Minneapolis, and Denver, and other cities on the slide. And some of these areas may not face much difficulty recruiting physicians and other health professionals.

This may call into question whether the floor on the work GPCI is the best policy for targeting access or whether other policies, such as the HPSA bonus or other targeted bonuses, are more targeted and efficient.

The Institute of Medicine recently released two reports on the geographic payment adjusters used in the Medicare program. In their principles and assumptions, the IOM stated that continued use of geographic adjustment factors in Medicare payments is warranted.

IOM also stated that Medicare payment adjustments related to national policy goals should only be made through a separate and distinct adjustment mechanism and not through geographic adjustments. In their Phase 2 report, when the IOM simulated the impacts of their recommendations on payment, they did remove the work GPCI floor.

To summarize, a geographic adjustment in the physician work component of the fee schedule is warranted.

There is variation in the cost of living and in physician earnings.

The work GPCI, however, is flawed in concept and implementation.

First, the market for the services of physicians and other health professionals appears to differ from the markets in the GPCI's reference occupations.

Second, there is insufficient data to validate the GPCI -- to know whether it is accurate -- because physician earnings data have many flaws.

We do not see an impact on access to care from the work GPCI. In targeted programs such as the HPSA or primary care bonus may be a better way of improving access than the work GPCI floor. We are unable to evaluate whether the work GPCI has an effect on quality.

And, finally, current law, is the one-quarter GPCI applied to all localities and expiration, at the end of this year, of the floor. And we do not see justification to deviate from current law based on quality, cost, or access. And while the GPCI is flawed, there is insufficient data in the short term to establish a new index.

To elaborate on that last point, if one wanted to

develop a new GPCI formula, there are a couple of different ways to do so.

The Medicare program could directly collect data on the earnings of physicians and other health professionals. The benefits of this approach are that CMs could specify what types of data to collect, such as the earnings of employed physicians. But these data would still be subject to the biases we've discussed -- the profitability of the practice, provider and insurance consolidation, and the volume of services provided.

The second option is to use market fees for a specific service or set of services. Advantages include that they are more likely to be obtainable from public sources and could address the volume incentives. Disadvantages include that they are still subject to market consolidation factors and the profitability of the practice.

The third option is to base the GPCI on an alternative such as a cost-of-living index or the hospital wage index. These indices are already established, and in the case of hospital wage indices are used to adjust other Medicare payments. But disadvantages include that it's unclear whether these other indices are truly a good match

for accounting for the work effort of physicians and other health professionals.

So, with that summary and discussion of future data collection options, we now put up the draft recommendation:

Medicare payments for work under the fee schedule for physicians and other health professionals should be geographically adjusted. The adjustment should reflect geographic differences across labor markets for physicians and other health professionals.

The Congress should allow the GPCI floor to expire per current law and, because of uncertainty in the data, should adjust payments for the work of physicians and other health professionals only by the current one-quarter GPCI while the Secretary develops an adjuster to replace it.

The implications of the draft recommendation are:

First, because it is current law, it has no effect on program spending.

Second, we do not expect that the recommendation would affect beneficiaries' access to the services of physicians and other health professionals nor the willingness of those providers to serve Medicare

beneficiaries.

We expect that the recommendation has no implications on the quality of care provided to Medicare beneficiaries.

And, fourth, the recommendation has no implications with respect to advancing delivery system reform.

That concludes it, and we're happy to take questions.

MR. HACKBARTH: Okay. Thank you, Kate and Kevin.

I hope that Commissioners will bear with me while one more time I say what the framework is that we're using to evaluate these. There's been some turnover in the audience, and I want to make sure that it's understood, our approach.

For each of these reports that we've been asked to prepare by the Congress on physician work GPCI, on outpatient therapy, and on ambulance services, we're applying the same framework, which is that in order for us to recommend an increase in the Medicaid expenditures above the current law baseline, there should be evidence that increased expenditure would either improve access to care,

improve quality of care, or facilitate movement to new payment systems and delivery system reform.

As indicated by Kevin and Kate's presentation, the recommendation here is based on the conclusion that there is no evidence to say that the roughly $500 million per year additional expenditure that would be incurred by extending the floor would result in improved quality, access, or facilitate movement towards delivery system reform.

That, however, does not mean that there are not important, legitimate issues worthy of further investigation around does the Medicare payment system assure adequate access to care for all Medicare beneficiaries. It could well be that more targets payment adjustments such as those for health profession shortage areas could be currently an important tool or assuring access and could be enhanced in ways. And I've asked Mark and the staff to undertake work that would allow us to investigate whether those tools function well, whether they can be improved, made more robust in the name of assuring adequate access for all beneficiaries. And that work will occur over the coming months, and we'll have public discussions of that work as well.

Would you put up the slide with the IOM recommendation? I just want to make sure that I am interpreting this correctly. So what page is that? 13.

As I read their findings, they're quite consistent with our recommendation, both on the appropriateness of geographic adjustment -- and as I recall the context for this second statement, basically what they're saying is what I just said about HPSA. If we have a concern about access for particular beneficiaries, more targeted approaches are the way to do that as opposed to using the adjustment mechanisms like wage index and the like. Is that the correct interpretation of this?

Okay. Oh, and the last point. You know, I think based on our previous discussions and my individuals discussions with you, I think there is broad concern about how well the current geographic adjustment works, and some of that I think is -- some of that concern is probably increased, buttressed by the analytic work that has been presented. The whole notion of tying this to reference occupations is, it seems to me, a bit problematic, and we can and should do better than that. But I believe it is possible.

I would remind you, as both the recommendation does and Kate did, that what we revert back to on January 1st is a one-quarter adjustment using the current GPCI mechanism. It's not a full adjustment.

So those are my comments. Peter, do you want to lead off here? Again, we will have only one round on this issue since we've discussed it --

MR. BUTLER: I have no comments.

MR. HACKBARTH: Okay.

DR. REDBERG: Just briefly, because you really said most of it, I think we all want to achieve enhanced access to care, but it is also clear from the work that you presented -- and thank you both for that excellent presentation -- that the current GPCI is not doing that. And so I would definitely favor letting that expire and then collecting data -- and it sounds like that's already underway -- on whether the other ways we've talked about to try to ensure physicians in rural areas the HPSA bonus and the primary care incentive, it certainly would be helpful to know how those are working or whether we need to explore yet other options. So I certainly embrace the goals of the GPCI, but clearly this is not effective, and I favor, based

on your data, letting it expire and collecting additional data.

Thank you.

DR. BAICKER: Yeah, I agree with the way -- I like the way that it's framed, that some geographic adjustment is necessary. The one we have isn't perfect, but we don't have a better one, so let's stick with current law. But let's at the same time develop the right geographic adjuster, which is something related to the cost of living but not exactly anything we have.

MS. UCCELLO: Thank you so much for the additional analysis on the reference occupations. I think I'm probably still more comfortable than most on using the reference occupations, but that said, I'm fully supportive of looking at alternatives that may do a better job. And I'm supportive of the recommendation in general.

DR. HOADLEY: Yeah, I thought this was really nicely summarized today and really brought the points that we've been making together, and including the notion of taking a better look at some of the targeting mechanisms like the HPSA.

I guess as I read this recommendation one more

time, I wonder whether we are saying that the Secretary should develop a new adjuster, and we say in the last phrase, "while the Secretary develops," we say at the top, "the adjustment should reflect," but we don't actually say the Secretary should work on -- and is that what we mean? And should we reword it slightly to more explicitly say that?

MR. HACKBARTH: Well, certainly that is what we mean, that the Secretary should develop an adjuster.

DR. HOADLEY: So we could say in that second sentence the Secretary should develop a new adjustment that would reflect blah, blah, blah, or something like that, as just a thought.

DR. MARK MILLER: You could --

DR. HOADLEY: The second sentence of the first paragraph I was looking at.

DR. MARK MILLER: I was going to go to the bottom and say --

DR. HOADLEY: You could do that, too.

DR. MARK MILLER: -- "and direct the Secretary to develop an adjuster to replace it," if you feel like that --

DR. HOADLEY: That would the other way to do it,

yeah.

DR. MARK MILLER: It might just be fewer words.

MR. HACKBARTH: Do you want to write that up while we go around? And then we'll read a revised version.

DR. MARK MILLER: If I remember it, yes.

MR. HACKBARTH: That's why I'm asking you to do it.

[Laughter.]

DR. MARK MILLER: What did I say?

DR. SAMITT: So in the prior topic, given that Michael stated this, now I feel safer to be able to say it as well, which is I don't like a third of this recommendation, but I will support it. Most specifically, I agree with what's been said, that the GPCI is flawed and we must replace it. The third of the recommendation I don't like is what we plan to do in the interim, because I do believe that removal of the floor does have a real impact on organizations that are currently below the floor, even with the one-quarter adjustment.

That being said, I recognize the policy implications of eliminating the GPCI as well as the financial implications of preserving the floor. And so it

feels like we're very much, again, between a rock and a hard place. And, thus, I will support the recommendation.

The most important part -- and I'm glad that we're going to underscore the last sentence -- is truly developing a strong methodology to replace it. And I appreciate very much the inclusion in the text about some innovative ways we can go about that, including how we can potentially even use information on physician incomes, adjusted and protected for the concerns that have previously existed, to perhaps use that as a real guide for geographic adjustment, as well as the comment of alternative ways to support rural areas, the HPSA bonus and such. So I think they help the recommendation and strengthen the recommendation.

Finally, the last comment I would make is about the last of our four dimensions, which is delivery system reform. I'm disappointed that this doesn't move that forward either, and my frank concern is about those organizations that are currently delivering value-based care that are now below the floor, and so they're not being rewarded for delivering value, and now the floor will no longer serve as a protection. And so if our intent is to reward systems that are truly delivering value, then making

adjustments such as this in a fee-for-service manner is really just penalizing the exact types of organizations that we want to reward.

MR. ARMSTRONG: I support the direction these recommendations are going and have no questions to ask.

DR. CHERNEW: I also support them, and I just sort of want to say briefly why because it is problematic.

And I think the most important thing I support is the theory of having some geographic adjustment because we're compensating individuals in terms of giving them goods and services. The prices of those goods and services vary, and therefore, you would expect that the amount that they would get paid would vary. The amount would depend on the sort of amenities and the offsets we talked about last time.

So, in the end, I think it's an empirical question, and a lot of our debate here is how to do this better empirically and what is a remarkably complex empirical challenge that I don't think we should actually underestimate.

So I think I am actually, in some ways, closer to Cori than I'm -- I'm sort of okay in some ways with the reference occupations. I'm not sure they're perfect. In

fact, I'm sure they're not, but from the data that was just presented I think there is some information there. You know. And so, I don't think would use that, but at least having that on the table when we look at these other methods.

At some point, we're going to have to look at a bunch of methods, compare them, see where they come out, and that's going to be a complicated discussion.

So I'm supportive of where we are, particularly since we down-weight the stuff we get out of there to a quarter. And I don't know if a quarter is right, or an eighth or three-quarters or something like that, but a quarter seems reasonable to me, where we are, and it certainly gets the benefit of the doubt because it's current law.

The other thing I would say is I really don't think, as a general policy principle, floors are ever particularly a great strategy. They tend not to be targeted so well. If you think that the GPCI is working above some level, why do you think it's absolutely not working below that level?

And so, the theory and the sort of spirit behind

this, of trying to target this better, I think is just substantially better than policy that tries to put in floors and worries about where people are relative to the floor.

So I actually -- I'm very much where Craig was. And exactly what he said was we can do better. We can try to do better. We're going to have to evaluate the impact of this when it comes out, and it will be an empirical question that we're going to have to investigate.

But for where we are now, it strikes me as the evidence that we will do harm in reverting back to current law is very weak, and so I'm comfortable with the way the recommendation goes.

DR. NAYLOR: I also support the recommendation. I think its alignment with IOM findings adds strength to our recommendation.

I think on the issue of delivery system reform as it was described earlier was are we on a path to getting to a more integrated system, et cetera. And I think anytime you make a recommendation where you're talking about allowing resources to be available to be redistributed, to get to a better goal, is part of reform. So I think you could make the case that almost everything that we've done

today, that that advances the kind of change in delivery system reform because enabling resources to be used for such distribution.

So I -- that may be a broad brush, but I really think they all align well.

DR. COOMBS: Yes, I agree that the work GPCI is flawed, and I don't like the recommendation, and I have hard time supporting it.

I think we have a couple of things moving at the same time, and one of the things -- thank you for the presentation.

Just the notion that there is $560 million in the Primary Care Incentive Program -- that's actually going to go away. And the HPSA funding -- you know, I don't know how long that's doable.

But I am concerned that the interim period can elapse, and we can actually -- because we're seeing that there's an access problem right now. Right now, I don't think it's equivalent to what may happen in years to come.

And I think the better plan would be to -- an extension of this process right now while there's a better tool, an adjuster to be made. Now that's in a perfect

world, and I know you can't have everything the way you want it, and I do understand that.

But my major problem right now is actually seeing that there are several moving things at one time and that the fact that you have an artificially implemented system with extra money to kind of obliterate any kind of impact that you might see once you actually remove the floor and you have simultaneous removal of capital resources into the practices within the rural areas.

Thank you.

MR. KUHN: I'll support the recommendation and agree with everybody else; it's not perfect. It's imperfect, but I think it's a reasonable way to go.

I would just make one comment, and I think this is something that both George and Tom, and I think Craig, kind of referenced it a little bit ago on the HPSA -- is kind of the impact on the rural areas and how this might be.

As we all know from the rural report that came out in the June report, or the rural chapter in the June report, we were able to kind of celebrate a little bit and talk about the fact that after a decade of hard work we had kind of reached an equilibrium between urban and rural areas

that's out there. And so, anything that might peel away from that could be problematic.

And so, I know one of the questions I asked at the last meeting was, is there -- would there be appropriate to think about a transition in this recommendation, but I think the data that we had showed last time that the differentials were so small, only about 2 percent, that it really was not that impactful as part of the play.

And so, I agree with the way we've kind of laid this out. More targeted areas through the HPSAs or through other HPSA bonuses, other things, are probably more appropriate in the rural areas than kind of messing with it or trying to move this, which is such a small percentage kind of adjustment.

So I continue to be wary about that, as George and Tom are as well, but I think this is a reasonable place to come out for now.

DR. HALL: I support the recommendations.

DR. DEAN: I have some serious concerns about this for the reasons that have been laid out, especially what Herb just said and what Craig said. I think this is really a flawed approach.

Part of it is that when we -- my experience in trying to recruit professionals to an area that's difficult to recruit; it's much more complex than dollars. And I live in a relatively low cost of living area, and yet the salaries we have to pay are probably significantly above average. And so, these kinds of formulas, I think, are just going to be misleading.

So I guess that I can grudgingly support the recommendation as long as -- to follow up on what Jack said -- as long as we really emphasize that this is poor approach and that we need to look for better approaches and that there needs to be some emphasis and some urgency about that.

MR. GRADISON: I support this, but I just want to share a thought that's been growing on me more in the last few years than earlier, and that is my hunch, more than a hunch, that it's really impossible to come up with fair formulas, centralized decision-making in this health care area for a country as large and varied as the United States of America. I don't know a country as large as ours that has done it yet.

And I think back to when I was a kid and became aware of numbers -- you know, 10 or 12 years of age -- the

population of the United States was 135 million. It's around 315 now. Within the lifetime of my younger kids, it could easily four or five hundred million. And the notion that folks as smart as we have around this table, and in the Congress and in the profession, are going to be able to come up with centralized decisions that are anything more than rough justice, I think is exceedingly doubtful, and I use this as a case example.

MR. GEORGE MILLER: I think Bill hit part of what I wanted to say very well, but conceptually, I support what I've heard around the table. Conceptually and in a perfect world.

But a lot like Tom, and what Herb alluded to and what Craig mentioned, I'm really concerned about the impact that this would have on recruitment for rural areas -- my bias, obviously.

I'm a rural hospital CEO and recruit positions, and I've never had one say yet, what's the GPCIs, when I try to recruit them. But they will tell me: Well, if you don't pay me X, the guy down the road in Tulsa will pay X plus-plus-plus. So what is it that you have in the community?

And we try to sell all the amenities and the great

things of living in a small, rural community that's not hear the Gulf of Mexico.

[Laughter.]

MR. GEORGE MILLER: I think over time that this has been the equalizer. And the report rural -- I think it was Herb who mentioned the rural report. We can look back and say this has been the equalizer for us.

This is a complex issue. You know, I struggle with it. Philosophically, I understand. I understand the arguments all around the table, but as another colleague said, for those of us who live in the real world, this is just difficult to vote for. So I'm torn.

We all agree that the GPCI is flawed. And I would love to see what would replace this, what we're going to put in place to make this work first because I'm afraid that we would lose some momentum by -- and, again, I fully understand the rationale, but I'm real, real concerned.

And with the recommendation, it says the Secretary will, but it doesn't say the Secretary will by such and such a date. So are we going to be back here next year or the following year before the Secretary puts this in place?

I don't know if we want to put -- I don't know if

we can tell the Secretary when to have this done by. But we know when the law expires, but we don't know when that new mechanism will be in place. And so, there could be some considerable time, and then we then lose the momentum, especially in the rural areas.

So I'll leave it at that.

DR. DEAN: I have one more -- slide 13 again. It almost seems to me that there's a conflict between those first two recommendations -- that on one hand there should be a geographic adjustment, but on the other hand, if we're talking about overall national policy goals and access, there shouldn't be a geographic adjustment.

MR. HACKBARTH: Yeah, that's why I asked Kate to clarify this.

DR. DEAN: Okay.

MR. HACKBARTH: So let me get the right page.

So, in the second bullet there, the reference to payment adjustments related to national policy goals -- that would be like improving access.

DR. DEAN: Right.

MR. HACKBARTH: And so, efforts to improve access should be made through a separate and distinct adjustment

mechanism like HPSA as opposed to by putting in floors, limits on wage index adjustments, et cetera. That was when you read this context.

DR. DEAN: But, in fact, that's what we're doing, isn't it, with this recommendation?

MR. HACKBARTH: No. So what they're saying is that if you're worried about rural access, for example, as a national policy goal --

DR. DEAN: Right.

MR. HACKBARTH: -- don't jigger with the wage index, the GPCI, things like that. Have targeted policies like HPSA. And that's what we're saying or proposing.

DR. DEAN: Yeah, I don't agree with that.

MR. HACKBARTH: Yeah. And that's why, as I said at the outset, I think it's important for us now once we finish this to turn to: How well are those targeted mechanisms working? Can they be improved? Can they be made more robust?

Okay. Anybody else?

Okay. So would you put up the recommendation?

All in favor of the recommendation, please raise your hand.

[Hands raised.]

MR. HACKBARTH: All opposed?

[Hands raised.]

MR. HACKBARTH: Abstentions?

[No response.]

MR. HACKBARTH: Okay. Did you them all?

DR. MARK MILLER: I think so.

MR. HACKBARTH: Okay. Thank you very much. Good work.

Okay. So we are now to our last session for today, and this has got a long title. It focuses on the effect on the prices charged by providers to private insurers from the effect on that of Medicare pricing, right Jeff? Did I get that sort of right?

DR. STENSLAND: You got it right.

MR. HACKBARTH: Yeah.

DR. STENSLAND: So, first, I'll start out to say Carlos couldn't be with us today, so Scott is going to be here to handle the tough questions.

Over the past year, we've been discussing issues related to benefit design. In our June report, the Commission recommended a series of improvements to Medicare

fee-for-service that would limit beneficiaries' out-of-pocket costs and encourage better decision-making on the part of beneficiaries.

In September, Julie and Scott discussed private plans and issues regarding different types of competitively determined plan contribution frameworks, what we called a CPC framework. And a CPC framework is where a Medicare plan and beneficiary contributions are determined by a system of competitive bidding.

A key issue for both Medicare Advantage plans and for any future private plans is the cost of the plan relative to current fee-for-service.

Today, we examine the rates private Medicare Advantage plans pay hospitals and how these rates can affect the cost of private plans.

In terms of the motivation for today's discussion, we start with the concept that the cost of private plan insurance, such as an MA plan, is affected by rates plans pay providers. All else equal, higher provider rates will generally lead to higher plan premiums.

Today, we look at the experience of Medicare Advantage plans.

First, I will discuss the rates MA plans pay hospitals relative to the rates commercial insurance plans pay hospitals.

Second, we will discuss factors that may affect the rates Medicare Advantage plans pay hospitals. For example, MA plans must compete with Medicare fee-for-service, and that may affect rates. In addition, there are limits on rates for emergency services which can affect price negotiations, as we will discuss.

There are a couple of key facts to start with. First, data from the American Hospital Association show that Medicare fee-for-service hospital rates are roughly 30 percent lower on average than private insurer rates. Of course, this varies by market and by hospital. In some cases, Medicare is one of the better payers, but private insurance usually pays hospitals higher rates than fee-for-service Medicare. On average, commercial rates are much higher than fee-for-service rates.

Second, on average, hospital payments represent 30 percent of fee-for-service Medicare expenditures. Because payments to hospitals are a material share of an insurer's costs, the rates insurers pay hospitals can affect MA plan

premiums.

Therefore, if MA plans paid commercial rates to hospitals, MA plans would be at a significant competitive disadvantage with fee-for-service. Beneficiaries would not choose MA plans if MA premiums were significantly higher than premiums for fee-for-service benefits and supplemental insurance.

So the question arises, what rates do the MA plans pay hospitals? To examine rates MA plans pay hospitals, we took three approaches.

First, we examined MA plan bid data. This is data MA plans submit to CMS. The plans project the costs of providing Part A and Part B benefits to the beneficiaries in their private plans. These bids will reflect the rates that Medicare Advantage plans pay hospitals.

Second, we examined financial data from hospitals on the relative profitability of Medicare Advantage patients compared to fee-for-service patients. If hospitals receive higher payments for MA patients, then profits on MA patients should be higher than on fee-for-service patients.

Finally, we report on findings from interviews by the Center for Studying Health System Change as well as our

own discussions with market participants who are familiar with the contract negotiations between MA plans and the hospitals.

Our first source of data was MA bids. Each MA plan reports the experienced -- expected expenditures for Part A and B services. If the MA plans paid the same rates as are paid for commercial insurers, then we would expect higher MA bids in markets where hospital prices for commercial insurers are high relative to fee-for-service.

The full regression results are in your mailing, and we can discuss those on question if you like, but the bottom line is we failed to find a strong relationship between commercial, private prices and MA plan bids. This implies that MA plans do not pay the same rates as other private insurers.

Next, we look at the issue from two other angles to see what are the MA plans paying hospitals and what are these rates anchored to.

The second source of data was financial data from hospitals, and we found that profit margins on MA patients were roughly equal to profits on fee-for-service patients. This suggests that MA rates, on average, are close to fee-

for-service rates.

The third source of data were the market reports from the Center for Studying Health System Change and our own conversation with the participants in the market, and these confirm that hospital payment rates are generally anchored to Medicare fee-for-service rates.

The net implication of this is that MA rates -- MA plans appear to pay hospitals rates that are roughly 30 percent lower than the average rate paid by commercial insurers.

So the natural question is, what is the difference about the negotiation dynamics that allow MA prices to be 30 percent lower than other private insurer prices?

The first point is that MA plans must compete with fee-for-service under the current system. If MA plans paid commercial rates, they would have to raise Medicare Advantage premiums. If this bid was above the MA benchmark, then beneficiaries would have to pay more to join the MA plan than they would to stay in fee-for-service. So, to keep the prices beneficiaries pay competitive with fee-for-service, MA plans must keep prices they pay hospitals close to fee-for-service prices.

Second, MA plans are in a strong negotiating position to keep the hospital payment rates close to fee-for-service. By statute, if a hospital does not come to terms with an MA plan, that MA plan only has to pay the hospital Medicare fee-for-service rates for out-of-network emergency services.

This is important because over half of Medicare beneficiaries enter the hospital in-patient department via the emergency room. Due to these emergency department price protections, the plan is not at risk for high out-of-network prices, and beneficiaries are not at risk for being balance billed for full charges. And this is not always the case in the commercial market.

The net effect of these two factors strengthens the MA plan's bargaining position and weakens the hospital's bargaining position relative to the position they are in when negotiating commercial rates.

So this is just an illustration of how hospitals have less of an incentive to negotiate with commercial insurers than they do in the MA context.

In this illustrative example, you can look at the first column, and this is the most extreme example -- a

closed HMO that owns its own hospital, such as Kaiser in California. This type of hospital would have close to zero scheduled admissions to outside hospitals.

So outside hospitals contracting with a Kaiser-type HMO would only expect to get emergency visits and emergency admissions. The hospital has very little incentive to negotiate with the HMO. It could just bill full charges for patients entering the ER and then balance bill the patients to the extent the HMO does not pay.

Because charges are so much higher than negotiated rates, the hospital may be better off just billing the full charges of $3 million, in this example, even if the portion of the 3 million ends up as bad debt.

And this was a strategy some hospitals took in California up until 2009. In 2009, the Supreme Court interpreted existing California statutes as saying that for emergency services the hospitals can only bill HMOs usual and customary rates and are not allowed to balance bill patients.

Other states, such as Florida, have offered similar protections due to similar concerns. However, there are many states where these protections are not available in

the commercial market.

Now, as you can see in the second column, a hospital has a stronger incentive to negotiate with a PPO plan, but the PPO plan still has some leverage if it can bill full charges for ER services if the PPO fails to come to an agreement with the hospital.

As I said, hospitals will still usually want to negotiate due to concerns over bad debts if they bill full charges, but this illustrative example should provide some intuition as to why hospitals may be able to drive a harder bargain with commercial insurers than they can drive with MA plans.

The purpose of this next slide is just to show that the importance to plans and to beneficiaries of avoiding full charges is increasing over time. This is because over the past 12 years, average markups on hospital services increased from roughly 100 percent to over 200 percent. What this tells us is that the benefit to the beneficiary from being protected against full charges for emergency room visits is increasing and the price protections may have a bigger and bigger effect on the negotiating process.

So one question is whether MA plans could still get the current levels of prices they're receiving from hospitals even if there was not fee-for-service competition and there was not any out-of-network price protection.

Would prices fall this much if there was simply more competition amongst the hospitals? And the literature shows that hospitals with large market shares tend to get higher rates from insurers. So, if there was a reduction in each hospital system's market share, rates would be expected to decline.

In recent years, the FTC has had some success at slowing down the rate of increase in each system's market share, but I'm not aware of any actual movement seen toward increasing competition.

To actually increase competition, that would require either building more hospitals or breaking up hospital systems. And I've not heard of anyone calling for the construction of more hospitals as a mechanism for reducing health care costs, and I've not heard of any calls to break up any of the well known hospital systems either that we're familiar with.

There has been some success with ACOs making

physicians more price conscious in their referrals, and there has been some success with tiered networks making consumers more sensitive to price. But there's been very little success in actually reducing hospital systems' dominant market shares.

Nevertheless, what if we could see an increase in competition?

What would that mean for prices?

How much lower would average prices go if hospitals markets are more competitive?

Our analysis in your paper indicates that hospital prices are 9 percent lower on average in markets where insurers have much more market power than hospitals. Our measures of market power are imprecise, and so the 9 percent measure we use is certainly imprecise, but I think the point is that that's substantially lower than the 30 percent differential we see in the data between the MA plan payment rates to hospitals and commercial insurer payment rates to hospitals.

So, in summary, provider rates affect insurance premiums, as we all know.

Hospital prices are roughly 30 percent lower for

MA plans, on average, and this may be due to a combination of 2 factors -- first, MA plans must compete with fee-for-service, and second, MA plans and beneficiaries benefit from out-of-network price protections. We cannot be sure which one of these factors on its own could keep prices at their current levels, if one on its own could.

Finally, competition tends to result in lower prices, but it's not clear that we can generate enough competition to bring market prices down to the level paid by MA plans.

And now, we'd like to open it up for discussion. Many of you have experience either working for an MA plan or working with a provider who has negotiated with MA plans. We'd like to hear your thoughts on how fee-for-service competition has affected the rates MA plans pay providers and the premiums charged by MA plans. In addition, we'd like to hear your thoughts on how price protections that MA plans have had for the past 25 years have affected price negotiations between MA plans and providers in the past.

Now we'll open it up for discussion.

MR. HACKBARTH: Okay. Thank you.

Craig, do you want to go first?

And, here, we'll have our usual two rounds. So first round is clarifying questions only. No?

Scott.

MR. ARMSTRONG: So somewhere in here is a question. You talk about how market share influences the ability to negotiate rates, either hospital share or insurer share. And then, you talk about the concerns about a difference between fee-for-service rates and the Medicare program has kind of like ultimate market share or at least authority to set rates.

We're wondering how can this future that looks kind of more like MA compete effectively to manage these provider rates, but we're comparing today's MA experience with fee-for-service when MA is really only 20, 25 percent of the overall market share. In this future we're talking about, wouldn't these plans have much more market leverage?

And so, I'm just wondering if that's really a great point of reference for us.

I told you somewhere in here was a question. I'm not really sure how to get at it, but it really kind of challenges the underlying concern about the 30 percent gap that exists because it's comparing today's market dynamics

to a hypothetical future that would be very different.

MR. HACKBARTH: So a question that I think is in there is, if the share of Medicare beneficiaries enrolled in private plans were to increase substantially, would that make it more difficult for private plans to command lower rates or less difficult for them to command higher rates? Lower rates, excuse me, from hospitals.

MR. ARMSTRONG: I think it would make it less difficult. It would put the plans in a better position to negotiate lower rates.

MR. HACKBARTH: Yeah. So sort of a standard analysis might be that as they get more enrollees they've got more leverage in the negotiation.

MR. ARMSTRONG: Right.

MR. HACKBARTH: All other things being equal, that would equate to lower rates.

On the other hand, if they become a larger share of a hospital's business and granting lower rates means a more dramatic hit on the overall revenue coming into the institution, it might give a low rate to a small fish that you will find difficult to give to everybody would be an alternative scenario.

MR. ARMSTRONG: Right.

MR. HACKBARTH: So I truly meant it as a question. Which way does it cut as MA enrollment increases, Jeff?

DR. STENSLAND: I think we do have some data in the paper. The stuff that we did on market concentration is clearly crude measures, but we have the hospital market share in there, and then we also have another thing I didn't discuss in the presentation, of the insurer market share.

And, if we look at prices, when the hospital dominates the insurer, we see they are about 9 percent higher. If we look at prices when the insurer dominates the providers -- and these are cases where they might have 80 percent of the market share in the state, the single insurer -- we see prices, on average, that are 9 percent lower than average. So you have this 18 percent spread there from hospital dominance to insurer dominance.

So maybe we could get more than the 9, but I don't know if we're going to get to the 30. And then, of course, we're saying this is the prices the hospital pays.

Now there is some work by Daphny that suggests, well, if the insurer has market dominance and they have 80

percent share, they might not pass all of those savings on to the beneficiary in terms of their premiums. They might keep some of that.

There's also the question of these are markets where the insurer dominates by having an 80 percent market share, and even if managed care as a whole has lots of market share, lots of -- I mean lots of people are in MA plans. The individual MA plans might not have big market leverage on their own because they only each have a little, teeny slice of it. So you might not see that full 18 percent that we saw in our regression results.

And I want to say again that, you know, this is -- I'm certainly not hanging my hat on 18 percent because our measures of market concentration are really imprecise, but that gives you some sort of a flavor for that differential.

DR. COOMBS: Yes, I was thinking about the cost variation studies that the attorney general in Massachusetts did, Martha Coakley, and just looking at the private market and some of the indicators that they had that were outside of just patient care.

You know, on your slide 8, I was thinking about the whole notion of one of the impacts of the states where

there's no balance billing. How do you predict, you know, if there was a CPC intersecting with the areas where you have, say, a 60 percent private market from a single player, almost a monopoly in terms of -- monopolistic, if you will. How would that play with a new product like the CPC?

DR. STENSLAND: I don't think I'll try to speculate on a new product, but we can look back at the MA plans and see what we have learned from those.

And at least we do see -- when we looked at -- there are some markets where you have both big insurer positions, like you're saying if an insurer has 60 percent market share, like they might in Massachusetts, and some big provider share. In some sense, those two things somewhat offset each other in our data.

DR. COOMBS: That's exactly what it is. It's matched by, you know, a dominant player on the provider side and a dominant player on the insurer side.

DR. STENSLAND: In those markets, we tend to see, on average, average market prices compared to the rest of the country.

Of course, within the market, I think, as you know, the attorney general said there are widely different

prices depending on the individual hospitals' market shares and some getting much lower payments than others.

DR. COOMBS: Thank you.

DR. HALL: I think you may have answered this. This is about market share. Let me just try one scenario here.

What about a community that has a dominant provider -- I mean a dominant hospital system, let's say, and has -- at the same token, there's one dominant MA program. How does this balance out?

I guess I'm thinking really more of, say, Florida or certainly some parts of my state that have this situation.

DR. STENSLAND: As far as we can tell, at least from the people we talked to, if you're talking MA plans, those MA plans are generally still following the prices that fee-for-service pays. So even though it's a big MA plan and it's a big hospital and a big insurer, they really are still following those fee-for-service rates. And maybe that's because they can't really move those much higher or they lose their people.

DR. HALL: They can't move them. That was my

impression, right.

DR. STENSLAND: And there are some other nuances in the rules that are in the paper that I won't get into, but I think that's the general perception.

Now, of course, in the private commercial market, it's going to be a different scenario, where those -- you know, we certainly have examples of those must-have hospitals extracting very high prices in certain markets.

MR. GRADISON: [Off microphone.] Fascinating. Very fascinating. Thank you.

MR. GEORGE MILLER: Yeah, fascinating. You asked the questions. We've had the experience. What you've just described is normally the case in our experience, that -- not on the commercial side but on the MA side.

And one of our concerns, especially being small rural hospitals, is if they will pay us what Medicare fee-for-services would pay. So, fascinating.

DR. NERENZ: Yeah, it seems like if I'm following this correctly the real meat of the discussion is near the end of it, and I'm thinking particularly about slide 10 because other than that it's pretty straightforward. If you assume that MA plans are going to have to pay higher rates

to hospitals, inevitably, the premiums go up. It seems like that follows.

The question would seem to be, will they indeed have to do that, or under what circumstances will they have to do that?

And I think you've done a nice job of talking about the leverage and market dynamics and negotiation.

I guess I'm trying to imagine the scenario a step or two with the chess game further ahead. If we imagine that fee-for-service has gone away; there is a set of plans; they're negotiating. And let's say imagine that as a first step they do indeed have to go up to what are currently private insurance prices. I think the net immediate effect I would just call a hospital windfall.

I mean hospitals are treating the same patients, but now they're getting paid more money.

Now the question is, do you assume that there is no additional market pressure of any kind that would then result in some down pressure on those increases, or do those windfall increase payments just ride forever into the future?

DR. STENSLAND: I think that's pretty complicated.

The only thing I would add into that dynamic is what we have seen in terms of our past work on financial pressure is when that windfall money rolls in that money can be spent because there's often the hospital system can think of good things to do with that money. And then once they start spending the money, then there's an incentive to keep those rates up so you can keep on doing the things you're doing.

DR. NERENZ: Understood. Understood. And I'm just trying to think through those steps because up to that point this is pretty straightforward. And I'm just sort of asking you to speculate, because you probably have speculated, about what that looks like.

The scenario you just described is certainly possible, but I'm also wondering if somewhere then in the resulting negotiating dynamics with whatever plans are active, with whatever leverage they have, is there not some power that produces some return back, meaning some later reduction in those prices.

MR. HACKBARTH: Dave, can I ask a question there?

I'm not sure how we get to the scenario that you're describing where the MA plan is paying much more than

Medicare fee-for-service rates.

DR. MARK MILLER: He said fee-for-service goes away.

MR. HACKBARTH: Oh, I'm sorry.

DR. NERENZ: That's the number one assumption in this whole discussion.

MR. HACKBARTH: So let me just make sure that I understand. So your opening assumption was Medicare fee-for-service goes away? Is that --

DR. NERENZ: I'm looking for the bullet point where it I think makes that statement. Is that not the hypothetical here?

DR. MARK MILLER: I mean, I took his -- I took your question as this: Given this analysis, which does not suppose that fee-for-service goes away, but you were saying, given this analysis, if fee-for-service went away, the MA plan payments to providers would go up. Just yes or no at that point?

DR. NERENZ: Yes.

DR. MARK MILLER: Okay. And then, the second part of your question was, would they stay up, or would there be any countervailing pressure to bring them back down? And

you asked Jeff to speculate about that.

DR. NERENZ: Also, yes.

DR. MARK MILLER: Okay. And what I would have thought Jeff would say was I do know a little bit about this.

And, Jeff, it's the 9 percent point, I think.

To the extent that we've seen a countervailing, you know, market pressure, an insurer-dominated market, there might be some pressure, but it's not going to offset that full amount.

DR. STENSLAND: The insurer situation would be something that's already kind of baked into the baseline.

The only thing I could think of; I think the story you're talking about might vary very much depending on the different markets. If you're in a market where there's only one hospital or two hospitals, you might really not see anything happening, especially if maybe they dominant all of the -- maybe they employee all the doctors in town also. I think you wouldn't see anything happening, but I could see maybe a little pushback in some markets.

And maybe Mike would have some opinion when this flows around to him on places maybe like Boston, where if

you do have these extra higher profits available and you have some ACO models or something where the physicians might be able to, you know, leverage their influence over where their patients go in terms of their referrals if someone gives them a lower price. Maybe you could see some increase, bringing that extra profit down a little bit through that kind of mechanism, but I think it would really depend on the individual market.

DR. NERENZ: Okay. Well, I just had to go back through my own thinking. I may have made an assumption that you actually didn't put in front of us, but as I look at the bottom bullet on slide 3, that is the hypothetical you're giving us -- if MA plans paid commercial provider rates.

And I was just trying to imagine under what scenario would that actually happen.

And then, the scenario that came to mind was, well, you pull the fee-for-service anchoring out of it, and that's why such a scenario would occur. But perhaps that's not why it would occur.

But then I would wonder why else would it occur.

MR. HACKBARTH: Yeah, yeah. So, just to be clear, Dave, the reason for my question is the whole purpose of

this analysis is, in fact, to think about how the negotiating dynamics and rates paid would vary under different scenarios.

But I just want to be clear, though. We're not assuming that Medicare fee-for-service goes away. That's a scenario you can think through what the implications would be, but we're not accepting that as a given in this analysis.

DR. MARK MILLER: Can I just -- oh, I'm sorry.

So back to you, in your hypothetical, you're correct. If that anchor is removed, you would expect on the basis of this analysis that Medicare payments -- expenditures would go up because the rates that would be paid to providers would go up and the premiums would have to go up. And so do you see any countervailing force that would drive them back down?

DR. NERENZ: That's why I asked for other smart people who have been working on this to --

DR. MARK MILLER: [Off microphone.] And our last slide was asking you guys --

DR. NERENZ: Well, but I just -- it just -- I was just envisioning the scenario where you have multiple plans

and at a first step, their payments to hospitals have gone up. But now, if that's true, then hospitals have received what I'll call a windfall and now I'm looking for the next year. Is there not some negotiating traction that at least one or two of these plans have that would sort of have selective contracting with one or two hospitals who are willing to give back some of that windfall in return for higher volume. And I'm just speculating on that kind of dynamic, but I --

MR. HACKBARTH: So the dynamic would vary by marketplace, and how many hospitals there are, where there are must have hospitals, whether plans are prepared to go to limited networks, whether they can sell limited networks in that given market, and you potentially get all sorts of different configurations based on those dynamics.

DR. NERENZ: All true. Very complicated.

MR. ARMSTRONG: Glenn, one quick point. So this was behind my point earlier, was that if you shift so that 75 or 100 percent of the Medicare business is going through these private plans. That also would really shift the dynamic in that negotiation with the local hospitals. I mean, I agree with your point. There are a lot of other

variables that would change this, too. But I think that is one view.

DR. CHERNEW: But 100 percent in one MA plan is different than ten percent in ten MA plans.

MR. ARMSTRONG: True, but going from 25 percent to something closer to 100 percent will change regardless of the hospital their relative position in those negotiations.

MR. HACKBARTH: [Off microphone.] Okay. Clarifying questions.

MR. BUTLER: So I was going to drill down on this nine percent thing, too, and ask if -- you made reference to do the insurers that are able to extract nine percent lower fees pass along the savings. You could look at medical loss ratio. You could look at -- do you think there's data that we could get at that would be able to give a reasonable estimate of per capita spending under the commercial market versus the -- so you get your answer to your question, because that would be an important piece of information.

DR. STENSLAND: I think I'm not very optimistic on how well we can do that. There is a paper out there by Dafny, and I don't remember all the details, how basically she was saying that they don't give it all back. But I

think if we actually went through that exercise of trying to figure out what's happening in the commercial markets, I think it would be a big exercise. I'm not sure we would want to go there.

MR. BUTLER: You're always up for big exercises.

[Laughter.]

DR. CHERNEW: I think she says, in fact, that the price -- if you consolidate amongst insurers, hospitals get paid less, but actually, the customers get charged more, which is loosely consistent with theory, incidentally. That's what she says.

MR. BUTLER: So the total cost to society and those paying the bills is higher --

DR. CHERNEW: Right, because you basically have a monopsony in the market for the inputs --

MR. BUTLER: Yes, well that's --

DR. CHERNEW: -- and your monopoly in the market that you're selling stuff.

DR. STENSLAND: And I just want to say, there's not a -- at least, I didn't see a huge literature on this, where there's a lot of other papers doing this. And it's not the simplest paper, what she's doing. So I wouldn't

completely hang my hat all on this one study, but that is the direction the one study goes.

MR. HACKBARTH: Rita, clarifying questions.

DR. REDBERG: Yes. I wanted to go back to Slide 9. I found this slide of mark-up of charges over cost, because that's been quite an increase, it looks like, from 1998 to 2010, and did you have any more feeling for what was going on there? I assume there was some geographic variation, maybe States near the Gulf of Mexico but not Oklahoma would be higher charges over cost, or other things. What was driving that huge increase?

DR. STENSLAND: I could speculate on different things, but there's wide variation across the country and there's variation from hospital to hospital. Probably some of the lowest mark-ups are in a lot of little teeny small towns, and maybe you could see this. You know, you think of a little small farming town where the farmers are on the board of the hospital and they don't have insurance and what are you going to do. Some of the biggest mark-ups of all are actually in California. That's where they tend to really have high mark-ups over charges.

And generally, I think, what people say was

driving a lot of this thing, the two main things we hear are people still getting paid discounts to charges on certain procedures, especially outpatient and thinking, well, we need some more revenue. What are we going to do? Okay, we'll move up our charges. And some people saying that, in some cases, the hospitals are maybe willing to go along with this because it makes it even more important for you to buy insurance from them, because one of the services they provide is they negotiate a price, and if their price is now one-fourth of the charges, well, then that insurance becomes more valuable because they've really been able to negotiate a much lower price.

DR. REDBERG: California in all the systems, like Kaiser and the private and nonprofit, or --

DR. STENSLAND: There's a lot of variation in California, but, on average, the mark-ups are bigger. And I'm not so sure about Kaiser. We don't have a lot of Medicare data from the Kaiser people because they don't do a lot of fee-for-service business. But in the other nonprofit, for profit, both in California, they tend to be some quite high mark-ups.

MR. BUTLER: If I could just ad quickly, you know,

virtually nobody pays these. It's like just a teeny part of your business that you're still trying to squeeze what you can out of somebody on a discount. And even those that don't have insurance or are under even four times the poverty level, typically, there are automatic discounts against these charges. So this is a dying -- but it is still some of the differences that you have been talking about. It's not irrelevant by any means. It just looks a little simpler than it is.

DR. STENSLAND: And just to reiterate what Peter said, under PPACA, if you are under commercial insurance and you are eligible for discounted care because you're poor, under whatever level of poverty, the hospital can't charge you full charges. It has to charge you a reasonable and customary rate. But you could be somebody with private insurance and you go into a market and you have an accident there and there's no contractual negotiation with the hospital. Then there's a potential that you might end up having a really big price tag.

MR. GEORGE MILLER: That, again, like Peter said, is so small. At my shop, for example, I'm 72 percent Medicare and Medicaid, ten percent commercial, and about

five percent self-pay. So nobody -- very few of us, few hospitals, get paid those type of numbers. I mean, we're talking about ten percent of my total revenue, $40 million.

MR. HACKBARTH: Okay. Kate, clarifying question.

MR. GEORGE MILLER: That doesn't mean they pay it. That means I charge it to them. It doesn't mean they pay it.

[Laughter.]

DR. BAICKER: Duly noted.

[Laughter.]

DR. BAICKER: So this is really interesting, and understanding why they're paying less, why MA plans are paying less, seems at the heart of the problem in understanding what reforms are going to do. You mentioned two factors, two potential explanations that are hard to disentangle and I had a question about each of them.

One was the sort of back-end protection against emergency charges out-of-network, and I didn't have a sense of how big the magnitude of that might be. You know, if you did sort of a bounding exercise and said, assume that that's passed directly through, my intuition would have been that that can't explain the majority of it, that it has to be a

fairly minority share of that. But it would be helpful to know how big could that possibly be.

And then the second channel was because they still have to compete with fee-for-service, then they have this extra negotiating clout. That story seems to me, you know, if we're going to believe anything about economic theory, should only work in a world where they're negotiating in a non-competitive market. But it shouldn't matter what -- that fee-for-service is an option if they're -- insurers are competitive and hospitals are competitive, but they're not. And so the nine percent number that you showed, I interpreted to be overall in insurer-dominated markets, payments were nine percent less.

But maybe an important complementary figure to that would be the interaction effect between the degree of competitiveness in the hospital market and the differential between the MA plans and the commercial plans in the sense that if the MA plans are able to exploit or able to use the fact that their enrollees have an outside option, they should be able to use that fact more in a situation where negotiation matters as opposed to a perfectly competitive market. So that wedge should be -- if that's part of what's

going on, I would think that the wedge effect would be bigger in the least competitive hospital markets. Now, we all know theory only works out 50 percent of the time, so we'll see if that's actually true, but that's what I might have guessed.

That's more of a request for more information than a question, I realize.

MR. HACKBARTH: Cori.

MS. UCCELLO: My head is still spinning from her question, so --

[Laughter.]

DR. BAICKER: Wasn't it perfectly clear?

MS. UCCELLO: Well, my head is not clear, so I think that's the problem. So I'm not sure there's overlap here.

I mean, clearly, the local market dynamics are playing into things. But I know -- I'm going to channel some other people, not necessarily me -- in thinking about the role that cost shifting has in this and that 30 percent that we're looking at, is that actually less than 30 percent if there's higher --

MR. HACKBARTH: [Off microphone.] Which 30

percent --

MS. UCCELLO: I'm not sure. Thirty percent --

MR. HACKBARTH: [Off microphone.]

MS. UCCELLO: The 30 percent differential between the pre-65 commercial and the fee-for-service. If the Medicare rates kind of go up, if there's less cost shifting, then we're looking at less than 30 percent.

My major question here is to what extent is cost shifting an issue here, aside from the local market dynamics, because I think there are a lot of people who still think that cost shifting, the lower rates paid by Medicare are increasing the commercial rates, which, again, it's tied into the local market dynamics, but -- I'm sorry this isn't clear.

DR. STENSLAND: Let me just -- the basic fact -- this is what people are telling us, that whatever your commercial rate is, going up and down, depending on what your market power is, the MA rate is sitting here at fee-for-service. So if you have a little bit of market power, fee-for-service is here and you're here. If you have a lot of market power, you're up here and fee-for-service just stays there.

So then the question of that cost shifting. I think the way most academics talk about it is if there's some exogenous shift in the Medicare price up or down, what happens to the private prices if Medicare exigency has a rule change and things go down? Do private prices go up? And I think the evidence there is really mixed. Maybe it does go a little bit of cost shifting, or some other studies say, no. But really, they seem to be following Medicare, like they kind of follow the lead of Medicare. So that's mixed.

I think what's a lot clearer, at least from the work that we did here a few years ago, is that it doesn't look like people are charging the higher rates just because they have to. This idea that I'm only going to charge these high rates because I have to. If I don't have to, I'm not going to charge them. And I think that part of the story really falls apart when you look at the data, because you look at the people that are really charging the high rates. Those are people with lots of money in the bank. These are the people, like, with the billion-dollar endowments. And if you look at the people that are getting the lower rates and have the lower costs, those are the people with the

eight-dollar endowments. And so I don't think it's the ones that have no money that are the ones that are charging the higher rates.

MS. UCCELLO: I think that there might still be, maybe not in the community that is writing some of these papers, but I think there is a perception out there that that still is a big part of this. And so the extent to which this work can kind of address that and maybe refute some of that, I think would be helpful.

DR. MARK MILLER: Yes, and I think it is worth repeating, and maybe for some of our new Commissioners we can do this again in December. I don't know how much time we have. But I believe you're correct. The perception is very widespread and I encounter this in every room that I walk into, which is no, no, no, this is about cost shifting. Medicare doesn't pay enough. We have to charge more. And we feel that we've shown pretty convincingly for many years that that's not the case, that the people getting the highest rates are the people who are engaged in this and that that's driving costs up in the system much more broadly and that, in a sense, it's almost the reverse problem, that that cost makes Medicare margins look worse.

And so I do understand what you're saying and I do understand that this perception is very widespread. We have kind of rejected that argument, and I'll tell you, every room I go into, I mean, I have to do it over and over again because people are still carrying that around.

MS. UCCELLO: Yes, and I just want to be clear that I'm not talking for myself. I'm just talking about people --

DR. MARK MILLER: [Off microphone.] You said channels --

MS. UCCELLO: Yes, other people --

MR. HACKBARTH: And on this issue -- I think Jeff was alluding to this -- there's been a fair amount of empirical research on this over the years, and Austin Frakt from BU just did a review of all of the available empirical research on cost shifting and his conclusion based on the research was there may be some that exists, but it's way less than that conventional wisdom that you're referring to States, and that's broadly consistent with the sort of work that we've done, as well. There's a lot of urban legend here.

MS. UCCELLO: And I think the point here is that

as we discuss these kinds of things, using it as another opportunity to highlight that would be useful.

DR. SAMITT: Round two. So I'm not sure what question we're supposed to be answering, so if my answer isn't right, just ignore it. But, you know, in the universe that I'm in, in response to the specific question, if Medicare fee-for-service did not exist, would we see rising prices in Medicare Advantage, my guess is no. In the universe that I'm in, I think we're hearing two phenomenons.

One is if you speak to most hospitals, many hospitals, the prevailing perspective is that they will need to learn to manage at Medicare reimbursement levels, that's it, for all of their payers. So their presumption is they need to bring their cost structure down to Medicare rates, and I'm hearing that more and more and more. So I think that while that chart shows rising charges, there is an overwhelming sense that there is going to be no more revenue.

The other phenomenon, though, is I think we've just begun to see enhanced competition between providers for quality and cost. So even in markets where there is mono -- it was a word you used, I'd never heard of it --

DR. CHERNEW: Monopsony.

DR. SAMITT: Monopsony -- even in an environment where there's a monopoly, I don't think those will prevail for long. I think there are organizations that are stepping into the value path, and we've mostly concentrated on discussions of unit cost whereas I think the greatest opportunity to manage under an MA plan is utilization cost. So I think there are going to be organizations that will come in, will seek to focus on wellness and utilization reduction, and aggressively compete as an MA plan, and that's their mechanism of preserving reimbursement levels to hospitals, because they're bringing the utilization cost down.

So it's great to have a safety net of Medicare fee-for-service to just assure that that doesn't happen, but my prediction is we'll see bids come in lower than Medicare fee-for-service because systems, hospitals and others, will not be able to survive otherwise in an increasingly competitive environment. That's -- you know, coming from the commercial side, I think that's what we're seeing on the commercial side. So why would we not think that would happen on the Medicare side?

MR. ARMSTRONG: So I would actually just start by echoing a point you just made, Craig, that this is a conversation that's focused on price per unit of service and, in fact, we do pay Medicare rates for MA hospital services. We pay higher rates for commercial services. I don't know if we are able to do that because of the presence of those fee-for-service rates, but the market is changing so much, as you said, that it's really hard to say for sure.

But we really don't look at those costs per unit of service independent of the overall costs net of the units of service. And, in fact, our model is much more focused on get the rate and then manage the units of service as aggressively as we possibly can.

One other point I would make about the plan I work for. Beyond getting the Medicare Advantage rates in terms of our hospital day rates, we also try to leverage a relatively small market share, you know, 20 to 25 percent market share overall, not just for Medicare, by consolidating all of our hospital business in a single hospital in each market. And so it's a great way for us to, as a commercial plan, be able to do things that create leverage that we wouldn't otherwise have. And I think just

one example of the kinds of dynamics that are variables that come into this evaluation of what is that dynamic in each one of these markets.

MR. HACKBARTH: Can I just jump in and ask a clarifying question I should have asked a minute ago. I want to make sure I understand the statutory provision that gives a Medicare Advantage plan the opportunity to basically command the Medicare rate for out-of-network services.

So does that mean that a Medicare Advantage plan could go into a negotiation with Peter and say, look, we'd like to include Rush in our network and you give us the rate we want, whatever that might be, in the negotiation. And, oh, by the way, if you don't agree and we exclude you from the network, we're going to pay you the Medicare rate anyhow, and it says here in Section 18 whatever of the statute that we have the right to do that.

DR. STENSLAND: At least that's true for emergency services. So if you're out of network and --

MR. HACKBARTH: But if they're out of network, truly out of network, that's the only way a patient would be admitted to that hospital would be through an emergency service, right?

DR. STENSLAND: Unless it's something that they don't offer at that hospital. But even if they don't offer it and the -- the way it's structured is if the insurer takes responsibility for that payment -- for example, maybe you don't have anybody that's in network that does transplant but somebody has to get a transplant and your hospital doesn't have it, even if you're a Kaiser or something. Then you're taking responsibility for that payment. They're going to that out-of-network provider. Because you're responsible for the payment, you can demand that they take the fee-for-service rate.

MR. HACKBARTH: Peter, you were --

MR. BUTLER: But you're right. Fifty-eight percent of the admissions come through the ER, is your estimate, and those ones would be immune to anything -- I mean, their Medicare rates is what you would get.

MR. HACKBARTH: So that's a pretty powerful negotiating tool.

DR. CHERNEW: So, actually, I'm having a harder time thinking through the sort of policy experiment that we're trying to think about. So it sort of started with what if fee-for-service went away. I can't envision it. I

probably can't imagine I would really support it. But in any case, that seems to be sort of the exercise, to understand what would happen, and I think that's challenging for a number of reasons, because it's -- for example, if fee-for-service went away, you'd have a hard time figuring out what the benchmarks are. So you need to figure out what the benchmarks would be, and then the benchmarks involve some competition and potentially interaction amongst the plans, depending on how you set it. And I think the answer to all the questions that are being asked would depend on the process that you put in for figuring out what the benchmarks are and the extent to which you think that the markets would be disciplined.

And I agree -- I have heard the exact same things and I believe very much what Craig said, that hospitals are trying to figure out how they're going to have to manage at Medicare rates, but I think that's because they think they're going to have to manage at Medicare rates. And in a world where they didn't think they had to manage at Medicare rates, it's not clear that the culture that has been -- I perceive as a dramatic shift over the past five years is one that they're so thrilled about and would remain, though it

might. But whether it did would depend on the exact set of structures you put in place for how benchmarks went.

And I can envision in, for a worst case scenario world, where you just wrote a blank check to everybody, that there wouldn't be an incentive for the strong negotiation or efficiency because people don't like networks and it would be hard to enter to figure out how you would do that. But I could envision other worlds that are much closer to the sort of competitive ideal that Craig outlined.

So I think the one thing that this shows, and I think is important to understand, and it pains me to say as an economist who's generally very supportive of markets, is markets are great, but they're not perfect and there's real problems with competition in a whole variety of ways. And understanding the dynamics of that competition is really important and will depend on the institutional structures that you put in place that folks are competing in.

But I think it's too simplistic to think that if we just allow competition, that prices will all be driven down. That clearly isn't happening in some markets. But I think it's also too simplistic to say, if we set up a competitive market, that it just would be a dismal failure.

And sorting out exactly what that experiment is that we're trying to hypothesize about is really hard, and I think once we do that, we might be able to be a little more concrete as to how to help us figure out what would happen.

DR. COOMBS: I'm just taking this as a learning session. Thank you.

[Commissioners passing.]

MR. GRADISON: I'm tempted to follow suit, but years ago when I went to business school, we were told there weren't answers to business problems, that the best you could hope to obtain were currently useful generalizations, so I'm going to reflect my current state of confusion by stating some generalizations that I'm not totally sure I would support, but they are just an indication of where my head's coming from on this.

First is that, typically, in a situation like this, if you're a purchaser and the goods or services you're trying to buy are being in your mind overpriced, you probably become -- you buy them out or buy somebody else or start a new one, start a new hospital or buy out a hospital. But there's a lot of evidence that combining insurance and hospital ownership has not worked very well. I think Humana

was one of the examples that tried this and put it together and then had to take it apart for a lot of reasons. So that general principle doesn't seem to apply very well here.

At the same time, there is a truly symbiotic relationship and these folks need each other. The hospital needs somebody to pay their bills and the insurance company needs somebody to provide services. So I don't see that the financial deal in the long run can -- I don't see that the arrangements that are worked out in the long run can be based solely, and maybe not principally, on financial considerations alone. I think that there has to be a longer view of the relationships in an individual community.

A third point which sort of was mentioned here already, and I'm not sure how it relates, but I do want to -- I think it's a factor -- much of our discussion has to do with what are the rates going to be for this year or the next couple of years, something like that, which is sort of a profit and loss consideration. Somewhere in here, I think we have to enter the question of financial reserves, the ability to ride out a couple of bad years. Kaiser almost went under one year when they underpriced their insurance and therefore weren't able to take care of all their

patients in their own hospitals and had to go out and buy hospital care at top dollar. It was a very bad period. It was about 20 years ago or something like that. It was really -- I mean, over a billion-dollar loss as I remember it in one year because of that imbalance. At the same time, I read -- and I don't know what the numbers are -- the partners has reserved some $7.5 billion or something, I mean, huge sums of money, and most hospitals, they get along, but the matter of financial reserves does affect your ability to negotiate in the short run and maybe in the long run.

And, finally, just to show you how opinionated I really am, I'm very skeptical of this argument of cost shifting because it seems to me that what's actually happening is a perfectly normal procedure where you segment your markets. And you may have the same good and service that you sell in one market for one price and another market for a different price. We may think of it primarily in international markets, where you might have a different price for a drug in one country than another, but the same thing can happen in other settings, as well. So the notion that if you don't get paid enough by Medicare, you're

automatically going to shift it, may be. I'm not denying the possibility. But it may be that you would charge that higher amount anyway if you can get it. In other words, you've segmented your market to the relationships, the condition of the buyer and seller, in that piece of the market, not the whole market.

As I said at the outset, I'm very confused.

MR. GEORGE MILLER: Yes, just general comments, very quickly. For those of us who have Medicare and Medicaid business above 50 percent, there's no such thing as cost shifting. It just mathematically does not work. And mine is only ten percent. I used the example.

A comment about what Scott said, that they negotiate and direct all of their business to one hospital, that's a very poignant point and I think he's using that as a market strategy for him in Seattle, which makes perfect sense. But if you're in a community like mine and, say, someone like Scott decides to consolidate all their business to one provider, that means, in my community, I would get none of that business if those insureds live in my community. All that business would go somewhere else. That may be market forces. That may be the right thing to do.

But then that infrastructure of providing health care in our community then will go away because the better-paying patients and those that he can drive business to his one hospital in that community then underpits what we're trying to do.

When I was in both Fort Stockton, Texas, and Jasper, Texas, the major insurer in Texas threatened to do that to our facility if we didn't lower our rates well below what Medicaid paid.

So I don't know the total answer, but these things happen in the world. I don't know, unless you're a large hospital system, I don't know how you get market domination. I think it's the insurers that have the upper hand. Now, I certainly could be wrong. Unless you're a part of a large integrated delivery system. So, again, for those of us -- there are about 1,800 rural hospitals around the country -- we don't have that power to do those things. It is a concern.

DR. NERENZ: Pass.

MR. HACKBARTH: This discussion has been illuminating for me. You know, even six months ago -- oh, I'm sorry. I'm sorry. Yes, I'm going to finish what I was

going to say and then I'll let Peter go.

MR. BUTLER: I do have something to say. This is -- I have been in organizations where we've owned our plans and where I am now, we don't. But I'll talk a little more from the provider side.

First, when you talk about discounts, and I'm not sure how you're looking at some of these, but the fact is, actually, a lot of the rates have far less variation in them than the contract language. All the money is in the contract language, an amazing amount of how you define outliers and carve-outs and, you know, what gets paid for. It's really a huge percentage of the contract. So when you look at your numbers, I don't know whether you just look at basic rates or you look at the contract language, but there are many days when I prefer a single payer system to get rid of the billions of dollars that are tied up in both sides of the equation here to haggle over the contracts and all the apparatus required to keep it going.

With respect to how providers look at this and why would they give Medicare rates other than the protection that was mentioned, I think many payers will come in, especially the national ones, with a book of business and

they'll say, I've got my PPO product or I've got my HMO product and I've got my Medicare Advantage. And they will say, you know, and the Medicare Advantage is not big, but they say, you know, I really need my Medicare rates over here. And I, myself, in contracting with you can help make it up over on the commercial side, which might be easier to pass through than the Medicare side.

So you look at your total book of business with the insurer when you negotiate, not just the Medicare Advantage in isolation. And because it's a small piece, some providers might say, okay, I'll give you Medicare rates for that.

Another reason is that in the -- I think if you looked at the participants in Medicare Advantage, they would be the ones that do have less clout in the market, that are looking for additional volume, that may have lower costs so they feel like they can live with the rate and feel that the patients can be steered into their institution, so they see that there may be a real pick-up in volume incrementally in a kind of narrower network Medicare Advantage. So I won't name names, but the big ad in the Chicago paper just two weeks ago made the major insurer rolling out, here is our

Medicare Advantage, and you look who's in there and it would fit the profile of those that, you know, they might be lower cost. They definitely are looking for business. And they're trying to play into filling some beds. Therefore, why not give the Medicare rate? It doesn't look too bad for us to do that.

Now, as far as the -- I actually come out the opposite of Craig on the -- I think that you have higher rates if you do away with the protection, almost for sure. I would agree totally that the whole world is saying you've got to live within Medicare rates, but as Mike pointed out, is it because you're willing to give those? Now, they look at their book of business and they say, okay, I've got 45 percent Medicare, 15 percent Medicaid, which is growing, maybe 30 percent in the commercial, and five percent uninsured, which is growing. And when they look at the collective revenue stream and project it out five years, they see the commercial market shrinking and not paying those charges.

So I see the prices coming down for the commercial market with greater transparency and I see the prices coming up for Medicare. On balance, they might be -- in an

effective competitive market, you will have lower rates overall, but I'm not sure that Medicare would get to have the advantage they have now if you really kind of played the whole thing out. So I do think it does provide protection for sure for now and I wouldn't let go of that too quickly.

DR. REDBERG: I also found this discussion very illuminating, but -- and I'm not an economist, but I find health care to be a very funny market because it doesn't -- the usual supply and demand really don't apply. Prices have no transparency. Peter corrected me and said, well, charges have nothing to do with what people pay. I mean, that's a little unusual for a market. Physicians can generate demand. Hospitals can generate demand like those ads we run in the paper. And so I think it's very hard to really extrapolate from usual market principles to what one would expect in the health care market because it's not really a market and we certainly can't lose sight that Medicare is a huge player, and for that reason, no matter what, has a lot of influence, or should.

And then I would just say that to keep in mind our framework, I think besides talking about costs, we should be looking at quality measures here, too, and what are we

getting for what we're paying in all of these different systems and really look at outcomes.

MR. HACKBARTH: Rita, as a physician, you shouldn't be at all shy about intruding on economics because our economists certainly aren't shy about intruding on medicine.

DR. CHERNEW: That's so true.

[Laughter.]

MR. HACKBARTH: Now to Kate.

[Laughter.]

DR. HOADLEY: I mean, this is, I think, really helpful, though it's big, complicated, and confusing. So, I mean, I think that we're all taking more time to digest what we're hearing.

I mean, I think the simple message out of the analysis is that having pay-for-service Medicare makes a difference. Even if you take it at that very simply stated, it makes a difference, without even talking about the direction, I mean, that's already saying something.

The other thing that -- two other things that at least implicitly in this analysis is that balanced billing rules make a difference. We don't talk as much about those

and I don't think most people who have talked about sort of future Medicare design have necessarily thought that through and what would you do with and without fee-for-service Medicare. It's also something that the private market is struggling with. I did a little bit of work on State laws about balanced billing on the physician side, and a few States have tried to do something, and none of them very happily, feel like they've mastered how those rules should work. And it does seem like it kind of is having some really interesting effects here.

And the third, I guess, is in thinking about the future of a world in which Medicare Advantage or whatever we'll end up calling it someday plays a larger role, whether it's just larger or 100 percent or whatever. I think thinking through what we might expect the balance within Medicare Advantage to be in terms of totally closed or relatively closed network models versus much more open network models. Obviously, PPOs in general in the under-65 market have a lot of popularity. There's clearly been a niche for very closed network model plans, particularly in some communities. But I think the way we think about all these things and a lot of the comments people made, it's

going to sound very different if we assume that -- and whether this is a question about what the public will accept or what the market will offer -- it's going to make a lot of difference whether that future is more heavily skewed to one or the other.

And I guess my last comment is sort of a question. Are we thinking of or are you working on anything to do a similar kind of analysis on the physician side of things, which is clearly a lot more complicated.

DR. MARK MILLER: Well, in this analysis, we didn't play it up here, but if you go through the paper a little bit in detail, the premium for MA is everything --

DR. HOADLEY: Right.

DR. MARK MILLER: -- and then what we entered or what Jeff entered was the index for hospital and physician services. And similar to hospital, you did not find a very strong effect and it's certainly not what you would have hypothesized or expected.

MR. HACKBARTH: You were talking about the relationship between physician fee levels and MA bids.

DR. MARK MILLER: That's correct.

DR. HOADLEY: But then, also, thinking through

some of what other things in the literature would say about some of the dynamics of market levels, it would be really interesting --

DR. MARK MILLER: [Off microphone.] Yes, absolutely. But I think just to note, for anybody who missed it, that was --

DR. HOADLEY: Right.

DR. MARK MILLER: [Off microphone.] And I got that right, Jeff, roughly?

DR. STENSLAND: Yes, roughly. I think the physician story was, at least for HMOs, there was a little bit of a relationship between the relative physician commercial rates and the rates that HMOs were paying. The sign actually flipped in the PPO thing and how you structured your model. It wasn't really solid, like it didn't just sit there. For an economist, you do these models. You do another one, another one. It's always just -- but the hospital thing, it's -- that's the story. It's the end of the story. I think for the physician one, it's not as clear, I think for a couple of reasons. One, because it's not as big a portion of the pie. And another thing, I think there also might just be a lot more complexity in how

you pay the physicians. Are you paying them some capitated arrangement or some bonus arrangement? And it just might not be as clean of a story as it was for hospitals.

MR. HACKBARTH: Cori and then Scott.

MS. UCCELLO: [Off microphone.]

MR. ARMSTRONG: Actually, you just made the point I wanted make, in that throughout this whole conversation, we haven't actually ever acknowledged that while fee-for-service may always be kind of an important point of reference, in fact, our organization is I'm sure not alone in talking with hospitals about how we get way beyond a cost per unit of service as a basis for reimbursement. And so we just at least, I think, need to put that out on the table, too.

MS. UCCELLO: So I changed my mind. I'm going to say something.

[Laughter.]

MS. UCCELLO: So we've talked today kind of in isolation about the provider prices and how that would work, perhaps with or without the fee-for-service in there. But I would suggest that other elements of the CPC can maybe affect these things. And in particular, I'm thinking about

how the government contribution is set. If we're talking about this and it's competitive bidding, that's kind of how this discussion went. But if we're thinking about setting the government contribution as a fixed amount that increases by something --

DR. HOADLEY: [Off microphone.]

MS. UCCELLO: -- then would that kind of mechanism be able to apply pressure in a way that maybe a competitive bidding process wouldn't? So I think we just need to think about these not necessarily in isolation but how the different features of a CPC design could interact.

MR. HACKBARTH: Scott, on your point, back in the 1990s when I was involved in the health plan and medical group business, at least in Boston, we did go through a period where we started sharing the Medicare revenue on a per member per month basis with at least select hospitals because they wanted to assume more risk with the potential of more gain by reducing utilization, et cetera. And those arrangements blew up around the country and we sort of reverted back to negotiated rates based on per diems or per admission. But there was a period when we tried some of these new mechanisms. I'm sure you remember that, as well,

Craig.

DR. SAMITT: The one other point I would add to that, which is, I guess, a third dynamic, is clearly the ongoing consolidation of the industry. And so the question is who will really bid for these plans in the future. My guess is many of them will be integrated systems that have their own health plans. So in many respect, it's going to be these integrated groups that already have internal alignment that may very effectively be able to compete and bid.

MR. HACKBARTH: Okay. Thank you. Very interesting analysis, Jeff, and we'll be coming back to this in the not too distant future.

Okay. We'll now have our public comment period.

MS. METZLER: [Off microphone.] I'm the only brave soul --

MR. HACKBARTH: Yes, and let me just quickly review the rules before you begin.

MS. METZLER: Yes, sir.

MR. HACKBARTH: So please begin by introducing yourself and your organization and I'll give you a brief amount of time. When the red light comes back on, your time

is up. And, as I always do, I remind people that this isn't your only or even your best opportunity to provide input on the Commission's work. You can place comments on our website and, of course, interact with the staff, and that latter one is your best opportunity.

With that, it's all yours.

MS. METZLER: Thank you. Christina Metzler. I'm the Chief Public Affairs Officer at American Occupational Therapy Association.

And thank you for that reminder about the contact with staff and other opportunities to communicate to the Commission, because we've taken advantage of that and have been pleased during the recent few months about the collaboration and the outreach from staff to AOTA, the Occupational Therapy Association and the rest of the therapy community. We thank you for that opportunity and we appreciate that some of the thoughts that we have put forward were reflected in the discussion as well as in the recommendations.

But nonetheless, I have to say that we are disappointed that the NPPR hammer was used. We don't believe that this is a good approach and we opposed it when

it was first suggested by CMS, primarily on the basis of the integrity of the AMA process that is used by -- used to determine the value for -- across all of medicine and health care and that using the NPPR invalidates what the AMA process has done. And we don't think that that is a sensitive way to reduce expenditures or assure appropriate utilization.

Furthermore, I just want to point out the concerns from a beneficiary point of view. Beneficiaries are really in a bad state right now. Therapists are getting calls from the beneficiaries because CMS has chosen to send letters directly to the beneficiary underlining that they are vulnerable to pay for therapy even if their therapist thinks it's legitimate. And underscoring this creates fear, confusion, and it puts a damper on people accessing therapy that is legitimate, that is medically necessary, that they are entitled to under Medicare, and that they should be getting to perhaps improve their life but also perhaps to save money down the road.

So I urge the Commission to watch what happens with the communication to beneficiaries, that that scaring of beneficiaries can be short-sighted and have negative

effects, especially on the quality of outcomes, as you were talking about.

CMS, I want to state that CMS and its contractors have always had the authority to do manual medical review. It's only in this newest iteration that manual medical review is now being interpreted as a prior approval process. It's ironic in some ways to us because AOTA has suggested several times that there be a prior approval process at a certain level. We suggested it at the 95th or 90th percentile. But CMS always said they did not have the resources to do that, did not want to do that, would tell Congress that that wasn't an acceptable alternative, and now that's what we have. But I think we need to call it a prior approval process so that beneficiaries and providers are clear about what this process is.

I wanted to mention that the notion of the improvement standard and this new ruling -- one of the Commissioners, I think, talked about how this may bring about a long-term care benefit. But I want to reiterate what Mr. Miller said about the therapy services have to be skilled. We're not talking about maintenance services. We're talking about the skilled services that can help

people maintain function. And as we see people with more chronic conditions, it's not just maintaining function or restoring function. It's habilitating people to their new status, whether they have a limited function from a stroke or they have a progressive disease. That needs to be remembered.

I also -- one last thing. Occupational therapy, physical therapy, and speech therapy are three distinct benefits and the functional status and any movement to develop an episodic payment should be developed with the awareness that they are distinct benefits and distinct services that have different purposes.

Thank you.

MS. WORZALA: Good afternoon. Chantal Worzala from the American Hospital Association.

Following on the comments about the multiple procedure payment reduction, the AHA is very disappointed that the Commission has recommended this 50 percent multiple procedure payment reduction for outpatient therapy services. We're especially disappointed that the Commission made the recommendation without any independent analysis of the number of visits per day or practice expenses. Instead, the

staff seemed to have referred to a CMS analysis on visits per day and that actually was subject to a comment letter from MedPAC that questioned the data as needing better justification.

Some of the questions about the CMS analysis about visits per day include the fact that they did not include any institutional settings in their analysis. It was only private practice. And they actually excluded from the analysis any claim that had a single service per day. So by definition it overstated the median services per day coming to the four median services per day that were referenced in the discussion.

Further, I'd just note that this payment cut for practice expense is recommended at the same time that the Commission is actually recommending increasing practice expenses by asking for data collection on patient status. I think everyone benefits from the collection of quality data and functional status data. But collecting that data is not free of cost and would, in fact, be part of a practice expense, were that recommendation to be taken up by CMS or Congress.

On the flip side, the AHA does greatly appreciate

the discussion of this balance between ensuring you disincentivize inappropriate care or unnecessary care with a burdensome manual review process. And when we think about where that cap should be set, I think it is important to think about the number of reviews that would be required and the cost and burden of those reviews.

It looks like, from the materials on Slide 5, that there are about 4.5 million beneficiaries that receive outpatient therapy services each year. Therefore, that one-third of beneficiaries being subject to the cap could lead to as many as 1.5 million manual reviews per year. So I think that's an important factor to keep in mind as conversation continues about where to set the cap.

Thank you very much for your attention.

MS. McILRATH: Sharon McIlrath, AMA. I just want to make a couple of points about the multiple procedure payment reduction.

One is that the CMS, even if you accepted that there were no problems in their study, the CMS study was based on the overlap in a single session. The way this thing is being applied is to a single day. So the kinds of efficiencies that you get when you moved an imaging machine

from the abdomen to the chest, you don't find the same kind of efficiencies when you have occupational therapy done in the morning and speech language therapy done by a totally different person in potentially even a different office on the same day. So as a precedent for every time you are going to be looking at multiple procedure payment reductions, you need to distinguish between a single session and a single day.

And then the other point about these is that this is being applied, the exact same number, to every single kind of service, where even the CMS study found a difference of 28 percent to 56 percent. So it's way too high for the procedures at the low end and way too low -- or not way, but too low even if you accept that everything in their study is correct.

MR. BUCCAFURNI: Hello. My name is Anthony Buccafurni. I'm a physical therapist, an associate in a large private PT practice, and I just wanted to discuss briefly the outpatient therapy discussions that you had today.

I'm in a private practice named Fox Rehabilitation. We specialize in home treatments of the

older adult. Patient average age for us is 85 years of age. Most of our patients have a multitude of medical complexities, obviously.

I first want to thank you all for your stance on the hard cap. Mary began the day by referencing the patients and implications that hard caps would place on access to care. You all echoed your concerns. I'm thankful on behalf of my profession for that. This is a difficult decision you all have to face and I'm thankful for the extensive attention that you all have made towards it.

You referenced in your analysis today that 33 percent of patients are potentially impacted by the 2013 lowered therapy cap. In our private practice, approximately 90 percent are potentially impacted by the regulation you have suggested. As a result, the most vulnerable of beneficiaries who are in need of rehabilitation care will have access issues to care due to the various roadblocks and administrative obstacles providers are having to navigate.

In our current practice, with an MMR approval rate of greater than 86 percent, we have submitted 2,309 reviews to date. We have received a response on 581. But the concern is that greater than 37 percent have exceeded the

ten business day threshold. In fact, earlier today, I was working with a group of physical therapists in Delaware County, Pennsylvania, who have submitted 40 MMR requests that are in excess of 15 days.

As a provider, how do I direct my clinicians to provide continuity of care and achieve optimal objective functional outcomes, as you have suggested today, when we have no idea when and if we'll receive the approval for the ten visits? And you've gone into great length today to discuss the need to make sure that Medicare has these systems more efficient and user friendly to the providers.

But I wanted to read a quick note I just received today from one of our therapists. "Anthony, this resident," I will withhold the name, "was on hold pending manual medical review authorization. In the interim, she fell. She fractured her elbow, went out to the hospital to the emergency room, had a myocardial infarction upon return to her assisted living, then went back to the hospital and was admitted." So, unfortunately, the delays that are the result of the administrative burden of these processes are a significant impact to beneficiaries, and I have a dozen more stories like this since the implementation of this process.

So, again, I understand the difficult decision you all face, but from the field's perspective and our beneficiaries and our patients, I just wanted to share that information with you today. Thank you.

MR. HACKBARTH: Okay. We are adjourned until 8:30 tomorrow.

[Whereupon, at 4:07 p.m., the meeting was adjourned, to resume at 8:30 a.m. on Friday, November 2, 2012.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 2, 2012
8:31 a.m.

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

AGENDA PAGE

P R O C E E D I N G S [8:31 a.m.]

MR. HACKBARTH: Okay. Good morning. We have two sessions today, one on Medicare Advantage special needs plans and the other on synchronizing payment rates across settings. On special needs plans we will discuss some draft recommendations that I am offering. They are draft recommendations. And so for those of you in the audience, no votes.

In terms of when we will come back on special needs plans, in part that depends on how the conversation goes, but have we scheduled time in the December meeting potentially for this? No. So when would we come back, Jim?

DR. MATHEWS: This would be January.

MR. HACKBARTH: January, okay. So assuming the discussion goes well and we see some either current agreement or potential for future agreement, we'll be back on this in January. And we'll hear in just a minute, I'm sure, about the timing of the special needs reauthorization and why it's important that we examine this issue now.

So who's going first? Carlos?

MR. ZARABOZO: Thank you for doing the first slide.

[Laughter.]

MR. ZARABOZO: I'd like to add to that, at last month's meeting, several Commissioners asked specific questions about special needs plans, which we'll answer over the course of our presentation. We will begin our presentation with a brief review of the current status of SNPs and then talk about each of the three SNP categories and present the draft recommendations by SNP category. We would like to thank Scott Harrison for his assistance in our analysis.

We are examining SNPs at this time because the statutory authority that enables such plans to enroll only certain categories of Medicare beneficiaries expires at the end of 2013 unless Congress acts to extend the authority. Under current law, if there is no change in the statute, special needs plans must decide by the first half of 2013 whether they wish to continue in the Medicare Advantage program in 2014. If the statutory authority allowing exclusive enrollment of special needs individuals does expire, these plans can continue in the Medicare Advantage program, but they will no longer be able to limit their enrollment to only special needs individuals.

Here is a road map for the presentation. We'll review information that was presented last month about SNPs, using updated data; we'll discuss the differences between SNPs and general MA plans in order to provide more clarity about what those differences area; we'll review information that we previously presented on quality in SNPs; and, again, we'll present the Chairman's draft recommendations and the basis of those recommendations.

Although the SNP program was not the subject of a mandated congressional report, it is similar to the issues discussed at yesterday's meetings in that Congress may take action to modify current law as it applies to SNPs. Therefore, the framework that you are familiar with for the analysis in the mandated reports -- shown in the slide -- can be applied to the SNP program.

With respect to the impact on program spending, a reauthorization of SNPs will increase Medicare spending. If SNP authority expires, some beneficiaries currently enrolled in SNPs will likely enroll in Medicare fee-for-service. If SNP authority were to be extended and there was not a movement of some enrollees to fee-for-service, that would result in higher program spending because, on average,

Medicare spending on SNP enrollees and on MA enrollees in general exceeds program expenditures for beneficiaries in fee-for-service Medicare.

In terms of access, broadly speaking beneficiaries have similar levels of access to Medicare-covered services and to providers in general MA plans, in SNPs, and in fee-for-service Medicare. We'll discuss quality-of-care issues for SNPs in more detail during the presentation. In terms of advancing payment reform and encouraging a more integrated delivery system, both general MA coordinated care plans and SNPs offer an integrated delivery system. Also as we'll discuss in more detail, some D-SNPs encourage integration between D-SNPS which are for dual eligibles, encourage integration between dual-eligible beneficiaries' Medicare and Medicaid benefits.

There are three kinds of special needs plans permitted under the statute. The greatest number of enrollees are in plans for beneficiaries who are dually eligible for Medicare and Medicaid. These SNPs, the D-SNPs, enroll about 1.3 million beneficiaries, or about 10 percent of all MA enrollment. However, we would note that there are about 900,000 dual eligibles enrolled in general MA plans.

As of the upcoming contract year, 2013, D-SNPs will be available to about three-fourths of the total Medicare population. By comparison, 99 percent of Medicare beneficiaries will have access to at least one coordinated care plan in their geographic area as of 2013.

C-SNPs enroll beneficiaries with certain specified chronic or disabling conditions and have far fewer enrollees and more limited availability.

The category with the smallest number of enrollees are I-SNPs, which provide care to people in institutions or who reside in the community but need an institutional level of care. All SNPs function as MA plans, and they are responsible for the full range of Medicare Part A and Part B benefits for their members.

Now we'll talk about how SNPs differ from general MA plans. The main difference between SNPs and MA plans is that SNPs can design benefit packages that are tailored to the special needs of the beneficiaries that they seek to enroll. An organization can sponsor both a general MA plan that appeals to the general Medicare population and a SNP plan with a very different benefit design. SNPs also have to report more quality data than MA plans, and SNPs submit

reports on their model of care and report on structure and process measures. Rules on enrollment are also somewhat different between MA plans and SNPs, as I'll explain in the next slide.

One of the differences between SNPs and general MA plans is the great ability of SNPs to enroll beneficiaries outside of the October–December open enrollment period. Two categories of Medicare beneficiaries can enroll in MA and disenroll from MA on a month-to-month basis, as shown in the two middle columns. The open enrollment right attaches to the beneficiary status and not to the plan type. However, because D-SNPs and I-SNPs specialize in these populations, which are the dual eligible and those who are institutionalized, they may be more likely to enroll such individuals. For C-SNPs, a beneficiary that has the chronic condition covered by the C-SNP has a one-time opportunity to enroll in the C-SNP outside of the open enrollment period. The right may not be exercised again after that, and the person can only change status at the next open enrollment period.

Glenn, at last month's meeting, you asked whether we knew how much C-SNPs benefit from the year-round open

enrollment provision. We looked at the enrollment patterns of two large C-SNPs in 2011 and found that they both had a substantial level of enrollment outside the October-December open enrollment period. For one of the plans, for example, 72 percent of its C-SNP new enrollment came from outside the open enrollment period.

A couple of other items to note on this slide are that general MA plans can enroll people year-round if they have a five-star quality rating. Beneficiaries with end-stage renal disease, or ESRD, cannot enroll in general MA as new enrollees, but the Commission has a long-standing recommendation that would allow such beneficiaries to enroll in MA. There are a few SNPs specializing in ESRD, but there are many more ESRD beneficiaries in other MA plans. About 10 percent of all Medicare beneficiaries who have ESRD are enrolled in MA because they acquired end-stage renal disease after having joined the plan.

Peter, you asked what we knew about enrollment growth in SNPs and the nature of organizations sponsoring SNPs. As indicated in the slide, D-SNP enrollment growth has been similar to general MA growth. C-SNPs have had the highest level of enrollment growth, and for I-SNPs, one

organization changed its status, causing a decline in I-SNP enrollment in the last 12 months.

MA is dominated by enrollees in for-profit plans, but both C-SNPs and I-SNPs have a much higher proportion of for-profit enrollment -- over 98 percent for each category.

Scott, you asked what we knew about the financial viability of C-SNPs. We looked at the stability of C-SNPs over several years. Among the 136 plans that were operating in 2010, about half will still be operating as C-SNPs in 2013, or the sponsoring organization will continue to have a C-SNP. We also examined several publicly available insurance commission filings of organizations that are primarily C-SNPs, and in each case the medical loss ratio was very low--at 82 percent or lower.

As we mentioned at the last meeting, it's also true that C-SNPs have bids for the Medicare Part A and Part B benefit that were on average below Medicare fee-for-service levels.

An important question to ask about SNPs is whether their special status enables them to provide better care to the targeted populations, an evaluation that is difficult to make in terms of comparing SNPs to general MA plans or to

fee-for-service.

To summarize what we discussed last month, using a proxy method of comparing plans that are primarily or exclusively SNP plans, we find that looking at a composite measure that includes process and outcome measures as well as beneficiary access measures and administrative performance -- which is the CMS star rating system -- we see that SNPs generally do not perform as well as other plan types. For most of the currently collected process and intermediate outcomes, SNPs on average do not perform as well as non-SNP plans. However, there are exceptions which we will point out as we discuss each SNP option.

Last month, we also noted that the industry does not feel that the current rating system is appropriate for SNPs. The industry also believes that new measures should be developed that are more appropriate to the populations that SNPs serve. Work is still underway to develop such measures, which would be applicable to both SNPs and non-SNP MA plans.

Mary, you asked a question about the status of new measures emanating from the work of the Measure Applications Partnership, or MAP. The MAP issued a report in June of

this year that included a recommended starter set of seven measures and a revised core set of 23 endorsed measures for dual eligibles. About half of each of those sets of measures is currently in use in some form, but it will take some time to have new measures in place. This would include more outcome measures and certain screening measures such as screening for depression.

On October 25th, CMS announced the testing of several new measures, including continuity of information and care from hospital discharge to the outpatient setting and continuity between mental health provider and primary care provider. But it will be two to three years before these measures would be part of the star rating system.

Alice, you asked the extent to which certain states are involved in the CMS dual-eligible demonstration projects or have waivers under Medicaid. Of the 23 states on the table that you were looking at, the majority hopefully Medicaid waivers, primarily to offer home and community-based services to certain populations. About half the states are working with CMS to implement one of the demonstrations on dual eligibles, with 11 of the 15 states that are interested pursuing the capitated model. As you're

aware, Massachusetts has signed an MOU with CMS, and Washington State recently signed an MOU to pursue the managed fee-for-service model.

We'll now turn to two of the Chairman's draft recommendations, which pertain to I-SNPs and C-SNPs.

This slide summarizes our findings on I-SNPs. I-SNPs serve a very distinct, identifiable population with specific needs resulting from their institutionalization or their risk of being institutionalized. Enrollment in I-SNPs is not large, and it is concentrated in urban areas, primarily in two states. I-SNPs perform well on an important measure of care for this population, the rate of readmissions to hospitals, as well as on certain other measures tracked at the SNP-specific level, such as functional status assessments and pain screening.

The Chairman's first draft recommendation for I-SNPs states that, "The Congress should permanently reauthorize institutional special needs plans." This recommendation would result in a small increase in Medicare spending relative to current law, as explained at the beginning of the presentation.

The draft recommendation will not have an adverse

impact on beneficiaries or plans. Current beneficiaries can remain in their plans, new beneficiaries can be enrolled, and plans no longer have the uncertainty associated with being in a program operated under temporary statutory authority.

Moving on to a summary of findings on C-SNPs, these plans offer tailored benefit packages to beneficiaries with chronic illnesses; however, the most frequently covered C-SNP condition -- diabetes -- is common among the population enrolled in general MA plans. The vast majority of C-SNPs are offered through organizations that also have a companion general MA plan. C-SNPs as a whole do not have better quality results than non-SNP MA plans, with the exception that several C-SNPs that are HMOs perform well on a number of quality measures, though the measures are not disease-specific measures. Enrollment in C-SNPs is concentrated in the South, the enrollment is growing, and the number of such plans being offered in 2013 suggests that there will be additional growth.

With respect to C-SNPs, the Chairman's draft recommendation reads: The Congress should:

- allow the authority for chronic care SNPs to

expire;

- direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions;

- and permit current C-SNPs to continue operating during the transition period as the Secretary develops standards but impose a moratorium on new enrollment in those plans as of January 1, 2014.

What this draft recommendation does is to fold the C-SNP approach into the general MA program by allowing all MA plans to fashion alternative benefit packages and care models tailored to a set of specific of chronic or disabling conditions, and making the models of care that C-SNPs use more widely available. This recommendation would increase Medicare spending relative to current law, again, because some beneficiaries would otherwise have been in fee-for-service Medicare. We would expect a limited impact on beneficiaries and a limited impact on plans in that we anticipate that the large majority of C-SNPs will be able to operate under the new rules after the transition period.

Christine will now discuss the D-SNP

recommendations.

MS. AGUIAR: I will now review our findings of whether D-SNPs integrate Medicare and Medicaid benefits for dual eligibles.

As a reminder, D-SNPs are the current managed care-based vehicle in the Medicare program for the integration of Medicare and Medicaid benefits. We found that the best environment for integration with Medicaid benefits occurs under two scenarios which are depicted on this slide.

Under the first scenario, one plan -- the D-SNP -- covers both Medicare and Medicaid services. We refer to these plans as financially integrated D-SNPs.

Under the second scenario, depicted on the right side of the graphic, one managed care organization has both a Medicaid plan and a Medicare plan, and the same dual eligibles are enrolled in both plans. In this scenario, the integration occurs across the two plans. It is not necessary for the Medicare plan to be a D-SNP under this scenario. However, the benefit of a D-SNP here is that it can limit enrollment to dual eligibles and can tailor the benefit package and supplemental benefits to those

beneficiaries.

Under both scenarios, the managed care organization has the financial incentive to manage and coordinate Medicare and Medicaid services because it is financially at risk for those services. And under both approaches, the managed care organization has the ability to coordinate Medicare and Medicaid services because it covers those services.

This chart shows our estimates of the number of integrated and non-integrated D-SNPs. As you can see on the second line of the chart, we estimate that there are fewer than 60 integrated D-SNPs that collectively enroll approximately 300,000 dual eligibles or about 24 percent of all dual eligibles enrolled in D-SNPs.

However, as you can see on the last row of the chart, the majority of D-SNPs are not integrated. These are D-SNPs that are neither financially integrated with Medicaid benefits nor are part of a managed care organization with a companion Medicaid plan. We estimate that the majority of dual eligibles enrolled in D-SNPs, about more than 75 percent, are enrolled in these non-integrated plans.

This slide summarizes our main findings on D-SNPs.

With respect to quality of care, we found that financially integrated D-SNPs tend to perform well on star ratings. There are fewer than 25 financially integrated D-SNPs, and there is sufficient data to calculate star ratings on 15 of them. Of these 15 plans, eight of them received star ratings of 4 or 4.5 in 2013.

In terms of integration with Medicaid benefits, we found that financially integrated D-SNPs or D-SNPs that are part of a managed care organization that offers a companion Medicaid plan are the only types of D-SNPs where Medicare and Medicaid benefits are integrated. All other D-SNPs do not integrate Medicaid benefits, but some of those plans may try to coordinate them.

This brings us to the Chairman's third draft recommendation. It reads: The Congress should permanently reauthorize dual-eligible special needs plans that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.

Under this draft recommendation, financially integrated D-SNPs and D-SNPs that are part of a managed care organization with a companion Medicaid plan would become

permanent. These are the D-SNPs that integrate Medicare and Medicaid benefits. As I previously discussed, we estimate that there are fewer than 60 of these plans and that they collectively enroll almost 25 percent of all dual eligibles enrolled in D-SNPs.

Non-integrated D-SNPs would not be reauthorized under this draft recommendation. However, to be clear, this recommendation does not preclude those plans from working with states to cover most or all Medicaid benefits and operating as an integrated D-SNP. These plans would have the option of working with states to become integrated or converting to general MA plans. If the non-integrated D-SNPs convert to general MA plans, they could still retain their contracts with states.

With respect to spending implications, this draft recommendation would increase Medicare spending relative to current law. Integrated D-SNPs would continue permanently, and spending on beneficiaries enrolled in these plans is higher than fee-for-service spending. We do not expect this draft recommendation to have adverse impacts on beneficiaries. The dual eligibles enrolled in integrated D-SNPs would be able to continue in those plans. The dual

eligibles enrolled in the non-integrated D-SNPs could remain in those plans if they convert to general MA plans. We also do not expect this draft recommendation to have adverse impacts on plans. The non-integrated D-SNPs could convert to general MA plans or could work with states to become integrated. Integrated D-SNPs would benefit from this draft recommendation by being able to continue permanently and would no longer have uncertainty about whether they will be reauthorized.

Returning now to an issue that we discussed in October, we also found that there are administrative misalignments between Medicare and Medicaid that are barriers to integration. One of those is marketing requirements. D-SNPs cannot describe the Medicare and Medicaid benefits they cover in the same place on their marketing materials. Another barrier is that Medicare and Medicaid have separate appeals and grievances processes. These barriers can be confusing and burdensome for both beneficiaries and the plans.

Herb, to address your question from the October meeting, the Secretary has authority to permit D-SNPs to jointly market their Medicare and Medicaid benefits.

However, an aligned appeals and grievances process would require congressional action to change the law.

This brings us now to the Chairman's fourth draft recommendation. It reads: The Congress should align the Medicare and Medicaid appeals and grievances processes for D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits. The Congress should direct the Secretary to allow D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits to market the Medicare and Medicaid benefits they cover as a combined benefit package.

This draft recommendation would align the appeals and grievances processes and the marketing misalignments for integrated D-SNPs. We do not expect this recommendation to affect program spending. We expect this draft recommendation to have a positive affect on beneficiaries and plans by eliminating two administrative misalignments.

This slide presents a summary of the Chairman's draft recommendations. This concludes the presentation, and we are happy to answer your questions.

MR. HACKBARTH: Okay. Thank you, Christine and Carlos. Well done.

As we proceed through the discussion, I would ask the Commissioners to, if they can, frame comments in terms of the framework that we've been using to assess these reauthorizations. In other words, if we're going to increase Medicare spending above the baseline, it should be because we believe there's evidence that it will improve quality, access, or aid movement to delivery system reform. So if you can frame comments in that context, that would be helpful to me in terms of moving forward.

Then I have a couple clarifying questions myself. Could you put up Slide 7, please. So I want to make sure that I understand this correctly. So as I interpret this chart, duals and institutionalized beneficiaries can enroll off-cycle in general Medicare Advantage plans, but beneficiaries with chronic conditions cannot. Is that correct?

MR. ZARABOZO: That's correct. The chronic condition person has the one-time opportunity off-cycle to -- so in July, if you have a chronic condition and it's C-SNP available, you can enroll in that plan, but that's it. That's your one-time opportunity, and to change status, you have to wait until the next open enrollment.

MR. HACKBARTH: Okay. And so I'd ask people, Commissioners, to also react to the possibility of a recommendation that that same opportunity be extended to all Medicare Advantage plans, so a beneficiary that has one of the covered chronic conditions would have an opportunity to enroll off-cycle in Group Health of Puget Sound. It wouldn't be only a right to enroll in a C-SNP. Is that clear, what I'm asking?

MR. KUHN: [Off microphone.] Can you say that again?

MR. HACKBARTH: So there's a list of conditions, chronic conditions, that C-SNPs are eligible to focus on. The law says that if a beneficiary has one of those conditions, they have a one-time opportunity to enroll in a C-SNP off-cycle. And I'd ask you to react to a recommendation that we extend that opportunity to all Medicare Advantage plans. So if I'm diagnosed with diabetes in July, I not only have the opportunity to enroll in a C-SNP, but in any Medicare Advantage plan. Okay? Is that clear?

DR. ZARABOZO: And I'd like to add, Glenn, that right now, C-SNPs also have a slight difference in payment

from other plans in that for a person who's a so-called new enrollee for whom there's no claims history because of that condition, they can be coded as having that condition as opposed to any other situation where you have to wait for the claims history to catch up. So that would be a companion piece.

MR. HACKBARTH: So perhaps also extend that opportunity to any Medicare Advantage plan.

DR. ZARABOZO: Right. And it's by the -- the authority is not specifically statutory, but it's under the opportunities for open enrollment as determined by the Secretary. So it's --

MR. HACKBARTH: Okay.

MR. ARMSTRONG: And just to clarify, you asked for consideration of that extension to MA plans to coincide with a recommendation that C-SNPs actually get brought into MA plans in the future?

MR. HACKBARTH: Yes. So the idea would be, let's do away with a special category of C-SNP but recognize that, in fact, when a beneficiary receives a major new diagnosis, like you have diabetes, that that's a significant event and it may alter their thinking about their health care

arrangements. And the way the law works right now is, well, you can say, oh, I have diabetes. Therefore, I want to go into a C-SNP focused on diabetes. I think that maybe what we ought to say is you can go into any managed care organization that you think can help you better manage your diabetes. It doesn't need to be a C-SNP. It can be any Medicare Advantage plan. Or, of course, you can elect to remain in fee-for-service, if that's what you wish. Is that clear? Did I answer your question?

MR. ARMSTRONG: Yes. But to clarify, but our recommendation is there won't be C-SNPs in the future --

MR. HACKBARTH: There won't be C-SNPs, but there will be a general opportunity --

MR. ARMSTRONG: Yes.

MR. HACKBARTH: -- to enroll in Medicare Advantage when you receive a significant new diagnosis off a list established by CMS. Okay?

DR. MARK MILLER: The other way I've heard you describe it is that the way it stands for I and D is that the off-enrollment attaches to the beneficiary, not the plan type.

MR. HACKBARTH: Right.

DR. MARK MILLER: And this would basically extend the chronic condition to the beneficiary, and so the right to enroll, or the opportunity to enroll off-cycle would attach to the condition of the beneficiary as opposed to the existence of the plan and, in a sense, normalizing the situation across all three types.

MR. HACKBARTH: Okay. And then one last clarification for me. Could you put up Slide 17, please. So I think it might be helpful -- actually, maybe I've got the wrong slide here. Well, leave it there. So the issue, Christine, is that you say the non-integrated D-SNPs coordinate benefits as opposed to integrate benefits. If you could just be a little bit more specific about what it means to coordinate benefits, that would be useful to me.

MS. AGUIAR: Sure. So, again, we spoke with a range of managed care organizations, both those that were on the chart that we showed that had the Medicare and the Medicaid within the one plan and then those that had the Medicare and Medicaid as two separate plans.

MR. HACKBARTH: Mm-hmm.

MS. AGUIAR: We also spoke with some plans that just had the duals in their D-SNP but did not have them in

the Medicare product.

And so there's a range of coordination that is going on under that scenario and it seems to -- I don't know if I'd say it's up to the discretion of the plan. So on one level, you'll have some plans that will assess the dual eligible for their Medicaid benefits for what they're eligible for, for what their needs are, and refer them, refer those individuals to those services. And then what we heard from those plans is because they don't provide those Medicaid services, that's sort of where their ability to help stops, is to make that referral. The responsibility then becomes onto the beneficiary to do the follow-up. And, there again, depending on the plan, there could, there could not be some follow-up as to whether or not that beneficiary is receiving those services are not.

Now, there are some other D-SNPs that we spoke with that are also non-integrated that will take a further step, that will actually try to make relationships with community-based organizations, with the organizations that provide those Medicaid services, and in addition to making referrals will try to help the beneficiary, actually make the referral for them, try to make sure that they actually

get that Medicaid service, and then do some follow-up on that.

MR. HACKBARTH: Okay. So here's my question. If non-integrated D-SNPs were to disappear, my understanding of Slide 7, if you'd put that back up for a second, is that even if non-integrated D-SNPs disappear, that duals would retain the opportunity to enroll off-cycle in Medicare Advantage plans.

MS. AGUIAR: Yes, that's correct.

MR. HACKBARTH: And so a Medicare Advantage plan, they could also refer dually eligible beneficiaries to providers for Medicaid services. There's no bar to them doing that.

MS. AGUIAR: Right. That is correct. And I think, from what we've heard, it really does sort of seem to be the plan makes the decision to make those relationships with the organizations in the community that could help their dually eligible members, but that possibly could also help their non-dual eligible members.

In addition to that, some of the same organizations that we were speaking with that sort of take that next step to make those relationships with the

community, they also are taking efforts to sort of build much more of a primary care network, to build much more clinical centers that could benefit their dual eligible and also non-dual eligible members if they were to convert to a Medicare Advantage plan.

MR. HACKBARTH: Yes.

MS. AGUIAR: So, again, there's nothing barring them from continuing to do what they're doing now.

MR. HACKBARTH: Okay. So those are my clarifications.

Let's see. Who looks ready to start the clarifying round? I think Cori is primed to. Cori.

MS. UCCELLO: I'll jump in. So in terms of the C-SNPs, I mean, my concerns are that plans get payments that are commensurate with the risks that they're bearing, and so there -- I'm just kind of thinking out loud here. I think things are okay, but I want to make sure.

So if C-SNPs can't enroll new entrants, in a regular plan, that would mean the risk in that plan is devolving over time. They're becoming more expensive. I'm not quite sure how that works with a C-SNP where they already have conditions. But in any case, the plan --

because the payments to the plan are risk adjusted, that that's going to make sure or ensure that the plan kind of remained viable, right? For the plans --

MR. HACKBARTH: [Off microphone.]

MS. UCCELLO: Translator, please.

DR. MARK MILLER: What my colleague, Cori, I think is saying, and I must remember she's speaking for her friend from yesterday --

[Laughter.]

DR. MARK MILLER: I think what she's saying -- and obviously, if this is wrong, say something -- there's a natural -- if you stop enrollment, you have an aging of a population so you have a devolving risk, okay, over time. And so I think the potential concern you're expressing is, well, wait a second. If we stop enrollment on these C-SNPs for three years, do we potentially put the plan in a financially not viable -- I'm not speaking well -- situation? Of course, counteracting that is that as their risk devolves, the payments should also be going up because there's some adjustment for risk. And the other thing I would say is it's a relatively short period of time that I think we're proposing. But I think that's what you're

saying.

MS. UCCELLO: Correct.

MR. HACKBARTH: In addition to that, they can potentially convert to regular Medicare Advantage status and enroll new --

MS. UCCELLO: Yes, and I was going to get to that next, actually.

MR. HACKBARTH: Okay.

MS. UCCELLO: But I guess I'm just making sure that from what Mark and I were saying, that there isn't a problem, that my friend was saying.

DR. ZARABOZO: Yes. Your friend should be fine, I think.

MS. UCCELLO: Okay.

[Laughter.]

MS. UCCELLO: So now, thinking about regular MA plans who now in the middle of the year have to start accepting people who are newly coming in with conditions, how are the plans going to be appropriately compensated for them? Is that what you were talking about, where they can automatically do the risk -- note that in the risk adjustment --

DR. ZARABOZO: Yes, but I think what you're proposing is that if the plan chooses to do so, it can set up a benefit package for diabetics, for example, and say, this is open year round for people with diabetes. It's not going to be the case that all MA plans would have to accept somebody with diabetes, for example. They would say, we are participating in this way, which is what used to be a C-SNP is now a benefit package under general MA that is only for these kinds of people and we will take these kinds of people year-round.

MR. HACKBARTH: Okay. I'd like people to react to both versions of that, in particular, people with experience in the plan business. If you say this is a right that attaches to the beneficiary, that would maybe indicate that it isn't a plan choice and so I welcome comments on that issue.

DR. ZARABOZO: The other point is that if somebody, for example, has had diabetes for a year, let's say, they decide, well, I feel like changing a plan, I can do that because a year and a half ago I was diagnosed with diabetes. I never exercised my right to do so, but I feel like doing so now. So it's not necessarily a matter of on a

certain day you are diagnosed with this and therefore -- I mean, that's a life-changing event thing. That would be a little bit different from the current situation. So you would also need to be specific about is that what you're thinking about.

MR. HACKBARTH: And as I understand it, what you're saying is that the current law for C-SNPs, it's not, strictly speaking, a life-changing event. It's a one-time opportunity that can be exercised on diagnosis or at some later point.

MS. UCCELLO: But in any case, the diagnosis is going to be attached to the person when the payment is made to the plan.

DR. ZARABOZO: Under the current rules, yes. Again, for the new enrollee for whom there is no history, they would say, yes, you have been diagnosed with this. You can now be coded with it.

DR. BAICKER: So following up on the C-SNP line of inquiry, I'm disappointed that they didn't work on some of these metrics, and do you have some sense about why they didn't work and then how those factors would play out in the new regime where we're sort of offering -- we're allowing

them to offer these kinds of benefits within the broader MA umbrella.

DR. ZARABOZO: Well, I wouldn't necessarily say that they didn't work because there's a lot of variation, as was pointed out. Some of the HMOs that are C-SNPs do actually pretty well. The regional ones do not do very well. So part of the reason is to essentially broaden the C-SNP model to other -- to a larger population, essentially.

MS. AGUIAR: I would just add to that. So some of the C-SNPs that we spoke with, when they were talking about what makes their model work, they were saying that it really is focusing on changing the actual system of care, so making that systemic change, you know, moving from an idea of an insurer is just paying claims to one that's actually changing the model of care.

And so the idea is that maybe -- and again, I think as Carlos has said, there's been some consolidation in the industry where some larger, broader MA plans have been purchasing the C-SNPs with perhaps the idea to move this model of care into a more broad base for the more general MA population. And so when we have heard what works, it's really been fairly consistently this notion of actually

being able to change delivery systems.

And then what we're thinking and sort of the hope is that if we move that into the broader MA, that that could perhaps push the broader MA plans to be thinking about actually changing systems of care. That goes with more of our framework of moving towards broader integration.

DR. BAICKER: So, obviously, we wouldn't want to draw too much from a few case studies, but in the examples of the more HMO-style C-SNPs that you said worked better, are there innovations in the kinds of things that are covered or in the way that services are delivered, or is it -- do they look like examples of the kinds of innovation in coverage that we were hoping this would spur?

DR. ZARABOZO: We would say yes.

[Laughter.]

DR. ZARABOZO: Cori's friend might say yes, also, but I don't know her that well.

DR. MARK MILLER: What I'm trying to remember is when we were meeting with some of them, as Kate was talking, are there specific activities within that that you can identify for them. And I don't want to put you on the spot, because I actually was having a hard time kind of dredging

up from those meetings, too, the specific activities, and I remember leaving the meetings thinking, yes, there were some identifiable things that they were doing, but -- and I think that's what you're fishing for.

DR. BAICKER: And part of the reason that I'm fishing for that is not just to know, oh, do those kinds of things work in this context, but then to make sure that in the new regime we're discussing, those kinds of things would still be fostered, and the fact that they would be open to enrollment from people without those conditions necessarily wouldn't be so much of a problem. So I just want to be sure that the hope stays alive.

MR. HACKBARTH: So, Kate, there are at least some C-SNPs that perform well for patients with chronic conditions. There are regular Medicare Advantage plans that also perform well for people with chronic conditions. And so if you imagine a diagram with high performers, the plan type does not seem to be the driving factor. The performance is based on delivery system characteristics that can be found in either plan type.

That raises the question for me, why perpetuate a difference in plan type with different rules when, in fact,

what we're searching for is a change in care delivery that can be readily found in other plan types. Plan type is not the critical variable here. Care delivery system is the critical variable.

DR. REDBERG: I think this question is trying to get more to what is different about the successful C-SNPs or what's different, because I think you said on Slide 4 that the spending was higher in C-SNPs than in other Medicare Advantage plans and I was wondering --

DR. ZARABOZO: They have lower bids, actually, compared to fee-for-service, so --

DR. REDBERG: Okay. Was the --

DR. ZARABOZO: Spending is generally higher in MA because the bid is on the Medicare benefit package and then there are rebate dollars and so on, so generally higher in MA.

DR. REDBERG: Do we have any -- my other question is on Slide 9, in which we said that the outcome measures are lower for SNPs than for MA averages and that the plans were concerned the outcome measures weren't appropriate. So I was just wondering, are the populations sicker? Do they think that's why it's not appropriate? Or what was

different?

DR. ZARABOZO: Their main concern --

DR. REDBERG: I'm trying to get at --

DR. ZARABOZO: -- is socio-economic status, and that's mostly for the D-SNP situation. These are the intermediate outcome measures in HEDIS. And, for example, for the C-SNPs, the SNP-level reporting, the only outcome measure is really control of blood pressure across the entire population. There is no disease-specific outcome measures included in the SNP-level performance. So that's why it's hard to judge.

You may recall there was a footnote in the reading material that said, well, let's look at the diabetic measures to the extent that we can.

DR. REDBERG: Right.

DR. ZARABOZO: And there, we didn't see necessarily better performance by the C-SNPs on those measures.

DR. REDBERG: Okay, because I'm just -- I'm still not, I guess, clear on what is different about the care delivery in the C-SNPs as compared to -- like, if I had diabetes and I'm in the MA plan, I'm probably going to get

the diabetes counseling or the classes. So what would be different if I was in a C-SNP that would theoretically be better?

DR. ZARABOZO: Yes. The C-SNPs, for example, in talking to one of them, they have -- in their general MA plan -- this is both general and -- they have, even for diabetics, they have cost sharing for diabetic supplies in the general MA plan. In the C-SNP for diabetics, they do not. And then the same with the shoes, they have cost sharing. Not so in the C-SNP for diabetics. The provider network appears to be the same. There does seem to be more non-physician contact with the patients and more making sure that they get to appointments. They have a better transportation benefit for the people in the C-SNP to ensure that they do get to appointments. So a lot of it is the benefit package and much more -- a lot of family involvement, for example, with the patients.

DR. MARK MILLER: My recollection from the conversation, beyond the structuring of the benefit, is, it's like much, much more engagement. I think if the C-SNPs, or the ones that seem to be doing a good job, were speaking, they would say, what we try and do is concentrate

our effort on a particular area and population and that's why they want the C-SNP designation. I think that's what they would say. There are different ways to look at it, but --

MR. HACKBARTH: So what are the current barriers to Medicare Advantage plans doing all of the things that you just said?

DR. REDBERG: That's the question.

DR. ZARABOZO: Yes. Well, the interesting thing in that case was that even for diabetics, in the general MA plan, they didn't remove the cost sharing for diabetic supplies, and the C-SNP --

MR. HACKBARTH: But my question is, is there any statutory or regulatory barrier to a Medicare Advantage plan doing those things?

DR. ZARABOZO: The barrier is you can do it if something is specific to the disease. Like diabetic supplies naturally only goes to diabetics. But if you wanted to say, I would like to have no cost sharing for primary care visits for diabetics but everybody else has to have primary care cost sharing, that, you can't do.

MR. HACKBARTH: And I forget which draft

recommendation, what number it is, Carlos, but part of it is to --

DR. ZARABOZO: Number two, right.

MR. HACKBARTH: -- yes, is to grant that flexibility to general Medicare Advantage plans.

MS. AGUIAR: And I would just add, because we did ask this very question of one of the better performing C-SNPs and we said, you know, why is it that a general MA plan couldn't be able to do this, and the answer that we had received is it's more sort of the orientation over the general -- not all general MA plans, but the one that we were talking about specifically, where they sort of came into the market thinking more as a typical insurer that pays claims, perhaps just telephonic case management. So this idea of really creating system change even in a sometimes more localized area is just a shift in mentality, a shift in sort of how they have to operate. And our understanding is that there are some broader MA plans that are really interested in adopting that more C-SNP model, if you will, for their broader population. It's just it'll take time. It's a change in how they've run their operations previously.

MR. HACKBARTH: One argument that I've heard from somebody who's involved with one of the very best of the C-SNPs is that it permits you to develop a critical mass that allows you -- it supports investment in certain types of programs, and I understand the economic logic of that. Would there be anything to prevent a Medicare Advantage plan from saying, boy, we want to develop an outstanding program in caring for diabetics and in order to get the necessary critical mass, we want to do some targeted marketing to diabetics, you know, calling out the fact that we've got this outstanding program and perform exceedingly well?

DR. ZARABOZO: Not if it's general marketing. One of the issues is how do you do provider marketing, and that's kind of a sensitive issue, that --

MR. HACKBARTH: Say more about that distinction.

DR. ZARABOZO: Meaning that if a medical group, let's say, is capitated and they have a program for diabetics but they are selective about which diabetics they refer to that, that's the issue that people have with provider marketing, that to the extent that there's financial risk involved and they may -- you know, the possibility of selection of one patient is referred, another

patient is not referred as being too costly, that's the sensitivity about provider marketing. I'm not sure what the current rules are on the extent to which there can be provider marketing, but there's always been a concern about selection.

MR. HACKBARTH: Okay. I'm dominating the discussion here too much, so maybe we can talk some more about that.

Rita, did you have any other questions that you wanted to ask?

DR. REDBERG: No. Actually, what you extended and then you answered clarified my question. But now I'm just -- would the difference between, then, caring for those same patients in the regular MA plan mean that they would be less desirable in a regular MA plan because they're going to be higher and the costs will be higher for people with chronic conditions in a --

DR. ZARABOZO: Well, of course, it's the risk adjusted payment. So, I mean, I think the issue there would be, well, in order to work within that risk adjusted payment, we would rather have a program where we can do all these things for these people, and so we actually do better

financially because of all the things that we can do by targeting these people as opposed to being part of a broader population where risk adjustment by disease as opposed to, yes, we know how to do this for this particular disease and we can really be successful financially by what we do.

MR. BUTLER: On page 8, slide 8. So I'm still grappling with who these plans are.

My first question is on the I-SNPs that have declined 39 percent in 1 year, I guess. And I know there are only 48,000, but that's a big drop. So -- and you have not disclosed who the entity is, but how did that happen, or what changed status means?

MR. ZARABOZO: I think what is happening with this particular organization is that previously you could be a SNP if you had predominantly served a particular kind of population -- the institutionalized, for example. So this particular organization was in that category.

And then, the law was tightened up to say, no, you had to serve exclusively these kinds of people. So this is that organization that over the years has moved from I-SNP status to not being an I-SNP.

MR. BUTLER: It just seems that you're making a

recommendation around I-SNP, and you said that 40 percent of the members are gone in one year. It's a funny thing.

And then, I still have a feeling. I feel like wasn't it Butch Cassidy when Paul Newman and Robert Redford said, who are these guys?

I still feel that about this a little bit because we've got 20 percent of the D-SNP enrollment in Puerto Rico, half of the I-SNP in California and New York, and you get some weird geographies.

And one side of me says, okay, you've got Humana and United and the usual MA suspects. Are they somehow selectively choosing where they think this will work?

And I said, I don't think it's so much that as smaller, different plans, but that's what I mean.

I don't quite understand who are these guys quite yet, and if you have more insights that would help me kind of frame whether the motivations and the likelihood of this spreading more successfully across the country rather than in a fairly weird distribution of where these are taking hold

MR. ZARABOZO: Well, in terms of the I-SNPs, it's important to have contracts for the skilled nursing

facilities. So there's an issue there.

And you want kind of a different provider makeup. So there's also a critical mass point there although they're not very big.

But the I-SNPs -- the origin of the I-SNPs is from the Evercare demonstration which was United HealthCare. So United is still big in the I-SNP area.

And there's also actually Eriksson, which is now part of United. It is a continuing care retirement community. So they are also sometimes in the I-SNP category.

MR. BUTLER: So how about D-SNPs because that's where the vast majority of these folks reside?

MR. ZARABOZO: Many companies have been involved in D-SNPs just because it's an opportunity to get enrollment outside of the open enrollment period. But, as noted here, there are many more not-for-profit organizations in the D-SNPs, and about 5 percent of the enrollment is in public authorities, like county health systems or like the Jackson Memorial Health System.

DR. NERENZ: I just want to make sure I understand the bullet points about implications for program spending in

the various recommendations.

And I want to make sure I clarify something you said, and I think you actually said it when this slide was up, but it's not on this slide. It's about the bids. It's seems to me we've got a couple of comparisons, and this is what I want to clarify. And then, you actually repeat it again.

The bids that you describe, you said, are lower than the regular MA bids?

MR. ZARABOZO: The C-NSP bids are lower, and this could be a function of geography because a lot of the enrollment is coming from Los Angeles, for example. The Los Angeles area.

DR. NERENZ: Okay. And then, in the text materials, there's also a similar statement, but it goes the other way. It also refers to bids, and it says that the bids are higher than fee-for-service. Are we talking about the same bids?

MS. AGUIAR: Right. So the bids for C-SNPs, and perhaps I-SNPs, are lower than fee-for-service, but total payments are over fee-for-service.

DR. NERENZ: Okay.

MS. AGUIAR: So the bids for C-SNPs are lower than fee-for-service. The payments are over -- are higher than fee-for-service. Bids for --

DR. NERENZ: Payments by them to providers?

MS. AGUIAR: Oh, no, no, Medicare payments.

MR. HACKBARTH: You may need to explain the benchmark system and how all the pieces fit together.

DR. NERENZ: Okay. I'm sorry if this is going to get us into deep water, but it seems like it's essential to the question of what the program spending implications are.

MR. HACKBARTH: Yeah, yeah, this is important.

DR. NERENZ: So I just want to make sure I can follow it.

MR. ZARABOZO: It's the way that the MA payment system works, which is plans present a bid for how much, what revenue do they need to cover the Medicare A and B benefits.

DR. NERENZ: Yes, yes.

MR. ZARABOZO: This is compared to an area benchmark.

DR. NERENZ: Yes.

MR. ZARABOZO: And in many areas the benchmark

itself exceeds fee-for-service.

DR. NERENZ: Yes. Okay, I understand that.

MR. ZARABOZO: So then the bid is compared to the benchmark. There's a rebate calculation that says you can have some of that.

DR. NERENZ: Yes. Right.

MR. ZARABOZO: So, if you combine the bid for the A and B benefit plus the rebate dollars-

DR. NERENZ: Yes.

MR. ZARABOZO: -- that's when you get over fee-for-service in terms of payment to the plan.

DR. NERENZ: Okay, okay. I get that. It's complicated, but I think I get it.

MR. ZARABOZO: Right.

DR. NERENZ: Okay, but if we go back to at least the first part of this, the bids in the SNPs -- and it may be different in the three different subtypes -- are lower than MA for the comparable people? Is that --

MR. ZARABOZO: It is different in the three subtypes.

DR. NERENZ: Okay.

MR. ZARABOZO: And what we were specifically

pointing out is that C-SNPs have low bids, relatively low bids. The other plans are close to fee-for-service.

MS. AGUIAR: D-SNPs are.

MR. ZARABOZO: And D-SNPS are higher, yeah.

DR. NERENZ: Okay. So now just let me play it out as if it were fairly straightforward.

If then, the C-SNPs were not reauthorized -- and we are -- I think there's another little line of text. This is on page 26 of the chapter, that says we are assuming most of those enrollees then will just move into general MA. Does that mean then that program spending will go up because of that movement from the lower-bid C-SNP to a higher-bid MA?

Is the logic as straightforward as that?

MR. ZARABOZO: Yes, that is a possibility. That's a logical possibility.

DR. NERENZ: I mean, is that actually the basis for --

MR. HACKBARTH: You'd have to do it on a geographic basis. So, as Carlos indicated, a lot of the C-SNP enrollment -- I think I heard you say -- is in Southern California. And so, there high fee-for-service costs in

Southern California, and so they're coming in lower.

Now if -- I don't know how the general MA bids compare to fee-for-service in Southern California. I suspect that they may be lower.

And so, if you have a conversion within Southern California of C-SNPs with below fee-for-service bids to MA plans with below fee-for-service bids, you may not have a significant budget.

MR. ZARABOZO: Although the point there, though, is if like 100 patients are in the C-SNP and they cost less because of the many things the C-SNPs can do, if they just go to general MA and they suffer -- you know, they have additional costs -- because they couldn't do what they did, then that's the logical consequence.

DR. NERENZ: Okay. Well, that's essentially the dynamic I was trying to understand with the question.

I know the bullet -- at least this is now slide -- I'm sorry I've got to flip through these. Top of 14 basically says that if the implication is increased program spending. I just want to understand what the underlying logic chain is to get to that point.

MR. ZARABOZO: The other point is that we expect

growth in the C-SNP area. So that -- because of they're almost doubling the number of plans in 2013 and it would be -- it is a broader geographic area.

DR. NERENZ: Okay. Fine. So the answer is complicated.

MS. AGUIAR: It is.

[Laughter.]

MS. AGUIAR: And I would just add to it. When we think about the bids, we've been thinking about them as how much that plan is able to provide Part A and B services for that beneficiary. So we've been thinking about if that beneficiary's cost -- has a certain cost of A and B services to them, if they were to move into MA, it should be about the same.

The difference in increase in program spending is not from whether or not these beneficiaries would move from the C-SNP to the general MA plan. It's actually because there is an assumption since C-SNPs are going -- since all SNPs are going to expire in current law, there is an assumption that a certain percentage of those beneficiaries will go into fee-for-service.

And payments to C-SNPs, I-SNPs and D-SNPs are over

fee-for-service. So if they go into fee-for-service under current law, spending on those beneficiaries will decline. That's already in the baseline.

So, if we keep them in MA, whether in a C-SNP in MA, in a D-SNP, that's -- so that's actually where the cost is coming from.

DR. NERENZ: All right. Okay. So then I'll elaborate my previous point; it's really complicated.

MS. AGUIAR: Yes.

[Laughter.]

DR. CHERNEW: I think that's the main effect.

Our recommendation actually keeps more people in MA than otherwise might. And MA benchmarks are higher in general. At least, they're assumed to be. And so, that's why in the transition period as opposed to just getting rid of them, it costs more.

DR. NERENZ: Yes. Thank you.

No, I didn't fully appreciate that dynamic until we got into this discussion. Thank you.

MR. GEORGE MILLER: Yes. And mine has to do with the reading material, and I really appreciate the information on the demographic characteristics. Following

this line of questioning about C-SNPs, especially on page 8, we project 21 percent growth in the last 12 months. But I notice in the C-SNPs, in the reading, that 32 percent of all C-SNPs are African Americans.

So part of my question deals back with the quality issue, and that is, do you know -- have you done research that the disparities are less or greater than the general population of fee-for-service?

At least I thought around the table there's still a concern about disparities in health care in general, across the Medicare population. So do we know, in spite of what you said about the quality for C-SNPs, if disparities are less or if there's a better coordination of care with C-SNPs being focused on the model of care to deal with that particular disease process?

So is there a better quality, less of disparity of care, or have you been able to tease that out?

MR. ZARABOZO: We're trying to look at that with the person-level HEDIS data that we're working with. So we're still looking at that data.

But I would point out on the distribution the distribution matches the geography; that is, the reason the

proportion of African Americans is so high is it matches --

MR. GEORGE MILLER: Where they are.

MR. ZARABOZO: -- the distribution in the geography.

MR. GEORGE MILLER: Okay. So it's not disproportionate.

MR. ZARABOZO: Right. It does not --

MR. GEORGE MILLER: Okay. Got it.

Yeah. Okay. Thank you.

MR. GRADISON: I have two questions. I think the answers to them are self-obvious, but I want to make sure.

I envision that at some point in time the reimbursement rates to MA plans are going to actually move towards fee-for-service rather than go north as they have been with the star rating and the election and a few other things going on.

So my first question in my mind has to do with the viability of MA plans. If our recommendations are adopted, I think the answer is it doesn't make any difference if you have appropriate risk-adjusted payments. Is that right?

Shall I rephrase the question?

The question is, if we make these changes, will it

influence one way or the other the viability of MA plans in an environment in which their reimbursement rates in general are going down?

MR. ZARABOZO: That's more of a general MA question. I don't think it is SNP-particular question.

DR. MARK MILLER: I think that's what he's saying.

MR. GRADISON: That's what I was -- that was my impression, but I just want to make sure.

MS. AGUIAR: And I would just add to that. I think, as we emphasized more in the mailing materials that have been sent to you, you know, there are dual eligibles, about 900,000 of them, in general MA plans already. You know. So it's not just -- they're not only in D-SNPs.

And then the same thing with the C-SNPs. There are beneficiaries with those chronic conditions, with many of those chronic conditions, that qualify for C-SNPs already in the MA plans.

So I think that we would not expect a greater influx of individuals with those same conditions into general MA, to have a negative financial impact on MAs, since the risk adjustment system is -- you know, the risk adjustment -- you know, the HCC scores attached to those

beneficiaries in the C-SNPs should be the same ones attached to those beneficiaries when they're in the general MA plan.

Does that make sense?

MR. GRADISON: Yeah, that's from the plan point of view.

MS. AGUIAR: Yeah.

MR. GRADISON: Same environment, let's assume significantly lower reimbursements for MA plans. What may be the effect of the beneficiaries who will be shifted into the MA plans?

I assume what happens is that step by step the premiums get higher, and the enrollment gets smaller. Maybe it's more complicated than that.

But from a beneficiary's point of view I suppose they are no more inconvenienced than anybody else that's gone into the MA plan, but I just want to make sure, if there are fewer options available among MA plans or the plans kind of struggle along but with a declining enrollment resulting from higher premiums.

MR. HACKBARTH: Do you see the higher premiums being the result of general changes in the payment system for MA plans, or are you saying as a result of this

migration of people from SNPs into MA?

MR. GRADISON: A general migration, yeah. My sense would be that the reimbursement rates, as they move toward fee-for-service levels, would probably force many of the MA plans to try to shift more of the costs to the beneficiaries.

MR. HACKBARTH: And so, the changes in PPACA that happened to payment for Medicare Advantage plans also will happen to the SNFs because they're basically in the same payment system.

So, to the extent that lower Medicare payments to MA plans results in higher increases in premiums for Medicare beneficiaries, that will be true across the board. That effect is general.

And then, what Christine is saying I think is that because of risk adjustment, if SNP people with higher risk scores migrate into Medicare Advantage plans, they will bring with them higher Medicare payments.

MR. GRADISON: Yeah.

MR. HACKBARTH: And so, in and of itself, that should not result in higher premiums for MA enrollees.

MR. GRADISON: Thank you. That was very helpful.

Thank you.

DR. DEAN: I had some of the same struggles that Peter had, to try and figure out who these guys are, especially the I-SNP, which seems like it might be a very appealing approach because it really is a unique population, more so maybe even than some of these others.

Do these organizations -- are they just -- do they actually deliver care as well as pay for care?

I mean, do they -- are they delivery organizations as well as financing organizations?

How do they -- how are they structured, and who are they?

MR. ZARABOZO: They are MA plans. So, in other words, they're responsible for the full range of A and B benefits.

DR. DEAN: But I mean do they -- I understand that, but do they actually employ caregivers, or do they just contract?

MR. ZARABOZO: I think they employ, for example, nurse practitioners that go into the facilities, and then they have the contracts with the institutions. I don't know whether, for example, the medical -- they use the medical

director of the institution or not.

DR. DEAN: And with the decline, is that something that is expected to continue, or was that because of just this one chain?

MR. ZARABOZO: That was that one organization.

DR. DEAN: And is there any prospects as to whether there's -- what is the interest within the industry?

Is it likely that there would be more interest in it because, like I say, in many ways this is a very appealing structure?

MR. ZARABOZO: Yeah. I don't know the extent of interest in expanding the I-SNP option.

DR. DEAN: Thank you.

MS. AGUIAR: I would just add to that that we call them the duals office for short, within CMS. It does have actually a demonstration going on now, which is sort of a little bit more of a relaxed model of the I-SNP model that's really sort of trying to bring -- you know, get interest from nursing homes to participate.

I believe that they have recently kicked off that demonstration. And so it's similar to the I-SNP model, and it's really sort of trying to broaden, you know,

participation into that model because if you think about it I think the I-SNP model is more or less that they'll embed a nurse practitioner or they'll have a staff there.

They obviously are responsible for all Medicare Part A and B benefits, but the real sort of value proposition is that they'll be there to help medically manage that patient there and then, ideally, to reduce unnecessary hospital readmissions.

So, you know, you could see from a nursing facility's perspective some of them have a financial incentive to not do that.

DR. DEAN: Right.

MS. AGUIAR: And so, I think that could be possibly why some of the I-SNPs have not been able to expand it. But again, there are sort of other movements more happening now to try to sort of broaden that concept, even if not in the exact same structure of the I-SNP model.

DR. DEAN: And the program you mention, that's completely separate from MA.

MS. AGUIAR: Completely. It's a demonstration.

DR. DEAN: Okay.

DR. HALL: Well, thank you for trying to shed some

light on this confusion.

We're spending a lot of time, it appears, on C-SNPs right now, which recommendation 2 is suggesting we should make a suggestion for deauthorization. And the numbers are relatively small relative, say, to duals. It's about 20 percent or -- it's over a million in duals and about 200,000 plus in C-SNPs.

One thing you said, Carlos, I guess I want to make sure I got this right. So we're seeing a decline in one sense, but you mention that some of the carriers are actually anticipating a large increase in enrollment. Could you clarify that for me?

MR. ZARABOZO: In terms of the C-SNPs?

DR. HALL: Yes.

MR. ZARABOZO: Yeah, the -- a couple of the firms have been bought by much larger firms that have C-SNPs. So -- and the number of plans are being offered in 2013 is almost doubled.

DR. HALL: Okay.

MR. ZARABOZO: So that's why we would expect a growth in the C-SNP enrollment.

DR. HALL: So one would think that from a clinical

standpoint what's good for a diabetic in Alabama might be good for a diabetic in Alaska. And yet, what seems to happen in this marketplace is that the drivers have relatively little to do with the rationale of clinical care of the chronic illnesses being covered. Am I missing something here?

Is this more a matter of profit-loss?

Why is this so regional, and how do you explain this -- these discrepancies?

MR. ZARABOZO: Well, I think the current C-SNP situation is partly the regionality of it, so to speak. It's because one regional plan, or regional organization, has entered this particular market. So that explains why the southern emphasis in terms of the enrollment, but I would expect that to change because of the larger entrance now.

DR. HALL: And the reason it will -- if we were to go to the major carriers, what would they say is the rationale for wishing to expand this program, which has been somewhat tenuous now over the years?

MR. ZARABOZO: Well, I think -- it's hard for me to say.

DR. HALL: Okay. You said enough.

MR. ZARABOZO: No, I would say that the C-SNPs, I mean, have been successful financially, it appears, and therefore, the model may be appropriate to extend to more people, essentially. And large organizations can also be successful with that model, I think is the --

MS. AGUIAR: And again, we've also heard that some of the reason for this acquisition is an interest in adopting the C-SNP model for their broader, general MA population.

DR. HALL: Right. That could be one possibility, that it's a pilot study. But a crude analogy is that we're moving from a very intense concentration on high-risk people to more of I guess you'd say community rating if we move back into MA, putting people with chronic disease back into the general pool.

Okay. Thank you.

MR. KUHN: Quick question, kind of related to C-SNPs but a little bit broader, but first, I do like the SNP concept overall. I think the differentiated structure adds some nice flexibility to the program, which I think is quite useful.

When I thought about C-SNPs -- and I'm glad, Glenn, you raised that question -- I've always thought a little bit that you need large numbers of patients in order to kind of bring together some of the -- it's easier to base some of the interventions when you have a larger group that's out there.

And Carlos mentioned the example about the benefit package, but I also heard what you said, Glenn. So it's something I want to think about a little bit more.

The real kind of question I have is kind of the differentiation in terms of the variation of performance of plans. We said we had some very high-value plans out there in all categories but some that were less so.

So just kind of once again kind of an inventory of the tools that CMS has now to kind of encourage innovations for plans -- obviously, there's the five star. There's the so-called quality bonus program. What are some of the things that they have in their tool kit now to kind of drive innovation, to drive higher performance of MA plans all over but predominantly the SNP plans?

And is there anything that's left on the sideline that might be helpful, that if they had those, it would be a

more robust opportunity to drive improvement?

MR. ZARABOZO: Well, as you mentioned, the primary driver is the star system. And one aspect of the star system is that SNP enrolles are rolled up into the star ratings by the proportion of their population.

And the elements that are -- some SNP-specific elements are included in the star rating system. They only apply to the SNPs. So that's really the principle tool of promoting better quality among the SNP plans

MR. KUHN: Is there anything that MedPAC has opined on in the past or that others in the policy world have talked about that if CMS were to add those, have that in their portfolio, either through Congress and through regulation, it would also help drive innovation?

MR. ZARABOZO: Well, we've recommended in the report on -- the MIPPA required report on comparing quality to have more outcome measures. I mean in terms of what is the main interest in quality measurement, so to increase the number of outcome measures. And CMS is working on that.

I don't know otherwise what additional approaches.

DR. COOMBS: Slide 16. In going over that slide, for the integrated D-SNPs, you know, I'm noticing that for

the percentage -- and I hope I'm understanding this correctly -- financially integrated was 5 percent, 65,000 enrollees and 25 approximate D-SNP enrollees. So, for the non-integrated, it's a large number.

Was there some kind of impression you had in terms of their way -- on their way to some kind of integration, whether financial or the combined Medicaid integration?

MS. AGUIAR: Yes, this is a frustration that we've heard from the D-SNP industry over the past few years. We've heard of plans that very much so want to integrate, to the extent that they perhaps -- even if not full, with full Medicaid benefits, are really interested in integrating for some or all of the Medicaid benefits.

And the just unfortunate limitation is that there are just some states that are either just not interested really in managed care and moving their long-term care benefits into managed care. There's a lack of resources on states, and so they can't right now.

Now since the demonstrations have come up -- CMS-state demonstrations have come up -- a lot of the states are sort of moving their focus on that and again less -- so this is what we've been hearing from the industry on working with

the D-SNPs.

And then, another concern we've heard on the part of the state was that the D-SNPs would be -- have to be reauthorized every few years, and so it would quite an administrative task on the part of the state to really move towards a managed long-term care for a product that they're not sure whether or not it was going to be able -- it was going to last.

So, again, we have heard frustration from those plans that want to become integrated and are just not able to.

DR. COOMBS: So, Glenn, I was just thinking about your recommendation in light of that and this large, you know, quantity of D-SNPs that are involved.

And I know, speaking with Massachusetts's head of the Medicaid and Medicare Services, that one of the challenges is just that they felt apprehensive about the state jurisdiction, and when the implementation grant came about it allowed them to do some very innovative things.

So I don't know that there's opportunity for some transition from the integrated -- the non-integrated to progress to the integrated, and so I was just kind of

interested in that next leap.

MR. HACKBARTH: Help me out here, Christine. I don't think the issue is states like Massachusetts.

DR. COOMBS: No, no, no.

MR. HACKBARTH: They're interested in the fully integrated models, and they're using those plans in their demonstration proposal. The issues about states being reluctant to support full integration are other states that don't share that orientation.

Let me ask this, which I think is a related question. Alice, as I think you know, there are 26 states that have expressed interest in doing demonstrations for dually eligible beneficiaries.

DR. COOMBS: Right.

MR. HACKBARTH: Some of those states envision using as the primary vehicle plans that they've worked with under Medicaid. Is that correct, Christine?

MS. AGUIAR: That is correct, and that also is a concern that we've heard from the D-SNP industry. Again, according to CMS information that they have put out, from what we've heard, it is supposed to be a joint selection process between CMS and the states. There has been some

concern about whether or not in truth it actually will end up that way in every state. There has just been some concern about that. But there has been preference from some states to work with the Medicaid managed care plans that they already are working with. And you can understand, I mean, they already have that set up with those plans.

Some of those plans in some states may already offer a D-SNP or at least an MA plan, so then perhaps that organization could still participate. But there has been concern in some states that the D-SNPs that are not already integrated -- and most of them aren't -- will not be able to participate in the demonstrations.

MR. HACKBARTH: So several years ago -- I think it was in PPACA -- the Congress included a provision requiring that D-SNPs, to be eligible as D-SNPs, had to have contracts with states, and that was based, at least in part, I think on a MedPAC recommendation to that effect. And the problem here is that you've got a program, Medicaid, with joint federal-state responsibility, and the Congress can say, you know, we want contracts for these plans. But unless the states are eager to use these plans as vehicles, it doesn't go anywhere.

DR. COOMBS: Right.

MR. HACKBARTH: And so many of the D-SNPs have met with frustrations. We'd love to contract, we'd love to financially integrate, but we don't have a willing partner in the state, because in some states they're more oriented towards using their Medicaid HMOs. And so, you know, it's a byproduct of this shared responsibility between the federal and state governments. Is that a fair statement?

MS. AGUIAR: I think that is, and I think, Alice, part of your question was about innovation and are states seeing the demonstrations as an opportunity to be more innovative than they are when they work with the D-SNPs.

DR. COOMBS: Right.

MS. AGUIAR: Part of that, which the fourth Chairman's draft recommendation tries to get at is to address some of these administrative misalignments. You know, so that was a sticking point for some states, and understandably that was a barrier.

There are differences amongst the demonstrations that you do not have in the current D-SNP system. Primarily the states are able to share in the Medicare savings, that they're not able to do so now when you have a D-SNP. And

the rates to the demonstration plans will be set below current spending, and, again, that's not how it is currently. And so I think part of what we've heard some of -- because there really was quite a rush to the table with the demonstrations around the states --

DR. COOMBS: Right.

MS. AGUIAR: -- was this opportunity sort of force, try to force savings up front through these lower capitation rates relative to lower spending. And then the states will be able to share that, to share in that savings in the beginning, you know, in year one of the demonstration. Again, some of reluctance with states to contract with the D-SNPs to be integrated is this concern that from what they have told us that, you know, the first year, sort of savings, if you think about it, tend to be from acute care Medicare services with long-term care savings coming later on. You know, we have argued that that is not perhaps always the case in every situation. But, nevertheless, under the demonstrations the states are -- you know, there will be a -- in some states, like a 1-percent, 2-percent, 3-percent forced savings up front in year one, and then that will be shared between Medicare and the

states.

DR. COOMBS: Right.

MS. AGUIAR: And so there's sort of a financial flexibility there that doesn't exist under the current D-SNP model, which I think has made these demonstrations more attractive.

DR. COOMBS: To whatever extent we could, if the Secretary could actually work with some kind of innovation to work with the states locally, I think that would help us tremendously with improved integration. I don't know how that can happen.

MR. HACKBARTH: In fact, that's the intent of the demonstration, is to bring the parties together and, you know, flexibility around the roles.

DR. COOMBS: I think that's the next level for us. Thanks.

DR. NAYLOR: So just following up on that, on Slide 20, I'm wondering if -- you talk about the administrative barriers in the context of better alignment with the appeals and grievance process. Why can't we seek just one process? I mean, for the beneficiary, they haven't a clue that this is coming from this stream and this is

coming from this stream. So why not just recommend a process?

MS. AGUIAR: Right. Well, I think that -- and correct me, please, Glenn, if I'm misspeaking. I believe that the intention of this draft recommendation is for there to be an aligned. So one --

DR. NAYLOR: An aligned.

MS. AGUIAR: Right.

DR. NAYLOR: Okay, because I was reading it as align the processes, but it sounded like there could be --

MS. AGUIAR: Right.

DR. NAYLOR: All right. On Slide 13, given the conversation that we've been having, help me to understand. If we're to take some of the lessons learned from the best practices around C-SNPs, so around targeting and this opportunity for flexibility and special service provision and then risk adjustment payments accordingly, I'm looking at the timeline here, and so the transition, if you were to think about that, into an MA plan is a moratorium starting a year from now, essentially, if we look at this again in January, directing the Secretary, though, to think about three years from now having assembled an opportunity for

benefit redesign that would allow to capitalize on best practices and so on. And I'm wondering -- we lose something here in momentum, especially given what you were talking about in terms of increased interest and so on in that time line.

MR. ZARABOZO: Potentially. I mean, if you would -- yes, you would have fewer C-SNPs, presumably, during that -- if it had been reauthorized, then you would have presumably more C-SNPs. But the reason for the three years is sort of an approximation of how long will it take the Secretary to do this, because it would involve here are the standards, here are the regulations that we would -- so three years or less, hopefully. So it's within three years, but setting it, you know, by the end of three years you will have done all of this, hopefully it will occur sooner than by the end of three years.

DR. NAYLOR: One other question. This talks about the benefit design, but part of C-SNPs was also this set of expectations around reporting process and outcomes. And I'm wondering, does that have -- does this recommendation now move those expectations into the MA plans generally for those that take advantage of the redesigned packages?

MR. ZARABOZO: Yeah, that's a good question that I think that part of the -- part of what is required of C-SNPs is to have this model of care that explains how is it that you're going to specialize in the treatment of these people. And I would presume that we would say, yes, that needs to continue, you need to show that if you're going to do this specialization, you have to be capable of doing it and be effective at doing it. So I think the reporting and the standards would continue.

MR. HACKBARTH: Okay. Round 1, clarifying questions [off microphone].

MR. ARMSTRONG: First, I just would disclose that I work for an organization that has 80,000 Medicare Advantage lives, and we started a C-SNP a couple of years ago. It never grew -- I can't remember the enrollment -- to more than 1,500 patients. And we've decided to close this effective January 1st. And I think that for us the issue has been the distinctive value of that C-SNP wasn't so great and different from what our MA plans had to offer, to be frank. So that just influences my point of view on this.

I also just would say I really like the fact that we're having a conversation about how we can organize these

prepaid, financed kind of plans to better match the special needs of different populations of our beneficiaries. I wish it wasn't a conversation forced by some deadlines and so constrained.

So that leads to just a question. In a way it's kind of rhetorical. I can't remember, but I think it's a very high percentage of all Medicare beneficiaries actually live with at least one chronic illness. Isn't that right?

MR. ZARABOZO: That's correct, and that's the point that we're mentioning, that 15 percent of beneficiaries have diabetes, for example. If you sum up the top three conditions, I think 30 percent of the people fall within, you know, the top three conditions.

MR. ARMSTRONG: So 30 percent of beneficiaries have at least one of those chronic illnesses, and we would expect that more and more of our beneficiaries are going to be living with at least one chronic illness as we go forward.

I guess the round two point I'll make is that I like the idea of folding the chronic illness -- the C-SNP kind of role into regular Medicare Advantage, because I think that's what Medicare Advantage is going to have to be

all about.

But the other question I had is a little bit broader, and that is, what we're proposing here leads us to a place where basically we have two SNPs -- one focused on the unique issues of dual eligibles, and, unfortunately, that ends up becoming kind of a bureaucratic kind of web we try to untangle, and that's too bad that gets in our way; and the other is institutionalized patients.

I just wonder if -- there's a presumption that those are two patient populations with special needs that could be met better by a special program. I just wonder what that tells us about what other populations or beneficiaries might also benefit from special needs plans. And I don't know the answer to that question, but my hope -- I guess my question is: Have we considered that? Is that something MedPAC has put on the table in the past? And if not, I would hope that that would be something that, as we go forward, we might put on the table.

DR. SAMITT: Two questions. We haven't at all discussed the materiality of the spending increases, so it's described as minimal for the I-SNPs and in transition for the C-SNPs and I assume more substantive for the D-SNPs.

Has an assessment or an estimate been done of what you'd predict the increase would be relative to current law?

MS. AGUIAR: We have done our own internal estimates. We're waiting now to hear CBO's to fact-check them with CBO to see if they match their estimates.

I would say on the D-SNP side, because it would be only the financially integrated and those that have a companion Medicaid plan, which is about 60 plans, and then the rest -- so the vast majority of the industry could convert to general MA. The financial impact is not as large as you sort of would assume if we were saying that all these SNPs would be reauthorized.

I believe that for the -- when we come to the final recommendations where you would vote on it, that is when we would present our buckets, our estimates.

DR. SAMITT: Although can I follow up on that? Would we estimate with the recommendation 3 that there would be non-integrated D-SNPs that convert to integrated D-SNPs? So it wouldn't just preserve those existing D-SNPs. I assume there would be some SNP transition if they --

MS. AGUIAR: Right, exactly. So the difference is sort of what we're modeling that's not current law. So if

it's under current law for all D-SNPs to expire and then the issue is a percentage of those individuals and current law have gone back into fee-for-service. So what their recommendation would be changed and what we would be modeling is the percent of beneficiaries in those financially integrated D-SNPs that would have gone into fee-for-service, were they to expire, that would remain in the MA program. And so that's where the cost is coming from.

DR. SAMITT: And --

MR. HACKBARTH: So making the estimate a critical variable is the assumption about how many go back into fee-for-service versus MA plans, and also the geographic distribution of those matters, because the gap between Medicare Advantage rates and fee-for-service rates is not uniform across the country.

DR. SAMITT: My follow-up question was really in line with that as well. Do we envision, especially for C-SNP and D-SNP, that we would see differential choices by the beneficiaries in each of those two? So, for example, C-SNP, would we envision that those beneficiaries would switch to fee-for-service or other MA plans to a different degree than those that are currently in non-integrated D-SNPs?

MS. AGUIAR: I believe -- and, again, I wouldn't want to be quoted on this because we have to fact-check this with CBO first. My understanding is that there is an assumption, a particular assumption of the percentage of beneficiaries in D-SNPs that would go into fee-for-service. And I don't believe it differs by type of plan.

DR. SAMITT: Okay. Thank you.

MS. AGUIAR: But, again, that is something that we're working with them now.

DR. SAMITT: Okay. Thanks.

MR. HACKBARTH: You would think -- and correct me if my logic is flawed here -- that how many convert to fee-for-service as opposed to another Medicare Advantage plan would vary geographically. In the areas where Medicare Advantage rates are well above fee-for-service, that gives the Medicare Advantage plans an opportunity to offer additional benefits that may make people in those areas more likely to go to an MA plan as opposed to back to fee-for-service. Where the gap is smaller, you might have more migration back into fee-for-service. And so, again, the patterns in how these things happen I think are critical for the final estimate.

DR. MARK MILLER: And the only thing I would say, just to lower the expectations as much as possible --

[Laughter.]

DR. MARK MILLER: Remember a few things. We won't in any instances produce a point estimate because that's a CBO job and that comes from legislation if somebody wants to pursue this. So we have this process -- and you wouldn't know this being the first time through -- where we estimate things within buckets. And some of the precision we may be talking about here will not influence that bucket, and so CBO's approach to this in our world may be a little bit different than when somebody shows up with a piece of legislation.

The other thing I think CBO would say is a lot of those dynamics are included in baseline types of assumptions, and to the extent it's wildly different, they might make a separate assumption. But if it's embedded in the baseline, they might not. But, again, this is something that is really their prerogative, and we're working with them.

DR. HOADLEY: So a lot of what I was going to raise has come up already in the discussion, but I guess I

want to ask about a couple of things.

On the C-SNP issues of -- and it really goes into the recommendation on 13 of the things that the Secretary might be able to do to change the current rules to make it easier and which of those are secretarial authority and which of those are laws. And you talked a little bit about, you know, some of the cost-sharing rules and things, and it seems like it would be really useful to figure out as much of what that list might look like as possible so we can think about it, and including leading down into the drug plan side because since to enroll in a drug plan you have to be in the drug plan affiliated with your MA plan, whatever changes will flow on down into that part of the program. And so, again, co-pay flexibility, the ability to do differential cost sharing for the drugs for a particular chronic condition might fit on that list.

But it seems like all that runs up against the tension of sort of the general nondiscrimination policy. You know, it's always been a thought that MA plans should be able to market themselves, and we talked about this, you know, because they're very good at treating people with diabetes. The flip side is we want to make sure they're not

trying to avoid people with X or Y or Z. And in some ways, this is -- you know, it's the two sides of the same coin. So how do you adjust those rules without opening up another problem it seems like is the real tension that we're trying to work at there. So the more we could think about, you know, sort of what those items might look like.

And then the other set of items it seems like where secretarial authority doesn't help are the things where -- and, Glenn, you talked about whether there was -- whether the label matters and whether the plan type matters. Are there things -- and it seems like we've had a couple examples of these where having the sole focus on one population is allowing a plan to do some things that they are less likely to end up doing when they have to worry about not just the people with diabetes but the people with cardiac problems and going down the list. And so are there potential losses that we can't fix that come through a more diluted focus? So those are some things that -- I guess it's not really a question, but a sort of request.

And then on your other question that you posed to us in the beginning about the sort of open enrollment or flexible open enrollment opportunity, the first thing that

came to mind to me is what would the administrative issues be. I mean, my understanding from when I've been on focus groups is that the duals that have this opportunity now often don't know they have that opportunity. Obviously, they can learn about it, they can be told about it, and it can be brought to them and they can act on it. So the question of education and sort of understanding -- and there was a distinction between the way you first phrase it as newly diagnosed versus the current policy of sort of ever diagnosed, ever diagnosed could be everybody, essentially, or close to everybody. What does that do to education and marketing? What does that do to the current notion of the open season? You know, how do you regulate that? Do you only allow the people to go into a plan that somehow has a special component or is it truly wide open? And if it's a special component aren't we just reinventing a SNP under some different rubric?

So I see a whole bunch of administrative education issues associated with that, which makes me skeptical about the ability for that to be effective, even though the idea might be appealing in some ways. And so, again, the more we can understand what the administrative barriers might be and

sort of the education barriers that would help us think through that option, I think. So I'll leave those requests.

MR. HACKBARTH: So you all remember how yesterday I ran ahead of schedule all day long, right?

[Laughter.]

MR. HACKBARTH: Remember that. Right now we're 13 minutes over for this session, and we just completed Round 1. So I'm going to propose -- well, first let me ask a question. We're currently scheduled to end at 11:45 after a public comment period. If we needed to go to 12:00 would that pose any big problems for people in terms of plane, train reservations? Okay. We will be done no later than 12:00. Maybe at 11:45, but no later than 12:00.

So as opposed to going around one by one in Round 2, what I'm going to propose is that I'd like to see the hands of people who have Round 2 comments that they really urgent want to make at this point. And my slipping "urgently" in there, I'm really not trying to, you know, aggressively discourage comments. In fact, I need comments so that we can figure out what to do for January. But if you could really, you know, focus on being efficient in terms of those comments, that would be helpful.

So who has Round 2 comments that they would like to get in here? We have about seven or so. Okay. So let's proceed with those.

DR. NERENZ: I think this is very quick. I'm asking you to consider possibly adding a recommendation about quality measures and whether this would be specific to one type or all types. I know this has been done in the past, and it seems to me that the recommendation is to find more outcome measures, add more.

My new point would be just to consider a recommendation that would recommend taking some quality measures currently in the star system out on the basis of there being not a high clinical priority for some of these specific populations. I don't think we've been given a list of those measures. I don't have a specific one to suggest. I'm just raising the concept.

DR. DEAN: Yeah, just quickly, I just wanted to reinforce what Scott said, that chronic disease is such a big part of our challenge as a society that -- and we've talked a lot about diabetes, and certainly there are a lot of specialized and types of approaches that we know help people that have diabetes. On the other hand, diabetes

rarely exists by itself. I mean, usually those folks will have some other chronic disease as well, and I think that we might even do harm to the care of these folks if we focus too much on a few selected conditions.

So I think it makes good sense to -- chronic care really ought to be part of the total part of coverage that Medicare provides, and I don't think we should focus on individual conditions that are so common.

Now, the possible exception to that might be -- I see you listed, you know, HIV/AIDS. That is probably a unique population, possibly the folks with ESRD. You know, there may be a few within that, but for the most part, I think a special program focused on "chronic disease" is probably not appropriate.

DR. HALL: Similar comments, I guess. Chronic disease never exists in a vacuum. These are incredibly complex clinical cases for the most part. A lot of decisions are made, room --

DR. DEAN: Weighing one against another.

DR. HALL: Right. Room for legitimate argument as to whether highly specialized care is more effective. It certainly isn't more cost-effective, that there's a lot of

uncertainty in all of this.

On the other hand, one thing I think we know for sure is that the increase in the Medicare-eligible population will be bringing with it an unprecedented amount of chronic illness, unless there's some extraordinary series of breakthroughs in medicine. But we know there's more obesity, more diabetes, cardiovascular complications related to that, more respiratory illnesses, et cetera, et cetera, et cetera.

Now, the whole point of this is that these diseases, for the most part, there are some reversible factors and a huge number of preventable practices that are not being utilized at the present time, certainly not for pre-Medicare but also for Medicare patients.

I wonder if it would inform our discussion when we come back to this if you might be able to give us a couple of slides or data on a couple of things. One is maybe some concrete numbers on the projections of what will the composite Medicare population look like in 10 and 20 years from now. I think it would be very informative. It's a very different landscape than what we deal with now.

And the other would be, Are there any home runs

that you can point out to us within the C-SNP plans? I don't know them that well. I'm not very familiar with them. But is there something that would say somewhere here there seems to be some light at the end of this tunnel that says this highly specialization has some merit. It might inform even how we modify recommendation 2. I'm not sure.

Just those two ideas.

MR. HACKBARTH: Bill, in answer to your second question, one plan that has received a lot of publicity is Care More. In fact, there are articles that have been written in some journals that you could look up if you're so inclined. And so they're one of the C-SNPs, in fact, I think, one of the ones that has a very high rating under the Medicare system.

MR. KUHN: Just quickly, overall, all the recommendations, I'm pretty comfortable with the direction we're going, Glenn, except for number two a little bit. I want to think more about the C-SNP one. I was moved by Scott's comment that they had been in this space but are now exiting it. I listened to what Tom and Bill had to say. But I want to think about that one as we go forward. So I just wanted to let you know so no surprise when we get to

January.

DR. CHERNEW: So -- and I didn't have a round one. I think the challenge in this area is to understand that while it seems like we're restricting things, because we're letting certain authorizations expire, in many ways, I think our intent is to expand those things to broader populations. And I think the broad philosophical line that we're trying to walk is between the idea of specialization, targeting things for particular people with particular conditions, and allowing plans the flexibility to do that through benefit design, allowing enrollment of people just when they get the diagnosis, coordinating with other programs. And I think that there's general -- I'll speak for me. I generally support that type of specialization.

The concern is if you run a whole bunch of different programs, so you're running the regular MA program and you're running a SNP program and the SNP programs have I-SNPs and D-SNPs and C-SNPs, it becomes administratively complicated. So very much in the spirit of what Jack said, I think that my hope would be that we could find a way to administratively simplify this from the CMS perspective as to what the programs are and allow this flexibility and

specialization. But any time you have specialization, there is complication. And I think my hope would be that we could do this in a way that we don't allow our opinion about the average to drive out those that are good. The places that are really doing good things shouldn't find recommendations like this will prevent them from continuing doing those good things.

And I think -- so I'm supportive of the recommendation. I believe that I have not yet heard any of the good things that we would be preventing in the way that this is crafted. But if you have thoughts on that, I would like to know.

MR. ARMSTRONG: So, generally, I just would echo the sentiment that Mike just expressed. I think this creates an opportunity for us to really think through how we advance some of the reforms around payment policy that we are constantly talking about.

I won't repeat what I said earlier, but I do think that inside of here, this -- I support these recommendations and the direction we're going. Inside, particularly, of the C-SNP recommendations, this idea around eligibility to enroll based on the patient's diagnosis rather than the

benefit type and so forth, I think is really an interesting idea. I really like that.

And I also like, I think as a way, I think, a way of dealing with the complexity, Mike, that you were referring to, to really think through how within the MA construct you can give more flexibility around benefit design and then the development of a care model, depending upon that patient's diagnosis. So I think that's a really potentially powerful idea and a way in which we could help the MA plans match better with the illness patterns that are going to be evolving through our beneficiary groups in the future. And so I'm enthusiastic about it. I feel like we spend so much time on the details of fee-for-service payment. I wish we could spend more time really sorting through some of these ideas, and that's no surprise.

DR. SAMITT: So two quick comments. To echo what Scott said, this is -- these recommendations, which I support fully, including the modifications you added later, I think are forward compatible with broader health care reform and we should keep moving in that direction. For the C-SNPs to recognize more specialization really isn't working and getting us anything else. And for D-SNPs to really

encourage this alignment regarding duals, which we really want to see alignment elsewhere.

The last comment that I want to make is about the notion you heard from C-SNPs about critical mass. You know, there are health care support organizations that are blossoming and doing very well that are taking on sort of the critical mass elements of this. So there are disease management organizations that could help any number of either commercial or Medicare plans manage complex populations. So each plan in their own right does not need to duplicate programs or services when there are support organizations that these plans have access to that can do that on their behalf. So, in short, I don't really buy the argument that it's a critical mass reason why C-SNPs should prevail.

DR. HOADLEY: I guess I'm still trying to sort this through, and sort of like Herb, I'm trying to think about the things that the last several people have all talked about around the C-SNPs. It does seem clear that a lot of them are accomplishing much. There may be some that really are, and whether we can incorporate that -- I mean, in the ideal world, the comments that Craig and Scott have

made make sense, that plans -- I'm not sure that all the MA plans across the board are really doing a very good job at doing that, and so those are the tensions, I think. So I'm just putting that on the table.

MR. HACKBARTH: Thank you very much, Christine and Carlos. Good job. And very good discussion. I'm sure we could have gone on for much longer.

Okay. We are now moving on to addressing differences in Medicare payment across different settings. And you can begin whenever you're ready.

DR. ZABINSKI: We have a nice, light, non-controversial topic to close.

[Laughter.]

DR. ZABINSKI: All right. But before starting our discussion, we'd like to thank Jeff Stensland and Lauren Metayer for their assistance on this analysis.

Okay. At the October Commission meeting, we presented an analysis of narrowing or eliminating payment differences across the OPD and physician office settings for ambulatory services that meet a set of criteria, and today, we'll review key features of those policies. Also, Commissioners asked many questions at the October meeting

and we will address those today. In addition, we will provide results of the combined effects of the policies that we presented in October and equal payments across settings for E&M office visits, which we recommended in our March 2012 report.

We have identified four criteria for services that could have equal rates in OPDs and freestanding physician offices. the first is that a service should be frequently performed in a physician office, and we define this as services where at least 50 percent of the ambulatory volume occurs in freestanding offices.

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

The third attribute is that the service should be infrequently provided with an ED visit when it is performed in an OPD, which we define as less than ten percent of the

time.

And the final attribute is that there should be minimal differences in patient severity between OPDs and freestanding offices.

On this slide, we provide a summary of the two groups of services we included in October's presentation. The services in Group 1 meet all of the criteria from the previous slide, while the services in group 2 meet three of the four criteria but they miss on the criterion of minimal packaging, as more than five percent of their total cost is from packaged ancillaries in the outpatient PPS. Ultimately, we have 24 APCs in Group 1 and 47 in Group 2.

For Group 1, we established equal payments across settings for each service by setting the rates in the outpatient PPS to the difference between each service's non-facility practice expense rate and its facility practice expense rate in the Physician Fee Schedule.

For Group 2, we allow for differences in packaging. This results in the outpatient PPS rates for each service being set equal to the difference between the service's non-facility PE and its facility PE rates plus the costs of additional packaging that occurs in the outpatient

PPS. This narrows but does not eliminate differences in payment rates across settings.

Jack, you asked what percent of hospitals' revenue from the outpatient PPS is included in the E&M office visits from the March 2012 report and the APCs that are in Group 1 and Group 2 on this slide. We found that the E&M visits are 4.5 percent of total outpatient PPS revenue and the APCs in Group 1 and Group 2 are 11.1 percent, for a total of 15.6 percent. I want to be clear, though, that this is not the reduction in revenue from those policies, which we discuss later, but it is the percentage of outpatient PPS revenue that actually resides in those services.

George, last month, you expressed some concerns over the idea that the OPD rate for APC 247, laser eye procedures, would decline by 92 percent, to $30. We want to first point out that this is an extreme example of the impact on OPD rates in the policies we discussed. On this table, we have an example of an APC with more of a median payment change among the services that we analyzed. This is APC 698, level two eye tests and treatments.

The first column on the table shows this service has a payment of $66 if it is provided in a physician's

office, while the second column shows the payment if the service is provided in an OPD. The physician receives $27 and the hospital receives $67 and the total payment is $94.

The under the policies we covered in October to make these payments equal across settings, the third column indicates the physician would receive $27, but the hospital payment would decline to $39 and the total payment would be $66, which is the same as when it is provided in a freestanding office.

And George's concern over APC 247 brought us back to examine the APCs in our analysis. We found that some APCs, including number 247, have 90-day global periods in the Physician Fee Schedule, and we also found that the 90-day global periods include time for physician staff to coordinate with hospitals and that cost is not included in other services. And this additional staff time is similar to the issue of additional packaging that occurs in the outpatient PPS, which we have been able to adjust for in Group 2 services. But we don't have adequate data to make a similar adjustment for the additional staff time.

Therefore, we decided to exclude all APCs from our analysis, including number 247, where more than five percent

of the volume is in services that have 90-day global periods. And we found there are 15 such APCs, which reduces the number of APCs in our analysis from 86 down to 71. It also reduces the savings to the program and beneficiary cost sharing from the $1.2 billion that we mentioned in October to about $1 billion. About $780 million of that would be program spending and $220 million would be beneficiary cost sharing. The remaining results we discuss today exclude the 15 APCs eliminated on the basis of the 90-day global payments.

At last month's meeting, we presented this diagram that shows the relation between hospitals' 30-day episode costs and their gain in overall Medicare revenue from the higher OPD rates for the services in Group 1 and Group 2. The point of the diagram is to illustrate that there is little correlation between how much hospitals gain from the higher OPD rates and hospitals' cost per episode. For example, a regression of gains from higher OPD rates on cost per episode has an R-square of just 0.07.

And Alice asked, where are the for-profit hospitals on this diagram, and we indicated them by the red dots on the chart. And the chart shows that among the for-

profits, there is little correlation between how much they gain from the higher OPD rates and their cost per episode. For example, for these hospitals, a regression of their gain from higher OPD rates on cost per episode produces an R-square of 0.11.

Okay. In October, we analyzed the effects of the policies we presented on the hospitals that are under the inpatient PPS. Part of this analysis compares the 100 hospitals that would be most affected by those policies to the overall PPS hospital population. Relative to the overall hospital population, the 100 most affected hospitals tend to have much lower DSH percentages. They have a lower percentage of major teaching hospitals, about the same percentage of rural hospitals, and a much higher percentage of proprietary hospitals. Also, we found that 53 of the 100 most affected are specialty hospitals.

And Craig asked about the profile of the 47 hospitals from the 100 most affected that are not specialty hospitals. So when we eliminated the 53 specialty hospitals from the 100 most affected, we found that relative to the overall hospital population, the remaining 47 non-specialty hospitals have a similar DSH percentage, a much higher

percentage of rural hospitals, about the same percentage of proprietary hospitals, and no major teaching hospitals.

And Herb wanted us to look into hospitals that have DSH percentages above the median for all hospitals and that are among the 100 hospitals that are most affected by the E&M recommendation we made in the March 2012 report and among the 100 most affected hospitals we discussed in October. And we find that in the E&M policy, there were 50 hospitals with above-median DSH percentages that appear in the 100 most affected hospitals. And under the policies presented in October, there are 24 with above-median DSH percentages that appear in the 100 most affected hospitals. And, finally, there are seven hospitals with above-median DSH percentages that are in the top 100 most affected in both studies.

Also in October, we showed you the effects of reducing OPD rates for Group 1 and Group 2 at the hospital level and for hospital categories, and the first column of this table displays those results again. As we pointed out, rural hospitals would face a greater reduction in revenue than urban hospitals, one percent for rural hospitals and 0.6 percent for their urban counterparts. But these results

do not include the additional hold-harmless payments that some rural hospitals would receive because of lower outpatient PPS payments where the hold-harmless payments provide additional revenue to small rural hospitals if the outpatient PPS revenue is below the amount they would have received under the cost-based system that preceded the outpatient PPS.

And Glenn asked about the effects of including the additional hold-harmless payments that would occur and the second column of numbers on this table shows these effects. In general, the hold-harmless payments have a nearly negligible effect, but they would reduce the effect on rural hospitals from a decline in revenue of one percent to a decline of 0.9 percent.

We also looked at the effect of the additional hold-harmless payments on the 100 hospitals most affected by these policies. Once again, there is only a small effect of the hold-harmless payments in general, but there is a reduction in the number of rural hospitals appearing in the number of most affected, from 29 down to 26.

Some Commissioners wanted to know the effects of combining the policies we discussed in October with the

changes in payments for E&M office visits that we recommended in the March report, and this table shows the aggregate effects of this combined policy, including the effects of additional hold-harmless payments that would occur for the small rural hospitals.

The first column of numbers shows the aggregate percent impacts on hospitals' Medicare OPD revenue. The effect of the combined policy decreases hospitals' OPD revenue by about 5.5 percent, and the two policies have about equal impacts.

The second column shows the effect on hospitals' overall Medicare revenue, and together, these policies reduce overall revenue by about 1.2 percent.

On this table, we show the effects on hospitals' overall Medicare revenue of the same combined policy on the previous slide, but we disaggregate the results to hospital categories. The effects vary widely across hospitals, as ten percent would have revenue decline by 0.2 percent or less, and ten percent of hospitals would have a decline of 2.7 percent or more. Also, rural hospitals would be affected more than urban hospitals. Major teaching hospitals would be affected more than other hospitals. And

government-owned hospitals would be affected more than voluntary or proprietary hospitals.

On this table, we compare the 100 hospitals that would be most affected by the combined policy on the previous two slides to the effects on the general PPS hospital population. It shows there are some important differences between the hospitals that would be most affected and the average overall hospital. The most affected hospitals would have a much greater loss of revenue from the combined policy. They tend to have lower DSH percentages. They are more likely to be major teaching, which is due to the effects of the E&M policy. They are less likely to be rural because of the hold-harmless payments. And they are less likely to be voluntary and more likely to be proprietary. And they also have much fewer beds, on average. Also, 30 of these most affected hospitals are specialty hospitals.

So our next steps on this analysis include a request from a few Commissioners to investigate a lower threshold for one of the criterion for equal payments across settings, that a service be frequently performed in physicians' offices. The analyses we have done so far

requires that the service be performed in a physician's office at least 50 percent of the time and we are currently investigating the effects of dropping that threshold to 25 percent.

We are also open to analysis of any issue that is of concern to Commissioners, and we are now ready for your discussion and questions.

MR. HACKBARTH: Okay. I think George is ready with his round one clarifying questions.

MR. GEORGE MILLER: Well, first, let me say thank you for this analysis. I guess I've got a couple of questions. The first one is, doesn't the hold harmless for the rural hospitals expire at the end of this year?

DR. ZABINSKI: Yes, it does, but it has been intended for sunset several times and it's always been extended by Congress in one way or another.

MR. GEORGE MILLER: But for this analysis, we have to assume it will expire because that's the current law, correct?

DR. ZABINSKI: Correct. I was just going with a request to include the hold harmless and see what the impacts would be. As I showed, generally, they're not very

big, and obviously, because they focus on rural hospitals, it has some effect on rural hospitals.

MR. HACKBARTH: So as Dan indicated, that was something I asked for and we're not at the point of making a recommendation yet. So we will likely know whether the hold harmless is extended or not by the time we get to the point of considering a recommendation.

MR. GEORGE MILLER: Okay. And I've got a lot of round two questions, but let me use another one here on round one. The assumption of this currently as presented is that the payments to the hospital clinics will save the Medicare program costs -- I'm sorry, by lowering the payments to hospitals, will save the program costs. But in the example we had when we had the gentleman from the Denver clinic and Ron Anderson from Parkland is that they were able to put together a whole network of clinics to provide better care in the community. So the theory I got from that, they provided great quality and that they were able to lower the cost to the program for providing a medical home for the patients in the community surrounding Dallas County and Denver and provided a better structure. The impact of these cuts may not allow them to do that and to have total

integrated care, which is the goal of the program.

So my question is, have you done the analysis that just because you lower the clinic costs, would this then lower the program costs for the Medicare program in the long run?

DR. MARK MILLER: So the first thing I'd do, guys, is put the correlation up.

DR. ZABINSKI: Right.

DR. MARK MILLER: And so do you want to take it from here, or do you want me to?

MR. HACKBARTH: Well, why don't you talk about the correlation, since you're better at that, and then I'll add on a comment.

DR. MARK MILLER: Well, it's going to be very brief, because that's an argument that a number of systems are making --

MR. GEORGE MILLER: Yes.

DR. MARK MILLER: -- and say that it's worth giving me these dollars because I'll save you money over the long run. This shows that that's not going on.

And I think the second comment, which may roll over to the Chairman, is even if you wanted to do that,

would this be the mechanism that you would do that. Is that where you're going?

MR. HACKBARTH: And that would be my point, is that I think we all believe that integrated care has the potential to reduce total cost and we wish to encourage it. Is higher outpatient department rates for all providers, including those who are not engaged in integrating care, the best way to accomplish that goal?

MR. GEORGE MILLER: Okay. I'll wait until round two.

DR. NERENZ: As long as the slide is still up, just a question of how we should interpret that, and I guess I'm going back to Mark on this. It seems like the issue is not that the dots, say, above 0.03 are lower. The question would be, is it remarkable or interesting that they're not higher than 1.0, the point being -- and this is, again, right to George's point -- if these hospitals are receiving a relatively high number of additional payments, would you not expect, all else equal, the average on the 30-day episode cost to be higher, and is it not then sort of interesting and curious that they are not higher? The point is not that they're lower. The point is they're not higher.

So I'm just asking a clarification. How should we interpret this?

And then a very basic -- I'll just put this out there. We can come back to this. The top of Slide 13, average loss, 7.7 percent. That is 7.7 percent of what, exactly? Is that of OPD or of overall Medicare?

DR. ZABINSKI: That is the average loss among the 100 hospitals that are most affected, 7.7 percent of their overall Medicare revenue.

DR. NERENZ: Of overall Medicare.

DR. ZABINSKI: Right.

DR. NERENZ: Okay. Thank you. Okay. Then maybe we can go back to that other figure, because I -

MR. HACKBARTH: So can I go back to the graph for a second. So what we're relating here is the revenue from OPD versus total cost and trying to examine whether there's a relationship, and at least at a gross level we don't find much of a relationship. Dave has offered sort of another way of thinking about that.

I think what we know about the total cost per Medicare beneficiary is that it's usually variable across the country with a lot of regional, big regional differences

and I'm not sure how that factors into this. So it could be that some of the places that have high OPD spending have low total cost, totally unrelated to their investment in OPD. They happen to be in areas of the country that have very low cost. And everybody in those regions has low cost.

DR. NERENZ: But just so I make sure we're clear, the vertical axis here is not overall OPD spending. It is at least labeled here as gain in, what, gain in revenue because of the provider-based payments. Is that -- so it's not just overall OPD spending, right?

MR. HACKBARTH: Yes. Okay.

DR. BAICKER: So are you asking --

MR. HACKBARTH: How does that alter the question, the answer to the question?

DR. NERENZ: Well, I guess I don't know how -- I'm trying to just understand what the true dynamic -- I don't know that regional variation is either reflected or important in what we see here, and I also am just trying to clarify the labeling of the vertical axis. I don't think this is overall OPD spending, either, that it seems like what I thought was captured here was -- it's labeled "gain," but it's basically the relative amount of OPD payments that

flow through this higher payment rate. I see Mark nodding, so that's what it is.

MR. HACKBARTH: Yes.

DR. NERENZ: And then I go back to my question, then. If that had the effect of raising overall program spending, or in this case overall episode spending, all else equal, would we not expect a shift to the upper right quadrant, and is it not then remarkable that we do not see such a shift?

DR. BAICKER: Just to make sure I understand the question, I think you're saying that there's a mechanical correlation built in potentially --

DR. NERENZ: We think so, yes.

DR. BAICKER: -- in which case the fact that there's a component that's mechanically showing up on both sides that should generate a positive correlation --

DR. NERENZ: Yes. Yes.

DR. BAICKER: -- the fact that we see it flat means the parts that aren't mechanically positively correlated must be negatively correlated to produce that thing that's flat that should be mechanically upward sloping.

DR. NERENZ: Exactly right.

MR. HACKBARTH: I think I understood that.

[Laughter.]

MR. HACKBARTH: Really. I think that was both clear and helpful, Kate. I'm not being sarcastic there.

DR. BAICKER: [Off microphone.]

DR. REDBERG: We don't need to channel Cori's friend.

[Laughter.]

MR. HACKBARTH: But unlike you two, I'm way out of my element here in talking about this. It still seems to me that what you'd want to do, if one of your variables is episode cost relative to the national average, sort of control for differences that may be regional or otherwise. It seems like there's a lot potentially going on on that bottom axis that doesn't necessarily relate to what's on the vertical axis. And I want to do some sort of -- let me stop there. Or am I just totally confused as a non-statistician?

DR. STENSLAND: So let's just start with the basic of what that bottom axis is, and that bottom axis is 30-day episode spending. So it's basically when you enter the hospital and all that inpatient visit plus all the visits in

the hospital and your post-acute care and your post-acute visits.

MR. HACKBARTH: Right.

DR. STENSLAND: But the inpatient visit is going to be the bulk of it, and it's not going to be affected by this at all.

MR. HACKBARTH: Right.

DR. STENSLAND: And then there's the visits that the doctors do in the hospital during your stay. That's not affected by this at all because there's no facility fee. That's all wrapped up into the DRG payment. So that's not going to be affected at all.

And then your post-acute payments won't be affected at all.

So the only thing that's really being affected is the difference between the post-discharge visits, like two weeks after you get discharged from the hospital, you go see your general practitioner, and do you see that person in an office-based or a facility-based practice. So there will be that $30 difference or whatever it is. But that $30 difference is just not going to be much relative to the variation you see in this --

MR. HACKBARTH: In the inpatient costs.

DR. STENSLAND: -- in the episode spending.

MR. HACKBARTH: Sort of dominate here.

DR. STENSLAND: And then there is the regional question, so we also did this two different ways. One way was to say, well, how much does this 30-day episode spending relate to basically how often you're seen in an OPD rather than a physician's office, is basically what we're asking.

MR. HACKBARTH: Uh-huh.

DR. STENSLAND: Just raw, on average, is what we're seeing here.

Another way I looked at it is to say, well, let's look at what is the episode spending for you relative to everybody else in your State. So is the people that are high in their State tend to have high relative -- and again, you see the same, almost no relationship whatsoever. So you can pull out the regional effect and you still get almost nothing.

There is that mechanical negative correlation that you would expect, but it is such a small magnitude, I just don't think it's going to move anything.

MR. HACKBARTH: Okay. That's helpful. Thanks,

Jeff.

Peter, clarifying questions.

MR. BUTLER: So I really appreciate the staff trying to assess the impact and provide additional data. It suffers a little bit, because without the narrative, it's a little hard to understand some of this. I should be an expert on this and I feel like I still don't understand some of it.

But on Slide 6, so we have listed two months ago, I think it was the top 25, right, in the text? The top 20? But this says there are now going to be 71 in the analysis, it's suggested, right?

DR. ZABINSKI: Yes.

MR. BUTLER: I'm just trying to clarify.

DR. ZABINSKI: Yes.

MR. BUTLER: Okay. And then they have the -- you've shown the eye example, a different one on the previous page, but so much was tied up, if I remember right, in, like, the top three were half of the echocardiograms and largely around heart and pain management and we still kind of haven't -- and I said, boy, I kind of felt if we understood that, particularly how it related to these

smaller for-profit probably heart and orthopedic hospitals, we would have a better understanding of what's going on. And then part of that is, too, are the physicians -- because this all started with employing physicians too rapidly because this was a mechanism to kind of help fund the salaries. And I'm not sure that that's going on in the smaller specialty hospitals. I'm not sure there is employment, yet they're getting the facility fee at a -- I just don't quite understand the dynamics in this, not the E&M codes, but these set of tests.

And I don't even know if I'm asking -- I'm obviously not asking the question quite right, but so much of these APC volume and where the reductions occurred in relatively few APCs that seem to be now skewing more towards the for-profit smaller specialty hospitals, I just don't quite understand what is happening there, and this data doesn't quite get at it. Can you answer that -

DR. ZABINSKI: Well, would it be helpful -- I'm wondering if it would be helpful if we looked just at the cardiac imaging codes, APCs. As you pointed out last time, they were the top two and they accounted for roughly, you know, half-a-billion dollars in savings, program plus

beneficiary. If we looked at which hospitals, you know, provided most of those services, or which would be the most affected by the payment changes, and if we saw -- it sounds like you're asking, is it really going to be the cardiac hospitals that would be affected by this policy proposal or other types of hospitals. So if we looked at it by category --

MR. BUTLER: Well, that might help. But it did strike me, like, half of the savings are coming from, like, two or three APCs, and yet we're looking at 71 of them and all this detail. Understanding those in particular, I think, would help understand the bigger picture.

DR. MARK MILLER: There are two things that occurred to me, and you were on to one of them, Ariel. What if you ran this analysis for just those? That could be one way to cut it. And the other way to cut it -- and I don't know whether we're taking them out or just looking at them, but I'm going to say it this way: take out the specialty hospitals and see what it looks like. They were my two --

MR. BUTLER: That might be good, too.

DR. MARK MILLER: -- gut reactions to what you said.

MR. BUTLER: Yeah, because one of my other comments would be, you know, we look at the top hundred. Well, if a bunch of them are these really dinky things, it's a small part of the total hospital. So even those they're smaller, it just explains part of the total spend that is being impacted by the policies. I know there are many, many ways you could slice the data, and you've been trying to do that. But I still don't feel I quite have a handle on what's going on on these high-volume APCs where the impact will be the greatest.

DR. ZABINSKI: Some of the obvious things, you know about them, you know, relative to the -- in the list of 71 APCs, they do have a high volume, and they also start with a very high, relatively high payment rate. So, you know, a lot of money as a share of the total is tied up to them to begin with, and then you drop their rate, and they do have -- in terms of their magnitude of their drop in their rate is large. The percent drop is not unusually large, but their magnitude is, and that's what really matters here.

And we also do know that there's a fair amount of shift in these APCs from free-standing offices to OPDs over

the last few years.

MR. BUTLER: I suspect, and I think most -- anecdotally you hear that the reductions in general for cardiologists and how they're being paid and technical, professional, et cetera, led to this rapid employment and particularly in cardiology, and this was a safer haven that provided more money than the previous model. And the more I think we kind of understand the dynamics around, for example, heart as just an area, I think the more we can target this in the appropriate way to get at an underlying issue.

I think it's a very different scenario, for example, for primary care or maybe some of the other areas that are less intense in some of these tests but have a lot of E&M codes, for example.

MR. HACKBARTH: This is helpful, Peter. So the impact analysis is showing a combination of three things. One, as Dan says, these are relatively high priced -- these cardiac things, they're a significant amount of money. There's a lot of volume and a relatively high price. We've got this move that Peter described that has occurred from physician office into OPD, and then the specialty hospital

numbers, this is also an area where there has been a lot of development of specialty institutions, the cardiac, and so those three factors are showing up in these impact analyses.

MR. BUTLER: Now, there aren't new -- a lot of new physician-owned specialty hospitals, but there have been barriers to making that occur. So --

MR. HACKBARTH: But a lot of them existed before the moratorium.

MR. BUTLER: Right. So there are different dynamics going on here.

And then on Slide 13, I just think we need to -- this would be very tricky to kind of bring together what we had in a previous recommendation, which was controversial by itself, and then layer on another one and look at the impacts on, you know, the 7.7 percent is a pretty big whack of your total revenue. So I don't know how we need to start thinking ahead. How do you kind of put that in the context of the other reductions that PPACA has or updates? I'm just trying to anticipate what obviously will be a tough discussion to try to balance all of these things, because it's hard to -- it's one thing to take an isolated issue and kind of a principle that makes sense and then fold it into

the other dynamics of everything else that we do when we make our recommendations and updates.

So I don't have a recommendation today other than to suggest that obviously some institutions would be -- if you did this all in one year, the way the data lays out, it would be pretty darn tough.

MR. HACKBARTH: This is the combined effect of E&M plus the new ones.

DR. ZABINSKI: That's correct.

MR. HACKBARTH: On the E&M calculation, does that include our hold harmless features in there?

DR. ZABINSKI: Yes.

MR. GEORGE MILLER: That assumption is that hold harmless will continue beyond this year in these numbers. Is that correct?

DR. ZABINSKI: Correct.

MR. HACKBARTH: I'm actually talking about a different hold harmless. I'm not talking about the hold harmless in under-100-bed rural hospital. I'm talking about the --

MR. GEORGE MILLER: I'm sorry.

MR. WINTER: Stop loss?

MR. HACKBARTH: Stop loss.

DR. ZABINSKI: It does not include any sort of stop loss in it.

MR. HACKBARTH: Okay. So even on the E&M stuff, those numbers that factor in here don't include our stop loss --

DR. ZABINSKI: No, it does not.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: Well, if I could just follow up, did we model -- I mean, the current -- if I remember correctly from last year, the margins in HOPD are negative. Have we calculated what this impact would be on those margins as well?

MR. HACKBARTH: We can do that.

DR. ZABINSKI: Yeah.

DR. MARK MILLER: When we get into that next month, George.

MR. GEORGE MILLER: Yeah. I would love to see that.

DR. MARK MILLER: Actually, I just wanted to finish off where I think Peter was. So the 7.7 is for the top 100, just to make sure that we're tracking through that.

And what I can't remember on this one is when we do the Group 1, Group 2, that top 100 had a lot of specialty hospitals in it.

DR. ZABINSKI: Correct.

DR. MARK MILLER: And when you put it together with the other policy?

DR. ZABINSKI: Thirty.

DR. MARK MILLER: Okay. I'm sorry. I had forgotten.

MR. BUTLER: So, Mark, though, another way to look at it is Slide 11, instead of saying, okay, the top hundred, there is, you know, on average 5.5 percent reduction in outpatient for hospitals in general and a 1.2 percent on their total Medicare revenue, which is the average impact.

MR. HACKBARTH: But this also, I assume, does not include the stop loss on E&M.

DR. ZABINSKI: No.

DR. REDBERG: Just to follow on from what Peter said, besides looking at the non-specialty hospitals, for example, on the top 100 and also in the most affected, you would also look at the specialty hospitals specifically? Because, obviously, it's a very diverse group of hospitals

that would be affected, or more affected, with very different characteristics. So I just think it would be interesting to break it out or helpful to break it out.

DR. ZABINSKI: [inaudible].

DR. REDBERG: And just the other point. Is it possible to also, besides looking at the costs like you gave us in Slide 7, to look at some of the quality measures, the performance measures that CMS measures for inpatients? For example, for the cardiac specialty hospitals, we have a lot of inpatient performance measures. Can you compare quality as well as costs and see if there's any correlations between these payments and types of hospitals and quality?

DR. ZABINSKI: Sure.

DR. REDBERG: Thanks.

DR. HOADLEY: Just two small ones, and thanks for the various responses from the previous questions.

On the answer to my question, the 11.1 percent on this second group, was that before -- the total bucket that was affected, was that before or after you made the APC global period exclusion of those additional APCs?

DR. ZABINSKI: That is after.

DR. HOADLEY: Okay.

DR. ZABINSKI: Yes, after.

DR. HOADLEY: And I don't think you've given us this, but it's sort of underneath several of the graphics. How correlated are the two policies in their impact on hospitals? I get a sense that they're affecting kind of different groups, but I'm not sure I'm actually seeing anything that shows that. Or maybe we don't know that right now.

DR. ZABINSKI: Yeah, I did not look at that. Just going by what I know and which hospitals fall in and where they fall in the distribution, I would guess that it does affect different groups of hospitals.

DR. HOADLEY: I mean, the Slide 9 that talked about, you know, the DSH statistic sort of implies that the list at least of the top 100 are different, but --

DR. ZABINSKI: That's definitely true, yes. The top 100 list, there's not much overlap, but I think in general --

DR. HOADLEY: But it would seem like it would be useful to know if -- you know, because if the two policies are reinforcing the impact on -- as opposed to one hits some and the other one really hits, it's kind of an uncorrelated

set that's just useful to know, it seems like.

MR. ARMSTRONG: So I'm not sure exactly to ask this, but we're looking at estimates that would reduce revenues to hospitals by 5.5 percent or 7.7 percent for the top 100. The question I have is: Given payment policy and the changes that we've seen that have inspired these policies, how quickly did the revenues go up by that much over the last few years? Has this been a gradual thing over the course of a decade? Or is this just...

MR. WINTER: Last year in our March report we showed that the shift of E&M office visits from physician offices to outpatient departments has been accelerating. Correct, Dan?

DR. ZABINSKI: Yeah.

MR. WINTER: It has been accelerating over the last couple years. We also looked at a couple of cardiac imaging codes, like echocardiography and nuclear medicine, and those have also been accelerating over the last couple of years.

We have not looked at all of the 71 APCs in Groups 1 and 2, but that gives you a flavor for what we're seeing in some of the really higher-volume, high-payment APCs where

there are big differences in payment rates.

MR. ARMSTRONG: Yeah, and I ask that because I think Peter raises a good point, that on the one hand there's kind of the discipline around the policy and does the policy make sense. But then there's also the impact operationally on changing the policy. But let's not forget that while we would be taking revenues out, those are brand new revenues that have been coming up. And so let's just not forget that, too. If that's the right way to think about that.

DR. COOMBS: So I was interested in if you were able to get at a granular level with the disproportionate share hospitals and the overlap with academic institutions to see what the impact would be, especially for, you know, inner-city urban teaching centers in terms of, you know, their margins might be very different than the for-profit. Thank you very much for answering my question, too, about the distribution correlation.

DR. ZABINSKI: We haven't done anything on really digging down to that level that you're asking about. That's something we can do.

DR. COOMBS: My concern is the disproportionate

share hospitals that actually have a major mission for teaching in the GME slots that are appropriate for what the government has slated and what's necessary for them to actually meet the demands of their surrounding communities. Some of the institutions have actually increased the number of GME slots on their own to kind of meet the needs of their community, and so what would this do to them. And in that same vein, we made an accommodation when we did E&M codes for DSH hospitals, and I was wondering if we had been thinking along those lines for this as well.

MR. HACKBARTH: That's certainly an option to do some sort of special protection for the above average disproportionate share hospitals.

MR. WINTER: And for the Groups 1 and 2 that we talked about in October, Dan did model a limiting -- a stop-loss policy similar to what we recommended for E&M, and I think the impact was minimal, very minimal. Right?

DR. ZABINSKI: Yeah. It's much smaller than what the impact would be under the E&M policy we recommended last March.

DR. COOMBS: So could you do that as well for the teaching institutions just to see the impact? Because I

think we just focused on the disproportionate share hospitals.

DR. ZABINSKI: Yeah?

MR. HACKBARTH: I want to make sure I understood what you said. So you're saying that for this second group of services that the impact on the disproportionate share hospitals is much smaller than for the E&M services.

DR. ZABINSKI: That's correct.

MR. HACKBARTH: Okay. Clarifying questions?

MR. KUHN: Yes, just one. Page 5 or Slide 5, just a quick question to make sure I understand on the numbers. So let's just take that top line, the fee schedule rates. So the $66 includes both the professional, the practice expense and the malpractice. And then as we move forward, then it goes to the 27. Is that the just the professional and malpractice only?

DR. ZABINSKI: That's the three parts. It's the professional, it's the malpractice, and it's the facility PE for the physician.

MR. KUHN: Okay. In the 27.

DR. ZABINSKI: In the 27.

MR. KUHN: Okay. It would be interesting as we

look forward that, you know, if you think about this, you're basically, you know, going into a hospital-based facility, so it basically is the hospital's machinery, it's the hospitals supplies, et cetera. So I would be really interested to look at it as how we really separate that the physicians are getting paid for what they are doing, that is, you know, their professional, their malpractice, and then the facility charges are separate. We might have a different look at this if we had it that way. It just seems like we're providing payment for services that aren't being rendered, if you follow my logic here.

MR. WINTER: Would it be helpful if we broke down the total fee schedule rate by the three components --

MR. KUHN: It might help us look at --

MR. WINTER: -- so PE, PLI, and work? Is that what you're asking?

MR. KUHN: Yeah, I mean -- you know, I guess if -- well, I guess it depends where the locus of the practice expense is. If it's all in the outpatient in the hospital-based, then that's where all of the expense is. Or in the example you have here, the physician is getting not only the physician rate but also practice expense when they're using

the hospital's equipment. It's kind of a little bit what George was talking about at the last meeting. It would be interesting if we could break it out differently just to see what it looks like.

MR. WINTER: Right, so -- and we can certainly break it out in greater detail as we did with the E&M stuff last spring, last winter and spring. There are going to be, even for services performed in a facility, there are still going to be some practice expense for the physician for costs related to billing and if -- these are not 90-day globals, but for billing and for perhaps coordinating the service in the hospital, that sort of thing. So there's going to be some -- there's going to be some costs --

MR. KUHN: Some costs.

MR. WINTER: And also just because of the way the formula works for allocating the indirect practice expense, that's based on the work and the direct practice expense input. So even for codes that have no direct practice expense inputs but do have work, so like surgical procedures that are done just in the hospital, there's still going to be indirect practice expense costs allocated for those procedures. So, you know, there's always going to be some

practice expense on the facility side, even when the procedure is always done in a hospital.

MR. KUHN: Yeah, and maybe the easiest way is to kind of break out those three components so that at least we can just see what they look like.

MR. WINTER: Sure.

MR. KUHN: Thank you.

MR. HACKBARTH: Round 2 [off microphone].

MR. GEORGE MILLER: Yeah, Herb covered one of my Round 2 because that was the question I had last time, if you remember, what component of the fee schedule for the physician and then reduce the proposal -- last time it was reduce that rate down to $30, and I commented about that. But to that point, once we break that out, it would be interesting to look at that.

The other thing is you mentioned that the physician office has to coordinate with the hospital. Well, it looks like we're going to reduce our payments, but I would imagine the same coordination would take place and the same --

MR. WINTER: That's really an issue for the 90-day globals, which we took those out for that reason, because

there are these higher costs, higher staff costs associated with coordinating and scheduling the service in the hospital. That's probably not going to be true for the zero-day globals or the 10-day globals. But we can look into that.

MR. GEORGE MILLER: Okay, great. And then just for Round 2, I'm still concerned that -- although Scott raised the question about how long we have been getting that, and you said and quoted that there's been a recent shift in certain areas, but for some of us, especially rural hospitals, that have had employment of physicians and rural clinics for a long time, the impact on the previous slide shows that it's going to be pretty hefty on the rural hospital. This is not a recent phenomenon for us.

And so, again, I'm concerned. Part of the challenge for us, again, is the standby capacity that a physician office does not have and that we have. Even our infrastructure, especially in that HOPD, is in the hospital versus a separate physician office, which I understand that argument still requires us to do things that a physician office does not have. And God forbid, what we just witnessed and when I was in Jasper, Texas, when we had the

hurricane, everyone came to the hospital. Nursing homes couldn't go anywhere else. They came to the hospital. And that's part of that standby capacity. It's not just to have an emergency room, but it's also to have a standby capacity in case of disasters and floods and hurricanes or anthrax threats. They come to the local hospital. So in my mind, that's what some of these fees address.

We have a different mission than a physician office, and it looks like what we're doing and discussing has a limiting impact on what we first proposed, but I am very concerned about the direction and the total impact.

I mentioned, and you said you would look at it, the hospital outpatient departments have negative margins, and I would love to see what the impact of this percentage would be on those margins already.

DR. MARK MILLER: I just want to say one thing. George, I do appreciate your comments last time. I think it did lead to a deeper dive on this, and we've come to a different place as a result of that. So I want to thank you again for what you said last time.

[Off-microphone comments and laughter.]

DR. NERENEZ: This is a very broad question, I

think, about MedPAC philosophy and history perhaps, and I ask it in that way because I'm new to this. If we just look at the slide that's up, you know, you compare 94 and 66, what's being considered here is dropping from 94 to 66. Or perhaps if we look at the current thing, it's saying, you know, what are hospitals doing with the difference between 66 and 94? And I can imagine many different scenarios, but at least two clearly different ones. One is that the extra $28, if I'm doing my arithmetic right, essentially just goes straight to the bottom line as profit or perhaps as executive perks on the way to the bottom line, and we could decide that maybe that's not such a good thing.

But, on the other hand, in other environments, that could support community outreach. It could support a safety net mission. It's basically an indirect subsidy of other perhaps socially desirable things.

So my question is, in general, do we like indirect subsidies like that because -- well, just -- but at least I'd like a detailed answer.

DR. CHERNEW: [off microphone].

DR. NERENEZ: And I could think that the answer could be simply because those area politically acceptable

ways, things that can pass to accomplish socially desirable things. Or, obviously, the alternative is that as a matter of principle, we do not like those things because they hide or they mask or they somehow should be replaced by things that are more specifically given their proper name. So I'm simply asking, is there a broad philosophy that is being applied here?

MR. HACKBARTH: Yes, there is, and it's to use direct targeted subsidies to achieve policy goals, not put out broad payments and then hope good things are done with them.

DR. CHERNEW: I'm sorry. I didn't mean to interrupt you before. I think the other thing to note is the indirect subsidies have all other types of indirect effects and distorting effects on prices and drive people in ways that you might not want them. So it's not simply, oh, we're giving you this money in some indirect way. We're distorting relative incentives in ways that could really affect behaviors in ways that we don't want. So it's not just the indirectness. It's the price right versus price wrong kind of thing where people get their care, where they don't get their care, and a whole bunch of other

distortions, as opposed to just the money.

MR. BUTLER: Yeah, I think, Mike, you were the one that last time said, you know, you aggressively apply a good principle in one place, and then it balloons and pops out somewhere else with some unintended consequences -- or consequences that you have to deal with, and that's a little bit of what we're dealing with here. And I've been supportive of the direction that this has been headed, but I angst deeply over those institutions that have a -- they tend to be more urban, they tend to be the larger safety net teaching hospitals that are providing access for patients in these clinics that wouldn't otherwise occur. And just to bring it a little more to light in a more personal way is that, for example, in Illinois, we're now up to -- we're 25 percent of the residents, citizens -- 25 percent of the people in Illinois are on Medicaid. And if you're not a safety net institution as defined by the state, you are looking at hospitals now that have 240 days in receivables. Now, Illinois is unusual. We have a number of these clinics on our campus, open for business to Medicaid patients to come in and be served, to dual eligibles, to others, and you have -- that's in contrast to some of these other private

offices that are off campus, may even be actually in some of the same systems as the ones that have the on-campus ones, that are suddenly getting new money for an office that doesn't look any different than it was yesterday.

And then you even have some prominent, progressive, integrated systems that we tout that may not have much hospitals in their integrated system at all, and also have a very low percentage of the Medicaid compared to the population that, you know, overall is on Medicaid in the -- so I struggle mightily with -- it is a subsidy, but I struggle mightily with that very tenuous source of care for particularly the Medicaid that -- where the doors aren't open -- and some of these ones, by the way, if you could determine if they flipped or they become -- they don't even take Medicaid in their practice. The hospital may through the emergency room, but some of these do not even take Medicaid. If you could have a switch that says do you take Medicaid or not -- and I know I really am mixing Medicaid with Medicare, but -- and we did a pretty good job last year of taking into account disproportionate share and phasing as a way to kind of get at this. I wish we could get a little bit more sophisticated around that to make sure we don't

have unintended consequences.

Thank you for listening to my passion.

MR. HACKBARTH: Peter, can you go one step further? The DSH protection was an effort to get at this issue. What might be different or better than that?

MR. BUTLER: Well, throughout the -- it would really be interesting to know if these clinics are open for Medicaid business or not. And I don't think there's a way to do that, and you couldn't say -- they say, sure, I'll take somebody that came through the ER, I'll do a follow-up visit in my office. But if you looked at the underlying nature of the business, they're really not in the Medicaid business.

MR. HACKBARTH: Yeah.

MR. BUTLER: And I find even in some teaching place some reluctance, they say we're going to cap, no more Medicaid, for example. So you just have to think about what might be other than DSH to get at it.

MR. HACKBARTH: So what I hear you saying is that you think there are high DSH hospitals that have minimal Medicaid commitment or declining Medicaid commitment.

MR. BUTLER: You could find a mismatch between the

DSH and the hospital versus what is occurring in the clinics. I could site a couple of place in teaching even that say no more Medicaid, we're not -- even though it's coming through the ER.

MR. HACKBARTH: Yeah, let's think some more about what the variables might be that could replace or supplement DSH as a tool.

DR. BAICKER: Following up on the issue Dave raised, I think we have -- ought to have a strong preference against subsidizing some activity on the margin that's not the activity that we want because it happens to disproportionately benefit entities that are engaging in a different activity that we want. I think we can -- I think figure out where the impact of this is concentrated is really valuable, and I can see an argument for smoothing the transition more carefully for hospitals or departments that are less able to weather the transition. But in the long run, I think we have to move towards a system where we are not using this very funny mechanism to subsidize an activity that we don't think is particularly beneficial for patients because it might have this correlated component that we think is good.

DR. HOADLEY: I would second that sentiment, and I guess the only thing I would add is that in the discussion yesterday we had -- because of our time constraints on the particular policy issues we were addressing, we had to say, yes, we have to make a decision on one thing now, and the targeted thing we will make a commitment to get to. To the extent that we don't have the same time commitment, you know, thinking about how to do them more in concert at the same time seems valuable.

DR. SAMITT: I support the direction this is heading. In fact, I would argue it hasn't gone far enough. And so my comments are about the Next Steps slide. You know, where should additional analyses be focused? We currently looked at 50 percent. We talked about investigating the 25 percent. I'm even wondering if the 25-percent analysis will miss something. And so recognizing the data's not available for Medicare Advantage, I guess the question is: Can we look at another source like the performance of the Pioneer ACOs with the lowest total cost of care or the shared savings program ACOs with the lowest total cost of care, and look within those organizations at this question, this issue of what's being done in hospitals

versus what's being done in physician offices. I don't know whether that data is available, but I'd be curious whether it reveals additional opportunities that some of these high-performing systems are exploring today.

MR. HACKBARTH: [off microphone] for Medicare Advantage?

DR. MARK MILLER: I cannot believe how quickly he's integrated right in [off microphone].

MR. ARMSTRONG: Thank God he did that, because I was about to do the same thing.

[Laughter.]

DR. SAMITT: That's the advantage of going first [off microphone].

MR. ARMSTRONG: I'm not sure we should be sitting so close together, actually, but I was going to make a very similar point.

First, actually I just wanted to say, you know, I really understand the concerns that Peter has been representing, and I think they are legitimate concerns. I just don't think this payment policy is the way to deal with those. And I like the direction that we're going with this work. I think we should challenge, just as Craig said,

whether that 50-percent standard of services still remaining in the physician's offices is the right standard, because so much has already migrated, I think that's a conservative standard.

I also just would say let's recognize that the concern we have about just sort of the issues with the policy for Medicare payment is one that's not limited to Medicare. So much of commercial provider payment is based on Medicare payment policy. And so this has an implication that extends quite beyond just the Medicare program.

And I would just add a personal anecdote, and that is that my organization recently sent letters to all hospital providers in our network disclosing -- or informing them that as of January 1st, we are no longer paying the facility fees for the E&M codes for all patients. So we just -- I don't just articulate my point of view here at MedPAC, but we are actually in practice making these changes. We're the only plan in the state that's doing this so far. I know it will be controversial, but I believe it's the right thing to do.

DR. CHERNEW: I only articulate my views here in MedPAC.

[Laughter.]

DR. CHERNEW: I don't have anything else to do.

But, anyway, that's wonderful -- that's good to hear, and let me say that it's important -- I guess with Kate. I think it's important to realize that this fits into a bunch of other things we do, like the updates and other types of things. So I very much think that George's point about standby capacity and stuff is valid. It's just paying for standby capacity by putting incentives for people to get services in places where it might not be the right way to get services isn't right way to pay for standby capacity. And I do think that we run the risk of undervaluing some of the things hospitals do if we try to pay for every little service at the margin because there's broader average things that they do, and we need to take that into account without a doubt in our payment system. And certainly we need to worry about the populations they serve and the overall health of our hospitals, which are essential.

It's just doing that in a way that distorts prices strikes me as fundamentally the wrong way to do it, and if we move to other payment models, it will become a little bit easier, I think, to get right. But, nevertheless, in the

payment models that we have, I think we have to start by trying to get the incentives right at the margin and not undervaluing things that institutions provide that we value.

So I very much think that David's question was the right question, and I, again, very strongly think that indirect subsidies are a disaster, and if we really support something, we should be able to stand up and say we support standby capacities or extra care for these populations and those types of things.

DR. NAYLOR: So I also support the direction of these proposed -- of this policy change. I think that the thing that has guided all of us all of these years, depending on how long you've been on the Commission, is that set of principles that -- and one here is equal payment for equal services. I think that for the 71 APCs you're talking about a $1 billion potential savings, 780 to the program but 220 to the beneficiaries. And I think we've also had a principle of really being sensitive to the impact of these payment policy directions on the beneficiaries' pocketbooks as well.

So I think that's it.

MR. WINTER: The other thing I just want to point

out is beyond -- we didn't say this in this presentation, but beyond the reduced coinsurance, this would also reduce Part B premiums for beneficiaries because they're paying part of the payment for that.

DR. COOMBS: There's a couple of subsets, and it's almost like -- as I listened to the discussion around the table, I always think of the common thing we say in Massachusetts: Not one size fits all.

Part of my concern is around the vulnerable population, around the graduate medical education, and what we do in terms of our trainees and how this would impact them.

But the other piece of it is in practice, having been an internist and now an anesthesiologist and ICU doctor, I know that some procedures are done in the hospital because there are certain things that need to be done a little different than a doctor's office can provide. And so that's one entity.

And the second entity is if you're in the hanza coots [phonetic] where George lives, you might not have the office of support, and you may feel that your comfort level for doing certain things in your office invokes some element

of safety. And so I don't know how we could enter into this discussion of the appropriateness of when to do it there and not be penalized for it in the sense that -- I'm thinking right now of an echocardiogram that's done in the hospital and they call for one of us to come down and do anesthesia, give a little propofol for someone with a low ejection fraction and there's all these other problems that are -- I was looking at $39, I said, Oh, my goodness. It's a very complex arrangement with a lot of co-morbid conditions.

So I think there's some reason for these things to be done in the hospital, and there are the things that could be done in the office, but it might be that it may be done safer there, and the patient may go home right afterwards as well.

So I'm thinking about that. I'm thinking about just the whole nature of what we do for large disproportionate share hospitals. You know, as Peter was talking, I was thinking. You need a marker of missionary dedication in terms of being dedicated to your community, the surrounding community. And if you had to look at the surrounding community that a hospital is located in, you know, you have some hospitals that are located in

communities that are the vulnerable populations. I don't know how we can get our arms around it, but I think that's where we should go. I think that's a healthy way to approach it.

MR. HACKBARTH: On both of those issues, I think there's broad agreement, and so when we did the E&M version of this, you know, we tried to build in protections for the high disproportionate share hospitals, or some modification that Peter will help us come up with could be included here as well.

On the issue of patients having different risk profiles and some procedures that are done either in the physician office or hospital outpatient departments, that the higher-risk people tend to migrate to the outpatient department. There, again, you know, that's a legitimate issue that we're trying to address. That was one of the reasons why we started with E&M services because we thought that those issues tended to be less significant. And you'll recall in this case, with this new batch of services, what we're trying to do is look at patient severity across settings and identify things where the severity levels are similar.

So my basic point is, you know, the issues you're raising are valid ones that we're trying to wrestle with and address, so help us do that.

MR. KUHN: Just looking at this through the lens of kind of the criteria that we've been using on other conversation over the last day and a half, let me start with access. And I think Peter said it very well, and I think the same kind of conversation came up when we were doing the E&M. I think there's an issue here that we have to think pretty hard on the access equation, so I think that conversation will continue.

On the quality dimension, I don't think there's any debate. I think the quality is basically the same. One of the other -- although I think as was raised just before, the whole notion of some higher acuity issues, you know, we can continue to kind of grapple with that.

On the issues of integration, however, I think there is an opportunity to further explore that one. I appreciate the information that was up on Slide 7. I've continued to look, like the rest of us, about the increasing opportunity for care coordination, and provider-based is one way to get to care coordination. And so now as we're

starting to get that, we're starting to say, wait a minute, maybe we need to think about how the payment on that works differently.

So I know there has been some interesting conversation here about indirect subsidies, but I don't think we can deny the fact that it is leading towards integration, towards care coordination as part of the process. So I want to continue to sort that out in my own mind.

The other kind of issue that hasn't come up here yet and what I'm trying to think more about is how this could impact the issue of the readmission policy which began on October 1. There are things people do post-discharge and hospital outpatient department because the hospitals are responsible for those patients under the 30-day rehospitalization out there. And would this inadvertently disrupt some of the feedback loops that go on as part of the process and create more disruption in the readmission policy? And so I'd like to kind of see if we could think about or that explore that one a little bit further as we go forward.

And the final kind of criteria we used is kind of

savings. Does it save the program more? Does it cost the program more. Whatever the case may be. I think the way we've looked at this is so far as a savings opportunity, but it would be interesting to look at this as what it would be like in a budget-neutral environment, because if I remember correctly, last year, the Medicare margin for outpatient departments was around negative 9 percent. We'll be looking at updated margin information here in a month from now. If this money was put back into the system, recalibrated across other APCs out there, what it would mean in terms of overall margin, that might be worth looking at as well.

DR. HALL: I'm in agreement with where we're heading with this, and I guess I've grudgingly come to understand the perverse nature of indirect subsidies. And I guess by way of conflict of interest, I work at a teaching hospital, and I get lots of feedback on this issue, probably more than anything that I've gotten on any other issues that have come forward.

So we can't tolerate indirect subsidies, but we have to take at least some responsibility for the unintended consequences of our decisions, it seems to me.

Now, maybe we have, but I don't think that has

been made very evident to some of the potential stakeholders in this whole arena. So things that come to mind for me is that -- I don't have the previous narrative in front of me, as Peter mentioned, but have we really taken a very careful look at what would happen if we dissected out all of the non-campus-related facilities that are now considered part of the hospital umbrella? If we took all of those out -- and maybe we can't; maybe we can only make an estimate -- what does that tell us? Does that inform us?

I think the rationale of trying to provide the OPPS subsidy to a practice that one day is free-standing and the next day is part of a university is probably subject to a lot of criticism, to say the least. But also to point out that we have been sensitive to the problem of teaching hospitals through disproportionate share and stop loss. That message, maybe it's been put forward, but I don't think it's been received in a way that's constructive for these hospitals to move forward. I think that's a real problem, and I hope that we can spend a little more time on that aspect of it.

DR. DEAN: I think this is a difficult issue, and I guess the more I think about it, the more difficult it

becomes. I think the issue of we should pay a fair price for a procedure that's done is pretty clear, and I think we'd all agree with that. But there is a fear -- and I certainly am sensitive to what George and Peter have said -- about the other less well defined services that are provided by the hospital as an institution being there. And I think the trend has been to whittle away at the ways to support those services as we focus more on taking sort of almost a Wal-Mart approach, we're just going to pay the very minimum for each individual item of service.

You know, I was just thinking, you look at the critical access hospital program where we realized that if we didn't do something different, if we relied only on payment for the individual care that those facilities provided, they were gone. They just wouldn't be there. And yet I think as a society the judgment has been -- and certainly I've been wholeheartedly supportive -- that that has been an extremely valuable program. I'm free to acknowledge that there have been abuses, and there are some that probably don't qualify and all that. But as a general program, that has been an extremely valuable program.

I guess I really do worry that when bad things

happen, whether it's a hurricane or whatever, we do look to hospitals to give us a lot of support, and we really are, like I say, whittling away at the resources that they have to provide some of these less well defined and less well articulated kind of services.

So, you know, I think that I agree with the direction that we're going, but longer term, I do worry. Are we undercutting and weakening these really vital institutions?

DR. MARK MILLER: I think we'll probably get into some of this in December, and I don't know whether to take your comment as, you know, the mission of the hospital as it stands outside of Medicare or as it stands inside of Medicare. But there's also other changes that are going on, you know, DSH being redistributed to an uncompensated care policy that's going on in the hospital that's trying to go at some of these functions. So it depends on whether you're talking about inside Medicare or outside Medicare, and we can think through some of that in December when we start walking through some of the broader changes that are going to occur under PPACA with DSH and that type of thing.

MR. GEORGE MILLER: Mark, to your point, there are

things that Medicare requires us to do with standby capacity, and that's why we're addressing the issue. And I think Herb brought a point up that I failed to mention and I want to just echo him on that. If this was redistributed -- I agree with everybody around the table about the philosophy of where this should be paid for, but then if it's budget neutral, then my argument would go away. If we redistribute to other parts of the hospital through the APCs, we would have no problem with this policy. But in itself, the way it's presented is just -- in my view, is just taking money off the table. And if that's the goal just to reduce the spend level, not looking at access or quality and just looking at the pure financial numbers to save money in the program, then if that's it, I got that. But we have looked at other things at redistributing and making sure it's budget neutral. If we want to make it budget neutral, I'd have a whole different opinion about this issue.

MR. HACKBARTH: Since we're already over, let me call an end to this. Obviously, we'll be coming back to it. So thank you, Dan and Ariel, for your work on this, and let's now turn to our public comment period.

And so, let me, as always, repeat the ground

rules. Please begin by identifying yourself and your organization. When the red light comes back on, that's the end of your time and please conclude swiftly. And, as always, I'll remind people that this isn't your only or your best opportunity to provide input to the Commission's work. The best opportunity is through the staff, but also letters to Commissioners or you can post comments on our website.

MS. HUANG: Thank you. Good morning. My name is Xiaoyi Huang. I'm with the National Association of Public Hospitals and Health Systems. NAPH represents approximately 200 safety net hospitals and health systems across the country that primarily care for the low-income, vulnerable, and other underserved populations. So in addition to primary care, our members provide the much needed specialty care to the vulnerable populations through their clinics.

And NAPH continues to be concerned with the potential consequences of these policy recommendations, especially as they relate to vulnerable populations' access to preventive, primary, and specialty care. With 2014 around the corner, these recommendations, if implemented, would hinder hospitals' efforts as they are trying to increase access to millions of patients. And safety net

hospitals, in particular, would be absorbing the impact of these cuts on top of existing and scheduled payment reductions and the ongoing costs of providing uncompensated care. For some, with their already low or negative margins, this may not be possible without reductions to service.

Thank you for the opportunity to comment.

MR. MYERS: Good morning, everyone. My name is Tom Myers. I'm General Counsel and Chief of Public Affairs for AIDS Healthcare Foundation. AHF is a nonprofit that, among other things, operates an AIDS C-SNP in Southern Florida and California. I think we're one of only two entities that provides such services.

I was very much concerned about the proposed elimination, clearly, of the C-SNPs. It seems to be throwing the baby out with the bath water. Most of the time, the debate and the discussion was over diabetes, which apparently affects up to 15 percent of all Medicare recipients. HIV affects less than one-tenth of one percent of Medicare beneficiaries. It simply isn't the scale or the number of people with HIV on Medicare to effectively fold them into the Medicare Advantage. There's no incentive for the Medicare Advantage plans to set up the quality and type

of care that the chronic care SNP does. The ability to design the provider networks to specifically meet the chronic condition, HIV experts, pulmonary care physicians, high-volume specialists with experience with HIV, how to do HIV, both HIV and heart, things like that, you know, the incentive simply is not there in the larger Medicare Advantage field.

So I haven't heard anything where doing this, eliminating the C-SNPs, would be a benefit or would help people who have HIV or AIDS and I would very much hope that the Commission would look at the various disease states and see which ones are perhaps worth keeping within the C-SNP program.

Thank you.

MS. MIHALICH-LEVIN: Good morning. My name is Lori Mihalich-Levin and I'm with the Association of American Medical Colleges. The AAMC appreciates this opportunity to speak to you about our ideas with respect to the Medicare payment differences across settings, and specifically, we have three recommendations for the Commission.

First, we strongly encourage MedPAC to release additional draft information to the public about the 71 APCs

that have been selected. Specifically, we urge you to provide a list of the 71 APCs as well as the detailed logic that was used to select those APCs so that we can provide informed feedback to the Commission in advance of any recommendations.

Second, while we do not believe that the Commission should move forward with these proposals, particularly given the lack of thorough analysis about each of the APCs that have been selected, we urge the Commission to revisit the idea of a stop-loss or a carve-out that actually protects access to ambulatory care services for needy populations. The stop-loss that the Commission recommended last year with respect to the E&M services did not sufficiently address these important access issues and would only have protected a very small number of hospitals, particularly in the very first year of the stop-loss. MedPAC could consider looking at factors including total outpatient revenue losses from proposed cuts and not just total losses, and whether, as Peter mentioned, the HOPD routinely accepts Medicaid patients.

Third and finally, the AAMC urges MedPAC to recommend to CMS that CMS collect better information on HOPD

clinics nationwide so that we all have more robust data to better understand the policy implications of making payment changes at the different sites of service.

Thank you for the opportunity to comment.

MS. CARLSON: Good morning. I'm Eileen Carlson from the American Nurses Association.

With respect to hospital outpatient departments, nursing costs are part of room and board in hospital and I don't think anybody directly reimburses those. So we are always concerned that any decrease in hospital payments are going to lead to cuts in nursing staff and we think it's very important that there's adequate and safe staffing for every patient in the hospital.

But also to lend a little bit of clinical viewpoint, I used to be a cardiac nurse in a hospital and did some care coordination and triage, and I have to say that I do think that clinics--in a cardiology clinic--clinics in hospitals that are located right there are--it's a different animal. I would schedule different patients to come to the hospital outpatient department versus other freestanding clinics, and some of those patients, we would watch until all hours of the night and admit them directly

when if they had gone to another freestanding clinic or outpatient facility, they would have had to go to the emergency room. So I think that's something that you all need to look at.

Thank you.

MS. WORZALA: Good morning. Chantal Worzala from the American Hospital Association.

I very much appreciate your robust discussion this morning about payment neutrality across ambulatory settings, or at least across two of them, hospital outpatient departments and physician offices. The AHA is extremely concerned with the proposal to expand your recommendations about pay equity across physician offices and hospital outpatients to additional services. We're concerned that, conceptually, these proposals do not account for the unique role of hospitals. This includes emergency response, stand-by capacity, complying with EMTALA, and meeting the Medicare conditions of participation. Physician offices do none of those.

And as an example of the unique emergency stand-by role of hospitals, we can certainly look at what is happening in the hospitals impacted by Hurricane Sandy. In

the midst of the devastation, hospitals have brought in extra staff, paid extensive overtime, supplemented their supplies and medications, and accepted large numbers of additional patients who were evacuated out of skilled nursing facilities.

I want to be very clear that hospitals do this gladly and as part of their mission. The point is that we, as a society, really need this kind of response capacity. And you did talk about paying for this directly. Funding for the Hospital Preparedness Program at the Federal level has declined by 12.5 percent between fiscal year 2010 and fiscal year 2012. Experience in the field is that these funds are very much appreciated, but they come nowhere close to meeting the costs of maintaining stand-by capacity and actually responding in the event of a disaster.

When it comes to the specifics of the policy and the recommendations, or the policies presented in the presentation today, I want to be clear that this policy would result in a negative 5.5 percent cut to hospital outpatient departments where there is already a negative 9.6 percent margin. That would imply a negative 15 percent margin, meaning that Medicare would pay 15 cents on the

dollar for care provided in all hospital outpatient departments, which does include the emergency department.

The impact on rural was shown to be higher in the slides, on average. You use 2010 data and the current policy of a rural hold harmless, but that does, by law, expire this year.

Maybe the underlying assumption from a policy should be looked at a little more closely. It seems to assume that the physician payment under Medicare is correct. We have hospital cost data. It's provided every year by hospitals as part of their overhead expenses. Physicians do not provide cost data to Medicare. So we have hospital cost data, but we don't have physician office cost data.

Also, the policy only addresses payments to hospitals and it doesn't consider adjusting the practice expense payment to physicians when they provide services outside their own office. This payment is in addition to the payment for the physician work and it's unclear why this is not considered by the Commission as it is part of the total payment that you're looking to equalize across settings.

On this topic, the Commission discussed last month

whether a hospital could charge a non-employed physician for the use of its facilities while also billing Medicare directly for the hospital's facility fee. Our legal team took a look at this and believes the practice would come close to double-billing and could raise fraud and abuse concerns, so that should not be considered a way to mitigate the impact on hospitals.

Finally, we'd ask MedPAC staff to provide the list of the specific APCs included in this analysis to the public.

Thank you for your attention. I appreciate the chance to comment.

MR. HACKBARTH: Okay. We are adjourned until December. Thank you very much.

[Whereupon, at 11:52 a.m., the meeting was adjourned.]